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Explaining the Reasons for Intentional Abortion in Iran: A Qualitative Content Analysis Study

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Abstract

Background

Intentional abortion is a complex reproductive health issue influenced by individual, family, economic, cultural, and legal factors. Despite national policies aimed at increasing fertility rates, there is a significant lack of in-depth, local qualitative data that explains the reasons for intentional abortion in smaller cities and rural areas such as Fasa County, Iran. This study protocol aimed to explain the reasons for intentional abortion in Fasa County, Iran, from the perspectives of women who have experienced it and healthcare providers.

Methods

This study employed a qualitative approach using conventional content analysis, guided by the Graneheim and Lundman method. The study was conducted in Fasa County, Iran, from Mach 2024 to March 2026. Participants included two groups: (a) married women aged 15–45 years with a history of intentional abortion and (b) healthcare providers (midwives, obstetricians and gynecologists) involved in women's reproductive health. Participants were selected using purposive sampling with maximum diversity. Data were collected through semi-structured in-depth interviews conducted in a private setting. Interviews continued until data saturation was reached. Data analysis included verbatim transcription, semantic unit identification, open coding, categorization, and theme development. Data validity was ensured using Lincoln and Guba criteria.

Results

Five main themes emerged from the data: (1) Inexorability of Non-Existence (encompassing economic hardship, lack of support, and family instability), (2) Secret Paths, Dangerous Destinations (including reliance on the internet, informal advice, underground clinics, and fear of stigma), (3) Enduring Harms (covering physical complications, psychological distress, and deep regret), (4) Missed Opportunities (highlighting lack of education and weakened religious beliefs), and (5) The Art of Preserving Dignity (emphasizing non-judgmental environments and respect for personhood).

Conclusion

Intentional abortion in Fasa County is driven by a confluence of economic despair, social isolation, inadequate education, and limited access to safe services. The hidden and illegal nature of these procedures exposes women to severe physical and psychological harms. Addressing this issue requires comprehensive reproductive health education, non-judgmental counseling, enhanced family support systems, and policy reforms aimed at reducing the socioeconomic vulnerabilities that drive women toward unsafe abortions.

1. Introduction

Abortion is one of the key issues in reproductive health, and it has consistently drawn attention across various dimensions medical, ethical, social, cultural, and legal. Broadly speaking, abortion refers to the termination of a pregnancy before the fetus reaches viability. It can occur either spontaneously (unintentionally) or intentionally (electively). Induced abortion happens when a pregnant individual decides to end their pregnancy for a variety of reasons. In this context, induced abortion is viewed differently across legal and ethical systems around the world, such that it is legal in some countries, while in others it is prohibited and criminalized.(1, 2)

Induced abortion is not only a health issue but also a sociocultural phenomenon, shaped by multiple factors including economic poverty, unwanted pregnancy, lack of sexual awareness and education, concerns about the child's future, family pressures, cultural beliefs, and legal restrictions. On the other hand, the declining fertility rate and the demographic crisis in the country have further underscored the importance of addressing the factors that contribute to induced abortion.(3, 4)

Globally, the World Health Organization (WHO) reports that Six out of 10 (61%) of all unintended pregnancies, and 3 out of 10 (29%) of all pregnancies, end in induced abortion. Globally, around 73 million induced abortions take place each year. However, nearly 1 out of 2 (45%) abortions are unsafe(5).

In Iran, under current laws, abortion is only permitted in specific cases and with the approval of forensic medicine and specialized committees; these include situations where continuing the pregnancy endangers the mother's physical or mental health, or where the fetus has severe and incurable abnormalities.(6, 7) Nevertheless, in recent years, there has been an increase in unreported and informal cases of induced abortion, often carried out illegally and outside the country's healthcare system. This issue carries dangerous consequences for maternal health, particularly in areas with limited access to healthcare services(8–10).

A lack of awareness regarding the causes and underlying factors of induced abortion poses a challenge to planning for prevention and delivering effective education in this area. Furthermore, the absence of local data will serve as an obstacle to developing effective, homegrown policies in the field of reproductive health and population(11). At the same time, a precise understanding of these causes can help develop effective intervention strategies to reduce high-risk abortions and improve reproductive health in society(12).

