

Navigating Crisis Pregnancies in Southeast Iran: A Qualitative Study of Factors Influencing Intentions for Induced Abortion and Subsequent Withdrawal

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ABSTRACT

Introduction: Although induced abortion is legally restricted in Iran, unintended pregnancies pose complex reproductive dilemmas. Research has focused mainly on central urban centers, leaving decision-making dynamics in disadvantaged border regions under-researched, particularly among women who consider abortion but ultimately decide against it. This study explored factors influencing abortion intentions and subsequent withdrawal among women attending NAFAS counseling centers in Iranshahr, southeastern Iran.

Methods: This qualitative study utilized conventional content analysis. Thirty-one women who experienced an unintended pregnancy, seriously considered abortion, but withdrew to continue the pregnancy were purposively recruited from NAFAS centers affiliated with Iranshahr University of Medical Sciences. Data were collected via in-depth, semi-structured interviews until data saturation was achieved, and analyzed following Graneheim and Lundman's approach. Trustworthiness was ensured via peer debriefing and member checking.

Results: Participants' mean age was 31.2 years (77.4% had ≥ 3 pregnancies). Five themes drove initial abortion considerations: (1) reproductive burden and physical exhaustion, (2) severe economic vulnerability, (3) fear from prior adverse obstetric experiences, (4) life-stage inappropriateness, and (5) perceived inability to provide adequate care. Conversely, withdrawal from abortion was facilitated by four themes: (a) emerging maternal-fetal attachment, (b) perceived support from NAFAS counseling, spousal and family encouragement, and (d) religious beliefs framed around divine will (Razā) and blessing (Barakah).

Conclusion: In southeastern Iran, abortion ambivalence reflects a dynamic tension between acute socioeconomic constraints and protective psychosocial and faith-based buffers. Context-tailored reproductive healthcare integrating poverty alleviation, accessible family planning, and culturally anchored, non-judgmental counseling is essential.

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Introduction

Induced abortion remains one of the most complex and ethically charged issues in reproductive health worldwide. Globally, an estimated 121 million unintended pregnancies occurred annually between 2015 and 2019, with approximately 61% ending in

induced abortion (1). While improvements in contraceptive access have reduced rates in some settings, unintended pregnancy continues to be a significant public health concern, particularly in regions with restrictive abortion laws (2, 3).

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Decisions surrounding abortion are rarely determined by a single factor (4). A substantial body of international evidence has identified a constellation of interrelated determinants, including severe financial constraints, relationship instability or intimate partner violence, women's educational and professional aspirations, concerns about maternal health, perceived inadequate social support, and existing family responsibilities (5-7). These factors do not operate in isolation but interact dynamically within broader sociocultural and economic contexts (8, 9).

In Iran, induced abortion is legally permissible only under specific, narrowly defined medical conditions, including a threat to the mother's life or fetal anomalies (10). Despite these legal restrictions, evidence from Iranian studies suggests that induced abortions continue to occur, frequently performed unsafely outside the formal healthcare system (11-13). A seminal qualitative study in Tehran by Razeghi Nasrabad and Sanjari (2017) found that decisions to abort are often the result of a rational cost-benefit analysis, where the perceived costs of continuing an unwanted pregnancy such as economic pressure, low male participation in childcare, and social insecurity outweigh the costs of abortion (14). Other research has highlighted the persistent role of stigma, fear of judgment, and the moral weight of religious beliefs (12, 15).

However, most existing Iranian research has been conducted in major urban centers like Tehran, Rasht, and Isfahan, leaving a critical knowledge gap regarding reproductive decision-making in the country's most socioeconomically disadvantaged and culturally distinct regions. Sistan and Baluchestan Province, particularly its capital Iranshahr, presents a uniquely challenging context. The province consistently ranks lowest in Iran on human development indices, with higher fertility rates (averaging 3.8 children per woman compared to the national average of 1.7), higher rates of absolute poverty, lower female educational attainment, and significant geographical barriers to specialized healthcare (16). These conditions may profoundly shape women's experiences and calculations regarding an unintended pregnancy in ways not yet documented.

Sistan and Baluchestan Province, particularly its capital Iranshahr, presents a uniquely challenging context. The province consistently ranks lowest among Iranian provinces on human development indices, with a Human Development Index (HDI) of 0.694 in 2023 substantially below the national average of 0.799 (17). It has one of the highest fertility rates in the country, with higher rates of adolescent and child marriage (18). The province also experiences the highest poverty rates nationally, with approximately 65% of its population living below the poverty line, higher unemployment rates recorded at 12.4% in 2023-2024 compared to the national average of 8.1% lower female educational attainment, and significant geographical barriers to specialized healthcare (19-21). These

conditions may profoundly shape women's experiences and calculations regarding an unintended pregnancy in ways not yet documented.

In response to the needs of women with crisis pregnancies, recent initiatives have established "NAFAS" (a Persian acronym for "Consultation and Support for Women") centers. These centers aim to provide counseling and support to discourage abortion and promote continued pregnancy. However, there is a lack of evidence regarding the experiences of women who, despite initially considering abortion, ultimately decide to continue their pregnancy after receiving support. Understanding these "withdrawal from abortion" experiences is crucial, as it can illuminate the protective factors that can be strengthened by interventions. Therefore, this study aimed to explore, in depth, women's lived experiences regarding the factors that influence their intentions toward induced abortion and their subsequent decision to withdraw from abortion among women referred to NAFAS centers in Iranshahr, southeastern Iran.

