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Low Socioeconomic Status leading to Unsafe Abortion-Related Complications in Rural Sukkur, Pakistan: A Sociological Analysis

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Abstract

Complications from unsafe abortion continue to be an avoidable type of reproductive-health inequality in resource-poor settings. This piece translates the data of a PhD thesis from rural Sukkur, Sindh, Pakistan, into a journal article on the sociological understanding of the role of socioeconomic status, place of residence, availability of services, and knowledge about family planning on women's assessment of the safety of the abortion procedure. A cross-sectional study design surveyed 385 women from rural areas. A questionnaire was used and descriptive statistics, cross-tabulation and Pearson chi-square tests were applied. The outcome of interest was the safety level of the procedure, rated as safe, less safe, or definitely unsafe. The results reveal that 36.4% of participants considered it less safe and 32.7% definitely unsafe, compared to 30.9% who considered it safe. Family income per month was a significant predictor of the safety of the procedure, $\chi^2(8, N = 385) = 22.614$, $p = .004$. Place of residence was significant, $\chi^2(2, N = 385) = 33.188$, $p < .001$, with rural respondents more likely to be in the definitely unsafe category. Service availability showed the strongest association, $\chi^2(4, N = 385) = 51.706$, $p < .001$, and knowledge of modern family-planning methods was also significant, $\chi^2(4, N = 385) = 18.932$, $p < .001$. By contrast, educational status was not statistically significant, $\chi^2(12, N = 385) = 10.842$, $p = .542$. The article suggests that unsafe abortion pathways in rural Sukkur are not a matter of individual choice, but rather are shaped by poverty, lack of service provision, social embeddedness, delays in care-seeking, and limited conversion of family-planning knowledge into action. The results indicate a comprehensive approach to intervention, offering respectful post-abortion care, confidential counselling, strengthening of local services, transport and fee support and community-based stigma reduction.

Keywords: *unsafe abortion; post-abortion complications; socioeconomic status; rural Sukkur; reproductive health; family planning; stigma; women's autonomy; Pakistan*

1. Introduction

Unsafe abortion is a highly sociological public-health issue because harms are not equally distributed. While abortion is a reproductive-health event, the risk of it becoming unsafe is determined by women's social position, the cost and acceptability of services, the confidentiality of local health systems, and the power dynamics surrounding pregnancy decision-making. The evidence shows that abortion occurs in different settings with varying legal, religious and economic climates; the variability relates to the safety of the pathway to care (Bearak et al., 2020; Ganatra et al., 2017; World Health Organization [WHO], 2022).

Unsafe abortion is most evident in low- and middle-income countries, where poverty, rurality, lack of health-care providers, transportation issues, stigma and inadequate post-abortion care can turn a health-care event into a life-threatening risk. WHO's consolidated abortion-care guidelines highlight quality, safety, timeliness, affordability, non-discrimination, privacy and respect as the core principles of abortion care (WHO, 2022, 2025). These are not just clinical criteria, but also social criteria because they require health systems to see women as active agents, rather than passive recipients, of care.

Pakistan is a sociologically rich context in which to explore abortion complications. National data suggest high levels of unmet need for contraception, unintended pregnancy and demand for post-abortion care are significant issues in reproductive health (Sathar et al., 2014, 2025). In this environment, abortion itself may be officially concealed but its complications are publicly present in hospitals, clinics, pharmacies, homes and private health-care settings. The silence and the burden of complications make abortion an important sociological topic.

In this article we explore rural Sukkur in Sindh. Rural women are often subject to multiple constraints: low household income, lack of transport, decision-making power of household head, unequal access to formal health services, fear of stigma, and misinformation about contraception. These factors do not work in isolation. But they intersect and affect women's ability to avoid unintended pregnancy, seek timely information, see a qualified provider, recognize complications, and access timely post-abortion care. The research therefore treats complications associated with unsafe abortion not simply as medical events but the result of unequal social relations.

This article contributes to the sociology of reproductive health by analyzing survey data from 385 women to examine relationships between socioeconomic status, rural/urban residence, and education, access to health service, family-planning knowledge and abortion safety. The point is that unsafe abortion in rural Sukkur can be understood as a cumulative process of disadvantage: poverty limits options, rural residence increases travel time and distance, services shortfalls limit timely access, family-planning knowledge does not translate to contraceptive use, and women may be silenced by stigma or family control until complications are severe.

