Profile of abortion seekers in the Colombo District and reasons for having induced abortions

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Abstract

The objectives of this paper are to identify (a) the profile of women seeking induced abortion and (b) the reasons for having them. The opinions of a group of respondents professionally involved with abortion cases in the Colombo district were investigated using a self-administered questionnaire, in 1998-99. Two hundred and forty seven health professionals were selected as respondents. One hundred and nineteen of them returned the questionnaire and, 92.43% of them had seen abortion cases in their professional career. The study obtained the information on the most recent abortion seeker. In addition, the respondents ranked a given set of reasons that lead women to seek induced abortion.

Over 3/4 of those seeking abortion were married and, over 50% of them were non-working women. A little over 50% of them were among the middle income group and, over 78% of them had some form of schooling. Over 50% of abortion cases were between 21-30 years of age. A majority of these abortion seekers were living in urban areas.

Unwanted pregnancy was ranked first by nearly a 2/3 of the respondents as the most important reason for having induced abortion. Being an unmarried mother was ranked second by nearly 1/3 and, ranked first by about 17% of them. Contraceptive failure was placed third in the ranking. Pregnancy as a risk to maternal health and the potential risk for the unborn child were considered to be less important reasons for abortions.

These opinions provide better information on the abortion issue, in the illegal context. The opinions, however, are basically 'approximations', and, therefore, may be subject to some errors. The validity of the results should be measured by the direct studies of abortion seekers.

Introduction

This paper attempts, through the analysis of data derived from a group of qualified and experienced health professionals involved with cases of induced abortion in Sri Lanka, (a) to build up the profile of women seeking induced abortion and (b) to identify the reasons for having them. The selected group of health professionals was presented with a self-administered questionnaire in 1998-99 in order to determine the salient characteristics and reasons of women seeking abortion.

Background

Contemporary legal status of abortion in Sri Lanka

The restricted nature of law concerning induced abortion in Sri Lanka is to be found in the Penal Code that was enacted in 1883. As the law stands today, a pregnancy can be terminated only when the act is done in good faith for the specific purpose of saving the life of the mother. In fact, the term "induced abortion" is not used in the Penal Code, but the offence is described as the "causing of miscarriage" or "injuries to unborn children" (Ministry of Plan Implementation 1983). For the relevant sections of the Penal Code, see Textbox 1.

There has been no revision or amendment in the law so far, even though some attempts have been made by the successive governments in response to the campaigning for reforms. More recently, the Ministry of Justice in 1995 had drafted a bill to amend the relevant sections of the Penal Code. When introducing the bill to the parliament, however, the Minister stated that he had decided to abandon in its entirety. He stated that this move had been prompted by the realisation that the issue of abortion was a very controversial matter (Abeyesekera 1997).

Sources of data on abortion in Sri Lanka

In an environment in which the legal restrictions have been imposed for more than a century and, a social stigma, arising out of cultural and religious aspirations, is dominant, the statistical picture of the availability of abortion services, and its implications on the profile as well as reasons is unclear,

conflicting and may be misleading. As it is evident from the data given in Table 1, the existing data provide only very limited information on the extent and nature of the practice.

In fact, the existing data do not give direct information on the availability of safe or unsafe services on induced abortion. The data do suggest that many women may seek abortion from illegal and mostly unskilled providers and, many of them have entered hospitals for treatment of abortion complications. Furthermore, maternal deaths due to unsafe abortion may constitute an important component of maternal mortality too.

Vital statistics on abortion mortality

The vital registration system handled by the Registrar General's Department, which is the official source of mortality statistics in Sri Lanka, publishes abortion mortality on an annual basis. As seen in Table 1, it is noteworthy that the category of "unspecified abortion" sometimes constitutes as high as 10% of all maternal deaths.

Text box 1: THE LAW RELATING TO ABORTION IN SRI LANKA: PENAL CODE ENACTED IN 1883.

Penal Code – Section 303, refers to the "causing of miscarriage" and enacts:

"Whosoever voluntarily causes a woman with a child to miscarry shall, if such miscarriage be not caused in good faith for the purpose of saving the life of the woman, be punished with imprisonment of either description for a term which may extend to three years or with fine or with both; and if the woman be quick with child, shall be punished with imprisonment of either description for a term which may extend to seven years and shall also be liable to a fine".

"explanation: a woman who causes herself to miscarry is within the meaning of this section"

Penal Code-Section 304 refers to the "causing of miscarriage without the woman's consent" and enacts:

"Whosoever, with intent to cause the miscarriage of a woman with child, does any act which causes the death of such woman, shall be punished with imprisonment of either description for a term which may extend to twenty years, and shall also be liable to a fine"

Explanation: "it is not essential to this offence that the offender should know that the act is likely to cause death"

Penal Code-Section 306 deals with "the acts done with intent to prevent a child being born alive or to cause it to die after birth" and enacts:

"Whosoever, before the birth of any child, does any act with the intention of thereby preventing that child from being born alive, or causing it to die after its birth, and does by such act prevent that child from being born alive or causes it to die after its birth, shall if such act be not caused in good faith for the purpose of saving the life of the mother, be punished with imprisonment of either description for a term which may extend to ten years, or with fine, or with both"

Penal Code-Section 307 deals with the causing of death of a quick unborn child by an act amounting to culpable homicide, the section states:

"Whosoever does any act under such circumstances that if he thereby caused death he would be guilty of culpable homicide, and does by such act cause the death of a quick unborn child, shall be punished with imprisonment of either description for a term which may extend to ten years, and shall also be liable to a fine"

Source: Sri Lanka Ministry of Plan Implementation (1983) "Perspectives on Abortion in Sri Lanka", Colombo. pp 73-74.

