Acta Scientific Women's Health

Volume 1 Issue 7 December 2019

Research Article

Women's and Healthcare Professional's Experiences and Perspectives for Safe and Unsafe Abortion in Developing Countries

Abu Taher Md Sanaullah Nury[1], Giasuddin Ahmed[2], Md Mahbub-Ul-Alam[1], Taha Husain[3]* and Tanvir Abir[4]

[1]*Deputy Director and Program Manager, Directorate General of Family Planning, Ministry of Health and Family Welfare, Dhaka, Bangladesh*

[2]*Consultant, PIACT Bangladesh, Dhaka, Bangladesh*

[3]*Research Fellow, Wholistic Integration, Bangladesh*

[4]*School of Science and Health, University of Western Sydney, New South Wales, Australia*

***Corresponding Author:** Taha Husain, Research Fellow, Wholistic Integration, Bangladesh.

Received: October 24, 2019; **Published:** November 11, 2019

Abstract

Background: Unsafe abortion in developing countries is a widespread and neglected public health issue. Nearly one-third of all pregnancies are unintended and abortion ends one in five pregnancies (Haddad, 2009). Sustainable Development Goals (SDGs) aimed at reducing the maternal mortality ratio in developing countries to 70 per 100,000 births (UN, 2016). This paper seeks to conduct a review to define, critically evaluate and synthesize the views and attitudes of women and health care providers in developing countries on safe and unsafe pregnancies, maternal morbidity and mortality.

Methods: A systematic literature review was carried out in June 2018 using the PIO model (Population, Intervention and Outcome). The literature's selection criteria included qualitative English-written research studies, observational studies conducted from January 1,2000, to December 31, 2018, and the population group was primarily pregnant women who witnessed menstrual control or abortion and health care providers from various developing countries around the world. The main factors involved here were the safe and unsafe abortion services, and experience, perception, attitude, and opinion were the factors of the outcome. We have compiled the literature from PubMed, Medline and CINAHL and Google Scholar. In this process, a total of 100 papers were chosen among them 12 articles were evaluated and reviewed for this study.

Results: The analysis results highlighted the behaviour of the service provider, understanding of abortion, contraception, religious; financial; social and cultural issues related to safe and unsafe abortion. It advocated that strong political will, better educational and employment opportunities, funding for therapy, safe sex between married and unmarried teens, long-term methods of family planning in post-abortion period, improving medical abortion, public and individual awareness campaign, favourable law and abortion policy would be possible remedies.

Keywords: Safe and Unsafe Abortion, Maternal Morbidity and Mortality, Developing Countries

Background

As a result of unsafe abortions, approximately 7 million women were admitted to hospitals in developing countries each year, and more than half of all unsafe abortions occurred globally reported in Asia [1]. 42 million women select abortion as an unwanted practice each year [2]. 68,000 women die from unsafe abortion every year and are considered one of the leading causes of maternal mortality [3]. However, between 1990 and 2015, maternal mortality has fallen by about 44 per cent worldwide. Between 2016 and 2030, the goal is to reduce the global maternal mortality ratio to less than 70 per 100 000 live births as part of the Sustainable Development Goals [4]. Although the problem was of immense importance, many patients were not happy with the care they provided in the hospitals. For example, in Sri Lanka, where patients expressed that the pain was the main symptom during the therapy period and troubled more than bleeding, but the patients were not told that the pain would be relieved after the retained products were expelled [5].

Thus it is clear that sharing of experience in the hospital by the patients will increase their awareness through inter-patient interaction. In developing countries, mild to serious post-abortion com-

plications are common [6]. For example, 77% of Kenyan women seeking post-abortion treatment had severe complications, compared to Malawi (28%) and Ethiopia (41%) [7]. Severe complications are primarily associated with delays in searching for care, lower-level hospital management and taking time to start treatment at the hospital referred to [6]. Abortion services have been unlawfully and seriously limited by the state in Latin American cities [8]. The clinic delivering abortion services must be in an undercover environment to support women with unwanted or mistimed pregnancies in dangerous conditions [8]. Sixty-three per cent of cases occurred among women under the age of 30 [9]. Financial constraints, stigma and racism, lack of awareness, family or community pressure, poor rural health facilities and inadequate referral networks remain major barriers to effective use of abortion services [10]. Financial constraints, including transportation costs, medications, registration fees and service costs, created obstacles to the quest for safe abortion care and could result in self-induced abortion [10].

