ELSEVIER

THE CEYLON MEDICAL JOURNAL

Established 1887
The Official Publication of the Sri Lanka Medical Association
Volume 49, No. 1, March 2004
Quarterly ISSN 0009-0875

All communications should be addressed to **The Editors, CMJ**

Continued Overleaf

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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Lajpat Nagar IV,
New Delhi - 110024, India
Tel: +91-11-2644 7160-64,
Fax: +91-11-2644 7156
Website: www.elsevier.com

Printed by

Saurabh Printers Pvt. Ltd.
NOIDA
India

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Wijerama House
6, Wijerama Mawatha
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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 continuance 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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