The very low reporting of illegal abortion deaths in some years questions the completeness of vital statistics. Due to the replacement of medical registrars in recent times, non-medical registrars now undertake more than 75% of the registration of deaths in Sri Lanka. As a result, difficulties are frequently encountered in correctly coding the causes of death. Given the inaccuracies in coding, there is a strong possibility that many cases of deaths due to induced abortion may be misclassified and even never reported. This has adversely influenced the quality of vital statistics relating to the cases of abortion mortality (Sri Lanka Registrar General's Department 1998). The maternal deaths reported to the Registrar General' Department in 1995, as given in Table 2, also indicate that the possibility of misclassification and under-reporting of induced abortion at any stage of data reporting cannot be neglected.

Table 1: Data on abortion in Sri Lanka as derived from various sources

(a) Vital statistics

Cause of death	Number of Maternal Deaths				
	1991	1992	1993	1994	1995
Spontaneous abortion	1	NR	NR	1	1
Legally induced abortion	NR	NR	NR	NR	NR
Illegally induced abortion	7	3	3	3	NR
Failed attempted abortion NR		NR	NR	NR	1
Missed abortion	NR	2	NR	NR	NR
Unspecified abortion	9	13	11	12	13
Complications following abortion	NR	1	1	NR	NR
Total	21	20	20	19	14

(b) Health services statistics

Category	1975	1980	1985	1990	1995
Hospitalised "abortion" cases per 100,000 women of reproductive age	829	870	811	846	833
Hospital deaths due to "abortion" per 100,000 women of reproductive age	1.1	0.3	0.3	0.3	0.2

(c) National surveys – Demographic and Health Survey in 1993

Category	Number
Reported cases of induced abortion	152
Ever-married women of Reproductive age (MWRA) in the sample	6983
Induced Abortion Rate (number of abortions Per 1000 MWRA)	21.8

(d) Surveys of women in the community 1988-90

Method of data collection	Number of MWRA	Number of abortion cases	Induced Abortion Rate
Direct questioning	16,770	589	10.9
Using Randomized Response Technique (RRT)	1,504	71	15.7

Sources:(a) Registrar General's Department (1998) **Child and Maternal Mortality in Sri Lanka** p.46 and unpublished data of 1992, 93, 94, and 95.

(b) Ministry of Health (1997) **Annual Health Bulletin**-1996, p.79.

(c) Department of Census and Statistics (1995) **Sri Lanka Demographic and Health Survey**–1993,p.89.

(d) Rajapaksa, L.C. and D.C. Perera (1994), 'Incidence of Induced Abortion :Determined by The Randomized Response Techniques', **Ceylon Medical Journal**, 39(1) pp.14-18.

Note: NR – Not reported.

Health services statistics on post-abortion care

There is indirect evidence from service statistics of the government health sector to show that the annual number of admissions for post-abortion care, and the treatment of complications for both spontaneous and unsafe induced abortion hospitals are very high.

According to Table 1, during the twenty-year period of 1975 to 1995, the annual number of 'abortion' cases hospitalized varied from 811 per 100,000 women of reproductive age to 870. The trends in the hospital admission rate, however, which fluctuate throughout the period, may also indicate reporting errors in the data collection system in addition to the real trends (Sri Lanka Ministry of Health 1997).

As Table 1 further indicates, the reporting system of abortion data in the health services statistics too has some limitations. For instance, even when a pregnancy loss has been correctly identified by medical

professionals as an 'induced abortion', this may be grouped under the general category of 'abortions' in the health statistics because no clear distinction is made among the types of abortion.

**Table 2: Maternal deaths by cause of death in Sri Lanka in 1995
as reported to the Registrar General's Department**

Cause of death	Number of deaths
Spontaneous abortion	01
Unspecified abortion	13
Hemorrhage in early pregnancy	01
Antepartum hemorrhage, abrupt placenta and praevia	14
Hypertension complicating pregnancy, child birth and puerperium	03
	01
Early or threatened labour	02
Other complications of pregnancy, not elsewhere classified	01
Other current conditions, child birth and puerperium	07
Malposition and malpresentation of fetus	01
Abnormality of organs and soft tissues of pelvis	01
Known or suspected fetal abnormality affecting management of mother	01
	01
Other indications for care and not elsewhere classified	24
Other obstetrical trauma	09
Postpartum hemorrhage	01
Other complications of labour and delivery	
Major puerperal infection	
Total deaths	81

Source: Registrar General's Department, Sri Lanka (unpublished data) 1995.

It is not clear as to what extent the clinical reporting system of induced abortion cases in government health service follows the International Classification of Diseases and Deaths. In fact, the data entry form of the government heath institutions has identified several types including illegally induced abortion, legally induced abortion, missed abortion, spontaneous abortion, failed attempted abortion and complications following abortion (Ministry of Health, Sri Lanka, unpublished).

Hospital-based studies on post abortion caseload

Fernando and Rabel investigated the post abortion caseload in government sector hospitals in Sri Lanka. This study was conducted using random sampling procedures covering obstetrician/gynecological wards of three tertiary level government hospitals in Colombo district. During a continuous three month study period, 371 admissions to obstetrician/gynecological wards of these hospitals gave a history of vaginal bleeding following a period of amenorrhoea of less than 28 weeks of gestation. Of these, 12% were classified as having had a 'certainly induced abortion', 17% were classified as having 'probably induced abortion', and 35% as having 'possibly induced abortion'. Thus, the total proportion of women in the 'induced abortion' group was 64% (Fernando and Rabel 1992).