Fasa County, as one of the most populous regions in the south of the country, may face its own specific cultural, economic, and social trends and factors regarding induced abortion. Despite the growing importance of induced abortion at various levels of health policymaking, comprehensive studies based on field data concerning the causes and underlying factors of abortion in Fasa County are very limited or scarce. Most studies conducted in the country have

examined the legal, psychological, or social aspects of abortion in metropolitan areas, while locally focused data on smaller counties such as Fasa have received less attention.(13, 14)

The lack of a thorough and systematic investigation of this phenomenon in the study area may lead to the continuation of hidden abortions, increased physical risks for mothers, heightened psychological and social problems, and exacerbated inequalities in access to safe healthcare services. Furthermore, the absence of local data will serve as an obstacle to developing effective, homegrown policies in the field of reproductive health and population. On the other hand, in line with the country's macro-policies aimed at encouraging childbirth, addressing factors that reduce birth rates including induced abortion is both unavoidable and essential(15, 16).

Therefore, conducting a qualitative study with a content analysis approach in 2024 to 2026 aimed at explaining the reasons for induced abortion in Fasa County could be effective in filling this scientific gap. Using interviews with individuals who have experienced induced abortion as well as experts, this study will seek to gain a better understanding of the motivations, circumstances, and factors involved in the decision to have an induced abortion in this region. Furthermore, its findings can serve as a basis for decision-making by health, cultural, and social authorities to reduce the rate of illegal abortions and enhance public awareness.

2. Material and Methods

Study Design

This was a qualitative study that used the conventional (inductive) content analysis approach as described by Granheim and Lundman(17). This approach is appropriate when existing knowledge about a phenomenon is limited or scattered, allowing themes and categories to emerge directly from participants' narratives, rather than being imposed by a pre-existing theory.

Study Setting

The study was conducted in Fasa County, Fars Province, in southern Iran. Fasa is a representative sample of smaller cities and surrounding rural areas where access to specialized reproductive health services and social support may be limited. Data collection was conducted from Mach 2024 to March 2026 in Fasa with 7 interviews with woman who had experienced induced abortion referred to the public hospitals and clinics and 6 interviews with Key Informants. The qualitative approach has been chosen as a complement to quantitative assessments because fixed clinical measures are inadequate to explain the complexity of human experiences, particularly abortion (18). Among various types of qualitative research methods, content analysis has been used. The method we used for this study is conventional content analysis. Content analysis is a way of having an objective and shared understanding of a text’s verbal characteristics and deducing an author’s personal and social characteristics, ideas, and attitudes. Because of our versatility, the research can start with an open question and continue from there. We choose the next scenario based on the information gathered from the first one (19, 20). researchers have thoroughly reviewed and revised the text of the article following the latest COREQ-32. The COREQ is a 32-item checklist that is designed to help researchers report on their results. It is divided into three domains: research team and reflexivity (eight items), study design (15 items), and analysis and findings (nine items) (21).

Participant Selection (Sampling)

After obtaining the necessary sampling authorization, the researcher visited the Comprehensive Health Service Centres in Fasa County, and the phone numbers of individuals who had experienced induced abortion were extracted from each centre’s visitor list. The integrated health record system (SIB) was used at these centres. Pregnancy among unmarried women is uncommon in Islamic culture; thus, we do not have statistics on this topic. All interviews were carried out at the CHSC in Fasa, and the adjacent areas, and the setting was appropriate for qualitative research. Fasa has four urban and 16 rural comprehensive health centres. In qualitative research, the sample size is not statistically predetermined. Sampling continued until data saturation the point at which no new information or themes emerged from the interviews (22).

Sampling Method

Participants were selected using purposive sampling, and a maximum diversity strategy. This involved intentionally selecting individuals with diverse experiences based on: Age, Education, level, Socioeconomic status, Number of previous pregnancies/children, Location of residence (urban vs. rural) In addition, snowball sampling was used to identify women who had had an intentional abortion but were not registered in formal healthcare systems, given the sensitive and hidden nature of this behavior.

Inclusion Criteria

Group A (Women with a history of intentional abortion)

- Women aged 15-45 years.

- Married at the time of pregnancy.

- History of intentional abortion (self-reported) that occurred in Fasa County between Mach 2024 to March 2026.

- Willingness to share experiences.

- Ability to communicate effectively.

Group B (Healthcare providers

- Midwives working in health centers or hospitals.

- Obstetricians.

- Maternal health supervisors.

- Minimum 2 years of experience in reproductive health services it is generally believed that more experienced healthcare providers offer higher quality care (23).

- Willingness to share their perspectives.

Exclusion Criteria (for both groups)

- Unwillingness to participate.

- Inability to provide informed consent.

Data Collection

Data were collected through semi-structured, in-depth, individual interviews. Interviews were conducted in a private, quiet location chosen by the participant (such as a health center, home, or the researcher's office) to ensure the comfort and confidentiality of the information. Interviews began with a general, open-ended question, followed by probing questions to explore deeper meanings. Sample questions included: (Appendix 1)

-Can you tell me about your experience of a pregnancy that ended in an induced abortion?

