

## Reducing abortions is a public health issue

*Health professionals' associations must not avoid the issue of abortion because it is controversial*

In no case should abortion be promoted as a method of family planning. All Governments and relevant inter-governmental and non-governmental organisations are urged to strengthen their commitment to women's health, to deal with the health impact of unsafe abortion as a major public health concern and reduce the recourse to abortion through expanded and improved family planning services. In all cases, women should have access to quality services for the management of complications arising from abortion. *International Conference on Population and Development Programme of Action, 1994* (1).

In a perfect world all pregnancies might be planned and wanted. Some unwanted pregnancies are carried to term, others abort spontaneously. Some women resort to termination.

In this article the term abortion refers to induced abortion. The law concerning abortion in Sri Lanka was enacted in 1883. Abortion is illegal in Sri Lanka except when it is performed in good faith and for the sole purpose of saving the life of the mother. While 61% of humanity lives in countries where termination of pregnancy is legal and generally available, Sri Lanka is one of the 21% of countries where termination of pregnancy is legal only to save the mother's life (2). Because abortions are clandestine, there is a lack of reliable statistics. Estimates indicate that 150 000 to 175 000 abortions are performed each year in Sri Lanka (3). Because of restrictive abortion laws, doctors are usually unwilling to provide the service. If provided, the cost in private facilities is high, or abortions are performed in unsatisfactory settings. Unsafe abortions are characterised by inadequate provider's skills, hazardous techniques and unsanitary facilities (4). Sometimes the woman herself carries out the procedure. The mortality and morbidity of abortion depend on the facilities available, skill of the abortionist, the methods used, certain characteristics of the woman herself, such as general health, presence of sexually transmitted infections (STI), age, parity and the gestation period, and the availability of treatment facilities for complications.

Abortions and their complications account for about 5 to 6% of maternal deaths in Sri Lanka (5). These deaths are tragic, because they are the easiest maternal deaths to prevent. Post-abortal morbidity is considerable. The expense involved in treating such complications is a heavy drain on scarce resources.

### Why do women seek abortion?

Rising aspirations resulting from increased educational level of women, increased costs of living and the desire to be gainfully employed have contributed to increased motivation to control fertility. Reasons given

by women seeking abortion (3) are that the youngest child was too young (27.3%), local or foreign employment prospects (14.6%), poverty (13.2%), and having completed their family (7%). The highest proportion of clients was in the 30 to 34 age group. Although only 2.5% of clients interviewed said they were unmarried, the researchers' estimate was that about 10% were unmarried (3). These findings are similar to those of a study carried out in 1983 by the Ministry of Plan Implementation (6).

Fertility levels during the past 20 years have shown a steady decline. The Demographic and Health Survey 1993 shows that the total fertility rate (TFR) has declined from 3.4 children in the early 1980s to 2.3 between 1988 to 1993 (7). Fertility decline has taken place within marriage from the increased use of contraception. Contraceptive prevalence rate (CPR) has increased from 57.8% in 1982 to 66.1% in 1993, but 22.4% of married women use the traditional method. The fallibility of traditional methods is well known, and it is possible that the high level of induced abortion is a consequence of contraceptive failure in women using traditional contraceptive methods.

Sterilisations contributed to 27.2% of the CPR but male sterilisation has shown a steady decline since the 1980s, when high rates were reached possibly because of incentives provided to acceptors (7). Thus family planning has become a predominantly women's responsibility. Almost two-thirds of women who are not using contraception do not want to have any more children or wish to postpone the next pregnancy at least by two years. The main reasons for non-use are health concerns (18.2%), infrequent sex (17.2%), opposition or disapproval of the partner (12.8%) and post-partum breast feeding (9.1%) (7).

There are geographical areas and population groups where contraceptive use is low and fertility is high. About 25% of currently married women were in need of family planning services, 14% did not want any children, and nearly 11% wanted to postpone the next pregnancy. However, only 11% were willing to use contraception although awareness of family planning was high. This indicates a need for better counselling to promote contraceptive use among this category (7).

### Strategies for preventing unsafe abortion

#### *Sex education*

The prevention of unwanted pregnancy involves the personal regulation of sexual behaviour and the use of contraception. How people behave sexually depends on many factors, such as the ethical standards they have acquired at home, from religious teaching, from school and from society, the need for a relationship that provides love and support, ability to communicate with a partner or a prospective partner about sexual matters, knowledge of sexual biology, knowledge of contraceptive technique and access to contraceptives.