The study further revealed that most of the women who had induced abortions were older, had one or more living children and had lower levels of education, compared to the group who had spontaneous abortion. A substantial proportion of women who had induced abortion said that they had practiced some method of family planning. The study reported that due to some reason, the method of contraception used had failed. The common methods practiced by those who had induced abortion were coitus interruption, rhythm method, oral contraceptives and condoms.

The very low case fatality rate seen in this study need to be interpreted with caution as the hospitals included in the study are a highly selected group, where available facilities could be considered optimal.

National surveys on prevalence of abortion

The Demographic and Health Survey (DHS) in 1993, which provides the first national level estimate on the prevalence of induced abortion has found 152 pregnancies that resulted in induced abortions, among

6,983 ever married women of reproductive age, giving an abortion rate of 21.8 per 1,000 women. The validity of the number of abortion cases as derived from the pregnancy history information in the DHS survey is basically subject to non-sampling errors, mainly due to the sensitivity of the issue. Further information, however, is not available to assess how the interviewer- administered questionnaire has handled the confidentiality and sensitivity of the issue (Sri Lanka Department of Census and Statistics 1995).

One way, to look at the limitations of the estimates of DHS is to compare the results with worldwide estimates of abortion rates. According to a recent study of the regional estimates on abortion incidence, the abortion rate is 'fairly high' in the regions of Eastern Africa, south-east Asia and the Caribbean, ranging between 40-50 induced abortions per 1,000 women (15-44 years) (Henshaw *et al.* 1999).

Sample surveys on incidence of abortion

As the direct interviewing of women is less likely to yield complete information on abortion under the illegal context, the researchers had employed other alternative methodologies that may help to improve the reporting of abortion cases.

For instance, Rajapaksa and Perera in 1988-90 have resorted to the indirect technique of data collection, the use of "randomized response technique"(RRT). As Table 1 suggests, the comparative data obtained by the direct study of women and, by the randomized response technique reflect that underreporting of abortion cases may have occurred when the women were questioned directly about their abortion experience.

One of the disadvantages of RRT method, however, is that it cannot provide in-depth information other than on incidence and prevalence of induced abortion (Rajapaksa and Perera 1994).

Evidence on self-induced abortion

Researchers have suggested that some women in Sri Lanka may be using many traditional methods of self-induced abortions. For example, Caldwell *et al.* in 1987 have reported that many traditional methods of abortion are known to couples in the country. They include consumption of particular types of yam, unripe pineapples, boiled cotton, taro leaves, bamboo-shoot water, porcupine flesh, banana or manioc flowers (Caldwell *et al.*1987).

Meanwhile, the indirect evidence available through other surveys indicates that self-induced abortion is less prevalent in Sri Lanka. A study done by using a sample of 502 health professionals involved in government health services in Colombo district found that over 75% of the respondents believed that self-induced abortion is less common in Sri Lanka.

In fact, the opinions of health professionals reflected a context in which illegal providers must perform most abortions. They thought that most women who seek abortion are willing to take health risks with unqualified practitioners. Only 19% of the respondents felt that the prevalence of self-induced abortion is high because the chance of having a safe medical procedure is so low (Hewage 1999). However, the respondents had mentioned a wide range of self-induced methods such as the insertion of instruments like bicycle spoke, saline tubes and knives, taking medicine prescribed for other purposes such as cancer and malaria and other forms of various traditional or *Aurvedic* medicine.

Reasons for lack of reliable information

There are number of reasons why the reliability and completeness of information on induced abortion is lacking in Sri Lanka. Some of the important reasons were discussed earlier and may be summarized as follows: (1) women may not directly acknowledge having had an abortion due to the social stigma, sensitivity and illegal context, (2) providers may not report abortion cases they encountered due to the illegal circumstances, (3) procedure itself is restricted by the law, (4) the official system of abortion reporting is weak or negligible.

As stated earlier, the information on mortality and morbidity due to induced abortion often relies upon vital registration systems and health service records. The legal status of abortion has seriously affected the quality of information available from these sources.

The fear of legal prosecution may also affect both abortion seeking women as well as medical professionals who perform induced abortion and they may not be willing to openly discuss issues relating to abortion.

The general attitudes on abortion in a country may also be a crucial factor on the gathering of information on induced abortion. In India, for example, in the 1970s, government clearance was not given for participation in an international study designed by WHO on social and behavioral aspects relating to

induced abortion. The Indian government accepted the importance of research on induced abortion, only under the circumstances where abortion was considered legal. In fact, an epidemiological and sociological study of abortion was approved after the legalization of abortion (Mussing 1988).

Conceptual framework of the present study
The investigation of the characteristics and reasons requires the utilization of exploratory research methods, often innovating and combining techniques that may derive from a variety of disciplines. Previous studies that emerged from various disciplines such as anthropology, demography, epidemiology, psychology, geography, sociology and health service research, have drawn their findings using various approaches through the abortion seekers or from service providers.

Types of studies
The abortion studies can be divided into several types according to their concentration. (i) hospital-based studies, (ii) prospective studies or follow-up studies, (iii) community surveys, (iv) special group surveys (v) national surveys and (vi) provider surveys (Mundigo 1999).