Many people of developing countries lived in rural areas where there was a shortage of skilled and educated workers, medicines and supplies to diagnose early pregnancy, abortion availability, counselling, and the provision of abortion and post-abortion care [11]. The referral system was not easy; financial constraints and lack of transport facilities were also a barrier [10]. And sometimes customers ' privacy and confidentiality were not protected properly [10]. In developing countries, unsafe abortions are therefore a major public health issue, mostly in sub-Saharan Africa, the Caribbean, Latin America, and South and Southeast Asia [12]. In some countries, abortion induced is legal, but abortion induced is regarded as immoral activity [13]. Although in many developing countries, nurses were trained for induced abortion to ensure the human rights of women seeking abortion and their training would also allow them to reduce maternal morbidity and mortality, it is found that in Southeast Asia and Sub-Saharan Africa, religion has been described as the most significant influencing variable that can affect women [17-24].

Healthcare providers and medical students considered inexperienced and unqualified to provide induced abortion services in most low-income countries and some mid-income countries [16,17,21,25,26]. For example, the abortion services considered by South African nurses as practices contrary to their professional codes [22]. They also felt contradictory about their professional responsibilities, personal norms and values, and blamed the women seeking abortion for destroying their commitment to care [17,18,22]. Consequently, many midwives and nurses hated abortion services and indicated that they refused to help clients with abortion [17,18,27,28]. Many studies in sub-Saharan Africa reported midwives and nurses had a negative attitude to serve abortion clients, for example, nurses ' resistance in South Africa was also a very powerful barrier to safe abortion services in rural areas [18,20,22,31]. The purpose of this systematic review of literature is to classify, critically evaluate and synthesize qualitative research on the experiences and perspectives of women and health care providers with respect to safe and unsafe abortion. The research also objectively examined the safe and unsafe use of abortion as well as the role of socio-culture and religion in the use of abortion services. Although context research was undertaken, there were no systemic studies which focused on the use of abortion services from cultural and religious perspectives. This research will, therefore, fill the knowledge gap on these aspects. In addition, this evidence-based study will assist developing countries ' policy and decision-makers in improving women's health status.

Methods

This study follows PIO (Population, Intervention and Outcome) as no comparable interventions were available. The population group was mainly pregnant women who had undergone abortion from various developing countries around the world in their sex life and healthcare providers. Safe or unsafe facilities for abortion were the key influencing factors and the resulting factors were experiences or beliefs or behaviours or opinions. Suitable synonyms or keywords were included in the PIO format in all classes.

Inclusion criteria

We agreed to limit our study to developing countries where maternal mortality is comparatively higher than elsewhere in the world. The attitudes and views of a comprehensive health care provider about abortion are addressed in this report. The inclusion criteria for this literature review were all research studies to examine the attitudes and expectations of health care professionals towards security.

Searching strategy and selection of studies

This analysis adopted the Board's five-step search strategy [34]. Available information on abortion services was considered in the first stage. The World Health Organization (WHO), the United Nations Population Fund (UNFPA), the World Bank, Guttmacher International, the Marie Stopes Clinic and EngenderHealth have been looking for basic information on abortion. Furthermore, some Demographic and Health Surveys (DHS) were searched from various developing countries. Second, it listed the specific sources of health-related databases. CINAHL, Cochrane, EMBASE, HTA, MED-

LINE, PROSPERO, PubMed were the main source for repositories of health-related inquiries. Medline and CINAHL were checked together, but with these two sites there was a number of full access posts. Although the number of fully accessible paper was too limited, on that search a list of prospective papers was found. Then Google and PubMed searched for the heading of the prospective articles. Key search terms were identified with synonyms at the third step and proper use was made of the boolean operator' AND,'' OR' and' NOT.'

Similar attention was given to mitigating biases at the fourth step. It was not possible to search any government reports or reports from any national or international organization due to time and other resource constraints. Finally, all available research evidence was properly stored and checked at the fifth stage to identify any duplicate records. To finalize the selected studies, three steps are pursued. The choice of research papers at the first stage was based primarily on reading titles and abstracts alone and considered the type of study, participants in the study, methods used and outcome measures. The entire process was straightforward and it was easy to analyze and replicate the procedure. Some of the experiments were considered duplicated shortly before that point and removed. Only the inclusion criteria and title and abstract of the papers followed this stage to determine either the studies fit for review. The full article was searched by Google and Google Scholar. After reading the full text of each post, the second choice was made. A systematic method of choice of research paper was used to find the papers that fit the selection criteria for both the first and final pick. This helped maintain a standard process for analyzing all the papers in similar ways and helped increase the overall truthfulness of the findings. The final paper choice primarily determines whether the research questions were actually met by the report.

