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Factors Influencing Women to Undergo Induced Abortion in Sri Lanka

Rathnayake M. Abeyrathne*

Department of Sociology, Faculty of Arts, University of Peradeniya

*Correspondence: abeyrathnayake1965@arts.pdn.ac.lk

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ප්‍රේරිත ගබ්සාව ලෝකයේ සියලු ම සමාජවලට බලපාන බරපතල මහජන සෞඛ්‍ය ගැටලුවක් බවට පත්ව ඇත. මෙ නිසා වාර්ෂිකව විශාල කාන්තාවන් සංඛ්‍යාවක් ප්‍රේරිත ගබ්සාවලින් පසුව ඇති ඇතිවන සංකූලතා නිසා මිය යති. මෙම පර්යේෂණය සිදුකරන ලද්දේ ශ්‍රී ලංකාව තුළ අනාවරණය නොකරනු ලබන පවුල් සැළසුම් ශායනයක පවත්වන ළඳ සමීක්ෂණවල තොරතුරු මුල් කරගෙන යි. එසේ නිශ්චිත ස්ථානය ප්‍රකාශයට පත් නොකිරීමට හේතුව වන්නේ ගබ්සාව ශ්‍රී ලංකාව තුළ නීත්‍යානුකූලව පිළිනොගන්නා තත්වයක නිසා යි. මෙම අධ්‍යයනයේ මූලික අරමුණ වුයේ ශ්‍රී ලංකා සමාජය තුළ ගබ්සාව පිළිබඳව පවතින දැඩි සමාජ සංස්කෘතික සහ නීතිමය තත්වයන් නොතකා කාන්තාවන් ප්‍රේරිත ගබ්සා කිරීම සඳහා යොමුවීමට බලපාන හේතුසාධක පිළිබඳව සොයාබැලීම යි. මෙම අධ්‍යයනයේ නියදිය වශයෙන් බහුසංස්කෘතික පසුබිම්වලින් යුත් කාන්තාවන් 10 ක් සහභාගී කර ගන්නාලදී. ගුණාත්මක පර්යේෂණ ක්‍රමවේදයට අනුව සිදුකරන ලද මෙම අධ්‍යයනයේ ප්‍රාථමික තොරතුරු ලබාගැනීම සඳහා නිරීක්ෂණ සහ ගැඹුරු සම්මුඛ සාකච්ඡා වැනි පර්යේෂණ ක්‍රම යොදාගත් අතර ද්විතීයික තොරතුරු එක් රැස් කිරීම සඳහා පොත්පත්, සඟරා සහ ජාලගත තොරතුරු භාවිතා කරණ ලදී. මෙසේ එකතු කරන ලද දත්ත පිරිපහදු කොට තේමාකරණයට අනුව විශ්ලේෂණ කරණ ලදී. මෙම අධ්‍යයනයේ සොයාගැනීම්වලට අනුව නිගමනය කළ හැක්කේ ප්‍රේරිත ගබ්සා සඳහා කාන්තාවන් යොමුවී ඇත්තේ විභාගවලට මුහුණ දීම, ලිංගික දූෂණයවීම්, මැද පෙරදිගට රැකියාවලට යාම, දෙමව්පියන්ගේ ආශිර්වාදය යටතේ විවාහ වීම, අලුත විවාහවීම නිසා දරුවන්

ලැබීමට තිබෙන අකමැත්ත, ළමයින් අතර පරතරය තබා ගැනීම සහ තව දරුවෙකු සැදීමේදී මුහුණ දෙන ආර්ථිකම දුෂ්කරතා වැනි විවිධ හේතුසාධක මුල් කරගෙන යි. මෙම පර්යේෂණ සොයාගැනීම්වලට අනුව විධිමත් ලිංගිකත්වය පිළිබඳව පාසල්වල අධ්‍යාපනය ලබාදීම, ගබ්සා ප්‍රතිපත්ති වෙනස් කිරීම සහ ජීවන තත්ත්වය වැඩිදියුණු කිරීම සඳහා අවශ්‍ය පියවර ගැනීම මඟින් මෙම සංකීර්ණ ප්‍රශ්නයට විසඳුම් සෙවිය හැකි ය.

මුඛ්‍ය පද: අධ්‍යයනය, කාන්තාවන්, පවුල, ප්‍රේරිත ගබ්සාව, සෞඛ්‍ය ප්‍රතිකාරමය චර්යාව.