Materials and methods

Study design

A qualitative study design with a conventional content analysis approach was employed. This approach is particularly suitable for gaining rich, detailed insights into subjective human experiences, especially for under-researched phenomena and populations (22).

Study setting

The study was conducted at two NAFAS centers operating under the supervision of Iranshahr University of Medical Sciences, located in Sistan and Baluchestan Province, southeastern Iran. This region is characterized by a unique cultural and tribal social structure, a Sunni Muslim majority (unlike the rest of Shi'a-majority Iran), and significant economic deprivation. Data collection was conducted between January 2025 to June 2025.

Participants and sampling

Eligible participants were women who: (1) had experienced an unintended or crisis pregnancy; (2) had seriously considered undergoing an induced abortion, defined as having actively contemplated abortion as a potential solution to their pregnancy, having sought information about abortion methods or providers, or having made a concrete plan to terminate the pregnancy; (3) had subsequently decided against termination and continued the pregnancy; and (4) were referred to or sought services from a NAFAS center. The age range of participants was 18 to 42 years.

Purposive sampling with maximum variation was used to recruit a diverse range of participants in terms of age, parity, educational level, and socioeconomic status. Recruitment continued until data saturation was achieved. Saturation was monitored continuously throughout the data collection process. After each interview, the research team convened to discuss emerging codes and themes. Data saturation was considered to have been achieved when three consecutive interviews yielded no new codes or themes, and when the categories were rich, well-developed, and supported by sufficient data from multiple participants (18, 20). This occurred after interviewing 31 women. At this point, no new codes or themes emerged from subsequent interviews.

Data collection

Data were collected between January 2025 and June 2025 through face-to-face, semi-structured, in-depth interviews. All interviews were conducted by the first author, an Assistant Professor in reproductive health with 5 years of experience in qualitative research and prior training in counseling and sensitive interviewing techniques. The interviewer was a woman with prior training in counseling and qualitative interviewing techniques, which facilitated rapport building and sensitive communication with participants. The interviewer was not involved in the clinical care or counseling provided at the NAFAS centers, thereby minimizing potential conflicts of interest and reducing social desirability bias.

All interviews were conducted in a private room at the NAFAS centers to ensure confidentiality and comfort. Each interview lasted between 45 and 75 minutes (average: 55 minutes). The interview guide was developed based on the literature and the study's objectives. Key guiding questions included:

"Can you please describe your feelings and thoughts when you first learned about this pregnancy?"

"What factors or reasons made you consider abortion?"

"What were your main concerns at that time?"

"What happened that helped you change your mind or decide to continue the pregnancy?"

"What kind of support did you receive during this difficult period, and from whom?"

Probing questions such as "Can you tell me more about that?" or "How did that make you feel?" were used to elicit deeper responses. The interview guide was piloted with two women who met the eligibility criteria but were not included in the final sample to assess clarity, comprehensiveness, and cultural appropriateness. Minor adjustments to the wording of questions were made based on the pilot feedback. All interviews were audio-recorded with the explicit written consent of each participant.

Data analysis

Interviews were transcribed verbatim in Persian. The transcripts were then analyzed using the conventional content analysis method described by Graneheim and Lundman (2004) (23). The analysis process followed

an iterative, systematic approach:

1. Reading all transcripts repeatedly to gain an overall sense of the content.
2. Dividing the text into meaning units (words, sentences, or paragraphs related to each other through content and context).
3. Condensing the meaning units while preserving their core meaning.
4. Abstracting the condensed meaning units and assigning them initial codes.
5. Comparing codes based on similarities and differences and grouping them into sub-categories and then categories.
6. Identifying the underlying, implicit themes that unified groups of categories.

To enhance the rigor and transparency of the analysis, the following additional procedures were implemented:

Coding Process: The first author performed the initial coding of all transcripts. To ensure reliability and reduce individual bias, a second researcher (the third author, a female assistant professor of epidemiology with expertise in qualitative data analysis) independently coded 20% of the transcripts (n=6). The two coders then met to compare their codes, discuss discrepancies, and reach a consensus through discussion. The final coding framework was developed through this iterative process of independent coding and collaborative consensus-building.

Category and Theme Development: Following the initial coding, the research team (all co-authors) engaged in a series of reflexive group discussions to review the codes, explore patterns and relationships among codes, and group them into higher-order categories. These categories were then further abstracted to identify latent themes the underlying, implicit meanings that unified the categories and represented the core experiences of the participants. The final themes were not imposed a priori but emerged inductively from the data. The process was documented in an audit trail, including memos, coding decisions, and team meeting notes.

Trustworthiness

Trustworthiness was established using the criteria proposed by Lincoln and Guba (24). Credibility was enhanced through prolonged engagement with the research setting, peer debriefing (regular discussions with co-authors not involved in data collection), and member checking (returning a summary of findings to five participants to verify alignment with their experiences). Additionally, the use of independent coders and team consensus-building contributed to the credibility of the findings. Dependability was supported by maintaining a comprehensive audit trail, including raw data, analysis notes, and coding decisions. Transferability was strengthened by providing a thick description of the participants'

characteristics, the study context, and the findings, allowing readers to assess the applicability of the results to other similar settings. Confirmability was ensured through reflexive journaling, wherein the first author documented her assumptions, preconceptions, and potential biases throughout the research process, allowing for self-awareness and bracketing of personal influences on data collection and analysis.