Assessment of quality

The quality evaluation is very relevant for a review since the final results or findings of the study are obtained from the results of individual studies [35]. This critical evaluation process used in the critical evaluation tool of the technical performance of the selected papers by the Joanna Briggs Institute (JBI). JBI recognizes the viability, suitability, meaningfulness and efficacy of clinical procedures of decision-making in evidence-based healthcare. In qualitative research, JBI's critical assessment checklist used 10 questions/criteria/ points on the performance of the analyzed studies. The answers were in 'Yes', 'No', 'Unclear' and 'Not Applicable' format. A paper was selected only when it answers at least seven 'Yes' scores out of ten points.

Data extraction

This paper follows the six-step data extraction method of the Board [36] in the synthesis of qualitative evidence. The expected data was extracted from the selected papers in the first step of the process. Secondly, piloting was carried out with the method of data extraction. Second, a work plan for data extraction was implemented very carefully to avoid prejudices and anomalies, to minimize mistakes or inconsistencies in data extraction and to obtain reliable data. Fourthly, data extraction was performed following the included studies 'methodological performance evaluation and processed in the computer electronically. Fifth, the thematically arranged data extracted. Finally, at the sixth step, extracted data were reported in the synthesis.

Results

Final selection of papers

A standard format was followed in the selection process at the final selection of the papers and the study requirement criterion was checked. It helped maintain a standard process for reviewing all the papers in similar ways and helped increase the overall truthfulness of the findings. The final papers chosen were;

Study	P	I	O	Approach	Action: Include/ Exclude	Remarks
Appiah-Agyekum	Yes	Yes	Yes	Qualitative	Include	Include
Ganatra., *et al.*	Yes	Yes	Yes	Qualitative	Include	include
Laura., *et al.*	Yes	Yes	Yes	Qualitative	Include	Include
Mohammadi., *et al.*	Yes	Yes	Yes	Qualitative	Include	Include
Mollar., *et al.*	Yes	Yes	Yes	Qualitative	Include	Include
Nashid., *et al.*	Yes	Yes	Yes	Qualitative	Include	include
Olsson., *et al.*	Yes	Yes	Yes	Qualitative	Include	include
Puri., *et al.*	Yes	Yes	Yes	Qualitative	Include	Include
Ramachanddn., *et al.*	Yes	Yes	Yes	Qualitative	Include	Include
Shahbazi	Yes	Yes	Yes	Qualitative	Include	include
Sied., *et al.*	Yes	Yes	Yes	Qualitative	Include	Include
Tsui., *et al.*	Yes	? Yes	? Yes	Qualitative	Include	Include

Table 1: Final selection.

Among the all selected papers, two studies were conducted each in Nepal, India and Iran. Each one studied was conducted in Ethiopia, Sri Lanka, Ghana, Haiti and Bangladesh. One study was conducted concurrently in 4 countries (The United States, Nigeria, Pakistan and Peru). Eleven out of twelve studies were conducted in a qualitative method and only one study was conducted with both quantitative and qualitative method. Majority of the studies used thematic analysis with the structured or semi-structured interview schedule. Some of the studies used case studies, content analysis and focused group discussion. The sample sizes of the respondents of ten studies were below fifty.

Ganatra [37] conducted a study with both quantitative and qualitative method with a large number for respondents. This study took an in-depth interview with 1717 married women, 197 adolescents and 43 never-married women. Another study conducted in Ghana with 142 participants through 18 focused group discussion [38]. All the study modalities were with abortion services with different synonyms like reproductive health issues, pregnancy termination, induced abortion, unintended pregnancy and menstrual regulation. Every study examined the socio-demographic background of the abortion service providers and /or abortion-seeking women, reasons and consequences of unintended pregnancies, factors that influenced decision making for taking abortion services, service providers experience and role of contraceptives for reducing safe and unsafe abortion.