1. Introduction

Throughout human civilization people suffer from multiple health hazardous situations and they range from various communicable diseases to complex non-communicable illnesses. Among such health matters, induced abortion, has for long time, been constituted as one of the most complicated and controversial health complications that women, their family members experience in all societies in the world. Similarly, the issue of abortion, to a considerable extent is one of the most contested, sometimes, misunderstood public health problems of women, swept under the carpet in modern societies for centuries.

Recent findings on abortion reveal that induced abortion has become one of the most critical public health concerns that all societies face irrespective of the fact that whether they are developed and developing countries. The reasons for such grave situations are that a large number of women die due to post-abortion complications if they have to be performed under unhealthy conditions and they also have to suffer from various social, psychological, legal and moral stigma attached to induced abortion. Many politicians, legal experts, social scientists, religious leaders and women rights advocates, have for years, made great efforts to understand the sensitivities and complexities surrounding the matter of abortion from various perspectives such as legal, political, moral, and ethical in respective societies. For instance, in the United States, over the dilemma of abortion, its society has been divided into many rival fractions, such as, pro-choice and pro-life.

This way, the former is composed of liberals and women rights advocates and they believe that women should have the right to decide whether to continue pregnancy of terminate the foetus rather than allowing others to decide what to do with their bodies. Therefore, the pro-choice group relies more on the reason than faith over the matter of abortion. The latter group consists more of right-wing and traditional members who advocate right to life, believing that a foetus is a person and motherhood is the most important role of woman's life, and the destruction of the foetus is simply a sacrilege. Thus, the prolife members count more on the faith than reason over the complicated question of abortion.

It should be highlighted that groups such as the mentioned above are not common only in the United States but they are visible in almost all developed and developing countries in the world at present (1).

In some countries abortion is viewed as the most accessible and affordable method of contraception in order to control population growth. For instance, China and many other communist counties allow women to terminate their pregnancies freely and sometimes these countries provide legally sanctioned facilities to such women. However, women who undergo induced abortion, experience psychological sufferings, physiological deteriorations and more severely they face social dilemma before and after terminating pregnancy.

As far as Sri Lanka is concerned, abortion is completely illegal and the government has introduced strict laws on abortion practices. However, hospital-based abortions are legally sanctioned on specific grounds. If the continuation of pregnancy creates adverse health complications in an expected woman's life, she can seek abortion at state hospitals under the authorization of a physician. In addition, women who have become pregnant due to the victimization of rape and incestuous relationships are legally allowed to obtain abortion at government hospitals with the approval of a medical doctor. Otherwise, in all circumstances, abortion is illegal, socially tabooed and socially stigmatized. The doctors who practice abortions are considered criminals or sinners by Sri Lanka society.

However, traditional and deeply rooted religiosity, and legal restrictions on abortion in Sri Lanka have now been in dilemma by the alarming number of illegal induced abortions practiced throughout the country. According to unconfirmed reports and women right groups' estimation, it reveals that more than 2000 pregnancies are terminated every day throughout the country, often under dangerous and unsafe health facilities in many parts of the country. Owing to illegal practices of abortions, women and Sri Lankan society as a whole face a very grave public health problem that requires immediate remedies from all walks of society to minimise the number of skyrocketing rate of illegal abortions practiced in the country. Therefore, it is important to investigate all complicated factors influencing women to undergo induced abortions while facing all strict legal conditions and social and cultural stigma attached to abortion in Sri Lanka society. The research questions of this included (1) what were the socio-economic backgrounds that women in the sample represented? (2) what were the psychological factors affecting women to seek induced abortions? and (3) what were the dynamics of health seeking behaviour of women who procured services at the private abortion clinic.

The purposes of this study were two fold: the main and specific objectives. Accordingly, the main objective of this research project was to study factors motivating women to terminate their pregnancies even under strict legal and social-cultural environments in Sri Lanka society. The specific objectives were to find out the nature of health seeking behaviour

of women who sought assistance at the private family planning clinic to terminate their pregnancies and to explore the nature of health facilities available for women who seek assistance to terminate their foetuses.