Researcher reflexivity

To acknowledge and mitigate potential researcher-related biases, the following reflexivity statement is provided: The first author is a female reproductive health researcher with a background in midwifery and public health who holds pre-existing academic and professional interests in women's reproductive decision-making. Her professional experience includes working with women in crisis pregnancy situations, which may have shaped her expectations about the study findings. To minimize the influence of these preconceptions, the interviewer maintained a reflexive journal throughout the study, documenting her thoughts, feelings, and assumptions before and after each interview. Furthermore, the research team included members from diverse disciplinary backgrounds (e.g., epidemiology, sociology, and clinical midwifery), which provided multiple perspectives during data interpretation and helped challenge individual biases. The interviewer's position as an outsider to the local community of Iranshahr not being a native of Sistan and Baluchestan may have influenced participants' willingness to disclose sensitive information; However, this also facilitated a non-judgmental and neutral stance during interviews.

Addressing potential biases

Several potential biases were considered and addressed in this study. First, selection bias: Recruitment through NAFAS centers may have selectively included women who were more receptive to counseling or who had more supportive social networks, potentially excluding women who experienced crisis pregnancies but did not seek NAFAS services. To mitigate this, the study employed maximum variation sampling to capture a diverse range of experiences, and participants were explicitly informed that their participation was independent of the services they received. Second, social desirability bias: Participants, having been referred to NAFAS centers that promote continued pregnancy, may have been inclined to provide responses that aligned with the centers' objectives or that were socially acceptable. To minimize this, the interviewer emphasized the voluntary and confidential nature of participation, used open-ended and non-leading questions, and established trust through active listening and empathetic engagement before initiating formal interviews. Third, recall bias: Participants were asked to reflect on past decisions and experiences, which may

be subject to memory distortion. To address this, the interviewer used probing questions to elicit specific examples and narratives rather than general recollections, and the interview guide encouraged chronological storytelling to enhance recall accuracy.

Ethical considerations

The study was approved by the Ethics Committee of Iranshahr University of Medical Sciences (Approval Code: IR.IRSHUMS.REC.1404.018). All participants were informed about the study's aims, the voluntary nature of participation, and their right to withdraw at any time without consequences. Written informed consent was obtained from each participant prior to data collection. Participants were assured that their decision to participate or withdraw would not affect their access to NAFAS center services or any other healthcare they received. Additionally, participants were informed that audio recordings would be destroyed upon completion of the study and that only anonymized transcripts would be used for analysis and publication. To ensure confidentiality, all personal identifiers were removed, and each participant was assigned a unique code (e.g., P1, P2, ...).

Characteristics of participants

A total of 31 women participated in the study. Their ages ranged from 18 to 42 years (mean: 29.4 ± 6.8 years). Regarding parity, 12 women (38.7%) were primiparous, 15 women (48.4%) had two to three children, and 4 women (12.9%) had four or more children. In terms of educational attainment, 8 women (25.8%) had primary or secondary education, 14 women (45.2%) had completed high school, and 9 women (29.0%) had university-level education. The majority of participants ($n=24$, 77.4%) were homemakers, while the remaining 7 women (22.6%) were employed in various occupations.

Results

Participant characteristics

A total of 31 women participated. Their ages ranged from 18 to 43 years, with a mean age of 31.2 years ($SD = 5.1$). As detailed in [Table 1](#), the majority had only elementary or middle-school education (71.0%), were multiparous (77.4% had three or more pregnancies), and nearly half (48.4%) had a child under two years old at the time of the unintended pregnancy. All pregnancies were reported as unintended, and in most cases (64.5%), the spouse was self-employed, often with a low and unstable income (e.g., daily wage labor, street vending). The gestational age at the time of first presentation to the NAFAS centers ranged from 6 to 20 weeks (mean: 13.4 ± 4.1 weeks).

Table 1. Demographic and reproductive characteristics of participants (N=31)

Characteristic	n	(%)
Education		
Elementary or Middle-school	22	(71.0)
High-school diploma or higher	9	(29.0)
Gravidity (number of pregnancies)		
1-2 pregnancies	7	(22.6)
3 or more pregnancies	24	(77.4)
Presence of a child under 2 years		
Yes	15	(48.4)
No	16	(51.6)
Spouse's Employment		
Self-employed (unstable income)	20	(64.5)
Unemployed / Daily wage laborer	7	(22.6)
Salaried employee	4	(12.9)

Overview of themes

The analysis revealed two overarching decision phases: (1) factors influencing women's initial intentions toward induced abortion, and (2) factors facilitating their subsequent withdrawal from this decision. For the first phase, five major themes emerged, each comprising two to three constituent categories. For the second phase, four major themes were identified, each with one to three constituent categories. [Table 2](#) presents the complete thematic structure, including all themes and their associated categories. Below, we present the findings for each theme, using participants' own words to illustrate their experiences. It is important to note that the themes reflect participants' retrospective accounts of their decision-making processes, and the quotations presented are their reported experiences rather than the researchers' interpretations.