Discussion

Most of the research discussed either from the viewpoint of consumers or from the perspective of service providers on the reviewed articles. Very few articles were found discussing the problems from the viewpoint of both consumers and service providers. Many surveys in various parts of developing countries found that service providers were very happy and proud to serve widows and divorced women [39], difficult to reach (rural) areas [40], and people were not aware of the availability of services [10]. Simultaneously, service providers helped clients make decisions [41], emphasizing community awareness of abortion, developing a referral system, and strengthening the financial situation [10]. Some studies adjust abortion causes. The male member or husband ultimately made the decision in a family and influenced the decision making [41]. One of the major causes for making a decision on abortion was health concern and potential pregnancy [42]. Extramarital births, untimely pregnancies, and baby preferences also cause pregnancy abortion [39,42].

Fear of difficulties in life and instability [42], better future life for their children [52], preference for their children [37], unmarried, isolated, adolescent, lack of family support and limited access to services forced women to go abortion [37,39]. Often aware of the availability of contraception and safe abortion service centres and financial constraints that have caused childbirth to continue [10,43]. One of the main obstacles to the use of abortion services was the financial costs, including service charges, drug costs, transportation and registration costs [10,11,50]. Often financial constraints can increase self-induced attempts at abortion, which could be risky and cause complications such as diseases, infertilities and deaths [51]. Legal abortion services were not available in some developing countries, such as delivery, antenatal care or postnatal care [10,50].

Societies do not easily accept abortion services in some developing countries, particularly males were not supportive and women had to conceal the data and went to unsafe abortion services. Negative attitudes often caused women to avoid centres for public health care and they went to unsafe and unlawful providers for abortion [44]. Due to additional costs and concerns of anaesthesia or public disclosure, the service providers' personal reaction and the lack of privacy for women's services avoided government facilities [44,45]. Some of the service providers referred to women as' killer' and nursing staff did not follow the ethical issues of abortion services[44]. When making a decision on abortion, Mohammadi [42] and several studies discussed guilty feelings and afterlife retribution produced moral and religious dilemmas [46-49].

Abortions have been viewed in various societies as unethical, evil and barbaric (Ferede, 2010; Seid, 2015). In most developing countries, pre-marital age, childbirth, separate or widowed pregnancy were not recognized and viewed as immoral [38].

In recent years, many developing countries have liberalized abortion law [53]. But it was not understood to a large number of women and abortion was regarded as illegal [54]. The new laws on abortion and safe abortion care were not identified to both patients and service providers [54]. The new abortion law has not been widely disseminated in Ethiopia, Goodman [55] said, and many people, including health care providers and prospective clients, have not been told about it. There was also a similar situation in Nigeria [56]. Seid [10] claimed that there may be a wide range of legality of abortion and health treatment, but in Ethiopia, there have been unlawful practices of abortion. It suggested that there was not

a wide range of information about programs and the plan failed to address the target group of people [10]. Nigerian research also showed a lack of awareness among women about the law slowed down safe abortion services [39]. Public tabulation and stigma have affected the actions of abortion [38]. Two children's policies influenced people in Iran not to take more children and facilitated abortion [42]. Unsafe abortions in developing countries with unfavourable legal systems to the legality of abortion; however, health care providers have a responsibility to recognize their role in protecting women's health.

Conclusion and Recommendations

The results showed that there is a need for a public health approach that integrates and discusses different aspects of abortion, including women and health care providers in public health initiatives. Haiti's government, international agencies, and HCWs have a unique opportunity to develop and implement sexual health interventions designed to reduce abortions and their complications for Haitian women, in general, and teenagers in particular.

This research article suggests that initiatives aimed at reducing safe and unsafe abortion and improving maternal health conditions such as strong political will, improved opportunities for education and jobs, therapy, safe sex between married and unmarried teens, long-term family planning strategies for post-abortion, enhancing medical abortion, public awareness campaign, favourable law or policy about abortion will be useful for policy-makers, health programmers, clinicians' decision making, researchers, human right activist, women and adolescent clients.

