Induced abortion in Sri Lanka

The high abortion rate in Sri Lanka represents a series of missed opportunities

Induced abortion in Sri Lanka is a problem that has been conveniently ignored for too long. In 1984, the Minister of Health said that over 500 abortions are done in Colombo daily, and that this was only the “tip of the iceberg” [1]. The proportion of women aged between 35 and 39 years undergoing an abortion in 1998 was estimated to be 0.0667 (95% CI= 0.0458–0.0877) [2]. In the present day it is estimated that for every 10 babies born in Sri Lanka, seven are being aborted [2]. About 700 induced abortions are done in Sri Lanka daily [2].

The practice of abortion has become so widespread in Sri Lanka that over the past three decades, many researchers feel that abortion is being used as a means of fertility regulation [3–5]. The total abortion rate for married women between the age of 15 and 49 years for 1998 was 1.92 (95% CI = 1.20–2.64), a figure close to the total fertility rate for the country [2, 6]. These induced abortion figures are surprisingly high for a country with a contraceptive prevalence rate of 70% [6]. The two common reasons for seeking an abortion in Sri Lanka are, becoming pregnant either when the youngest child is too small [7, 8], or after the completion of the family. The abortion seekers are most likely to be rural married women [7]. Less than 10% of them are single [7,8]. Since abortion is illegal in Sri Lanka, except when it is performed to save the life of the mother, there is a chance that many of these are performed under unsafe conditions.

Enquiry into maternal deaths, conducted by the Ministry of Health in recent years, show induced abortion to be in the second or third place after obstetric haemorrhage and hypertensive diseases of pregnancy, accounting for about 12–13% of the deaths. A comprehensive report on maternal deaths in Sri Lanka in 1996 indicated that induced abortion accounted for 11.3% of the deaths [9]. Again, it ranked third as a direct cause. Maternal death is only one of the long list of complications caused by induced abortion.

The global situation is that wealthy women all over the world can buy a safe abortion [10]. Unsafe abortion is a problem of poor women. There is a 500-fold difference between the risk of death from abortion using vacuum aspiration technique and traditional methods [11], and 10–50% of induced abortions would require medical intervention for one of its complications. The International Conference on Population and Development held in Cairo in 1994 recognised induced abortion as a major global public health issue [12], and the need to provide services to treat post-abortion complications and compassionate post-abortion counselling.

The complications of unsafe abortion vary from incomplete evacuation of the uterus to life-threatening septicaemia. Unsafe abortion thus remains
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the most easily preventable cause of maternal mortality. In the long run, it can cause chronic pelvic inflammatory disease and potentially ectopic pregnancy.

The rate of abortion in Sri Lanka raises questions about the present state of the family planning services, and whether there is a need to review the century old abortion law. The pro-life versus pro-choice debate is intense and passionate even in countries where abortion is available liberally. In Sri Lanka, an amendment to the law sponsored by interested groups to liberalise abortion in cases of lethal congenital anomalies, incest, rape and contraceptive failure was presented to the National State Assembly in 1995. It was abandoned after the debate that followed its very first reading [13]. Although abortion is commonplace, Sri Lanka apparently does not seem ready for a change in the law. Restrictive laws will neither deter women from seeking abortion nor compel them to prevent unwanted pregnancies [14]. The Sri Lankan situation illustrates this clearly.

Statistics from the intensive care units of the three teaching hospitals providing maternity care in and around Colombo for the year 2002 show that they have received only eight patients with a diagnosis of septic abortion and that only one died. This trend is reflected in the latest available maternal mortality figures. In the year 2001, septic abortion has gone down to fifth place as a cause of death, accounting for only 8% [15]. The question arises whether this decline could be due to the emergence of a safe abortion service. It is known that the manual vacuum aspiration method is widely used for abortion in Sri Lanka [10]. Its safety is well recognised [16].

