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The Emerging Problem of Induced Abortions in Squatter Settlements of Karachi, Pakistan

Introduction

ACCORDING to a 1994 estimate, 53 million induced abortions occur world-wide annually; of which about 20 million are unsafe, performed by unqualified persons or in unhygienic conditions. Health professionals and social scientists have long acknowledged the adverse consequences of unsafe clandestine abortions including mortality, infertility and other gynecological problems such as pelvic inflammatory disease, in addition to the broader costs to society of using scarce medical resources to treat women with health complications of unsafe abortions.

It is estimated that illegal abortion in developing countries kills 1 of every 1,000 to 2,000 cases induced. With an estimated 20 million unsafe abortions occurring annually, 10,000 to 20,000 women die. Illegal abortion is 10 to 250 times more dangerous than any kind of contraceptive measure, depending on the age of the woman and the method used (Laskin 1980). Regarding the relationship of age and parity with complications from clandestine abortions, a four country study from Latin America indicated that younger women had a greater medical risk while parity did not have much effect on the likelihood that complications were the certain result of an induced abortion (Singh and Wulf 1993).

Underreporting and misreporting of abortion (spontaneous and induced) in surveys and health statistics are widespread throughout the world. The magnitude of underreporting is especially significant in those countries where abortion is illegal, as in most Muslim countries and in Africa and South America. Because induced abortion is an extremely sensitive topic, attempts to elicit information from women in developing countries about their abortion experiences have rarely been considered successful. Women who are under legal sanctions are reluctant to admit having had an induced abortion. Even when they

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are compelled to seek help at a hospital, for conditions clearly resulting from an induced abortion, they are often unwilling to acknowledge the cause (Barreto *et al.* 1992). As a result, the incidence of abortion in these countries is difficult to measure (Barreto *et al.* 1992 and Casterline 1989). The rates that are quoted represent, by and large, only the tip of the iceberg, or in other words, just the visible part of the far larger number of women having abortions. This underreporting exists even in those developing countries, such as India, where abortion is legal (Kapoor 1995).

Clearly, the principal reason of women undergoing voluntary termination of pregnancy is because they have unplanned pregnancies that they are determined not to carry to term. But what are the underlying reasons that women undergo the stress and dangers of an unsafe, illegal abortion rather than have an unwanted child. The reasons most often cited for pregnancy termination in countries where induced abortions are illegal were economic constraints, husband's or partner's objection to the pregnancy, woman's feeling that the pregnancy was socially unacceptable primarily because she was single and young, maternal ill-health, bleeding in early pregnancy and extra-marital pregnancy (Hutington *et al.* 1993 and Okonofua *et al.* 1992). However, although the knowledge of contraception was high among Nigerian women, 90 per cent of them had never used contraception and only 45 per cent were prepared to use it in the future (Okonofua *et al.* 1992). In another study in Mali, even after being hospitalised for induced abortion complications, only 19 per cent of the women went home with an effective contraceptive method (Bikin *et al.* 1984).

Several studies indicate that clandestine abortions are generally conducted by physicians, nurses and other paramedical staff, non-medically qualified persons or self-administered (Okonofua *et al.* 1992; Binkin *et al.* 1984; Aggarwal and Mat! 1982 and Khan *et al.* 1984). The methods of self induction commonly reported include self instrumentation with pins, knitting needles, ball-point pens, coat hangers, iron and metal rods, insertion of native vaginal pessaries, ingestion of tablets, injections, ingestion of strong alcoholic drinks, vaginal instillation of potash and vaginal instillation of gunpowder (Okonofua *et al.* 1992; Binkin *et al.* 1984; Aggarwal and Mati 1982 and Khan *et al.* 1984).

In South Asia, it is estimated, albeit under-reported, that six million unsafe abortions take place annually; and that 14 per cent of all maternal deaths can be attributed to clandestine abortions (Kapoor 1995). In addition, it is estimated that the known abortion rate has more than doubled in recent years; an indicator of the vast unmet need for contraception (Kapoor 1995).

Induced abortion is a leading cause of clinical and social concern in Pakistan, especially in the metropolis of Karachi. The mortality and morbidity burden resulting from induced abortions in Pakistan is presumed to be immense. The maternal mortality ratio from a multicentered study conducted in 30 private and public Pakistani hospitals estimated the maternal mortality ratio as 670 per 100,000 livebirths with 11 per cent possibly attributed to induced abortions", nearly 70 per cent of which were due to sepsis (Sadiqua 1994).