Hospital-based studies may be one of the best sources of data for studying epidemiological aspects of induced abortion. In countries where abortion is illegal and unsafe, gynaecological wards receive numerous cases of abortion complications. As such, hospitals offer a convenient place to interview such women. In settings with large variations in the accessibility to hospitals, however, abortion caseload of gynaecological wards may not adequately represent the national level epidemiological aspects of abortion. In other wards, identifying epidemiological aspects of unsafe abortion in a selected hospital population may be useful only for those specific settings, and cannot be generalized to a national level.
Prospective studies or follow-up studies are difficult in abortion research and, they are mostly restricted to countries where abortion is legal. To obtain follow-up data, researchers prefer to use personal diaries, which the women would complete and return to the researchers. The actual data collection, however, may be incomplete because some women may return diaries with blank entries or may not return diaries at all.
The community surveys or intervention studies are designed as experiments that include a service intervention too. A 'before' and 'after' community survey are conducted to measure the changes in the abortion behaviour. These studies may be costly, time consuming and may have methodological drawbacks. If the women interviewed in the 'before' survey had moved out of the study area, have aged, or completed family size, the 'after' survey will have to be restricted, thereby reducing the sample size for final analysis.
Special group surveys may differ in different contexts, and in relation to the objectives of the study. For example, in regions with large numbers of young, unmarried women, a study may be conducted by using a purposive sample design. While these purposive samples may lack the representativeness, they offer an effective alternative to the samples obtained from hospital cases.
The large scale national surveys have seldom been attempted because of the reluctance of women to answer questions on abortion. National surveys may be conducted in both countries where abortion is legal as well as illegal if relevant methods of data collection are used. Information collected through the national surveys provide the best source for understanding the extent of the practice of abortion and, such data can be utilized to influence policy makers.
Studies on service providers constitute a very reliable source of information in abortion research. There are legal, ethical and situational factors that need to be considered before embarking on this type of research. The problems, however, will be less difficult in situations where the practice is legal. Where abortion is not legal, better alternative is to study the opinions of hospital or clinical professionals. This can especially be helpful to improve post abortion care for women arriving with complications at hospitals or clinics. These studies are usually based on purposive samples and may rely on both qualitative as well as quantitative approaches(Hewage 1999).

Application of survey instruments
Abortion studies have utilized quantitative as well as qualitative approaches (Mundigo 1999). When employing quantitative methodologies, a self-administered, short questionnaire relating to abortion issues may be used as a complement to the interviewer- administered questionnaire, in order to ensure the anonymity.
The present study was designed to collect relevant data through the service providers, keeping in mind the advantages and disadvantages of existing approaches. Our study adopted a self-administered

questionnaire, which was administered to a selected group of health professionals, who are highly knowledgeable about the cases of induced abortion.

Investigation of profile of abortion seekers

The investigation of the profile of women resorting to induced abortion has been one of the frequently attempted topics in abortion research in countries where abortion is legal. A variety of characteristics of abortion seekers, which are usually considered as "explanatory variables" of the prevalence of induced abortion, have been examined, using varying measurements and survey methodologies.

In the USA, the vital statistics were used in a study to investigate the socio-demographic characteristics of abortion seekers and, to determine the women at risk of having induced abortions (Powell and Trent 1987).

Another study conducted in the USA, measured the association between the degree of involvement of the physicians in providing abortion services and the characteristics of abortion seekers (Nathanson and Becker 1978).

In countries where abortion is legally restricted, however, little is known about the range of characteristics pertaining to abortion seekers, as compared with countries where liberalized abortion laws exist. In the attempts that have been made in such countries, the women's characteristics have been perceived through smaller study areas or samples. For example, in Bangladesh, the data on women's characteristics were obtained from a vital registration system in rural Matlab (Ahmed et al. 1998). Another study, carried out in Mozambique, has analyzed the data obtained from a maternity ward of an urban hospital (Agadjanian 1998).

Both these studies had commonly examined maternal age, number of living children and religion. In addition, the Mozambican study investigated other variables such as marital status, race, and place of birth, residential district, occupation and contact person. On the other hand, Bangladesh study included pregnancy interval, maternal education and the amount of household space as other variables.

Much of these previous studies indicate that the profiles of abortion seeking women in different contexts have been drawn up by employing a wide range of characteristics.

The existing evidence also shows that studies had worked under various contexts and, there appears no agreement either on the 'appropriate methodology' of investigation or the 'characteristics of abortion seeking women'. It is in this context that the present study obtained perspectives of qualified health professionals in order to obtain alternative data on the profile of women seeking induced abortion.

Investigation of reasons

Studies exploring the reasons for having induced abortion have generally adopted two approaches in the design of the questionnaire, each presenting advantages and limitations. Firstly, most studies ask the respondents only a single question about the woman's most important reason for having an abortion. The respondents are usually given the option of mentioning the most contributory factor, even though the woman's decision may have been motivated by more than one reason (Bankole et al. 1998).

The main disadvantage of this approach is that the restrictions imposed on responses may prevent a complete understanding of the reasons why women have induced abortions, especially when women have more than one reason.

The second approach allows multiple answers to the questions. For example, the respondents can be simply asked why women are having abortions or may be requested to rank a given set of reasons in the order of importance (Torres and Forest 1988). Thus, using questions that allow the respondents to give multiple reasons adds another dimension to understanding the reasons that underlie the decision. As such, this study adopted the second approach, in order to inquire into specific reasons that lead women to seek induced abortion.

Data and methodology

Rationale for the self-administered questionnaire survey

We decided on this methodology that respected the respondents' complete anonymity and confidentiality for gathering information on abortion. This approach also permitted the respondents to respond to several sensitive topics in a secluded environment.