Table 2. Themes and categories identified during data analysis

Influence on Decision	Themes	Categories
Factors Influencing Intention Toward Abortion	1. Reproductive burden and maternal exhaustion	Closely spaced pregnancies, High childcare burden, High parity (≥ 3), Physical and mental fatigue
	2. Economic vulnerability and uncertainty	Insufficient household income, Spouse's unemployment/underemployment, Rising daily expenses, Concerns for children's future
	3. Fear of adverse reproductive experiences	History of miscarriage/hemorrhage, Previous difficult labor, Fear for own life
	4. Inappropriate life stage	Advanced maternal age (>35), Lack of psychological readiness, Pregnancy despite contraceptive use
	5. Perceived inability to care	Feeling of being overwhelmed, Lack of adequate housing, No perceived support for another child
Factors Facilitating Withdrawal from	1. Emotional attachment to the fetus	Hearing the fetal heartbeat, feeling fetal movements, Viewing ultrasound image

Abortion

2. Effective NAFAS center counseling	Non-judgmental listening, Information on pregnancy and maternal health, Emotional support
3. Family support	Spouse's encouragement and support, Support from mother/mother-in-law
4. Religious and spiritual beliefs	Belief in divine will (Razā), Hope for divine blessing (Barakah), Fear of sin (Gonāh) and divine punishment

Factors influencing intention toward induced abortion

Five major themes emerged regarding the factors that influenced women's initial intentions to undergo induced abortion. These themes represent the participants' reported reasons for seriously considering abortion as a potential solution to their crisis pregnancy. All participants described having actively contemplated abortion, and many had taken concrete steps toward obtaining information or making plans before ultimately withdrawing from the decision.

Theme 1: Reproductive burden and maternal exhaustion

The most frequently cited factors leading to abortion intentions were those related to the physical and mental strain of repeated pregnancies and childrearing. Women described feeling "broken" and "drained" by the constant demands of caring for many young children, especially when pregnancies were closely spaced. This theme comprised four categories: closely spaced pregnancies, high childcare burden, high gravidity (≥ 3), and physical and mental fatigue. Participants frequently described how the cumulative toll of repeated childbearing had eroded their capacity to cope with another pregnancy.

A 32-year-old mother of three children under six years articulated this exhaustion:

"I was so tired. My youngest was just 10 months old, and I found out I was pregnant again. I couldn't do it anymore. Just thinking about another pregnancy, another baby crying at night... I felt like I was going to collapse. I told my husband, 'I can't, I'll die.'" (P14, 32 years old, mother of 3 children under 6)

Another participant, a 29-year-old mother of four, described the physical toll of closely spaced pregnancies:

"My body hadn't recovered from the last birth. I was still breastfeeding, still exhausted every single day. When I saw the positive test, I cried for three days. I thought, 'How can I go through this again? I don't have the strength.'" (P8, 29 years old, gravida 4)

Similarly, a 34-year-old participant with five children emphasized the mental burden:

"It's not just the physical tiredness. It's the mental exhaustion. Every day, I wake up and I'm already tired. The children need me constantly. I have no time for myself. Another child would mean I would completely lose myself." (P21, 34 years old, gravida 5)

The high childcare burden, particularly when combined with limited support, was a recurring concern. Women described feeling overwhelmed by the daily demands of caring for multiple young children.

Theme 2: Economic vulnerability and uncertainty about the future

Severe financial hardship was another powerful driver of abortion intention. Participants spoke of daily struggles to provide basic necessities like food, rent, and clothing for their existing children. The addition of another child was perceived not just as an increased expense, but as an impossible burden that would doom the entire family to deeper poverty. This theme included four categories: insufficient household income, spouse's unemployment/underemployment, rising daily expenses, and concerns for children's future.

A 28-year-old mother of two whose husband worked as a casual laborer explained:

"My husband is a casual laborer. Some days he works, many days he doesn't. Last month, we couldn't even pay the rent. And now another child? How would we feed it? Buy milk? Clothes? My children are already asking for things I can't give them. This child would have a life of nothing but misery. I thought abortion was the only merciful choice." (P22, 28 years old, mother of 2)

Another participant, a 31-year-old woman with three children, described the constant financial anxiety:

"We live day to day. My husband sells vegetables on the street. Some days we have enough; many days we don't. I look at my children and I worry about their future. How can I bring another child into this uncertainty?" (P11, 31 years old, gravida 3)

A 26-year-old participant reflected on the cumulative financial burden:

"Every child need clothes, shoes, school supplies. My husband works so hard but we are always in debt. When I found out I was pregnant, I thought, 'This will break us.' We couldn't afford another mouth to feed." (P4, 26 years old, mother of 2)

Concerns about children's future, including education and marriage prospects, were also prominent. Women feared that having another child would compromise their ability to provide for their existing children's long-term needs.

Theme 3: Fear arising from previous adverse reproductive experiences

A history of medical complications during pregnancy, labor, or postpartum significantly heightened women's fear for their own safety. This theme comprised three categories: history of miscarriage or hemorrhage, previous difficult labor, and fear for one's own life. Participants who had experienced life-threatening complications described how these memories shaped their abortion intentions.