2. Literature Review and Conceptual Framing

Recent international research on abortion conceptualizes unsafe abortion as a structural health-equality problem. Bearak et al. (2020) estimated unintended pregnancy and abortion to be common across the spectrum of income and legality, showing that restrictive settings do not eliminate abortion. Ganatra et al. (2017) also demonstrated that many abortions are unsafe or least safe, and are concentrated in

developing countries. These analyses point to a simple sociological truism: abortion is universal, but its risk is social.

The second key concept is stigma. Hanschmidt et al. (2016) identified that women who undergo abortion face fear of social judgment, self-judgment and secrecy. Sorhaindo et al. (2022) added to this by demonstrating that stigma can impact the quality of abortion care through barriers in disclosure, judgment of providers, and seeking help. In rural areas, where there is little privacy and high levels of social monitoring, stigma can delay care and lead to the use of hidden channels.

Third, there's family planning. When women have knowledge of modern contraception but cannot access it due to partner opposition, false beliefs, cost and poor service availability and quality, knowledge is not enough. Pakistan's evidence has consistently shown unmet need for family planning to be associated with unintended pregnancy and abortion burden (Sathar et al., 2014, 2025). MacQuarrie and Aziz (2022) also emphasise that women's decision-making control over contraception is critical in Pakistan, suggesting the need to consider reproductive health in the context of gendered household dynamics.

The article is informed by three perspectives. The social determinants of health framework explains the role of income, place, education and access in health outcomes. The access-to-care perspective explains why services need to be accessible - reachable, affordable, acceptable, timely - for their formal availability to matter. The gender and power theory explains how family decision-making, partner and family permission, and stigma shape women's reproductive decision-making. These three perspectives enable unsafe abortion to be understood as a social phenomenon rather than simply a biomedical one.

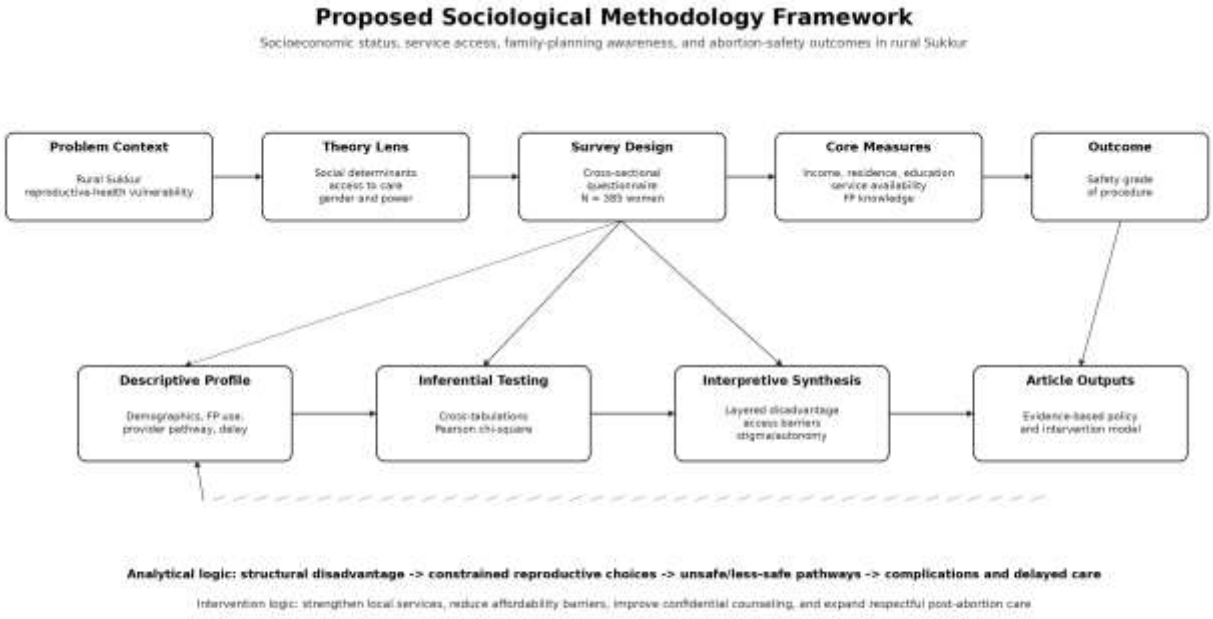

Figure 1. Proposed methodology and analytical framework for the article.