^aWomen or their family members are extremely reluctant to report an induced abortion but severity of the complications clearly indicate its true nature to the physicians

On the other hand, community-based data from low squatter settlements of Karachi estimated maternal mortality ratio of 281 per 100,000 livebirths with 6 per cent attributed to induced abortion, all resulting from sepsis (Fikree *et al.* 1994). Generally, Pakistani women report only spontaneous abortions though reports by obstetricians and public health physicians illustrate the prevalence of induced abortions. However, due to the illegality of induced abortion, population-based estimates of levels, risk factors and morbidity consequences of induced abortions have not been recently conducted.

Many complications of induced abortion can be prevented by provision of appropriate health education and contraceptive services, liberalisation of the abortion laws and training of physicians and non-physicians in the management of abortion. However, there is lack of sufficient information about the women who seek termination of pregnancy, and the factors that influence their choice of abortion methods. Such information would help towards identifying a target high risk group on whom preventive measures could be selectively applied.

This paper initially presents the findings of a small study which was conducted to establish whether women would respond, in our cultural milieu, on such a sensitive issue. Following the positive response in this initial study, we proceeded to an in-depth interview of 30 women who we had prior knowledge had undergone an induced abortion.

Materials and Methods

The Department of Community Health Sciences, The Aga Khan University has operational primary health care centres in several squatter settlements of Karachi. Trained community health workers visit each household at least once per month and have developed excellent rapport with the community, especially the women. Learning about a maternal death consequent to induced abortion, the primary health care team of Orangi, the largest urban squatter settlement of Karachi with an estimated population of one million, felt the dire need to investigate the problem of induced abortions in their catchment area.

Thirty-four women, reporting at least one abortion in their pregnancy histories, as extracted from family folders maintained by community health workers, were interviewed in December 1994, to elicit the type of abortions they had experienced, and if an induced abortion was reported, to further investigate the health care provider they went to, the abortifacients used, and their current knowledge and ever use of family planning methods. This preliminary investigation provided only a bird's eye-view of the immensity of the problem though the willingness to report the occurrence and details of induced abortions was very encouraging. However, the lack of information on the decision-making process, reasons for opting for induced abortion, risk factors or morbidity consequences lead us to consider a follow-up study. We identified 30 key informants through discussions with the primary health care teams in two urban squatter settlements - Orangi, where the initial survey was conducted, and Azam Basti, a squatter settlement with a slightly higher economic status than Orangi.

Our case definition of induced abortion refers to those cases who were identified as having an induced abortion by the community health workers but on interview either acknowledged the event ('true' cases) or refused to acknowledge that they had undergone an induced abortion but reported the event as occurring either for a relative, neighbour or friend (cases). A semi-structured interview format was developed and field tested in Orangi on community health workers and other women of the community.. The questions asked included (1) the socio-economic background of the respondent and husband (2) demographic characteristics of the respondent at the time of the first and subsequent induced abortions (3) the abortionist, methods and costs of induced abortion (4) the reasons for the induced abortion (5) knowledge, attitude and practice of contraception prior to and after the index induced abortion and (6) any morbidity occurring consequent to the abortion. Despite a vigorous attempt made for privacy, in our sociocultural context it was well nigh impossible to conduct one on one interviews, generally other female relatives (mainly sisters-in-law, mother-in-law or neighbours) and children were present during the interview. The interviews, conducted by physicians, were administered in Urdu and the field notes made in English. The interviewer was assisted by a transcriber who wrote extensive notes during the interview process in addition to prompting the interviewer for any missing information or probing whenever needed.

Within a few days after completing the interviews, the field notes were entered in 'word' according to the questionnaire guide. Key informants were revisited when discrepancies and missing information were identified during this process. Hand tabulations of the data was then conducted.

Descriptive frequencies for categorical data and means and standard deviations for continuous data are presented initially for the preliminary investigation and then for the 30 key informant interviews.