It was expected that the results of self-administered questionnaire survey would highlight some of the distinct groups of women who are at the risk of having induced abortion.

Our assumption here was that a self-administered questionnaire, filled at leisure by a group of knowledgeable, qualified and experienced health professionals who have the direct access to abortion cases, would have valid information regarding the characteristics of abortion seekers.

It would be easier to respond to a self-administered questionnaire, since professionals could take time and think carefully about appropriate answers.

It was also assumed that a self-administered questionnaire directed to health professionals might be a better methodology in ethical terms since answering a self-administered questionnaire would not negatively affect the quality of their services.

Sample design

Respondents were confined only to health professionals who are known to have direct access to cases of induced abortion. As such, the health professionals were defined as "those who have had direct experience with cases of induced abortion, through their services related to induced abortion such as performing safe abortion, providing treatment for complications arising from unsafe abortion, abortion counseling, autopsy investigation of women died due to abortion and providing contraceptives to women who had an abortion".

The selection of an experienced group of health professionals as the sample meant that they would be in a better position to identify the profile of abortion seekers in Colombo district.

It was also assumed that the sample would provide more authoritative opinions on the other aspects of abortion as well, such as reasons for having abortions, availability of abortion services, consequences arising from unsafe abortion and preventive strategies, thereby increasing the understanding of the problem. This paper, however, will pay primary attention on analysing the data on the characteristics of abortion seekers.

The sample consisted of eight categories of experienced health professionals working in the government as well as in the private sector health institutions, as given below.

1. Obstetrician/gynecologists (GYN)
   who would have useful information on the
   cases with abortion complications well as cases of safe abortion.
2. Psychiatrists (PSY)
   who may be involved in post abortion counseling.
3. Judicial Medical Officers (JMO)
   who investigate women died due to unsafe induced abortion
4. General practitioners (GPR)
   or family physicians who are believed to be involved in
   providing safe abortion services in the private sector
5. District Medical Officers and Medical Officers In-Charge (DMO/MOIC)
   who are aware about the cases of abortion requiring treatment for complications
6. Medical Officers of Health (MOH)
   who may have experience in their field areas in contacting women who had abortion.
7. Senior nursing Sisters (SNS)
   who are working in gynaecological wards and who regularly come into contact with women having abortion complications.
8. Senior Public Health Midwives (Family Health Workers) (PHM)
   who work in the field areas under the supervision of an MOH. They are often in contact with women who have had induced abortion.

Sources for selection of respondents

The following sources of information were utilized in the selection of relevant health professionals.

    1.   The Directory of Medical and Dental Professionals 1998.

        This was compiled by the Government Medical Officers' Association (GMOA). This directory gives the names, addresses and qualifications of medical graduates who are registered with Sri Lanka Medical Council (SLMC). The directory provides information on qualified and registered Medical professionals by their specialty up to 31 August 1997. Using this directory, it was possible to select the categories of Obstetricians/Gynecologists, Judicial Medical Officers and, Psychiatrists in the sample.

    2.   The 1998 Sri Lanka Telecom Telephone Directory (Greater Colombo).

        This gives the names of health professionals involved in senior positions in the government health institutions in Colombo district. This directory contains a separate section for Ministries of Health,

which includes the names and addresses of all qualified and Senior Medical professionals working in the government health institutions of the country. As such, the names of Medical Officers of Health (MOH), District Medical Officers (DMO) and Medical Officers-In-Charge (MOIC) were identified from the government section of the telephone directory.

3. The lists of Life and Ordinary membership, complied by the College of General Practitioners of Sri Lanka.

The College of General Practitioners of Sri Lanka provided the complete list of their membership. It is believed that the general practitioners constitute an important component of providers of safe abortion services in the country.

4. Directors of the five teaching hospitals and a base hospital and Medical Officers of Health (MOH).

The Directors of the five teaching hospitals and the base hospital in Colombo district provided assistance in the identification of the most Senior Nursing Sisters who were working in their gynaecological wards. Also, all Medical Officers of Health (MOH) in the Colombo district assisted in identifying the most Senior Public Health Midwife in their respective areas.

The first three sources mentioned above covered almost all qualified and registered medical professionals in each area of specialisation in the public and private sectors in the country. These sources, however, do not provide information whatsoever on a quacks who may be an important component of illegal abortion providers in the country.

Using these four sources, it was possible to select eight categories of Obstetricians/Gynecologists, Judicial Medical Officers, Psychiatrists, General Practitioners, Medical Officers of Health, District Medical Officers and Medical Officers In-Charge, Senior Nursing Sisters and Senior Public Health -Midwives.

However, as there were very few Joss working in the Colombo district, it was decided to recruit all Joss island-wide, into the sample. JMO was the only category of health professionals, which was not confined to the Colombo district. The Judicial Medical Officers who were selected in the sample were official Forensic Medicine consultants to the Judiciary, the Attorney General and the Police Department for the maintaining the law and order in the country.

For all medical professionals in the sample, the questionnaire was mailed to their official or home addresses. The questionnaires for sent to all Senior Nursing Sisters and Public Health Midwives, however, were handed over personally to the Heads of the respective health institutions, as the addresses of these respondents were not available through the above sources. The selected respondents were requested to return the completed questionnaires, within a period of a month.

A Letter of Support issued by the Ministry of Health was attached to the questionnaires sent to the health professionals in the government sector. Also, a Letter of Support given by the President of General Practitioners' Association was attached to the questionnaires sent to the General Practitioners. In addition, a letter of invitation ensured the anonymity and confidentiality of the respondents and their views.