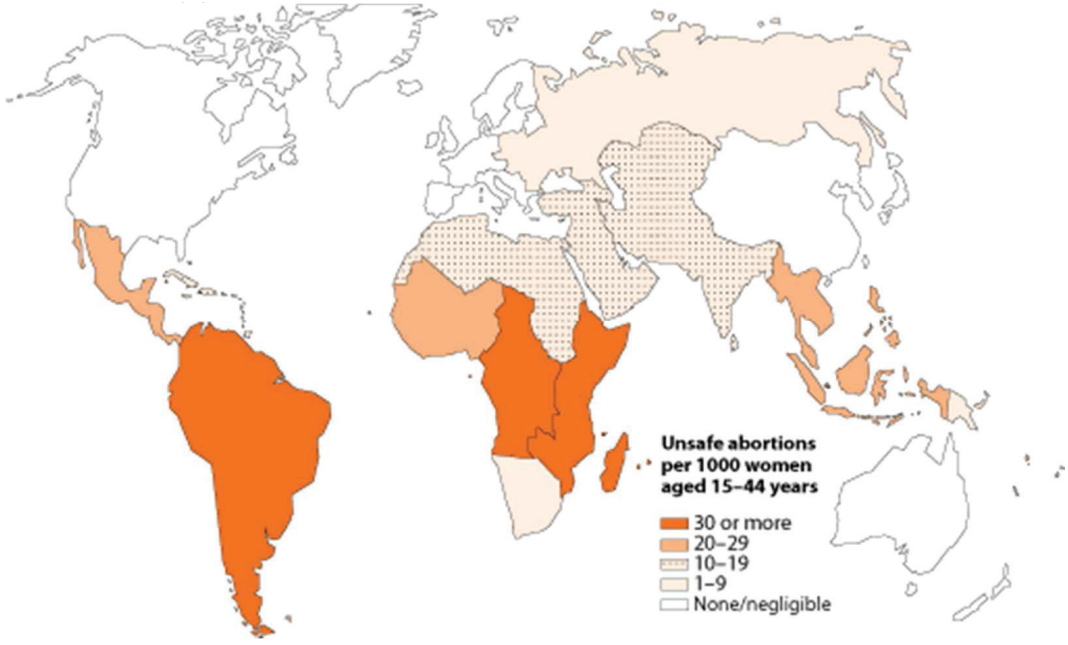
2. Literature Review

The purpose of this literature review is to briefly investigate the available literature on abortion. Thus, this literature survey consists of three sub-sections. In the first part, this literature review elaborates on the magnitude and incidence of unsafe abortion in the world. The third section of this literature review describes legal and human right aspects of abortion. Finally, this literature survey summarizes the state of abortion in Sri Lanka society.

2.1 The magnitude of Abortion

The issue of abortion has for long time been a controversial issue since the written records began in the world. The Geek and Roman civilization accepted the termination of pregnancy, but with the development of Christian and Islamic civilizations, the destruction of fetus was prohibited due to strong religious beliefs of the people of these two civilizations. However, in the nineteenth century, religious philosophies and secular ideas became more contradictory to one another over the issue of abortion, because traditional norms and social values were questioned by modern scientific rationality. Therefore, many countries introduced new abortion laws, and doctors were allowed to practice abortion under certain circumstances, and people accepted them as legal and ethical and legal abortions (WHO, 1997).

According to the World Heath Organization, from 2010–2014, on average, 56 million induced (safe and unsafe) abortions occurred worldwide each year. There were 35 induced abortions per 1000 women aged between 15–44 years. 25% of all pregnancies ended in an induced abortion. The rate of abortions was higher in developing regions than in developed regions. Around 25 million unsafe abortions were estimated to have taken place worldwide each year, almost all in developing countries (2). Among these, 8 million were carried out in the least- safe or dangerous conditions. Over half of all estimated unsafe abortions globally were in Asia. 3 out of 4 abortions that occurred in Africa and Latin America were unsafe. The risk of dying from an unsafe abortion was the highest in Africa. Each year between 4.7% – 13.2% of maternal deaths can be attributed to unsafe abortion (3). Around 7 million women are admitted to hospitals every year in developing countries, as a result of unsafe abortion (4). The annual cost of treating major complications from unsafe abortion is estimated at US$ 553 million (5). Safe abortion must be provided or supported by a trained person using WHO recommended methods appropriate for the pregnancy duration. Almost every abortion death and disability could be prevented through sexuality education, use of effective contraception, provision of safe, legal induced abortion, and timely care for