3. Methodology

3.1 Research design

This was a quantitative cross-sectional survey. This design was used because the aim was to determine the associations between socioeconomic and service-related factors and perception of the abortion procedure's level of safety at a single point in time. It also permitted the development of cross-tabulations and chi-square tests to test hypotheses.

3.2 Participants and setting

The study was carried out in some rural communities of Sukkur District, Sindh, Pakistan. The unit of study was the individual woman/respondent. A total of 385 cases were filled out. Inclusion criteria were that the person belonged to the selected rural areas, was in the appropriate reproductive age group, was willing to answer questions, and had completed the questionnaire.

3.3 Instrument and variables

The data were collected using a questionnaire. The outcome variable was the respondent's assessment of the procedure (safe, less safe and definitely unsafe). Independent variables for hypothesis testing were family income per month, place of residence, education, availability of services and awareness of modern family-planning methods. Other descriptive variables included age, marital status, number of living children, use of contraception at conception, partner approval, intention to have the pregnancy, gestational age, method, service provider, place of attempt, travel time, affordability, stigma, decision-making process, partner coercion, delay in seeking help, and type of facility.

3.4 Data analysis

We used frequencies, percentages, cross-tabulations and Pearson chi-square tests to analyze the data. A p-value less than .05 was considered significant. We used a chi-square test because the primary variables were categorical and we wanted to test whether distributions of procedure safety were equal across categories of the explanatory variables.

3.5 Ethical considerations

Given abortion is a sensitive reproductive-health issue, the research design needed to ensure voluntary responses, anonymity, non-loaded questions, privacy when administering the questionnaire, and non-judgmental attitudes when interacting with respondents. The article should include the name of the ethics approval committee, approval number and consent method used in the fieldwork of the thesis, if it is submitted for publication in a journal.

Table 1. Sociodemographic profile of respondents (N = 385).

Variable	Category	n	%
Marital status	Married	308	80.0
	Unmarried	49	12.7
	Other	28	7.3
Age group	16-20	31	8.1
	21-25	82	21.3
	26-30	121	31.4
	31-35	90	23.4
	36-40	43	11.2
	41-45	18	4.7

Monthly income	PKR 10,000-15,000	77	20.0
	PKR 16,000-20,000	69	17.9
	PKR 21,000-25,000	119	30.9
	PKR 26,000-30,000	74	19.2
	PKR 31,000+	46	11.9
Education	Uneducated	62	16.1
	Primary	55	14.3
	Secondary	47	12.2
	Matriculation	86	22.3
	Intermediate	61	15.8
	Graduate	49	12.7
	Postgraduate	25	6.5
Residence	Near to urban	43	11.0
	Rural	342	89.0

As Table 1 illustrates, the sample is mainly comprised of married women and those living in rural areas, as well as lower- and lower-middle-income categories. This is relevant because family structure, poverty and rural living are conditions that socially constrained reproductive-health decision making.

Table 2. Key reproductive-health, service-access, and care-seeking indicators.

Domain	Most relevant finding	n	%
Knowledge of modern family-planning methods	Yes	221	57.4
Family-planning use at conception	No	273	70.9
Partner approval regarding family planning	Disapprove	228	59.2
Pregnancy intention	No/unintended	207	53.8
Gestational age at termination/attempt	9-12 weeks	134	34.8
Method used	Medical pills	150	39.0
Provider/performer	Doctor	131	34.0
Place of abortion/first attempt	Private/NGO clinic	121	31.4
Travel time to service point	31-60 minutes	145	37.7
Economic feasibility	Low	265	68.8
Service availability	Poor	198	51.4
Availability of fee waiver/support	No	231	60.0
Severity of complication	Moderate	149	38.7
Delay in seeking care	3-5 days	132	34.3
Main decision-maker	Joint decision	121	31.4

Coercion/pressure during decision	Yes	181	47.0
Facility for complication care	Private	128	33.2
Safety grade of procedure	Less safe	140	36.4

Table 2 shows significant knowledge-gap. While 57.4% of the respondents knew about modern family-planning methods, 70.9% did not use any method during conception. The table also reveals poor partner support, low affordability, poor service accessibility, poor health care seeking, and considerable pressure in decision-making. These descriptive findings indicate that having knowledge does not translate into safer reproductive practices and outcomes when access, affordability and autonomy are constrained.