"With my third child, I had a severe hemorrhage after delivery. I was in the hospital for two weeks, and the doctors said I was very close to death. When I found out I was pregnant again, all I could see was that blood. I was terrified. I begged my husband to let me have an abortion. I didn't want to leave my other children motherless." (P7, 39 years old, mother of 4)

A 33-year-old participant who had experienced a miscarriage described her fear:

"I had a miscarriage at five months. It was the most painful thing I've ever experienced—physically and emotionally. When I became pregnant again, I was terrified not just of losing the baby, but of going through that pain again. I thought, 'Maybe I should just end this before it gets harder.'" (P16, 33 years old, gravida 3)

Another participant, a 36-year-old woman, described her fear of dying during childbirth:

"My last delivery was very difficult. The baby was big, and I had a tear that took months to heal. I was in pain for so long. When I saw the positive test, I thought, 'This might kill me.' I honestly believed I would die if I continued this pregnancy." (P25, 36 years old, mother of 3)

Theme 4: Pregnancy occurring at an inappropriate life stage

Women described their pregnancy as "bad timing" or "out of place." This theme comprised three categories: advanced maternal age (perceived as "too old" by the woman herself, typically ≥35 years), lack of psychological readiness, and perceived discordance with life planning. Notably, this last category included women who had used contraceptive methods and perceived the pregnancy as a profound betrayal of their planning.

A 35-year-old woman whose husband had undergone a vasectomy expressed her shock:

"We had decided we were done. My husband had a vasectomy. So, when I missed my period and the test was positive, I couldn't believe it. It felt like a mistake, a physical impossibility. We had planned our lives, our finances, everything around not

having more children. This pregnancy wasn't supposed to exist. For two weeks, the only solution I could see was abortion." (P29, 35 years old, mother of 3)

A 38-year-old participant described feeling "too old" for another pregnancy:

"I'm 38 years old. I already have four children. My eldest is 16. I thought I was done with this phase of my life. I was looking forward to having some freedom, maybe even going back to work. This pregnancy felt like a cruel joke. I thought, 'I'm too old for this. My body can't handle it.'" (P18, 38 years old, gravida 5)

A 24-year-old participant who had recently married described her lack of psychological readiness:

"We had only been married for one year. I was still getting used to being a wife, learning how to manage a household. I wasn't ready to be a mother. I felt like a child myself. When I saw the positive test, I panicked. I thought, 'I can't do this. I'm not ready.'" (P3, 24 years old, gravida 1)

Another participant, a 30-year-old woman, described how the pregnancy disrupted her life plans:

"I was studying. I had just one year left to finish my degree. This pregnancy would have ended everything. My education, my dreams, my future. I thought about abortion every single day. It felt like the only way to save my future." (P12, 30 years old, gravida 1)

The category of "pregnancy despite contraceptive use" was particularly striking. Women who had used contraception perceived the pregnancy as an "invasion" of their carefully laid plans, intensifying their initial intention to abort.

Theme 5: Perceived inability to care for another child

This theme encompassed women's feelings of being overwhelmed and their perception that they lacked the physical, emotional, and material resources to adequately care for another child. The three categories were: feeling of being overwhelmed, lack of adequate housing, and no perceived support for another child.

A 27-year-old mother of two described her housing situation:

"We live in one room. My husband, me, and two children. There is no space. Where would we put another child? How would we sleep? I couldn't imagine bringing a baby into that small room. It felt impossible." (P9, 27 years old, mother of 2)

A 31-year-old participant described feeling completely overwhelmed:

"I was already struggling. I couldn't keep up with the housework, the children, the cooking. My husband works long hours and doesn't help at home. I felt like I was drowning. Another child would have been the final wave that pulled me under." (P15, 31 years old, mother of 3)

A 25-year-old woman described the lack of perceived support:

"I have no one to help me. My mother lives in another city. My mother-in-law is old and unwell. My husband works all day. I would be completely alone with a newborn and two other children. I didn't think I could survive that." (P6, 25 years old, mother of 2)

Factors facilitating withdrawal from abortion

Despite the powerful forces pushing them toward abortion, participants described several factors that ultimately helped them decide to continue their pregnancy. These factors operated at individual, interpersonal, and institutional levels. Four major themes were identified.

Theme 1: Participants' perceived helpfulness of NAFAS center counseling

A critical factor in the withdrawal process was the supportive counseling received at the NAFAS centers. Women contrasted this care with the judgment they feared elsewhere. This theme comprised three categories: non-judgmental listening, information on pregnancy and maternal health, and emotional support. Participants consistently emphasized that the counselors' non-judgmental approach was instrumental in creating a safe space for them to explore their feelings.

A 26-year-old mother of one described her experience:

"I went there to find a way to have an abortion. But the counselor... she didn't judge me. She just listened. She told me about the baby's development, how I was feeling, and what help was available. She made me feel like I wasn't alone. For the first time, someone asked me what I needed, not what I was doing wrong." (P1, 26 years old, mother of 1)

A 29-year-old participant echoed this sentiment:

"I expected her to tell me I was a bad person, that I was going to hell. But she didn't. She listened to my fears. She told me that many women feel this way. She made me feel normal. That was the first time I could really think clearly." (P13, 29 years old, gravida 3)

Another participant, a 34-year-old woman, described how the counselor helped her see options she hadn't considered:

"The counselor told me about the support that was available—food assistance, healthcare, even help with finding housing. I didn't know any of this existed. She gave me hope that I could do this." (P23, 34 years old, mother of 2)

The provision of information about pregnancy, fetal development, and maternal health was also valued by participants:

"She showed me pictures of the baby at this stage. She explained what was happening inside me. I

started to see this not just as a 'problem' but as a life that was growing." (P17, 27 years old, gravida 2)

Theme 2: Emotional attachment to the fetus

Emotional attachment to the fetus, often triggered during counseling or ultrasound, was a powerful turning point in the decision to withdraw from abortion. This theme comprised three categories: hearing the fetal heartbeat, feeling fetal movements, and viewing the ultrasound image.