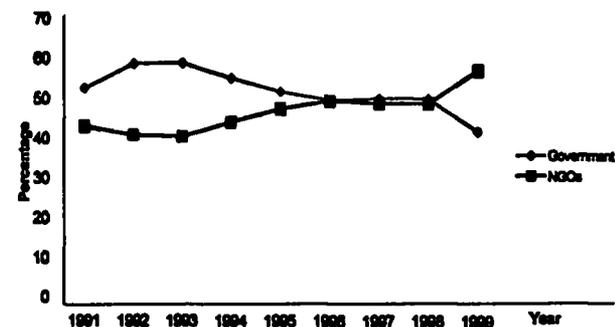
Many difficulties that couples have in managing their sexual activity is due to their feeling that sex is embarrassing, disapproved of and potentially dangerous. Hence sexual pleasure is mixed with guilt and anxiety. Young people may know about the biology of sex but rarely have the vocabulary or skills to communicate with each other about sexuality. This is a consequence of the frequent inability of parents and teachers to talk openly about sex. Mutual respect and the ability to communicate are fundamental to the avoidance of unplanned pregnancy.

**Improved access to contraception**

Despite the government's efforts to strengthen the family planning service coverage, the unmet need is estimated to be 6 to 12%. Access to family planning counselling and services is urgently needed for urban slum dwellers, the plantation sector, export processing zones, internally displaced persons, and those living in remote rural areas. To increase the uptake of modern contraceptive methods it is important to stress their beneficial health effects. Misconceptions about the safety of modern contraceptives need to be dispelled. This requires accurate information and adequate family planning counselling.

The increasing gap between menarche and marriage (25.5 years in 1993 for women) may result in an increased incidence of pregnancy out of wedlock (7). The unmarried young are not directly targeted for contraceptive services under the government program, though contraceptives could be provided to any individual who requests it. Marital status is no longer recorded when obtaining contraceptives from the government program. It is important that counselling and services to the unmarried are provided in a confidential manner.

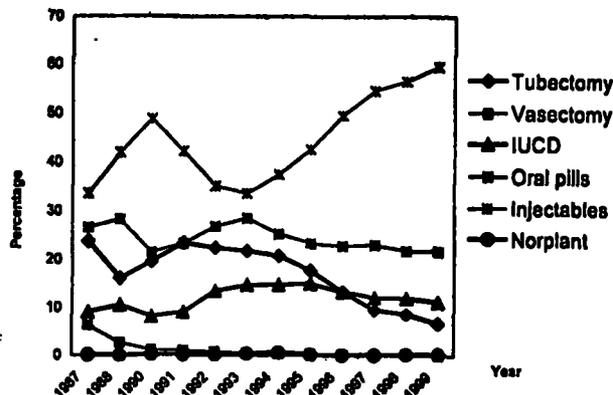
The government sector adopts a 'cafeteria' approach to providing family planning. However, gaps in the services exist such as the poor availability of modern terminal methods. For the first time 1999 non-governmental organisations performed more tubectomies than the government sector (Figure 1). The dramatic increase of injectables as



Source- Annual Health Reports on Family Health- Sri Lanka Family Health Bureau

**Figure 1. Female sterilisation carried out by government and NGOs (NGOs include Family Planning Association of Sri Lanka, Population Development Services, Community Development Services, Sri Lanka Association for Voluntary Surgical Contraception)**

the method chosen by new contraceptive acceptors could well be a result of the unmet demand for terminal and other modern methods of contraception (Figure 2). Furthermore, breakdown of supplies of contraceptives is another reason for non-availability of family planning methods at service outlets.



Source- Annual Health Reports on Family Health- Sri Lanka Family Health Bureau

**Figure 2. Contraceptive uptake by new acceptors (from 1987-1999)**

**Emergency contraception**

Emergency contraception (EC) is an effective, but underused, means of preventing unplanned pregnancies following unprotected intercourse or contraceptive failure. Estimates indicate that EC will prevent about 50% of all unintended pregnancies, one half of which would have ended in abortion (8). Easy access to EC is important because the first dose must be taken within 72 hours of intercourse. Currently the Family Planning Association of Sri Lanka markets the only emergency contraceptive pill available through retail sales outlets. The government sector, which is the primary source of contraceptive for 83% of current users, does not provide a branded emergency contraceptive pill. Staff has been instructed to use the combined oral contraceptive which is used for routine family planning, for EC (9). It is pertinent to provide dedicated EC pills through the government program. The copper IUCD is used for the EC but requires trained personnel and clinic facilities. It is best suited for those who wish to continue with it for regular contraception. Health professionals should provide information to all women in the reproductive age group on EC.

**NGO-private sector co-operation**

In addition to the government, four NGOs and the private sector also provide family planning information and services. They should be recognised as important partners. General practitioners need regular distance education programs to update their knowledge.

**Promote male involvement**

The prevailing social attitudes condone male dominance. Greater gender sensitisation and incorporation

of gender component is required in reproductive health programs. Men should be targeted to increase their knowledge on reproductive health issues. This will increase their awareness of partners' reproductive health choices and enhance access to male contraceptive methods.

#### *Strengthen the contraceptive logistics system*

Ensuring an unbroken supply of contraceptives and other equipment is necessary. An adequate buffer stock of contraceptives must be maintained. Policy makers must be conscious of the increasing number of women in the reproductive age group whose contraceptive requirements will increase in the next 10 years.