Estimated number of unsafe abortions each year per 1.000 women aged 15-44 years

2.2 Abortion laws and policies

Among the countries in the world, induce abortion laws are complex, ranging from complete prohibition to legally sanctioned abortion under certain circumstances that allow women to seek abortion. Thus, in the United States after the liberalization of abortion laws in the 1970s, freestanding abortion clinics were established, because many public hospitals were not willing to practice abortion in their promises. Although, the debate on abortion still continuous whether the public money should be spent on abortion or not and the American society has divided into many rival fractions over the issue of abortion, namely, prochoice and prolife. As far as Canada is concerned, all laws related to abortion have been liberalized in 1967. However, in 1989 the federal government's law on abortion laws struck down as unconstitutional and now there is no clear policy about abortion in Canada.

Abortion laws in Latin America and South America are restrictive. Among 22 independent countries in the region, seven countries with strong Catholic background forbid under all circumstances, while another six countries permit only to avert a threat to pregnant women's life. Inn addition, nine countries in the region allow abortion under strict medical grounds. Specifically, in Cuba elective abortions are allowed at government hospitals.

As far as the United Kingdom is concerned, abortion laws have been liberalized since 1967, and nowadays abortion can be obtained through the National Health Service and private facilities as well. The laws on abortion are more complex in other Western European

countries. For instance, in Germany, legal abortions are much more accessible in protestant dominated Northern part of the country than the predominantly Catholic region in the south. Furthermore, in France and Australia, abortion can be obtained during the first ten weeks of gestation. In addition with a strong opposition from the Catholic Church and medical professionals, Italy legalized abortion in 1978. Under new abortion laws, women over the age of 18 may obtain abortion in the first trimester of gestation, while women under the age 18 may obtain consent from train parents. The Nordic countries, namely, Iceland (1935), Sweden (1937), and Denmark (1938), liberalized abortion laws to minimize unwanted pregnancies and induced abortion-related fatalities. In addition, Norway changed restrictions on abortion in 1979 and permitted women to obtain induced abortion. Among the former socialist countries, the USSR was the first country to liberalize abortion, and subsequently other countries in the Eastern block made amendments to you their abortion laws. However, Yugoslavia was the only one country where the decision to seek induced abortion was left up to women.

In 1972, China legalized abortion as a method of population control and barefoot doctors, nurses and midwives were allowed to practice abortion under government authorization, while Taiwan prohibited it with no exception but induced abortions are practiced throughout the island. In Japan and Korea, abortion is permitted on certain conditions. In other Southeast Asian countries, abortion is illegal but throughout the region induced abortions are practiced illegally. As far as the South Asian region is concerned, restrict laws on abortion are in effect, but in India and Pakistan and Sri Lanka abortion clinics perform induced abortions under ambulatory menstrual regulation services. Specifically, in India an alarming number of abortions are performed on the ground of sexual preference of the child. If the preference of the child is likely to be a female, it is highly likely to get destroyed because since an unknown time Indian society has been giving priority to male children over female children.

In many Islamic countries in the Middle East and North America, strict abortion laws are practiced. However, in Iran and Tunisia abortion is legal on medical grounds, while in Israel abortion has been legalized. In African Sub-Saharan countries, strict laws on abortion were in effect when the British were ruling the region. Nevertheless, in Zambia abortion laws are similar to the United Kingdom, liberal. Finally, in Oceania, namely, Australia and New Zealand abortion laws come under the jurisdiction of the regional state.

2.3 Abortion in Sri Lanka

In Sri Lanka, abortion is completely illegal and the government has introduced strict laws on abortion practices. Sometimes, hospital-based have been declared legal on specific grounds. If the continuation of pregnancy creates adverse health complications in an expected woman's life, she can have the access to seek abortion at government hospitals

and under the authorization of physician. In addition, women who become pregnant, owing to rape and incestuous relationships are legally allowed to obtain abortion at government hospitals with the approval of doctor. Otherwise, in all circumstances, abortion is illegal, socially tabooed and socially stigmatized. The doctors who practice abortions are considered criminals or sinners by Sri Lanka society.