-What factors influenced your decision to terminate the pregnancy?

-How did you learn about this procedure?

-How did your healthcare providers respond to your questions or concerns?

-How did you feel before and after the procedure?

-What support systems (or lack thereof) did you experience?

Each interview was audio-recorded (with permission). The researcher also used detailed note-taking during the interviews to ensure completeness of the data. Interviews lasted between 30 and 80 minutes (average 40 to 60 minutes). Field notes on nonverbal cues (e.g., tone, pauses, crying) were also documented.

Data Analysis

Data analysis was conducted simultaneously with data collection, following the conventional content analysis approach described by Granheim and Lundman(24).

First, each interview was transcribed verbatim into Persian as soon as possible after the interview Then, the researcher read the text several times to gain an understanding of the whole topic. At the same time, The text was divided into semantic units (words, sentences, or paragraphs related to the main concept) to identify semantic units. Next, each semantic unit was summarized and labeled with a code that captured its main content, and then the codes were compared and grouped Similar codes were grouped into subgroups and then broader categories based on common features. Finally, underlying themes were identified as expressions of latent content flowing through the categories. Data management was facilitated using MAXQDA software (version 2022).

Trustworthiness (Rigor)

To ensure the accuracy of this qualitative study, we applied four criteria of Lincoln and Guba(25).

For Credibility The researcher had long-term engagement with the data. Data were shared with participants to verify accuracy. Codes and themes were discussed with members of the research team who were not involved in data collection. For dependability An independent researcher reviewed the research process, including transcripts, codes, and notes. For Confirmability The research team used multiple data sources (women and providers). For Transferability also, The researcher used in-depth description (providing rich and detailed descriptions of participants, context, and findings so that readers can assess applicability to other settings) and sampling with maximum diversity.

Ethical Considerations

This study was conducted in accordance with the Declaration of Helsinki. The protocol was reviewed and approved by the Research Ethics Committee (REC) of Fasa University of Medical Sciences (Code: IR.FUMS.REC.1404.217). Key ethical measures include: Informed consent: Written informed consent was obtained from all participants after a full explanation of the purpose, methods, risks, and benefits of the study. Participants were informed of their right to

withdraw at any time without consequence. All identifying information was removed from the transcripts and replaced with pseudonyms or codes. Data will be stored securely and will only be accessible by the research team.

Clinical trial number: not applicable

3. Results

7 women who have experienced induced Abortion and 6 key Informants participated in this study. This study examined induced abortion experience among women. They had at least a 5th-grade education and mainly resided in towns or villages. all participants had experienced pregnancy and delivery. Interviews with 6 healthcare providers revealed diverse backgrounds and experiences dedicated to improving maternal health. (Tables 1) and (Tables 2) show the demographic characteristics of the participants.

The findings from the interview analysis revealed hidden narratives of induced abortion across five main themes: Inexorability of Non-Existence, Secret Paths, Dangerous Destinations, Enduring Harms, Missed Opportunities, and The Art of Preserving Dignity.(Tables 3) These themes show that for these participants, induced abortion was not merely an individual decision but a chain of socioeconomic pressures, lack of support, incomplete information, and multiple physical and psychological consequences all of which remain hidden in the shadow of social stigma.

Hidden Narratives of Induced Abortion

The findings from the interview analysis revealed hidden narratives of induced abortion across five main themes: "Inexorability of Non-Existence," "Secret Paths, Dangerous Destinations," "Enduring Harms," "Missed Opportunities," and "The Art of Preserving Dignity." These themes show that for these participants, induced abortion was not merely an individual decision but a chain of socioeconomic pressures, lack of support, incomplete information, and multiple physical and psychological consequences all of which remain hidden in the shadow of social stigma.

Inexorability of non-existence

Inexorability of non-existence is one of the core themes in the hidden narratives of induced abortion. Economic hardship, alone in the Crowd, and A Home Without Peace constitute the subthemes of this main category.

- Economic Hardship

Both participants and key informants spoke of economic hardship how families begin and end each day with a specific financial threat, seeing no horizon for escaping this cycle. This daily grind is not merely a financial situation; it has become an inability to think about the future, where childbearing has turned into a luxury cost an impossibility. By eliminating the expenses of a new child, individuals are actually trying to preserve the bare minimum of survival for themselves and their existing children, not simply shirking responsibility.