#### **Safe abortion services**

An attempt to reform the restrictive abortion laws to permit termination for fetal malformations and pregnancy following rape or incest failed when the 1995 Penal Code Amendment was withdrawn. 'Right to life' arguments and other justifications based on tradition were articulated in the parliamentary debate (10).

Restrictive legislation is associated with higher rates of unsafe abortion and correspondingly high mortality. Such restrictive legislation does not, by itself, decrease abortions, or compel women to prevent unwanted pregnancies. Legalisation is a prerequisite to making abortion safe. In Romania, for example, abortion related deaths increased sharply when the law became very restrictive in 1966, and fell after 1990 with a return to less restrictive legislation (11). In Sri Lanka physical, legal and social implications of abortion impinge selectively on poor women who lack the necessary knowledge and money to obtain a safe abortion. Besides, it is socio-economic problems that prompt many women to seek an abortion. Under such circumstances a woman's determination to avert an unwanted pregnancy will be sufficiently strong for her to undergo an illegal procedure. Decriminalising abortion is seen by concerned individuals and women's activists as a means for achieving social justice.

Liberalising abortion does not necessarily increase abortion rates. The Netherlands, for example, has a non-restrictive abortion law, widely accessible contraceptives and free abortion services, and the lowest abortion rate in the world (12). Merely decriminalising abortion is insufficient if services are not readily available and safe. In India where abortion is legal since 1972, services are severely limited. Of the estimated 6.7 million abortions performed each year in India, only 500 000 are reported. Hence 6.2 million are carried out under unsafe conditions. In 1994, 20% (15 000 to 20 000) of maternal deaths in India were due to unsafe abortions (13).

The estimated number of abortions is about half the number of births each year in Sri Lanka (3). Legalising abortion and performing them in government hospitals would impose a considerable strain on resources.

#### **Post-abortion care**

High quality services for treating and managing complications of abortion should be accessible to women (14). Key elements of abortion care include emergency treatment of abortion complications, family planning counselling and services (15). Health professionals should provide humane treatment and counselling for women who suffer complications from unsafe abortions. Curettage under general anaesthesia is the standard clinical method for uterine evacuation for incomplete abortion. Vacuum aspiration either by electric pump or manual vacuum aspiration (MVA) is more appropriate than curettage for treating incomplete abortion (16). MVA can be performed as an outpatient procedure without anaesthesia and at lower cost.

Women who abort must use an effective contraceptive method immediately. Ovulation typically occurs within two to four weeks after the abortion and 75% of women have ovulated within 6 weeks (17). Since they are at high risk of another unwanted pregnancy, they represent an important group with unmet family planning needs. Post-abortion counselling is often neglected both in hospitals and in domiciliary care.

#### **Violence against women**

Violence against women has increased in recent years. Police reported 229 complaints of rape in 1980. By 1990 they had risen to 1300. In the first half of 2000 alone there were 593 complaints of rape (18). The withdrawn 1995 Penal Code Amendment expressly allowed termination of pregnancy in the case of rape and incest. Judicial medical officers and NGOs working with these women should provide EC. Respect for and equality among the sexes need to be engendered especially among the young. There is an urgent need to address the issue of violence against women in Sri Lankan society.

#### **Role of professional organisations**

Advocacy by professional organisations for liberalisation of the archaic abortion law resulted in the proposed 1995 Penal Code Amendment. The medical community must not neglect the abortion issue merely because it is controversial. Professional organisations can scientifically demonstrate the magnitude of the problem and cost to society. They have a responsibility of informing the public of the serious complications of unsafe abortion. A dialogue among all concerned, respecting different ethical and religious perspectives, are necessary to reduce abortions. Misconceptions about the safety of modern contraceptives must be dispelled. Professional organisations should also address the issue of violence against women.

#### **Conclusions**

One of the goals of population and reproductive health policy is to ensure safe motherhood and reduce reproductive health system related morbidity and mortality

(19). Eliminating unsafe abortion will make an important contribution to achieve this goal. Providing information to men and women on ways of preventing unwanted pregnancy is another strategy. Increasing access to affordable and acceptable quality contraceptive services goes hand in hand. Emergency contraception should be widely promoted. Despite these strategies there will still be women who wish to terminate unwanted pregnancies. The extremely controversial nature of abortions will not change, given the well entrenched views among those opposed to abortion and those who support a woman's right to have an abortion. Women, especially those less privileged, not only confront the legal system, but also put their lives at risk each time they seek an abortion. Women should not be compelled to continue pregnancies when the fetus is abnormal or following rape and incest. Reforming the ancient and restrictive abortion law in Sri Lanka is not merely a moral or legal issue. Medical and health issues are also important. Withdrawing the amendment to the Penal Code in 1995, the then Minister of Justice and Constitutional Affairs stated "Decriminalising of abortion is a feature of evolving legal systems in many parts of the world and I do not see any reason why Sri Lanka should be out of step with that general development" (10).

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