It could be argued that the main reason to impose strict laws in Sri Lanka and the social stigmatization related to abortion activities is associated with the people's deeply rooted religious beliefs and practices embedded in its culture for centuries. If one were to analyse different religious traditions practiced in Sri Lanka, it helps understand the general public's perception on abortion. According to religious composition of the country, Buddhists who comprise 73 per cent of the population believe that killing or destroying a human being or an animal is an immoral act according to five Buddhist precepts. Hence, aborting a foetus is almost an unbelievable act for them. Then, Hindus who consist of 15 pre cent of the total population consider slaying either human being or an animal is a sacrilege the philosophy of Hinduism is based on avihinsa, non-violence. Therefore, abortion makes no exception for them similar to Buddhists. Muslims who comprise 8 per cent of the population hold the view that killing a foetus is an amoral act, according to Islam. Finally, Christians who represent 6 per cent to the population of the country believe that only God can create human being and therefore, only God had the power to destroy him/her. This way, abortion is simply a murder for them.

As mentioned earlier, in Sri Lanka, abortion is legal, if it is to save the life of the mother, but it becomes criminal when it is performed for other purposes. In the meantime in 1995, the Ministry of Justice of the government of Sri Lanka introduced a bill in parliament in the hope of decriminalizing the Penal Code on abortion and proposing the legalization of abortions in instances where the victim is a prey of a sex crime, such as rape, incest or where the fetus is impaired. However, the members of Parliament voted down the amendment highlighting that if Sri Lanka were to legalize abortion, it would encourage women to be more promiscuous, conniving, and eventually, they become vulnerable to more sexual violence.

Irrespective of strict abortion laws, the horrendous rise of illegal induced abortion practices throughout the country has become one of the most critical reproductive and public health issues that the country has to face at present. The most recent national study, a UN Population Fund-sponsored project in the late 1990s, estimated that some 650 abortions take place each day, country-wide [see Source 1, below]. The rate now is conservatively estimated to exceed 1,000 a day. Indeed, in a 2009 paper [2] Dr N.L.Abeyasinghe of the Department of Forensic Medicine and Toxicology of the University of Colombo estimated that for every 1,000 children born, 740 have ben aborted.

The economic cost of treating post abortion complications and the hazardous situations that women have to face is rather critical due to all complications and social stigma attached to induced abortions. For instance, the Ministry of Health's 'Annual Health Bulletin' (2001) estimated that 7-16% of female admissions to Government hospitals are the result of a botched abortion. That amounts to more than 100,000 hospitalizations annually: a huge toll on the hard-pressed national healthcare budget, and a huge cost (including dozens of lives lost annually) to women.

Suranga, et.al (2016) conducted a research project to assess the knowledge and attitudes of adults towards induced abortion in Sri Lanka. In this study, they found out that only 11% of the respondents were familiar with the situations in which abortion is legal in Sri Lanka. Approximately, one tenth of the respondents (11%) did not accept the opportunity granted by the current law to perform induced abortion to save the life of the mother. However, a majority agreed to legalize abortion for rape (65%), incest (55%) and pregnancies with lethal fetal abnormalities (53%). Less than one tenth of respondents agreed to legalize induced abortion for other reasons such as contraceptive failure (6%), bad economic conditions (7%), on request (4%), etc., (Suranga, et, al, 2016).

Deok et.al (2002) conducted another study to find out socio-economic factors affecting induced abortion seekers and reasons for them to procure abortion services at private clinics in the city of Colombo. The findings of this study reveal that almost all women had some formal education. However, only 20% were employed outside the home. Over 95% were currently married and at the peak of their childbearing age. It also revealed that more than one-half were aged 30 years or over, while adolescents only comprised about 3%. Fourteen per cent were nulliparous and about two-thirds had one or two living children at the time of obtaining the abortion. A significantly high proportion also had a very young child. In total, the 356 women had had 1130 pregnancies, and the mean rate of abortion was 42 per 100 pregnancies. Over one-quarter had had more than one abortion and about 10% had had three or more. The most common reasons cited for the present abortion were 'pregnancy was too soon after previous delivery', 'no more children desired' or 'curtailment of opportunity for foreign employment' (Deok et.al, 2002).