Bibliography

1. WHO. World Health Organisation (2016).
2. WHO. "Maternal Mortality" (2016).
3. WHO. World Health Organisation: About the Diabetes Programme (2016).
4. WHO. World Health Organisation: Health Systems (2016).
5. Wijesinghe Prasantha S. "A qualitative study on patients' perceptions of expectant management of first trimester incomplete miscarriage". (2012): 145-149.
6. Ziraba AK., *et al*. "Unsafe abortion in Kenya: a cross-sectional study of abortion complication severity and associated factors". *BMC Pregnancy and Childbirth* (2015).
7. Gebreselassie H., *et al*. "Caring for women with abortion complications in Ethiopia: national estimates and future implications". 36(2010):6-15.
8. Strickler J., *et al*. "Clandestine Abortion in Latin America: A Clinic Profile". *International Perspectives on Sexual and Reproductive Health* (2001).
9. Ilboudo PGC., *et al*. "Key determinants of induced abortion in women seeking postabortion care in hospital facilities in Ouagadougou, Burkina Faso" (2014).
10. Seid HY. "Barriers to accessing safe abortion services in East Shoa and Arsi Zones of Oromia Regional State, Ethiopia". *Ethiopia Journal Health Development* 29 (2015): 13-21.
11. Essendi HM. "Barriers to Formal Emergency Obstetric Care Services' Utilization". New York: Journal of Urban Health: Bulletin of the New York Academy of Medicine (2010).
12. Grimes DA. "Unsafe abortion: the preventable pandemic". *The Lancet* 368 (2006):1908-1919.
13. Sedgh GB. "Abortion incidence between 1990 and 2014: global, regional, and subregional levels and trends". *The Lancet* 388 (2016): 258-267.
14. Potgieter AG. "South African nurses' accounts for choosing to be termination of pregnancy providers". *Health SA Gesondheid* 9 (2004): 20-30.
15. Harries CD. "Conscientious objection and its impact on abortion service provision in South Africa: a qualitative study". *BMC Reproductive Health* 11 (2014): 16.
16. Djohan IR. "The attitudes of health providers towards abortion in Indonesia". *Reproduction Health Matter* 1 (1993): 32-40.
17. Mayers PB. "Experiences of registered midwives assisting with termination of pregnancies at a tertiary level hospital". *Health SA Gesondheid* 10 (2005): 15-25.
18. Botes A. "Critical thinking by nurses on ethical issues like the termination of pregnancies". *Curationis* 23 (2000): 26-31.
19. Belton WAB. "Attitudes towards the legal context of unsafe abortion in Timor-Leste". *Reproduction Health Matters* 17 (2009): 55-64.

20. Cooper DK. "Medical abortion: the possibilities for introduction in the public sector in South Africa". *Reproduction Health Matter* 13 (2005): 35-43.

21. Buga G. "Attitudes of medical students to induced abortion". *East African Medical Journal* 79 (2002): 259-262.

22. Harrison ME. "Barriers to implementing South Africa's Termination of Pregnancy Act in rural KwaZulu/natal". *Health Policy Plan* 15 (2000): 424-431.

23. Kasule MM. "Abortion: attitudes and perceptions of health professionals in Zimbabwe". *Central African Journal of Medicine* 45 (1999): 239-244.

24. Potgieter AGC. "South African nurses' accounts for choosing to be termination of pregnancy providers". *Health SA Gesondheid* 9 (2004): 20-30.

25. Paul GD. "Barriers and facilitators in the provision of post-abortion care at district level in central Uganda - a qualitative study focusing on task-sharing between physicians and midwives". *BMC* (2014): 14-28.

26. Wheeler ZL. "Attitudes and intentions regarding abortion provision among medical school students in South Africa". *International Perspectives on Sexual and Reproductive Health* 38 (2012): 154-163.

27. Kidula KR. "A survey of the knowledge, attitude and practice of induced abortion among nurses in Kisii district, Kenya". *The Journal of Obstetrics and Gynaecology of Eastern and Central Africa* 10 (1992): 10-12.

28. Mokgethi EV. "Professional nurses' attitudes towards providing termination of pregnancy services in a tertiary hospital in the North West province of South Africa". *Curationis* 29 (2006): 32-39.

29. Klingberg-Allvin NNA. "Perspectives of midwives and doctors on adolescent sexuality and abortion care in Vietnam". *Scandinavian Journal of Public Health* 34 (2006): 414-421.

30. Harries SK. "Health care providers' attitudes towards termination of pregnancy: a qualitative study in South Africa". *BMC Public Health* 9 (2009).