<u>The daily grind of installments and debt</u>

"I couldn't afford a child's expenses; I had no source of income… With these prices, we can barely buy groceries" (Participant 4)

"With high inflation, most people cite financial issues as the reason for not wanting a child" (Key Informant 6)

- Alone in the Crowd

A significant theme raised by both participants and key informants was the feeling of loneliness despite being among people a lack of emotional support they described as more bitter than the abortion decision itself. This lack of support most often pointed to the absence of emotional partnership from a spouse, leaving participants unable to share the complexity of their decision with them. Often, participants are forced to carry the full weight of their choice entirely on their own shoulders.

<u>Lack of support</u>

"I'm tired of the kids, no one is there to help me… Everyone first thinks about their relationship with their spouse and support" (Participant 5)

"If the man of the family isn't supportive, no advice will make a difference" (Key Informant 4)

- A Home Without Peace

Another theme that emerged in the interviews was the experience of a home without peace—a place that erodes one's sense of psychological security on a daily basis. In such an environment, abortion is interpreted as a means of escaping further turmoil; a flight not born of disregard for the value of life, but of an inability to endure an ongoing daily crisis. This decision, more than being a conscious choice, is a helpless response to an environment that, day by day, piece by piece, strips away one's capacity to live and drags them, in absolute solitude, to a dead end with no way out.

<u>Family problems</u>

"I was having problems with my husband… What's a child supposed to do with a mother who wants a divorce?" (Participant 6)

"Addicted spouse, domestic violence… A woman whose husband beats her—with what hope is she supposed to continue a pregnancy?" (Key Informant 5)

Secret Paths, Dangerous Destinations

Secret Paths, Dangerous Destinations is another core theme in the hidden narratives of induced abortion. Dr. Google, Neighbor's Prescriptions, Underground Clinics, and Fear of Judgment form the subthemes of this main category.

- Dr. Google

In the interviews, various sources of information were discussed, with Google emerging as a source for participants who lacked the courage to see a doctor. Despite its unreliability, this path becomes the only open window for information, and many take action based on these searches engaging in self-treatment. In other words, the internet functions as a free but high-risk doctor, bearing no responsibility for the consequences of its advice.

Information from the internet

"I searched online because I couldn't ask anyone… I was afraid someone would find out" (Participants 5 & 3)

"Information from cyberspace is the only source for many women" (Key Informant 6)

- Neighbor's Prescriptions

Findings showed that participants turned to people with no medical expertise but who, because of similar personal experiences, became their primary source of consultation. This local information is accepted not out of real trust, but out of sheer desperation due to lack of access to a physician.

Information from acquaintances

"My friend told me if I lifted something heavy, I'd miscarry… I got help from herbalists and neighbors" (Participants 4, 6 & 2)

"Most consultations are provided by relatives and neighbors, and friends' experiences have a tremendous impact" (Key Informants 2 & 6)

- Underground Clinics

Interviews referred to underground clinics as dangerous destinations, typically involving cash payments without receipts and confidential phone appointments. Beyond the physical risk, a pact of silence is sealed between the individual and the provider, making any follow-up impossible.

Unreliable channels

"I asked a medical supply shop and used suppositories at home… The shopkeeper told me what to do" (Participants 3 & 5)

"These days, medical supply shops have replaced doctors and unfortunately, they both dispense and prescribe medication" (Key Informants 1 & 2)

- Fear of Judgment

Both participants and key informants spoke about the fear of social stigma. People fear the judgmental gaze of others a gaze that lingers not just at the time of the abortion but for years afterward in their memory, cutting deeper than any physical wound. To protect their reputation, individuals are forced to risk their health, and this is the greatest cost of social stigma.

Social stigma

"I couldn't ask anyone, in case they judged me… What would my family think if they found out?" (Participants 5 & 3)

"Pregnancy during engagement is a social taboo, and fear of judgment is the biggest barrier to formal medical consultation" (Key Informants 1 & 6)

Enduring Harms

Enduring Harms is another core theme in the hidden narratives of induced abortion. Ailing Body, Restless Soul, and Deep Regret form the subthemes of this main category.

- Ailing Body

Physical complications from induced abortion emerged as a major concern raised by both groups—complications that persist for years after the abortion and overshadow daily life. These complications are described as more severe and treatment-resistant, especially among those who used unreliable methods. Individuals are forced to make repeated medical visits to treat complications, making the healing process lengthy, costly, and exhausting.

Physical complications

"After the abortion, I became weak, I passed out from heavy bleeding… I had severe stomach and back pain for a long time… I became anemic from the curettage" (Participants 1, 4, 7 & 3)

"Severe bleeding, infection, anemia, and even infertility are common complications; abortion at home multiplies the risk of death" (Key Informants 3 & 6)

- Restless Soul

Psychological issues were raised as an inescapable and hidden consequence of induced abortion. This emotional restlessness often manifested as sudden emotional outbursts or a feeling of emptiness, and typically accompanied the individual for many years.