Results

Preliminary Study

The average age among the 31 ever-married women was 40.74 [(7.52) years ranging from 28 to 56 years⁵. Forty-one percent of the 34 women interviewed reported at least one induced abortion with three women reporting four induced abortions each. Among the 283 pregnancies reported, the frequency of induced abortions was 11.7 per cent. The most frequently reported practitioner was the traditional birth attendant (49 per cent), though physicians (29 per cent) and self-induction (17.6 per cent) were also frequently reported. The main type of abortifacient used was oral though 9 per cent reported insertion of objects into the vagina⁰. The methods used by physicians were dilatation and curettage (D&C), injections and oral medications while the self-induced methods were limited to oral medications. The traditional birth attendant conducted D & C, gave oral medication

^aAge not reported by three women

^c By the traditional birth attendants

and inserted objects into the vagina. Of the 15 women who reported a history of an induced abortion, 80 per cent had knowledge of family planning methods while 68 per cent reported ever use of a contraceptive method, with condom being the most frequently used method.

Key Informant Study

The comparative ease of obtaining any information on this extremely sensitive issue led to in-depth interviewing of 30 key informants^d. The key informants were pre-selected from the family folders maintained in the primary health care centre in consultation with the community health workers or as verbally communicated by the community health workers. We interviewed 18 key informants from Orangi and 12 from Azam Basti. Of these 30 key informants, only 16 openly admitted to seeking a voluntary termination of their pregnancy ('true' cases). We had prior knowledge that the 14 cases had undergone a clandestine abortion as the community health workers had either advised them, accompanied them or had visited them shortly after they had undergone the abortion. Among the 34 women previously interviewed, we could re-interview only three of them—of these only one was a 'true' case. Four (13.3 per cent) of the key informants mentioned that they had twice resorted to induced abortion in their reproductive histories.

At the time of interview, the respondents mean age was 34.66 (\pm 7.65) years, gravidity was 6.07 (\pm 2.93) and parity 4.68 (\pm 2.56). The mean age at marriage was 18.47 (\pm 4.37) years. Nearly 60 per cent of the women were illiterate, while illiteracy level among their spouses was much lower (40 per cent). Educational attainment of over 10 years was significantly higher among husbands (23.3 per cent) as compared to their spouses (3.3 per cent). Three of the 30 key informants were health workers while the remaining were either housewives (83.3 per cent), paramedics (3.3 per cent), or tailors (3.3 per cent). Nearly 40 per cent of their spouses were clerks though 10 per cent were currently unemployed. Twelve of the 30 women (40 per cent) were currently using a contraceptive method. The methods being used were condoms (3/12), injections (2/12), intra-uterine contraceptive devices [IUCDs] (1/12), pills (1/12) and tubal ligation (5/12).

First Induced Abortion

The mean age at the time of the first induced abortion was 28.50 (\pm 6.14) years. The youngest woman was 20 years, married at the age of 12 and had 5 living children (3 boys and 2 girls) and the oldest was 45 years, with 6 living children (4 girls and 2 boys). The women reported, on average, 3.70 (\pm 2.44) living children. The mean gestational age when the index pregnancy was established was 6.14 (\pm 1.05) weeks.

Nearly 80 per cent (24/30) of the women had knowledge of family planning methods prior to and after the induced abortion. The remainder did not have knowledge prior to the induced abortion but four (13.3 per cent) of them reported knowledge of family

^d November - January, 1996

planning after the induced abortion. Of the 24 women who had knowledge of family planning, 11 were using a method prior to and after the abortion. The methods being used prior to the abortion were pills (3/11), condoms (5/11), injections (2/11) and IUCD (1/11) though after the abortion, these women were more likely to use the injection (3/11) and IUCDs (3/11). Six women who were not using a contraceptive method prior to the abortion were using either condoms (3/6), IUCDs (2/6) or Pills (1/6) after the abortion. Thus, following the voluntary termination of pregnancy, the contraceptive prevalence rate rose from 36.7 per cent to 56.7 per cent (p -value > 0.05).

The women reported that they sought advice generally from their husbands (23.3 per cent), health workers (26.7 per cent), neighbours (20.0 per cent), sisters-in-law (23.3 per cent) or traditional birth attendants (10.0 per cent). In addition, advice was also sought from mothers-in-law (3.3 per cent) or mothers (3.3 per cent).

We were interested to establish who was consulted prior to seeking an abortion and then from among these, who was initially consulted. Nearly all women consulted their husbands though only nine (30.0 per cent) consulted their spouses first. Others who were also consulted were sisters-in-law, mothers-in-law, traditional birth attendants, other health workers, neighbours and mothers. Fifty per cent (15/30) of the women reported that the final decision was taken singly. Of these, 12 women (80.0 per cent) said that they took the decision themselves whilst three reported that the decision was taken by their husbands. Among the remaining 15 women who reported that the decision was taken jointly, the most common joint decision was taken by the couple. Only one woman from Orangi reported that she definitely needed her husband's permission before she could seek a clandestine abortion.