The reduction in deaths from septic abortion may also be due to the availability of Postinor 2, the emergency contraception tablets. The Family Planning Association of Sri Lanka, a non-governmental organisation, has conducted a successful advertising campaign and monthly sales have increased from 400 packs in 1998 to about 20 000 in 2003 (Personal communication, Dr. Sriyani Basnayake). There may be lessons for the national family planning campaign from this success story.

The majority of abortions in Sri Lanka occur within marriage. In one study involving six centres offering an abortion service in five districts, 93.7% of the clients were married women [7]. Contrary to what would be expected, the majority of abortion seekers in this study were from rural areas (55.5%) and unemployed (74.2%). The most frequent reason for requesting an abortion was that the youngest child was too young, 28.8% giving this reason. This represents a missed opportunity to prevent abortions through education regarding postpartum contraception.

A mother who has recently delivered a child would be available for counselling on contraception throughout the pregnancy, during the period of hospitalisation for childbirth and during the postnatal period. Mothers delivering in the year 2000 received 2.8 visits on an average from their area midwife during the first 10 days after delivery [17]. While this aspect of the service seems to be concentrated in the immediate postpartum period to reduce maternal and infant mortality, later visits would be needed to counsel regarding postpartum contraception. This would address one of the main reasons for seeking an abortion.

In a recent study in a maternity hospital in Colombo involving 100 mother-father pairs we found that only 39% of the mothers and 7% of the fathers were aware that contraception is required from six weeks postpartum onwards [18]. Only 76% of the mothers and 28% of the fathers had received information regarding family planning during the current pregnancy. Such statistics from the premier maternity hospital in the country suggest that knowledge regarding postpartum contraception is poor in Sri Lanka, and may explain the main reason for seeking abortion.
The other major reason to seek an abortion was conception after completion of the family (21%) [7]. According to the latest available statistics, 21% of women who have completed their families were not using any contraceptive method and another 23% were using traditional methods, notorious for their unreliability [6]. These are similar to the figures found in 1993, indicating a deficiency in educational efforts that went into improving contraception [6].

The main reasons given for seeking an abortion relate to women who have had at least one baby. This holds out hope that educational interventions for contraception could be carried out during pregnancy. The personnel providing antenatal care should offer individualised advice on contraception to mothers, the advice should be an integral part of at least the booked visits to the clinic. The contact between the field staff and mothers should extend beyond the initial postpartum period. The importance of contact six weeks postpartum mainly to discuss contraception must be emphasised.

In a recent study, 87.3% of new acceptors of the intrauterine device (IUD) said that they did so after being motivated by a Public Health Midwife (PHM) [19]. The figure for depomedroxy progesterone acetate (DMPA) was 55.7%. The predominant service provider for the IUD is the Public Health Nursing Sister, accounting for 78.2% of the insertions [19]. Also, 94% of the women who accepted an IUD were given post-insertion counselling, indicating quality service [19]. This probably explains the high continuation rate for the IUD in Sri Lanka, with 80% continuing the method for over 18 months. The comparable figure for DMPA is only 53.1% [19].

The low continuation rate for DMPA is a matter of concern, since it is the most commonly accepted modern temporary method in Sri Lanka, accounting for 55% [17]. Again, this may relate to the quality of service provision. A recent survey showed that as many as 48% of the women who stop DMPA do so due to side-effects [17].

The abortion rate in Sri Lanka is too high, and it signifies a series of missed opportunities on the part of health care providers. The vast majority of abortion seekers are women who have had repeated contact with the health system, and thus been available for counselling, and motivation for family planning. Health planners will need to take a serious look at how contraception services are delivered. The service has to become accessible, and education of the public on the safety of contraceptive methods has to be a priority.

A safe abortion service may be emerging in the private sector in some parts of the country, with the public accessing it freely. The poorer women from remote areas will however continue to depend on dangerous traditional methods of abortion and in doing so risk life. Despite a high contraceptive prevalence, abortion contributes in a major way to maintaining a “replacement value” total fertility rate.