Psychological complications

"After the abortion, I fell into depression, I cried, I lost all motivation… Guilt stayed with me for a long time" (Participants 4, 5, 6 & 2)

"Most women experience depression and a sense of emptiness after an abortion, and those who went against our advice always feel a sense of lack" (Key Informants 5 & 6)

- Deep Regret

Both participants and key informants spoke of regret so profound it was as though the word "if only" screamed from within them a silent, unanswered cry echoing in their inner void. This deep-rooted regret plunges them into chronic depression and endless obsessive thoughts; a cycle from which they find no escape, growing more trapped each day in the repetition of a memory they cannot change.

If only I hadn't done it

"If only I'd had an ultrasound, I would have known it was twins—maybe I would have changed my mind… If I could go back, I wouldn't do it" (Participants 2, 3, 4 & 5)

"Most come when it's already too late and they're full of regret; financial regret is the most common of all" (Key Informants 1, 3 & 5)

Missed Opportunities

Missed Opportunities is another core theme in the hidden narratives of induced abortion. Lost Prevention and Forgotten Boundaries constitute the subthemes of this main category.

- Lost Prevention

Knowledge has always played a decisive role in people's decision-making power. Both participants and key informants spoke of a deep knowledge gap rooted in unfamiliarity with effective prevention methods and incomplete information an educational blind spot from which unwanted pregnancy directly originates.

Lack of education

"They let us get to this point; in health centers, they said we're not allowed to teach prevention" (Participants 5 & 3)

"Teaching prevention isn't a sin—abortion is. If we don't educate and illegal abortions happen, we are to blame" (Key Informants 1 & 2)

- Forgotten Boundaries

What stood out most in the narratives was the weakening of religious beliefs at the moment of decision-making. Both participants and key informants admitted that the deterrent boundaries of faith were absent from their minds at that critical moment. This absence is not rooted in irreligion but is a product of the fast pace of urban life a city that pushes beliefs to the margins amidst the noise of daily struggles. Yet after the abortion, it is this spiritual regret that, in participants' own words, adds a fresh layer of injury to existing physical and psychological wounds, making the path to healing considerably harder.

Weakness of religious beliefs

"I feel guilty, I wouldn't recommend anyone do this… Depression and regret stayed with me for a long time" (Participants 4, 3 & 5)

"We tell women this is religiously forbidden; if we feel it makes a difference, we definitely discuss its religious prohibition" (Key Informants 1, 2 & 3)

The Art of Preserving Dignity

The Art of Preserving Dignity is another core theme in the hidden narratives of induced abortion. A Non-Judgmental Environment and Respect for Personhood constitute the subthemes of this main category.

- A Non-Judgmental Environment

One of the most valuable experiences emphasized by both participants and key informants is the safe space for dialogue a space where the individual is seen as an autonomous human being, not a wayward mother. According to this group, the most satisfying aspect of such a space was the ability to speak openly and without judgment about abortion-related issues an environment that freed them from the burden of blame and allowed them to tell their story without fear.

Building trust

"The staff treated me well, even though they knew why I'd come… Even though they discouraged me, I could still count on them" (Participants 1, 4, 5 & 7)

"Maintaining privacy and refraining from judgment is the fundamental principle of counseling; without trust, a woman will go elsewhere" (Key Informants 1 & 2)

- Respect for Personhood

Both participants and key informants cited respect as the most prominent marker of preserving dignity. This preservation of dignity transcends any validation or rejection of the decision itself meaning that regardless of others' judgments about the rightness or wrongness of the abortion, the individual is still regarded as a worthy and respected person. Participants believe that respect shown by medical staff, family, or counselors helps them.

Showing respect

"Even though I was angry and spoke harshly, they still treated me with respect… They referred me to a specialist their behavior was excellent" (Participants 3, 6, 2 & 7)

"Our job is to treat, not to judge; neutrality and respect prevent dangerous actions" (Key Informants 4, 6& 5)

4. Discussion

This qualitative study explored the multifaceted reasons for intentional abortion in Fasa County, Iran, revealing a complex interplay of socioeconomic pressures, informational voids, psychological burdens, and systemic gaps. The five emerged themes Inexorability of Non-Existence, Secret Paths, Dangerous Destinations, Enduring Harms, Missed Opportunities, and The Art of Preserving Dignity collectively illustrate that abortion in this context is not merely a personal choice but a reactive decision driven by a confluence of structural and social vulnerabilities. Our findings both corroborate and expand upon the existing literature on abortion in Iran and similar socio-cultural settings.