Using this approach, 247 health professionals who are believed to be directly in contact with cases of induced abortion were identified for the study. This sample covered a wide range of health professionals as well as institutions that were spatially diffused within the district. The working establishments of these health professionals spread from the heart of the capital city of Colombo to the peripheral areas of the Colombo district. As such, it was determined that a minimum sample size of 100 health professionals (about 40% of all identified professionals) would be large enough to make a reasonable assessment of the profile of abortion seekers.

Response rate
Within a month, 67 questionnaires were completed and returned. In addition, four questionnaires were returned due to the inability to locate the addresses. In order to increase the response rate, a follow-up letter was mailed to non-respondents one month later, while a second follow-up was made over the telephone, to several non-respondents. As a result, 52 more questionnaires were completed and returned achieving an overall response rate of 48.2% (119 questionnaires).

The response rate to the questionnaire by categories of health professionals, as given in Table 3,indicates that the highest response rates (over 50%) were recorded among the categories of MOH, Public Health Midwives, Senior Nursing Sisters, Demos and Medical Officers In-Charge. On the other hand, the lowest

response rates were recorded among the categories of obstetrician/gynecologists, JMOs, psychiatrists and General Practitioners.

Table 3. Percentage distribution of health professionals by their responses to the self-administered questionnaire (N=247)

Categories of health professionals	Original sample			Number of respondents					
				Responded in one month		Responded After a follow-up		Total responded	
	%	No.	%	No.	%	No.	%	No.	%
Obstetrician/Gynecologist (GYN)	19.8	49	100.0	13	26.5	06	12.3	19	38.8
Judicial Medical Officer (JMO)	6.9	17	100.0	03	17.6	05	29.4	08	47.1
Psychiatrist (PSY)	8.1	20	100.0	04	20.0	04	20.0	08	40.0
Medical Officer of Health (MOH)	4.5	11	100.0	07	63.6	03	27.3	10	90.9
District Medical Officer (DMO)and Medical Officer In-Charge(MOIC)	4.5	11	100.0	03	27.3	03	27.3	06	54.6
General Practitioner (GPR)	42.8	106	100.0	23	21.7	22	20.8	45	42.5
Senior Nursing Sister (SNS)	8.9	22	100.0	10	45.5	05	22.7	15	68.2
Senior Public Health midwife (PHM)	4.5	11	100.0	04	36.4	04	36.4	08	72.8
TOTAL	100	247	100.0	67	27.1	52	21.1	119	48.2

When compared with the high response categories, it is seen that the low response categories were specialists in their respective fields. They may be too busy with their professional work and this may possibly have contributed to the relatively low response rate. It may also be true that the endorsements given by the Ministry of Health and the President of General Practitioners Association of Sri Lanka had positively influenced on some respondents, encouraging them to respond to the questionnaire. The low response rate (42.5%) recorded in the category of general practitioners may probably be explained by the fact that abortion is legally restricted in Sri Lanka.

The higher response rates (over 50%) were recorded in the categories of Medical Officers of Health, Public Health Midwives, Senior Nursing Sisters, District Medical Officers and Medical Officers In-Charge. The Ministerial endorsement of the questionnaire may have encouraged them to respond to the questionnaire.

On the other hand, the lower response rates were recorded in the categories of Obstetrician/ Gynecologists, Judicial Medical Officers, Psychiatrists and General Practitioners. The low response rate recorded in the categories of general practitioners and obstetrician/gynecologists may probably be explained by the fact that some of them may have actually involved in providing illegal abortion services. It is also seen that low response categories are specialists in their respective fields. The heavy involvement with their professional work may also have contributed to the low response rate.

Questionnaire design

The self-administered questionnaire contained several topics that were important in measuring the extent of induced abortion. While all the questions were structured with fixed responses, which are extremely important for a self-administered questionnaire, a number of questions were designed using the 'Likert scale' since many questions were designed to identify the degree of agreement of respondents on a certain issue.

The main sections of the questionnaire are given below:
(a) Sample characteristics:
        Sample characteristics such as type of institution, age, sex, number of years in the professional experience, professional and educational qualifications, ethnicity and religion.

(b) Awareness on various types of abortion-seeking women

The awareness on various types of abortion seeking women. The categories of women identified were who had safe abortion, unsafe abortion, repeat abortion, self induced abortion, physical complications, psychological complications, died due to abortion, required counseling and unable to obtain abortion.

(c) Involvement with cases of induced abortion in the professional career and the number of abortion cases attended in the last three months

(d) Characteristics of the most recent case of abortion

The requested information were the context of contact, woman's marital status, approximate age, working status, income status, educational status, and residential status. (See Text Box 2).

(e) Reasons for having induced abortion

The next question attempted to identify the importance of a set of reasons for women to have induced abortion.

Textbox 2. Design of questions on abortion seekers
Marital Status 1. Unmarried 2. Married
Age 1. Under 20 years 2. 21-30 3. 31-40 4. over40
Working status 1. Working 2. Non working
Income status 1. Low 2. Middle 3. Upper
Educational status 1. Uneducated 2. has had schooling 3. highly educated
Residential status 1. Urban 2. Rural

Profile of respondents

Degree of involvement with cases of abortion

Before presenting a series of questions on the characteristics of abortion seekers, the respondents were presented with a question to find out whether they have professionally come across cases of induced abortion during their professional career.

Those who responded 'yes', were further requested to indicate the approximate range of abortion cases they were professionally involved in the last three months.