The two main reasons for opting for a clandestine abortion were economic reasons (66.7 per cent) and short pregnancy interval (56.7 per cent). Other reported reasons included complications in prior pregnancies (20.0 per cent), heavy work load (16.7 per cent) and inability to handle young children (10.0 per cent). Interestingly three women reported that they resorted to induced abortion because of their desire to space births whilst two women reported a failure of contraceptive methods (ruptured condoms). Maternal ill-health was quoted as a reason for resorting to induced abortion by only three women.

The most frequently used method of these clandestine abortions was D&C. Of the 30 key informants, twenty women (66.7 per cent) reported undergoing a D&C conducted either by physicians (16 women) in their private clinics, at the homes of the women or in a family planning centres⁶, by nurses (2 women) or by lady health visitors (2 women). Injections as an abortifacient were reported by two women while the remaining resorted

^e Located in Azam Basti.

^f *The stick'* on physical examination is a slender wooden filament having a black tip. It resembles the age old method of *'laminaria tents'* which have been profusely used in the past and are recently being used in some areas. *The stick'* is inserted into the cervix and, generally, within 24 hours the fetus is aborted. The *'laminaria tents'* brings about a slow atraumatic dilatation of the cervix. The traditional birth attendants are, however, aware that sepsis can result, and they prescribe antibiotics for a week. Among the six women who resorted to *'the stick'* as their preferred method, only two were unsuccessful as they had incomplete abortion. Both referred to the tertiary care hospital where a D & C was performed.

to either *'the stick'** (3 women), tablets (one woman), moving a heavy object (one woman), or taking herbal potions (2 women)^g.

There were four unsuccessful attempts reported. Of these, three women reported that their initial attempt by injection and tablets or *'the stick'* was unsuccessful but, consequent to haemorrhage (one woman) or sepsis (two women) referred to a tertiary care hospital for D&C^h. However, one woman had a totally unsuccessful attempt after resorting to tablets, injections and finally a herbal potion (*ajvain*).

Sixteen women reported a post-abortion illness' though only three of them reported fever while one reported fever and foul smelling vaginal discharge. However, women were generally aware that there were dire consequences following an unsafe abortion. The common consequences reported were weakness (43.3 per cent), loss of blood (33.3 per cent), death (20.0 per cent) or infertility (10.0 per cent). Seven women did not report any consequences of induced abortion. However, a sense of guilt was reported by four women (13.3 per cent)—one, resorting to an induced abortion at age 30 with two girls, felt guilty after she realised that the aborted fetus was male.

There was no gender discrimination observed among 29 women for seeking an abortion. Only one woman from Azam Basti specifically reported that she sought abortion as she already had four girls and had 'somatic feelings' that the current pregnancy was of a girl child. None of these women identified the gender of the fetus prior to seeking an abortion.

The practitioners generally consulted ranged from physicians, lady health visitors, traditional birth attendants, homeopaths and pharmacists. The physicians and lady health workers generally conducted D&C without general anaesthesia, though tablets and injections were also provided as an abortifacient. The traditional birth attendants gave herbal potions' or inserted *'the stick'* into cervix, whilst the homeopaths prescribed tablets or drops and the pharmacist gave tablets. The most expensive method was D&C (mean Rs 1,663.50 (1,562.50)), though there was a disparity between Azam Basti (mean Rs 649.41 (150.68)) and Orangi (mean cost Rs 2,334.00 (1,856.31)). Most of the clandestine abortions reported in Azam Basti were from one clinic which, officially reported that they daily conduct approximately six abortions^k. The 12 women interviewed from Azam Basti were all aware of the services provided by this clinic. *'The stick'* was the preferred method used by traditional birth attendants in Azam Basti but was not reported by any woman in Orangi. Tablets was the cheapest method reported - cost ranged from Rs 10 to Rs 50.

The skill rather than the cost was the most frequently reported criteria for deciding which practitioner to approach. Eighteen women (60.0 per cent) reported that skill was their primary concern, though seven women (23.3 per cent) reported cost.

^g Herbal potions taken were a concoction of eggs, tea and choaray (dried dates).

^h These have been included among women reporting a D&C.

ⁱ Backache, weakness, fever, foul smelling vaginal discharge and generalised body pain.