The theme of Inexorability of Non-Existence strongly aligns with previous research identifying economic hardship and lack of spousal support as primary drivers of induced abortion in Iran (3, 4). However, our study provides a deeper, localized nuance by emphasizing the concept of "daily grind" and "a home without peace." For participants in Fasa, financial instability was not an abstract concern but an omnipresent reality that eroded their capacity to envision a future for another child. This finding resonates with studies from other developing countries where poverty creates a "rationale for termination" (15). The profound sense of being "alone in the crowd," exacerbated by an unsupportive spouse, highlights a critical gap in the Iranian family support structure, particularly in smaller cities where social safety nets may be weaker. Our findings extend the work of Alijanzadeh (2024)(12). who identified economic factors as central to abortion decisions in Lorestan province, but we add the dimension of "inescapability "participants did not view their financial situation as temporary but as a permanent condition. This perceived permanence transforms abortion from a difficult choice into a necessary survival strategy. The presence of domestic violence and marital discord as underlying factors further complicates the narrative, suggesting that abortion may serve as an escape mechanism from toxic environments, a finding consistent with studies on reproductive coercion and intimate partner violence(26). A particularly alarming finding was the theme of Secret Paths, Dangerous Destinations. The reliance on "Dr. Google," "neighbor's prescriptions," and "underground clinics" reveals a significant breakdown in the formal healthcare system's accessibility and trustworthiness. This is consistent with the global concern over unsafe abortions (27), but our findings detail the specific pathways in a semi-urban Iranian context. The "pact of silence" and cash payments underscore the complete isolation of these women from evidence-based care.

The pervasive "fear of judgment" acts as the primary gatekeeper, preventing women from seeking legitimate medical advice. This is a direct consequence of the strong social stigma surrounding abortion in a religious and traditional society (8) and is a major contributor to the high rate of unreported illegal abortions in Iran (28). Our study reveals that this fear is not merely about social ostracism but about the internalized shame that persists long after the procedure. Women described making decisions based on information from "medical supply shops" and "herbalists" sources completely outside the formal healthcare system. This finding echoes the work of Haddadi et al. (2025), who noted the divergence between medical students' attitudes and existing legal frameworks, suggesting that even within the healthcare system, there is a lack of consensus on how to address women's reproductive needs. The reliance on informal information sources points to a critical gap in health communication. Participants did not lack access to information per se; rather, they lacked access to trusted, confidential, and non-judgmental information. This suggests that simply providing more information is insufficient; the healthcare system must also address the barriers of stigma and fear that prevent women from seeking help. The role of "cyberspace" as a primary source is particularly concerning, as it exposes women to misinformation and potentially dangerous self-treatment methods, a phenomenon observed in other studies on reproductive health in restricted settings(15)

The Enduring Harms reported by participants both physical ("ailing body") and psychological ("restless soul") are a stark testament to the consequences of unsafe abortion. The severe complications, including hemorrhage, anemia, and infertility, mirror global data on the dangers of clandestine procedures(9) . However, the "deep regret" expressed by many women adds a crucial emotional dimension not always captured in quantitative studies. This regret, often tied to "what if" scenarios, suggests that many women may not be fully informed about the risks or their own emotional resilience. This finding challenges the simplistic binary of 'pro-choice' vs. 'pro-life' and instead reveals a narrative of constrained choices where regret is a common, albeit silent, outcome. The psychological consequences described by participants depression, emptiness, guilt are consistent with the findings of Akbarzadeh (2015)(10) in Shiraz, but our study provides a more nuanced understanding of how these psychological harms interact with physical complications. Women described feeling "trapped" in a cycle of regret, where the physical reminder of the abortion (e.g., infertility, chronic pain) constantly triggers psychological distress. This interplay between physical and psychological harm is often overlooked in reproductive health research, which tends to treat these domains separately. The fact that both women and providers reported that "financial regret is the most common of all" is particularly telling. This suggests that even when women make the decision to abort, they are often left with a sense of economic desperation that the abortion itself did not resolve. This challenges the assumption that abortion is a solution to poverty; instead, it may simply replace one form of suffering with another. The chronic nature of these harms spanning years after the procedure indicates that the healthcare system must be prepared to provide long-term support for women who have undergone unsafe abortions, rather than treating the event as an isolated incident.