Table 3. Cross-tabulated distribution of procedure safety across selected predictors.

Predictor	Category	Safe n (%)	Less safe n (%)	Definitely unsafe n (%)	Total
Income	PKR 10,000-15,000	14 (18.2)	26 (33.8)	37 (48.1)	77
	PKR 16,000-20,000	18 (26.1)	24 (34.8)	27 (39.1)	69
	PKR 21,000-25,000	42 (35.3)	45 (37.8)	32 (26.9)	119
	PKR 26,000-30,000	29 (39.2)	28 (37.8)	17 (23.0)	74
	PKR 31,000+	16 (34.8)	17 (37.0)	13 (28.3)	46
Residence	Urban/near-urban	71 (42.0)	59 (34.9)	39 (23.1)	169
	Rural	48 (22.2)	81 (37.5)	87 (40.3)	216
Service availability	Good	35 (63.6)	14 (25.5)	6 (10.9)	55
	Average	49 (37.1)	52 (39.4)	31 (23.5)	132
	Poor	35 (17.7)	74 (37.4)	89 (44.9)	198
FP knowledge	Yes	79 (35.7)	87 (39.4)	55 (24.9)	221
	No	7 (16.7)	10 (23.8)	25 (59.5)	42
	Somewhat	33 (27.0)	43 (35.2)	46 (37.7)	122

A social gradient is evident in Table 3. Those in the lowest wealth categories, who live in rural areas, who report poor service availability and those with no knowledge of family planning are over-represented in the definitely unsafe category. This is particularly marked for service availability: 10.9% of respondents with good service availability in their areas reported definitely unsafe procedures, while 44.9% of those with poor service availability reported definitely unsafe procedures.

Table 4. Summary of Pearson chi-square tests.

Hypothesis	Variables tested	χ^2	df	p-value	Decision
H1	Monthly family income × safety of procedure	22.614	8	.004	Supported
H2	Residence × safety of procedure	33.188	2	< .001	Supported
H3	Education × safety of procedure	10.842	12	.542	Not supported
H4	Service availability × safety of procedure	51.706	4	< .001	Supported
H5	Knowledge of modern FP methods × safety of procedure	18.932	4	< .001	Supported

Table 4 shows that four of the five hypotheses were confirmed. Household income, place of residence, access to services and family-planning knowledge were significant. Education was not significant in this model, which implies that education might not be a safeguard when women are unable to make decisions about how many children to have due to financial hardship, lack of service availability, family pressure and stigma.