Those who responded as having contacted at least one single case of induced abortion during the last three months, were then invited to answer the sub-questions on the characteristics of abortion seekers, with the last case in mind.

Of the 119 health professionals who responded to the questionnaire, 92.4% acknowledged that they have been professionally involved with cases of induced abortion in their career (See Table 4).

A few respondents gave 'no answer', or 'no' responses possibly indicating some underreporting. An exceptional response was that an obstetrician/gynecologist, who had recently returned to Sri Lanka after practicing in UK for the last 28 years, had mentioned that he had no experience with regard to abortion

cases in Sri Lanka. Also, there were six general practitioners and one psychiatrist whose responses were in the negative. Two of these general practitioners were very old (over 72 years) and perhaps they had retired from their private medical practice now. Another general practitioner who said 'No' had expressed his displeasure for not phrasing the term 'induced abortion' as 'criminal abortion.' A Senior Nursing Sister, working in a gynaecological ward, had also stated 'no', indicating the possibility of underreporting.

Table 4. Percentage distribution of health professionals according to their involvement with cases of induced abortion in their professional career (N=119)

Categories of Professionals	Response						
	Total			Yes		No/ No* answer	
	%	No.	%	No.	%	No.	%
Obstetrician/ Gynecologist	16.0	19	100.0	18	92.9	01	7.1
Judicial Medical Officer	6.7	08	100.0	08	100.0	-	-
Psychiatrist	6.7	08	100.0	07	87.5	01 ?	12.5
Medical Officer of Health	8.4	10	100.0	10	100.0	-	-
District Medical Officer and Medical Officer In-Charge	5.0	06	100.0	06	100.0	-	-
General Practitioner	37.9	45	100.0	39	86.7	06	13.3
Senior Nursing Sister	12.6	15	100.0	14	93.3	01	6.7
Senior Public Health Midwife	6.7	08	100.0	08	100.0	-	-
Total	100.0	119	100.0	110	92.4	09	7.5

Note: * One gynecologist who responded "No", has recently returned to Sri Lanka after practicing in UK for the last 28 years and therefore, he has no experience about abortion patients in the context of Sri Lanka.

Concerning the degree of involvement with abortion cases in the last three months, nearly 2/3 of the health professionals had acknowledged that they had attended to a varying number of abortion cases during this period. See Table 5.

Table 5. Percentage distribution of health professionals, according to their professional involvement with cases of induced abortion in the last three months of 1998. (N=110)

Categories of Professionals	Total health professionals involved with cases of induced abortion			Number of induced abortion cases involved in the last three months							
				Over 100 cases		11 – 100 cases		Up to 10 cases		None/ No answer	
	%	No	%	No	%	No	%	No	%	No	%
Obstetrician/ Gynecologist	16.4	18	100	-	-	05	27.8	11	61.1	02	11.1
Judicial Medical Officer	7.2	08	100	-	-	02	25.0	04	50.0	02	25.0
Psychiatrist	6.4	07	100	-	-	01	14.2	02	28.6	04	57.2
Medical Officer of Health	9.1	10	100	-	-	01	10.0	08	80.0	01	10.0
District Medical Officer and Medical Officer In-Charge	5.5	06	100	-	-	-	-	02	33.3	04	66.7
General Practitioner	35.5	39	100	-	-	07	17.9	18	46.2	14	35.9
Senior Nursing Sister	12.7	14	100	-	-	02	14.3	08	57.1	04	28.6
Senior Public Health Midwife	7.2	08	100	-	-	-	-	03	37.5	05	62.5
Total	100	110	100	-	-	18	16.4	56	50.9	36	32.8

Awareness on abortion cases

The respondents were requested to make a self-assessment on their awareness on abortion cases under various circumstances. The respondents assessed their level of experience under nine circumstances. The data is given in Table 6.

Little over 50% of all respondents had highly extensive or fairly extensive awareness about women who had safe abortion. Meanwhile, more than 40% of the respondents also had highly extensive or fairly extensive knowledge on women who had unsafe abortion. These opinions firmly confirm the fact that abortion services are available, either unsafe or safe, to a certain extent to women in need in Sri Lanka even though abortion is legally restricted. It can also be confirmed by the opinion that shows only 20% of them had highly extensive or fairly extensive knowledge on women who were unable to obtain abortion when they were in need.

Forty percent of the respondents acknowledged that they had highly extensive or fairly extensive knowledge on women who were treated for complications of abortion. Furthermore, 34% of them accepted that they had similar knowledge on women who required counseling on abortion. These opinions indicate that the role of health professionals even in the illegal context may be wide ranging.

The proportion of the respondents who are aware about women who had psychological complications and who had self-induced abortion are fairly low when compared with the other categories of women.

In addition, about 25% the respondents believed that they had highly extensive or fairly extensive knowledge on women who died due to induced abortion, or about women who had repeat abortion.

Educational and professional qualifications

The sample of respondents was professionally and educationally highly qualified in their respective fields. About 16% of the sample had achieved very high educational qualifications such as MD, Ph.D. or MS qualifications. Within the categories of obstetricians/ gynecologists and Judicial Medical Officers, around 60% had achieved this level of educational qualifications. It is noteworthy that some general practitioners too were in the highest category of educational qualification.

Also, about 1/4 of the respondents have had obtained very high professional qualifications such as FCGP, FRCOG and FSLCOG. This meant that they were in the medical practice over 10 years and, also were involved in continuous medical education.