The Missed Opportunities theme directly points to a systemic failure in primary prevention. The lack of comprehensive education on contraception and family planning, as voiced by both women and providers, is a critical gap. The providers' statement that "teaching prevention isn't a sin" highlights a tension between national pronatalist policies and the practical needs of women to avoid unintended pregnancies. This aligns with the paradox in Iran where reproductive health education is limited despite a high prevalence of abortion(6). Furthermore, the "forgotten boundaries" of religious belief indicate that while religiosity is a strong social and cultural norm, it is often overshadowed in moments of acute crisis, and the subsequent spiritual regret only compounds the trauma. The finding that providers themselves acknowledge the paradox where they are unable to teach prevention but are expected to prevent abortions reveals a fundamental contradiction in health policy. This contradiction places both providers and women in an impossible position: providers are constrained by legal and institutional mandates, while women are left without the tools to prevent unwanted pregnancies. The result is a situation where "illegal abortions happen" and "we are to blame," as one provider stated. This institutionalized silence around prevention represents a missed opportunity that directly contributes to the rates of unsafe abortion. The weakening of religious beliefs at the moment of decision-making is a complex finding. On one hand, it suggests that religious prohibitions are not as absolute as social norms might suggest; in moments of extreme crisis, practical considerations may override moral or religious frameworks. On the other hand, the subsequent spiritual regret indicates that these beliefs are not absent but are suppressed, and their re-emergence after the fact creates an additional layer of suffering. This suggests that interventions should not simply reinforce religious prohibitions but should address the underlying crisis that leads women to violate these prohibitions. This nuance is critical for developing culturally sensitive interventions that respect women's religious values while also addressing their practical needs.

Finally, the theme of The Art of Preserving Dignity offers a positive and actionable insight. It shows that despite the legal and moral complexities; healthcare providers have a powerful role in mitigating harm. A non-judgmental environment and respect for personhood were identified as crucial factors that could build trust and potentially guide women toward safer paths. This supports the WHO's recommendations on person-centered care and underscores the need for counseling that emphasizes empathy, not condemnation (26). The issues raised including economic hardships, marital relationship problems, reproductive health concerns, and cultural factors were the most frequently cited reasons for unsafe abortion in the literature. Health-related issues, such as unintended pregnancies and fear of cultural stigmatization, also played a significant role. Women's experiences in this context are shaped by a complex interplay of individual, social, and cultural factors. These findings illuminate the multifaceted determinants of unsafe abortion in Iran following the implementation of pro-natalist policy shifts. By adopting targeted strategies informed by these insights, policymakers and stakeholders can work to reduce the prevalence of unsafe abortion practices and promote women's health and well-being(28, 29).

The finding that women valued "respect" and a "non-judgmental environment" even when providers discouraged the abortion is significant. It demonstrates that women are not seeking validation of their decision but rather a space where they can be heard without fear. This suggests that the role of the provider is not to judge or to enforce moral compliance but to ensure that women are as safe as possible, given their circumstances. The providers' statement that "our job is to treat, not to judge" reflects a professional ethic that is often at odds with the legal and social environment. This theme also highlights the importance of interpersonal dynamics in the healthcare encounter. Women described being able to "count on" providers even when those providers were discouraging the procedure. This suggests that trust is not contingent on the provider's agreement with the woman's decision but on the provider's commitment to the woman's well-being. This finding has significant implications for training healthcare providers in communication and counseling skills. It suggests that providers can be effective in harm reduction even when they cannot condone the abortion itself, by ensuring that women have access to accurate information, follow-up care, and a non-judgmental space to process their decisions.

Strengths and Limitations

The main strength of this study is its in-depth qualitative design, which captures the lived experiences of a hidden, vulnerable population in a small county through rigorous methodology. Maximum diversity sampling and data triangulation from women and providers enhanced credibility and comprehensiveness. Rich narrative data revealed complex interactions among socioeconomic, psychological, and systemic factors shaping abortion decisions insights unattainable through quantitative methods alone. However, several limitations must be acknowledged. The findings are context-specific to Fasa County and may not be generalizable to other regions. Reliance on self-reporting for a stigmatized behavior may introduce recall and social desirability bias. The study did not include direct observation of patient-provider interactions, nor did it incorporate perspectives from men, religious leaders, or policymakers. Moreover, the sensitive nature of the topic may have deterred women with the most traumatic experiences from participating. Despite these limitations, this study offers valuable insights into the drivers of intentional abortion in a resource-limited, semi-urban Iranian setting, and provides a foundation for developing culturally sensitive, context-specific interventions to reduce the harms of unsafe abortion and improve women's reproductive health.