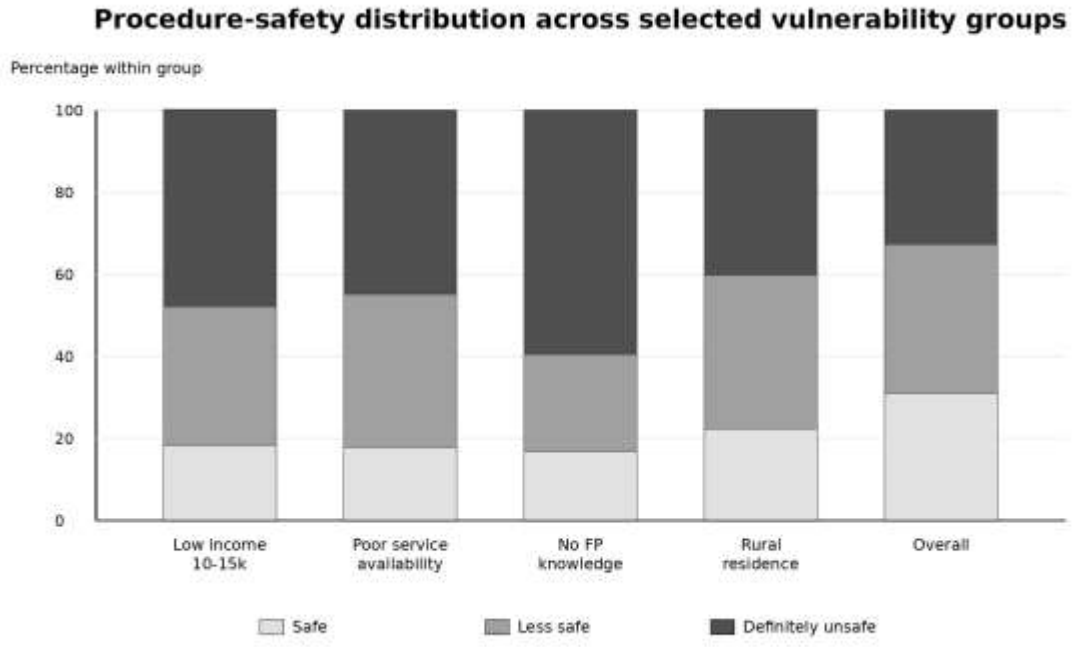

Figure 2. Procedure-safety distribution across selected vulnerability groups.**4. Results**

4.1 Respondent profile and social position

The social location of the respondents reveals a family- and rural-based population. A total of 80.0% of the sample were married women, and 89.0% were rural. Almost two-thirds of the sample had a monthly income of PKR 10,000-25,000. These characteristics demonstrate that the study is not addressing a theoretical group of women in reproductive health but a group whose behaviour is framed by dependence, mobility restrictions and service delivery constraints.

4.2 Knowledge of family planning and the prevention gap

The family planning findings show a prevention gap. Most women reported they knew about modern methods of family planning, but most were not using a method at the time they conceived. Further, 59.2% reported partner disapproval of family planning. This suggests that knowledge does not necessarily translate into use for women who don't have partner support, autonomy, effective counselling or access to methods.

4.3 Service availability, affordability and delay

Overall, service conditions were poor. Over half of the sample reported low service availability, 68.8% reported low economic feasibility and 60.0% reported that there was no fee waiver or financial assistance. Travel distance was also long, with 37.7% reporting 31-60 minutes and 33.8% reporting over

60 minutes for transportation to a service. These barriers directly affect the safety of abortion pathways because delays and lack of continuity of care are associated with abortion complications.

4.4 Safety of procedure and hypothesis testing

The distribution of the outcome indicated that only 30.9% of procedures were safe, while 36.4% were less safe and 32.7% definitely unsafe. The test statistic was highest for service availability, and then residence, income, and family-planning knowledge. This suggests that complications resulting from unsafe abortion are influenced by structural access to abortion rather than individual actions.

4.5 Null finding for education

The null finding for educational status is significant, not surprising. It may not be a protective factor in its own right in conditions where women still suffer from low affordability, low partner approval, stigma and low service availability. Education may enhance knowledge, but it cannot ensure confidential, affordable and respectful care.

5. Discussion

Our results are consistent with a multi-faceted disadvantage interpretation of unsafe abortion complications. Economic pressure, poor service access, gendered decision-making, and lack of family-planning action appear to shape women's abortion pathways in rural Sukkur. This finding is supported by global evidence that unsafe abortion occurs where women lack economic, geographical, social and health systems' support (Ganatra et al., 2017; WHO, 2022).

The strong income association suggests the safety of the procedure is partly dependent on the capacity to afford travel, consultation, medication, follow-up and emergency treatment. Low-income women may delay seeking care, rely on cheaper but less safe providers, or prematurely drop out of treatment. This is not a matter of choice. It is a manifestation of a choice-poor environment where impoverishment limits women's safe choices.

Geographic location was also important, with a greater proportion of definitely unsafe procedures among rural women. Rurality is not just a geographic distinction, it is a social condition, involving geographical distance, transport dependency, limited service provision, and lack of confidentiality and increased social control. These factors can force women into secretive or fragmented ways of accessing services, particularly in sensitive reproductive contexts.

The greatest association with procedure safety was with service availability. This is highly policy relevant. Poor services means women can go through pharmacies, informal providers, home-based attempts and/or private care with a delay before accessing a facility. Even if a method is medically safe, inadequate information, limited recognition of danger signs and no referral can transform the pathway into a dangerous one. This finding echoes WHO’s quality-of-care approach to abortion provision, which emphasises the need for care to be safe, accessible, acceptable, equitable and respectful (WHO, 2022, 2025).