31. Gmeiner VW. "Support for nurses directly involved with women who chose to terminate a pregnancy". *Curationis* 23 (2000): 70-78.

32. Lamina MA. "Health care providers' attitudes towards termination of pregnancy: A qualitative study in Western Nigeria". *Open Journal of Obstetrics and Gynecology* 3 (2013): 400-410.

33. D Laura., *et al*. "Women's and Healthcare Workers' Beliefs and Experiences Surrounding Abortion: The Case of Haiti". (2017).

34. Bolard AC. "Developing my search Strategy and applying inclusion criteria". In Y. D. Fleeman (Ed.), Doing a Systematic Review: A Student's Guide (pp. 35-60). London: Sage Publications Ltd. (2014).

35. Popay JR. Guidance on the Conduct of Narrative Synthesis in Systematic Review (Version 1 ed.). Lancaster: Lancaster University (2006).

36. Bolard ACMDR. Developing my search Strategy and applying inclusion criteria". In: Y. D. a. N. Fleeman, ed. Doing a Systematic Review: A Student's Guide. London: Sage Publications Ltd., (2014): 35-60.

37. Ganatra Ba. "Induced Abortions among Adolescent Women in Rural Maharashtra, India". *Reproductive Health Matters* 10 (2002): 76-85.

38. Appiah-Agyekum NN. "Abortions in Ghana: experiences of university students". *Health Science Journal* 8 (2014): 531-539.

39. Möller AS. "Proud, not yet satisfied: The experiences of abortion service providers in the Kathmandu Valley, Nepal". *Sexual and Reproductive Healthcare* 3 (2012): 135-140.

40. Ramachandar LP. "The Role of Village Health Nurses in Mediating Abortions in Rural Tamil Nadu, India". *Reproductive Health Matters* 10 (2002): 64-75.

41. Puri MR. "Factors Affecting Abortion Decisions among Young Couples in Nepal". *Journal of Adolescent Health* 40 (2007): 535-542.

42. Mohammadi ER. "Iranian Azeri women's perception of unintended pregnancy: A qualitative study". *Iranian Journal of Nursing and Midwifery Research* 20 (2015): 255-262.

43. Olsson PK. "Unmarried women's decisions on pregnancy termination: Qualitative interviews in Colombo, Sri Lanka". *Sexual and Reproductive Healthcare* 1 (2010): 135-140.

44. Shahbazi S. "The consequences of unsafe abortion: a qualitative study". *Journal of Advanced Nursing* 68 (2012): 1247-1255.

45. Pheterson G. "Abortion practice in the northeast Caribbean: 'Just write down stomach pain'". *Reproductive Health Matters* 13 (2005): 44-53.

46. Lie MR. "Experiences of abortion: A narrative review of qualitative studies". *BMC Health Service Research* 8 (2008).

47. Zamani-Alavijeh FN. "Related factors of unwanted pregnancy and intention of women for continuation or termination based on HBM". *Payesh* 10 (2012): 876-885.

48. Chinichian MH NS. "Voluntary abortion in Iran: A qualitative study". *Payesh* 6 (2007): 219-232.

49. Moos MP. "Pregnant women's perspectives on intendedness of pregnancy". *Women Health* 7 (1997): 385-392.

50. LD Albuja. "Women's and Healthcare Workers' Beliefs and Experiences". *Journal of Nursing Scholarship* (2017): 170-176.

51. Shaw J. "Reality check: A close look at accessing abortion services in Canadian hospitals". *Canadian Women's Health Network* (2012).

52. Wilson EM. "Motivations for pregnancy planning among Mexican immigrant women in North Carolina". *Maternal and Child Health Journal* 10 (2010): 311-320.

53. Rahman KL. "A global review of laws on induced abortion, 1985-1997". *International Perspectives on Sexual and Reproductive Health* 24 (1998): 56-64.

54. Singh SE. "Induced Abortion and Unintended Pregnancy in Guatemala". *International Perspectives on Sexual and Reproductive Health* 32 (2006): 136-145.

55. Goodman NA. (2008).

56. Olayinka OA. "Awareness and barriers to utilization of maternal health care services among reproductive women in Amassoma community, Bayelsa State, Nigeria". *International Journal of Nursing and Midwifery* 6 (2014): 10-15.

Volume 1 Issue 7 December 2019
© All rights are reserved by Taha Husain.*, et al.*