Whatever the legal status or safety of abortion in Sri Lanka, it is only by a thorough revamping of service delivery of family planning that the abortion rate in Sri Lanka could be brought down to any reasonable degree. The country needs this badly.

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Wound care in Sri Lanka: our patients deserve better care

A multidisciplinary approach and dedicated clinical care are prerequisites

Chronic ulcers are a major problem in health care worldwide [1–5]. Wound care is a much neglected field in Sri Lanka. Care of a wound, and advising and supervising the medical team to carry out the necessary measures in wound care, is a basic duty of a clinician. Wounds are an ideal opportunity to demonstrate the ‘art and science of healing’. Patients with chronic wounds are often shunned by the family, employers and the society. Empathy and compassion should be essential attributes of the wound care team; in addition to a sound scientific knowledge on wound healing. A person with a chronic wound would be happy to see the wound heal. Even the care-giver derives much satisfaction to see a wound-free patient.

Much progress has been made in understanding the wound healing process in the last two decades and some of that knowledge has translated into practice by way of advanced dressings and genetically engineered bio-products. No studies are available from Sri Lanka on the economic burden of chronic ulcers and their sequelae. It has been estimated that in the UK the total annual cost of treatment of leg ulcers is UK £ 230–400 million [6].

Causes of chronic ulcers

In Sri Lanka the common causes of chronic ulcers include, diabetic ulcers, neuropathic ulcers (e.g. leprosy), pressure ulcers, burns, venous ulcers and arterial ulcers [7]. In addition, there are non-healing ulcers such as pyoderma gangrenosum and Marjolin’s ulcers.

The mechanisms currently adopted by doctors and the ‘care’ that the patients receive in the case of chronic ulcers, is certainly suboptimal in Sri Lanka [7]. Sometimes in busy wards, doctors and nurses delegate the duty of wound inspection and dressings to unqualified medical attendants. This is far from satisfactory.

Several factors have led to the inadequate care of patients with chronic ulcers. Poor emphasis on wound care by clinicians and health care managers, and lack of proper dressings and other facilities, trained wound care nurses, cohesive multidisciplinary approach (e.g. vascular surgeons, dermatologists, plastic surgeons, diabetologists, wound care nurses, pediatrists), and ignorance about the long term cost of improper wound management are some reasons. Recognition of curable causes of chronic ulcers (e.g. tuberculosis, amoebiasis, cutaneous meliodiosis) and more sinister causes (e.g. squamous cell carcinoma, basal cell carcinoma, amelanotic melanoma) cannot be done by untrained personnel. Clinicians should evaluate chronic ulcers at least periodically.

Overuse of topical antibiotics on chronic ulcers is a common practice, especially at primary care level. This often complicates the healing process (e.g. development of resistant organisms, contact dermatitis, wound bed irritation). What is more relevant is to prepare the wound bed so that the natural healing mechanisms can take effect [8, 9]. Severe pain is a distressing feature of certain types of ulcers. Pain management of chronic ulcers, especially at dressing changes, is another aspect which needs more attention [10].

The size of the ulcer or the area of the ulcer is not measured or recorded in most wards. At dressing changes this should be recorded. Some centres use simple methods of measurement, whereas some centres abroad use computerised methods [11]. Recording the status of the ulcer base, margins and the size should be emphasised in routine wound management.

Inadequate care of ulcers can have an immediate serious medical outcome or a great socio-economic impact. For example, as an immediate result, a diabetic patient may lose a limb through an emergency amputation or even die of septicaemia or ketoacidosis if a wound is not managed properly. Proper management of diabetes and diabetic ulcers would save lives as well as prevent amputations; and in the long run, save millions of rupees that would be spent on unnecessary wound care. As a long term sequel, any chronic wound has the potential to develop a squamous cell carcinoma (Marjolin’s ulcer) which could lead to fatal secondary deposits if not detected and treated early. Even a non-