Carukshi, et, al, (2014) in another study of decision-making on abotion controls, the cases were significantly less-educated, employed, unmarried and prime-gravid ($p < 0.05$). All knew the 'illegal' status of abortion, mainly through media (65.5% cases versus 80% controls). When making a decision, the risk of undergoing an unsafe abortion was significant among those who sought assistance (44% versus 32%; OR = 1.7 (95% CI = 1.2-2.4)), with more reliance placed on non-medical sources such as spouse/partner, friend, neighbour and family/relation. Speaking to women with past experience of induced abortions (31% versus 21.5%; OR = 1.6 (1.1-2.4) and failure in making the final decision with partners also imparted a significant risk for abortion (64% versus 34%; OR = 3.4; 2.4-4.8). A decision

favouring unsafe abortion was predominantly based on their economic instability (29.5%) and poor support by partners (14%), whereas a decision against it was based on ethical considerations (44% religious beliefs: 12% social stigma) over its legal implications (4%). Most abortions were performed by unqualified persons (36.1% self proclaimed abortionists; 26.2% not revealed their qualifications) for a wide range of payment in non-sterile environments (45.9% unknown place) using septic procedures (38.5% trans-vaginal insertions; 24.6% unaware of the procedure) (Carukshi, et, al, 2014).

Charuksi et, al (2017) in a hospital-based study of contraceptive practices among women in Sri Lanka indicate that the knowledge and the use of contraceptives played a pivotal role for women to decide whether to continue or terminate pregnancies. In this they revealed that at conception, 'non-use' of contraception imparted a two-fold risk for abortion against ineffective use (adjusted-OR = 2.0; 95% CI: 1.2–3.2). The abortion risk on 'non-use' varied further according to 'early' (adjusted-OR = 1.7; 95% CI: 1.1–3.1) and 'late' (adjusted-OR = 2.3; 95% CI:1.5–3.6) discontinuation of contraception, but not with 'never-use' (crude-OR = 1.1; 95% CI: 0.6–2.3). Among the ever-users, the risk of abortion varied within each contraceptive practice by their last used contraceptive method and reasons for discontinuation. A significant interaction between modern contraceptives and early discontinuation (adjusted-OR = 1.4; 95% CI = 1.1–3.1) demonstrated a seven-fold abortion risk for early discontinuation of modern methods against its ineffective use. In particular, hormonal methods seemed to be responsible for this risk (51.1% cases versus 42.5% controls) (Charuksi et, al, 2017).

In addition, those who studied post-abortion complications after hospitalizations of women in Sri Lanka found out that the severity of post-abortion problems have reduced due to the methods that service providers applied to terminate pregnancies. For instance, Athula, et, al (2018) in a study carried out in Sri Lanka on the said field indicated that service providers perceived that the number of women presenting to hospitals after an induced abortion caused by a mechanical method is minimal or not at all at present. Over time, a significant reduction is seen in the number of women presenting with any abortion-related complications and the severity of complications has also reduced significantly. The common method of termination at present identified by the providers was the use of "drugs" or "the drug–Misoprostol. Therefore, they conclude that women appear to have switched from surgical and mechanical methods to medical means (drugs) to induce an abortion and this change has contributed to reduce the severity of complications (Athula, et, al, 2018).

The details in the above literature survey witness that induced abortion is a dreadful public and reproductive health issue in many country of the world and legal conditions applied to induced abortions are different world-wide. As far as Sri Lanka is concerned, the reviewed information highlights that irrespective of high literacy rate of its population and high prevalence rate of both traditional and modern contraceptive practices, it experiences

reckless practices of abortion throughput the country. The contents of this literature survey highlight that there a scarcity of information available on women's motivation to terminate pregnancies at illegal abortion clinics in the country. Therefore, this research finding will to certain extent help cover existing research gap on the subject.

3. Methodology

This research project was carried out at an undisclosed the so called ambulatory menstruation regulation family planning clinic in Sri Lanka. The reason to not to declare the exact place of the location of the clinic and other details is because abortion is not legally sanctioned and socio-culturally it is a tabooed topic in Sri Lanka. This study employed only qualitative research tools to collect both primary and secondary research material. The main reason to use qualitative methods to collect data was that due to the sensitivity of the topic secondary information is really meagre and there is no recognised sound research done on the current subject matter. In order to collect primary data, ten women from multicultural backgrounds who sought the assistance at the so called family planning clinic were interviewed with their consent using an in-depth-interview guideline developed, based on literature survey findings on the subject. The researcher personally conducted all interviews at the clinic promising that all information would be treated with utmost confidentiality and the informants provided all information without any hesitation. In addition, the researcher carefully observed the activities at the clinic during all visits. Secondary material was gathered by collecting information from various sources ranging from the World Health Organization-related publications, books, journals and online material available on the subject. This study used both theme-list and content analyses methods for analysing the collected study findings. In the process of analysing data, all data was refined based on the themes mentioned in the conceptual framework.