A 30-year-old mother of two described her transformative experience:

"The counselor asked if I wanted to see the ultrasound. I said yes. And then... I saw the tiny heartbeat. It was flickering so fast. At that moment, I knew I couldn't do it. That little flicker was my baby. How could I stop its heart?" (P19, 30 years old, mother of 2)

A 31-year-old participant described hearing the fetal heartbeat:

"The counselor put the Doppler on my belly. I heard the heartbeat—whoosh, whoosh, whoosh. It was so fast and strong. I started crying. I realized this was a real life inside me. I couldn't end it." (P20, 31 years old, gravida 4)

A 26-year-old woman described how feeling fetal movements changed her perspective:

"I started feeling the baby move. At first, I tried to ignore it. But the movements became stronger. I would feel a little kick and think, 'There's someone in there.' I couldn't pretend it wasn't real anymore." (P5, 26 years old, mother of 1)

A 33-year-old participant described the cumulative effect of multiple encounters:

"Every time I went to the center, they showed me the ultrasound. I saw the baby growing, the tiny hands, the nose. The attachment grew stronger each time. By the end, I couldn't imagine not having this baby." (P30, 33 years old, mother of 3)

Theme 3: Family support

Support from family members, particularly the spouse and the woman's mother or mother-in-law, was another critical factor in the withdrawal decision. This theme comprised two categories: spouse's encouragement and support, and support from mother or mother-in-law.

A 28-year-old participant described her husband's support:

"My husband said, 'We will manage. We always have. This child is a gift from God. Don't be afraid.' His words gave me strength. I knew I wasn't facing this alone." (P22, 28 years old, mother of 2)

A 35-year-old woman described the crucial support from her mother:

"My mother said, 'I will help you. You are not alone. I

raised five children; you can raise this one too.' Her support changed everything. I knew I had someone to turn to." (P29, 35 years old, mother of 3)

A 31-year-old participant described how her mother-in-law's encouragement made a difference:

"My mother-in-law said, 'This child will bring blessing to our family. Don't be afraid. We will all help.' I was surprised because I thought she would judge me. Her support made me feel accepted." (P11, 31 years old, gravida 3)

A 26-year-old woman described the importance of her husband's emotional presence:

"My husband held my hand and said, 'Whatever you decide, I support you.' I knew I could talk to him honestly. That gave me the courage to think about continuing the pregnancy." (P2, 26 years old, mother of 1)

However, it is important to note that not all participants received support. Some described feeling isolated, and their decision to withdraw was made despite, rather than because of, family pressure.

Theme 4: Religious and spiritual beliefs

Religious and spiritual beliefs provided a strong moral and spiritual framework for continuing the pregnancy. This theme comprised three categories: belief in divine will (Razā), hope for divine blessing (Barakah), and fear of sin (Gonāh) and divine punishment. While some women feared the sin of abortion, others framed the continuation as an act of faith and trust in God's provision.

A 33-year-old mother of three described her spiritual reasoning:

"I was very conflicted. My logic said 'abortion.' But my heart and my faith said 'no.' I prayed a lot. I realized that this child is a gift from God (Razā). If He has given it to me, even in this hardship, He will also provide a way. I decided to trust God and keep my baby. I believe there is blessing (Barakah) in that." (P30, 33 years old, mother of 3)

A 37-year-old participant described her fear of divine punishment:

"I know that abortion is a sin (Gonāh). I was terrified of God's punishment. Every time I thought about going through with it, I felt sick. I knew I couldn't live with that guilt. I would rather struggle in this life than face punishment in the next." (P26, 37 years old, mother of 4)

A 29-year-old woman described her belief in divine will:

"I started praying Istikhara. I asked God to guide me. I felt a peace in my heart that I should continue. I believe that this child was meant to be. Everything happens by God's will. I surrendered to

that." (P13, 29 years old, gravida 3)

A 32-year-old participant described how her faith gave her hope:

"I remembered that God says, 'With hardship comes ease.' I decided to trust that promise. I knew it would be difficult, but I believed that God would help me. That faith carried me through." (P14, 32 years old, mother of 3 under 6)

Translation and presentation of quotations

All interviews were conducted in Persian (Farsi), the native language of both the participants and the interviewers. The audio-recorded interviews were transcribed verbatim in Persian. Participants' quotations were then translated into English by a bilingual researcher fluent in both Persian and English. To ensure accuracy and preserve the original meaning, the translations were reviewed and verified by a second bilingual researcher who was not involved in the initial translation. Back-translation of a sample of quotations was not performed; however, the research team ensured that the translations captured the participants' intended meanings, including culturally specific expressions and idioms.