^j The herbs inserted or eaten were carrots, castor oil seeds, ajwain, sonth, gur and choaray. ,

^k A health worker reported that she regularly observes approximately 30-40 women daily seeking abortions at this family planning centre.

We asked the key informants to report their best estimation of the prevalence of induced abortion in their community¹. Only 16 women responded to this question. Nearly 19 per cent of these 16 women observed that, in their best estimation, the prevalence of induced abortion was 50 per cent and over. Prevalence of under five percent was reported by 6 women (37.5 per cent).

Not only were husbands most often approached for advice and consulted prior to proceeding for an abortion, they were generally the ones to pay the expenses for the abortion (76.7 per cent). There were four women who paid the costs from their household budget and one woman who borrowed from her neighbour.

Second Induced Abortion

Four of the 30 key informants mentioned that they had twice resorted to an induced abortion. The mean age at the time of their second induced abortion was nearly 30 years, reported, on average, 3 living children, and realised that they were pregnant at approximately 7 weeks of gestation. Though all were aware of contraceptive methods prior to the abortion, three were using a method both before and after the abortion¹, while three are currently using a method². Advice, decision and expenses for the clandestine abortion were taken from husbands as reported by three women, whilst the fourth reported that she sought help herself and borrowed money from her neighbour⁰.

Three women resorted to the same method¹ while one resorted to a D & C for the first abortion but for the second sought a traditional birth attendant who used *'the stick'*. None of these women reported any post-abortion illness.

Discussion

The results from the preliminary study illustrated women's awareness and willingness to discuss the sensitive subject of induced abortions. Underreporting of abortions (spontaneous and induced) is universally acknowledged to be widespread (Barreto *et al.* 1992 and Casterline 1989). In Pakistan, the major demographic surveys such as The Pakistan Demographic and Health Survey and the Pakistan Demographic Surveys report birth histories and not pregnancy histories, primarily due to the extensive underreporting of abortions. We are aware of only one other population-based study conducted in a low socio-economic settlement of Lahore, Pakistan (1963-65) which reported an induced

¹ We asked: 'In your opinion, can you approximately tell me how many women undergo an induced abortion in your community?' Very few women would directly respond to this question. The interviewer would then further explain the question by asking them, in their best estimation out of 100 women, or if they could not respond to this, out of 10 women, how many women would resort to an induced abortion.

² Pills, condoms and IUCDs were the methods reported.

³ Two using an IUCD and one had a tubal ligation.

⁰ This woman had borrowed money from her neighbour for her first induced abortion too.

¹ D & C by physician reported by two women and 'the stick' by traditional birth attendant by one woman.

abortion rate of 2.8 per cent (Awan *et al.* 1994), significantly lower than the 11.7 per cent reported from our study. The higher abortion rate from our study may be partly explained by the fact that our respondents were pre-selected based on their reproductive histories. However, we feel that household economic constraints and easier accessibility to abortionists may have played a much larger role in the higher abortion rate reported than selection bias.

The key informant study, conducted in the same area as the preliminary study, revealed that though women did not show inhibitions about discussing induced abortions, only 53.3 per cent openly acknowledged that they had resorted to an induced abortion ('true cases'). In fact, of the three women whom we were able to re-interview from the preliminary study, only one was a 'true' case illustrating the sensitivity and the inhibition around this subject.

The abortion seekers from our study were generally all married, young, illiterate with, on average, 3.7 living children at the time of their first induced abortion. On the other hand, for the second abortion the women were, on average, a year older but had fewer living children. In studies conducted in some African countries, the women were also young, but their parity ranged between 0 and 8 with 58 per cent being single, never married women *et al.* (Okonofua, 1992) while in some Latin American countries, the women tended to be older, urban, married and have several living children (Singh and Wulf 1993).

Our results, in contrast to reports from Africa and Latin America, indicate that women are perhaps, resorting to induced abortions as a method of terminating unwanted pregnancies for limiting births and thereby achieving their ideal family size. This is further supported by the fact that, though 80 per cent of women reported knowledge of family planning prior to the unwanted pregnancy, only 36.7 per cent were actually using any method previously. The contraceptive prevalence rate increasing to 56.7 per cent after the clandestine termination of pregnancy bodes well and emphasizes the acute need for good quality reproductive health services. These figures are in sharp contrast to studies conducted in Africa where only 19 per cent of African women were reported as having been sent home with an effective contraceptive method after hospitalization for complications resulting from unsafe abortions (Binkin *et al.* 1984) or the 45 per cent of African women who were only prepared to use contraceptive methods in the future (Okonofua *et al.* 1992).