The finding of a strong association between family-planning knowledge and procedure safety needs to be qualified. Knowledge is important but the descriptive findings reveal knowledge is no guarantee of contraception. Many women were aware of modern methods, but were not using any method at time of conception. The reason is partner, cultural, mythical, financial and accessibility factors. The finding thus favours an integrated approach to family planning where counselling is private, method options are wide, partner and community factors are tackled, and post-abortion counselling is offered with voluntary contraception.

The null education finding is sociologically meaningful. That education may be trumped by other factors in rural Sukkur. Women with education may still have trouble travelling, paying fees, negotiating sexual activity, and vocalising symptoms. This insight suggests that there are no simple answers, that education is not a panacea. But education needs to be coupled with access to services, women's autonomy, respectful treatment, and financial assistance.

Stigma and autonomy are also themes. The high agreement with statements about stigma, fear of blame, permission-seeking, and poverty suggests that complications related to abortion happen in a moral and social context. Women may not seek care when needed because sharing personal health information can be stigmatising. Stigma research demonstrates that fear, secrecy and judgement can impact help-seeking and quality of care (Hanschmidt et al., 2016; Sorhaindo et al., 2022).

The study therefore makes a contribution to sociology by demonstrating that complications from unsafe abortions cannot be explained by one factor. They occur in a chain: unintended pregnancy, limited family-planning practices, partner/family pressure, affordability, poor service availability, delay, service selection and post-abortion complications. This chain is preventable, but multiple levels of intervention are needed, not just individual counselling.

6. Policy and Practice Implications

Table 5. Practical intervention model emerging from the findings.

Area	Observed problem	Recommended response
Service availability	Poor local availability was strongly associated with unsafe procedure ratings.	Strengthen rural reproductive-health services, referral links, and respectful post-abortion care.
Affordability	Most respondents reported low economic feasibility and limited fee support.	Introduce transparent fee support, transport vouchers, and targeted subsidies for poor women.
Family planning	Knowledge did not translate into method use.	Provide confidential, women-centered contraceptive counseling linked with post-abortion care.
Gender and autonomy	Partner disapproval, permission-seeking, and pressure were visible in the dataset.	Develop culturally careful couple/community engagement without weakening women’s confidentiality.
Stigma	Fear of blame and judgment can delay care.	Train providers in non-judgmental counseling and strengthen privacy protections.
Data systems	Abortion-related complications are often hidden.	Build district-level monitoring of post-abortion care, delays, referral pathways, and complication severity.

7. Conclusion

This article shows the sociological patterning of unsafe-abortion complications in rural Sukkur. The most robust findings include the correlates of service availability, place of residence, income, and family-planning knowledge. While educational level has been identified as important in other research on

women's reproductive health, it was not significant in this data set, suggesting that structural and relational factors may mask individual differences in education in this case.

The results suggest a move from blaming interpretations to prevention. Women do not turn to unsafe abortion because of their poor choices. They do so when safe, affordable, confidential and respectful abortion is unavailable, or socially dangerous. So an integrated explanation - or Q1-level contribution - of this research is that unsafe abortion complications are the result of poverty, rural disadvantage, service gaps, low autonomy, stigma, and a knowledge-use gap in family planning.

Next steps are to validate these results with the original data, use multivariable models, and supplement the survey with in-depth interviews to explore the invisible decision-making that lies behind the survey responses. For policy, the take-home message is clear: rural reproductive-health systems must offer family-planning access, respectful post-abortion care, affordability support, privacy protection and stigma reduction. Such a holistic approach can prevent complications, enhance women's dignity, and prevent social harms.

8. Limitations

First, the design is cross-sectional, so the associations cannot be interpreted as causal. Second, abortion is a sensitive topic that could be subject to underreporting, recall bias or social desirability. Third, the statistical analysis is categorical chi-square testing and does not control for confounding; future editions should be based on logistic or multinomial regression. Fourth, the thesis chapter includes the term "simulated analysis"; the statistical tables should be verified against the original SPSS/ raw data before submitting the article for publication.

Overall, the dataset is a valuable sociological data set on the vulnerability to unsafe abortion in rural Sukkur, and can be a good starting point for a publishable paper after final verification, ethics review, and formating for the journal.

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