Acknowledgment of potential biases in the findings

It is important to acknowledge that the findings presented here may be influenced by the study's recruitment and data collection context. All participants were recruited from NAFAS centers— institutions that explicitly aim to provide counseling and support to discourage abortion and promote continued pregnancy. Consequently, the sample may have selectively included women who were more receptive to counseling, more likely to have supportive networks, or more motivated to continue their pregnancies. Women who decided to proceed with abortion or who did not seek NAFAS services are not represented in this study. Additionally, participants may have been subject to social desirability bias, potentially expressing views that aligned with the NAFAS centers' objectives or that were socially acceptable within their communities. To minimize this, the interviewer emphasized the voluntary and confidential nature of participation and used open-ended, non-leading questions. Nonetheless, readers should interpret the findings with these potential biases in mind.

Discussion

This qualitative study provides an in-depth understanding of the complex and often contradictory forces shaping reproductive decisions among women facing crisis pregnancies in Iranshahr, one of the most socioeconomically disadvantaged regions of Iran. The findings show that the decision either to terminate or to continue a pregnancy is rarely a simple or static one; rather, it is a dynamic and emotionally burdensome process in which women continuously negotiate competing pressures. In this regard, the present findings are both consistent with and additive to

previous studies conducted in other parts of Iran and beyond (25).

In line with studies from Tehran and international contexts, economic hardship emerged as one of the most powerful drivers of abortion intention as reported by participants (25–28). Participants in the present study described their financial constraints in particularly acute terms, frequently speaking of an inability to afford rent, food, and other basic necessities. While direct comparative data on poverty levels between Iranshahr and Tehran are beyond the scope of this qualitative study, it is noteworthy that Sistan and Baluchestan Province consistently ranks among the lowest in Iran on human development indices, with higher poverty rates and unemployment than the national average (21). This contextual information suggests that the decision-making environment in Iranshahr may be shaped by more severe material deprivation than that typically reported in urban middle-class settings such as Tehran (29, 30). However, we caution against making direct comparisons, as our study did not include participants from Tehran or other urban centers. Rather, we present participants' own descriptions of their economic circumstances as they related to their reproductive decision-making. While earlier research has interpreted abortion decision-making partly as a rational cost-benefit calculation (29), the accounts in the present study indicate that for many women this calculation was more fundamental, involving a perceived choice between immediate survival and the fear of deeper future deprivation. Importantly, we frame these economic considerations as participants' reported experiences and perceptions rather than as deterministic causes of their abortion intentions. All participants ultimately continued their pregnancies, and their economic concerns—while powerful—were not sufficient to lead to abortion. This highlights the dynamic and multifaceted nature of reproductive decision-making, in which economic factors interact with other influences such as emotional attachment, religious beliefs, and social support.

The findings also emphasize the role of reproductive burden in shaping abortion considerations. Although this issue has been noted in prior Iranian studies, our results provide greater depth by showing that women's distress was not merely related to the number of children they had, but to the close spacing of pregnancies, physical exhaustion, and the demands of caring for very young children in the absence of adequate support. This pattern is consistent with the concept of maternal depletion, which has been described in settings characterized by high fertility and limited resources (12). In this context, abortion intention as reported by participants may reflect not only social or economic concerns, but also cumulative physical and emotional fatigue. It

is important to emphasize that these are participants' own descriptions of their experiences rather than an assertion that reproductive burden "caused" their abortion intentions. Rather, women described these factors as contributing to their consideration of abortion as a potential solution.

One of the main contributions of this study is its exploration of factors associated with withdrawal from abortion intention. While many previous studies have focused on the determinants or prevalence of abortion decisions, relatively few have examined what leads women to reconsider and continue their pregnancy (31, 32). The findings suggest that participants perceived the NAFAS counseling intervention as helpful in their decision to withdraw from abortion. Importantly, we distinguish between participants' perceptions of counseling and our own assessment of its effectiveness. Participants consistently described the counseling environment as supportive, non-judgmental, and empathetic. They reported that this environment reduced their feelings of isolation, fear, and stigma, thereby enabling them to reflect more safely and more openly on their circumstances and alternatives. This finding is in line with the principles of client-centered reproductive counseling (33). However, we must interpret these findings with caution. As all participants were recruited from NAFAS centers, the sample may have selectively included women who were more receptive to counseling or who had more supportive social networks. Furthermore, the absence of a comparison group of women who did not receive NAFAS counseling or who proceeded with abortion limits our ability to attribute the withdrawal decision solely to the counseling intervention. It is possible that women who attended NAFAS centers were already predisposed to continue their pregnancies, and the counseling served to reinforce rather than initiate this decision. Therefore, we frame the role of NAFAS counseling as a perceived facilitator among this specific sample of women, rather than as an established cause of withdrawal from abortion.

In addition, the findings highlight the importance of emotional and spiritual influences in decision-making as reported by participants. For several participants, observing the fetal heartbeat during ultrasonography was described as a turning point that transformed the fetus from an abstract concern into a tangible and emotionally meaningful presence. Participants reported that this experience strengthened their emotional attachment and contributed to a re-evaluation of their decision to terminate the pregnancy (34). However, we emphasize that these are participants' own narratives rather than an assertion of a causal effect. Not all participants described this experience, and for some, emotional attachment developed gradually over time rather than through a single transformative moment. The diversity of experiences reported by participants underscores the individual nature of reproductive decision-making and