4. Results and Discussions

This study findings indicate that even though all informants in the sample had one main influencing reason for their decision to terminate foetuses during the early trimester, all of them had more than one specific reason to end their pregnancies prematurely. They presented ten different reasons for their motivation to come to the clinic for undergoing induced abortion. They ranged from facing an examination, rape, going to middle east to work, wished to get marred with parents' blessings, newly married and too early to have children, desire for keeping space between children, schizophrenia, financial constraints to have another child, lack of time to raise another child and to not to have a another child while there were having grown up children.

This study findings also reveal that all informants of the multi-cultural study sample were very much aware of both natural or traditional and modern birth control methods

and how to prevent pregnancy. They generally knew all types of natural and modern contraceptive devices that the people in Sri Lanka use in modern time. Under natural birth control methods, they had an understanding about the practice of safe period, withdrawal, and rhythm, and regarding modern family planning methods, they generally listed condom, vasectomy, pills, IUD, injection, female sterilization, and no-plant insertion as commonly used methods in the country.

The results of this study further highlight that social support and other social networks help them find a reliable place to terminate their pregnancies. As far as their health seeking behaviour is concerned, accept one woman, all others had resorted to the western medicine-based professional sector rather than practicing local methods such as drinking boiled with cinnamon, drinking Epsom salt, consuming raw pine apple, and jumping from heights, such as, table to induce bleedings. They all said they their family doctors referred them to the present place after they conducted urine tests for them to confirm the state of conception. They all expressed that they were really satisfied with the services that they received at the clinic in terms of the doctor's service, minor staff's assistance and more importantly the nominal fee that they had to pay for undergoing an induced abortion.

Although, in a normal situation, the decision to terminate pregnancy seems an individual choice of a woman who visits abortion clinics but this study findings show somewhat contrary to the usual situation. The reason is that all the women who participated in this study sample said that the decision to end their pregnancies was not their alone but they arrived at a decision to do so collectively. The researcher of this study witnessed this situation when conducting interviews at the clinic because all women said that none of them came to the clinic alone but all of them visited either with their husbands or mothers to receive the required service.

The doctor who provided abortion also said that he charges a very low price for these women because they cannot pay high prices since they came from economically impoverished backgrounds. However, he further stressed that women who belong to upper classes occupy more advantaged position to undergo induced abortion locally or internationally because of their privileged social positions when compared to poor women who do not have such privileged social positions in Sri Lanka society. He finally said that he does not accept women to provide induce abortion service if their gestational period is beyond three months even of they continue to plea for termination of pregnancies. Therefore, he stress that he provided the service to the current sample of women because no one in the sample had a gestational period beyond three months into their pregnancies.

5. Conclusions and recommendations

In conclusion, this research findings suggest that whether the people of Sri Lanka realize or not, induced abortion has become a silence death situation for women from various socio-economic backgrounds in the island. It is unfortunate that almost all responsible citizens are aware of the magnitude of the present induced abortion problem, but nobody seems to pay enough attention to address the matter to find ever lasting solutions. One can speculate that the deeply rooted socio-cultural and religious values have been the main obstacle to debate about the existing situation to understand the underline reasons for Sri Lanka to experience an alarming number of induced abortions practiced annually throughout the country illegally and thereby this situation negatively contributes to surpass the number of annual alive births of the country.

In order to minimize the present reckless practice of induced abortion in Sri Lanka, the following recommendations are presented for designing better policies to come up with long-tern solutions to control the prevailing situation of abortion in the country. They include the introduction of formal sex education at schools as a long-term measure to solve the problem of induced abortion, improvement of family planning methods, organization of awareness programmes for men on reproductive health matters, changing abortion policies, improvement of living conditions of Sri Lankan families, development of health social science programmes and increase new avenues to conduct research on reproductive health-related maters in the country.

END NOTES

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