The low contraceptive rate among these largely illiterate women who, knowing about and even having access to contraceptives, still opt for terminating their pregnancy may be, as suggested by Dixon-Mueller and Germain (1993), due principally to the fact that the decision to terminate a pregnancy is taken only when actually pregnant. Consequently, voluntary termination of pregnancy, indicating a 'curative' rather than a 'preventive' approach to birth control, is perhaps considered the better option, as its outcome is more certain than a contraceptive that may or may not be effective. The high prevalence of clandestine abortions, as quoted by these women, further supports the notion that a curative rather than a preventive approach to birth control is contemplated as a more feasible option. Despite the limitations of this small, pre-selected group of women, the ineffectiveness'

of the 'preventive' approach to birth control is illustrated by contraceptive failure among two women (6.7 per cent) and the misinformation given to a woman (3.3 per cent) about injectables.

The ideal family size for ever-married and currently married Pakistani women is 4.1 children on average (Ali and Rukanuddin 1992) while the parity status of women undergoing abortions was, on average, 3.7 living children. This suggests that Pakistani women, on average, are perhaps seeking voluntary termination of pregnancy to achieve their ideal family size rather than attempting to use contraceptive methods. The question whether induced abortions is being considered a limiting rather than a spacing method of contraception cannot be established by our study, though the data provides some insight into the birth limiting role of induced abortions.

The inventory of underlying reasons for undergoing the stress and danger of an unsafe, illegal abortion rather than carrying an unwanted pregnancy to term from our and other studies in developing countries and even in developed countries is very similar, suggesting a certain universality to women's experiences with unwanted pregnancies. However, what is striking in our study is that clandestine abortions were sought, by and large, in connivance with spouses, sisters-in-law, mothers-in-law or mothers. They were generally the ones who were approached for advice and consulted prior to the final decision being taken. In addition, the cost of these clandestine abortions were frequently (76.7 per cent) borne by husbands.

The abortifacients and health care practitioners used in our study is comparable to those reported from other studies (Okonofua *et al.* 1992; Binkin *et al.* 1984; Aggarwal and Mati 1982 and Khan *et al.* 1984), though D & C as well as physicians providing D&C were more frequently reported in our study, suggesting that despite its illegality, the economic gains (average cost Rs. 1,663.50) is substantial enough for health care practitioners to undertake the risk and perform this procedure.

Though our study revealed that 53.3 per cent of women reported some sort of perceived post-abortion illness, only four women (13.3 per cent) reported either fever or fever and foul-smelling vaginal discharge. In addition, two of the women who had an incomplete abortion subsequently developed sepsis and were admitted to a hospital. Unfortunately, we could not establish the mortality rate from this investigation but community (Fikree *et al.* 1994) and hospital (Sadiqua 1994) based studies conducted in Pakistan and other developing countries clearly depicts a dismal picture.

The morbidity and mortality consequences of clandestine abortions reported in our study clearly demonstrates that Pakistani women are knowledgeable about the problems that they will face when seeking a clandestine, unsafe abortion. When asked whether the cost or the skill of provider was the determining factor in selecting the abortionist, only 23.3 per cent of women reported that cost was their primary concern. The findings from our study indicate that Pakistani women, aware of the consequences of induced abortion and deeply concerned about their health, generally seek the most skilful abortionist, irrespective of cost.

Conclusion

In summary, the results of our study suggest that Pakistani women, living in low socio-economic settlements of Karachi, seek voluntary termination of their pregnancy in complete cognisance of its dire consequences, as a result primarily of their determination not to have more children than they and their families can responsibly care for.

That the ideal Pakistani family size of 4.1 children is being achieved, in part, by means of widespread reliance on induced abortion—at considerable cost to women's health, safety and dignity—receives little recognition. The cost—in terms of the expenditure of scarce health resources to treat women hospitalised for abortion complications, and in terms of women's economic productivity—also is considerable. It is suggested that the government acknowledge that clandestine abortions are a daily occurrence in the megacity of Karachi and that prevention of unwanted pregnancies is more effective and less expensive than caring for its complications.

We suggest that prevention of unwanted pregnancies by good quality contraceptive services sensitive to women's needs and concerns, with a strong emphasis on counselling coupled with reproductive health education that raises a woman's awareness about her own body, her sexuality and her ability to decide about her fertility will go a long way in decreasing the prevalence of clandestine abortions.

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