the need for personalized counseling approaches. At the same time, religious beliefs particularly beliefs related to divine will, acceptance, and blessing served as an important source of inner support (35). Rather than functioning only as a prohibitive moral framework, faith appeared to offer women hope, endurance, and a means of making sense of hardship (36). Religious beliefs emerged as an important source of inner support for many participants, particularly beliefs related to divine will (Razā), blessing (Barakah), and sin (Gonāh). Importantly, we present these findings as participants' own interpretations rather than as general statements about all women or communities in Iranshahr. The role of religion varied considerably among participants. For some, religious beliefs functioned as a prohibitive moral framework, with fear of sin and divine punishment serving as a deterrent to abortion. For others, faith offered hope, endurance, and a means of making sense of hardship. These women described their pregnancy as a gift from God and expressed trust that divine provision would accompany divine will. This finding contributes to the broader literature suggesting that religiosity can act as a perceived facilitating factor in reproductive health decision-making (37, 38). However, we caution against overgeneralization; the diversity of religious experiences reported by participants indicates that spirituality is neither uniformly prohibitive nor uniformly supportive of continued pregnancy. Rather, it is a complex and individually negotiated dimension of decision-making. Notably, some participants described a dynamic interplay between religious beliefs and other factors. For example, one participant described being "very conflicted," with her "logic" pointing toward abortion and her "heart and faith" pointing toward continuation. This internal conflict was resolved through prayer and a decision to trust in God's will. Such narratives highlight the importance of understanding religious beliefs not as static or monolithic influences, but as actively negotiated frameworks that interact with personal, social, and economic considerations.

While our findings corroborate nationwide patterns identifying economic constraints, reproductive burden, and relationship dynamics as key drivers of abortion intentions (14, 15, 20, 24), they delineate critical regional disparities grounded in the socioeconomic and cultural realities of Iranshahr.

Most notably, the material deprivation articulated by our participants was marked by an acute subsistence crisis—particularly around fundamental needs such as food security and housing costs. This heightened vulnerability likely mirrors the pronounced poverty and socioeconomic disadvantages documented in

Sistan and Baluchestan relative to central metropolitan areas like Tehran (39). Compounding this economic precarity was an exacerbated reproductive burden, manifested through high gravidity, short interpregnancy intervals, and delayed presentation (mean gestational age: 13.4 weeks). Such clinical markers underscore substantial structural barriers to early prenatal and modern contraceptive services in this underserved region.

Furthermore, the socio-religious milieu of Iranshahr—being predominantly Sunni Muslim—introduces distinct cultural nuances to decision-making. Although both Shi'a jurisprudence and Sunni doctrines strictly circumscribe pregnancy termination, the deeply internalized constructs of divine will (Raza) and providential blessing (Barakah) observed in our cohort illustrate how localized religious idioms uniquely frame reproductive choices (40). Finally, unlike the majority of domestic literature focusing strictly on completed abortions, our investigation uniquely captures the trajectory of women who ultimately withdrew from pregnancy termination, thereby revealing key protective mechanisms that can be leveraged in targeted health and social welfare interventions.

A key strength of this study is its novel focus on women who discontinued intended abortions within an underrepresented, socio-culturally distinct population in southeastern Iran. Methodological rigor was supported through maximum variation sampling and data saturation. However, several limitations should be noted. First, recruiting solely from NAFAS centers may have introduced selection and social desirability biases, as participants were receptive to counseling and might have aligned their responses with institutional or cultural expectations despite assurances of research independence and confidentiality. Consequently, these findings may not capture the perspectives of women who proceeded with termination or carried pregnancies to term without institutional support. Second, inherent to qualitative designs, the findings reflect subjective, context-specific perceptions rather than causal determinants, limiting direct generalizability to other settings with different socio-religious profiles. These findings offer critical directives for localized reproductive healthcare. First, the positive reception of NAFAS services underscores the value of non-judgmental, client-centered counseling in crisis pregnancies, though longitudinal comparative studies are needed to evaluate long-term outcomes. Second, mitigating abortion demand requires addressing upstream social determinants by expanding family planning services, modern contraceptive access, and socioeconomic support (e.g., financial and childcare aid). Third, incorporating local faith-based values and religious frameworks can enhance intervention acceptability and engagement (41). Finally, policies must move beyond one-size-fits-all models to develop context-tailored reproductive health strategies that address the acute economic vulnerabilities and distinct

socio-religious dynamics of underserved regions like Iranshahr.

Conclusion

This study offers novel insights into abortion ambivalence and withdrawal in Iranshahr, southeastern Iran. While acute material precarity, high parity, and situational distress initially prompted abortion ideation, pregnancy continuation was enabled by perceived counseling support from NAFAS centers, familial encouragement, maternal-fetal bonding, and localized religious values (Razā, Barakah, Gonāh). Although participants viewed counseling positively, prospective comparative studies are needed to evaluate its long-term efficacy. Ultimately, addressing crisis pregnancies in socioeconomically marginalized regions requires moving beyond standardized policies toward tailored strategies that integrate structural poverty relief and family planning access with culturally grounded, non-judgmental support systems.

Ethics approval and consent to participate

This study was approved by the Ethics Committee of Iranshahr University of Medical Sciences, Iranshahr, Iran, under the ethics code IR.IRSHUMS.REC.1404.018. The study was conducted in accordance with the ethical principles of the Declaration of Helsinki. Prior to participation, all participants were informed about the objectives of the study, the voluntary nature of participation, confidentiality of their information, and their right to withdraw from the study at any stage without any consequences. Written informed consent was obtained from all participants before data collection.

Competing interests

The authors have no conflict of interest.

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