5. Conclusion

This study provides a rich and detailed understanding of the reasons for intentional abortion in Fasa County, revealing that it is a deeply contextual and multidimensional phenomenon. The findings demonstrate that women's decisions are not made in a vacuum but are shaped by an overwhelming combination of economic despair, social isolation, and systemic failures in education and healthcare access. The hidden and illegal nature of these procedures exposes women to severe and lasting physical and psychological harms, reinforcing a cycle of suffering and regret.

Declarations

Use of Artificial Intelligence

During the preparation of this manuscript, the authors utilized ChatGPT-4 (OpenAI) as a writing assistant for language editing, grammar refinement, and initial structural organization of the discussion section. All AI-generated content was critically reviewed, substantially revised, and contextualized by the authors to ensure alignment with the original interview data, local cultural nuances, and the interpretive framework of the study. All authors take full responsibility for

the accuracy, integrity, and scientific validity of the final manuscript. No artificial intelligence tools were used for data collection, data analysis, coding, theme development, or the generation of tables and figures.

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Conflict of Interest

The authors declare that they have no competing interests. All authors have reviewed and approved the final manuscript and agree to its submission to this journal.

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Data Availability Statement

The datasets generated and/or analyzed during the current study are not publicly available due to the sensitive and confidential nature of the interview data, which contain potentially identifiable information. However, anonymized data may be available from the corresponding author upon reasonable request and with the approval of the Research Ethics Committee of Fasa University of Medical Sciences.

Authors' Contributions

FN and SS designed the study and conducted the research. FN, LB, and SS monitored, evaluated, and analysed the study results. Further, FN, LB Reviewed the article. All authors approved the final manuscript and take responsibility for the integrity of the data.

Consent to Participate in the manuscript

All authors expressed their consent to participate in the manuscript.

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Tables

Table 1. Demographic Characteristics of Mothers Who Have Experienced Induced Abortion

No.	Age	Education	Residence	Age at Marriage	Delivery Type	Marriage Duration (years)	Gravidity	Number of Living Children	Spouse's Age	Spouse's Education	Spouse's Occupation	Financial Status
1	20	6th	Urban	14	NVD	5	G2L1Ab0	1	32	6th	SE	Good
2	25	6th	Rural	16	NVD	9	G3L2Ab1	2	40	BS	E	Moderate
3	44	BS	Urban	35	C/S	9	G5L3Ab2	3	45	5th	U	Poor
4	35	BA	Rural	20	NVD	15	G3L2Ab1	2	40	5th	U	Poor
5	32	BS	Urban	16	NVD	16	G5L2Ab3	2	34	BA	SE	Good
6	20	BA	Urban	15	C/S	5	G3L2Ab1	2	31	BA	SE	Moderate
7	24	5th	Rural	20	NVD	4	G2L1Ab1	1	26	BS	E	Moderat

NVD: Natural vaginal delivery, C/S: Caesarean section delivery, BA: bachelor of art, BS: Bachelor of Science, SE: Self-Employed, E: Employee, U: Unemployed

Table 2. Demographic Characteristics of Key Informants

Number	Position	Education	Years of Experience	City
1	Maternity Ward Supervisor	BS	15 years	Fasa
2	Head of Midwifery Department	BS	16 years	Fasa
3	Gynecologist – Department Chair	OB/GYN	28 years	Fasa
4	Lead Specialist for High-Risk Mothers	MSC	25 years	Fasa
5	Faculty member in Reproductive and Sexual Health	PhD	13 years	Fasa
6	Lead Specialist for Maternal Health	MSC	18 years	Fasa

BS: Bachelor of Science, PhD: Philosophy of doctoral, OB/GYN: Obstetrician and gynecologist, MSC: Master of Science

Table 3: Themes, Main Categories, and Sub-Categories extracted from qualitative data analysis

Theme	Main Categories	Subcategories	Meaning Units
Hidden Narratives of Induced Abortion	**Inexorability of non-existence**	Economic Hardship	The daily grind of installments and debt
		Alone in the Crowd	Lack of support
		A Home Without Peace	Family problems
	Secret Paths, Dangerous Destinations	Dr. Google	Information from the internet
		Neighbor's Prescriptions	Information from acquaintances
		Underground Clinics	Unreliable channels
		Fear of Judgment	Social stigma
	Enduring Harms	Ailing Body	Physical complications
		Restless Soul	Psychological complications
		Deep Regret	"If only I hadn't done it"
	Missed Opportunities	Lost Prevention	Lack of education
		Forgotten Boundaries	Weakness of religious beliefs
	The Art of Preserving Dignity	A Non-Judgmental Environment	Building trust
		Respect for Personhood	Showing respect

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