Apart from the above qualifications, other post-graduate qualifications such as MSc, DFM and DLM had been obtained by 21% of the respondents. They belonged to several categories like, JMO, MOH, Psychiatrists, DMO, MOIC and General Practitioners.

The respondents who had only the basic educational qualifications such as MBBS, GCE (Advanced Level) or (Ordinary Level) were about 24% of the sample. Furthermore, about 50% of both Senior Nursing Sisters and Senior Public Health Midwives too had obtained professional qualifications such as Certificate of Family Health Training, Proficiency Certificate of Nursing, Certificate of Post Primary Nursing Training and Diploma in Hospital Administration and Supervision.

Experience and age

A major feature, in terms of the duration of professional experience, as seen in Diagram 1, was that there were about 87% of the respondents in the sample who had over 10 years of professional experience. The sample, therefore, has largely constituted a highly experienced group of health professionals.

The age of the respondents may be considered as an indirect indicator of their level of involvement in the respective professions, if they had continuously engaged in medical practice. It is seen from the data that, over 57% of the respondents were older than 50 years of age. One psychiatrist and nine general practitioners were older than 70 years. In fact, no respondent in any professional category had reported less than 30 years of age. There were many general practitioners who were involved in private practice are in the sample. The retirement age, 55 years would not necessarily affect their medical practice. As such, the survey had the advantage of approaching more senior health professionals who were involved in their professions for a longer time.

Table 6. Percentage distribution of health professionals according to the self- assessment of awareness on abortion cases in different contexts (N=119)

Women's context and level of awareness	ALL 119	GYN 19	JMO 08	PSY 08	MOH 10	DMO 06	GPR 45	SNS 15	PHM 08
Had safe abortion									
Highly extensive	14	21	-	-	20	-	11	20	13
Fairly extensive	37	37	62	25	70	-	36	40	62
Not very extensive	40	37	25	62	10	100	42	27	13
None/No answer	9	5	13	13	-	-	11	13	13
Had unsafe abortion									
Highly extensive	12	21	25	13	-	-	4	13	13
Fairly extensive	31	47	38	38	30	50	22	33	25
Not very extensive	39	26	38	25	70	50	47	21	38
None/No answer	18	6	-	25	-	-	27	33	25
Treated for complications	16	42	-	-	10	-	4	33	13
Highly extensive	24	32	63	50	20	17	18	33	13
Fairly extensive	39	21	38	50	70	83	53	7	13
Not very extensive	21	5	-	25	-	-	25	27	62
None/No answer									
Died due to unsafe abortion	8	32	-	-	10	-	2	20	13
Highly extensive	15	21	25	25	10	-	4	27	13
Fairly extensive	22	16	75	25	30	33	25	20	-
Not very extensive	55	32	-	50	50	66	69	33	74
None/No answer									
Unable to obtain abortion	5	5	13	-	-	-	5	7	-
Highly extensive	15	21	-	-	30	50	16	20	38
Fairly extensive	30	32	38	63	20	17	33	7	-
Not very extensive	50	42	50	38	50	33	46	67	63
None/No answer									
Had repeated abortion									
Highly extensive	5	5	-	-	-	-	4	13	-
Fairly extensive	22	26	25	25	30	17	13	27	25
Not very extensive	35	53	13	25	30	33	47	20	38
None/No answer	38	16	63	50	40	50	36	40	38
Had psychological complications	5	16	-	-	-	17	-	-	-
Highly extensive	10	21	13	13	10	-	7	7	25
Fairly extensive	41	48	38	87	30	-	47	27	25
Not very extensive	44	16	50	-	60	83	46	67	50
None/No answer									
Required counseling on abortion	12	32	-	-	-	17	11	13	13
Highly extensive	22	32	-	-	60	-	22	20	38
Fairly extensive	28	16	25	75	10	33	36	13	-
Not very extensive	38	21	76	25	30	50	31	53	50
None/No answer									
Had self-induced abortion	4	5	13	-	10	-	2	-	-
Highly extensive	13	5	-	25	10	-	9	33	-
Fairly extensive	22	32	38	13	20	50	22	7	-
Not very extensive	61	58	50	63	60	50	67	60	100
None/No answer	100	100	100	100	100	100	100	100	100

Note: **ALL**: all respondents; **GYN**: Gynecologists; **JMO**: Judicial Medical Officers; **PSY**: Psychiatrists; **MOH**: Medical Officers of Health; **DMO**: District Medical Officers; **GPR**: General Practitioners; **SNS**: Senior Nursing Sisters; and **PHM**: Public Health Midwives.

Sex

The distribution of health professionals by sex in the sample, in terms of male-female proportion was approximately two to one. Also, high male proportion was well evident in all categories of medical professionals. The highest male participation was in the category of Obstetrician/gynecologists, accounting for about 95%. In a sense, the high male involvement in this category is well evident in the country too.

Results

The profile of abortion seekers drawn up in the survey

The drawing of inferences on abortion seekers was based upon the information of an "actual abortion case" which was specifically known to the health professionals within a given period of time. Six characteristics of abortion seekers were identified for inclusion in the analysis as given in the Text box 2. Assuming that the validity of opinions regarding the profile of abortion seekers would be higher when the questions were asked in relation to a particular case of abortion (the most recent case of abortion in our study), the respondents were provided with specific questions as well as responses that were specific in relation to a particular case of abortion.

Table 7 gives the over all responses of the characteristics of abortion seekers. The data given in Tables 8, 9, 10, 11, 12 and 13 provide the cross tabulation of responses by the categories of health professionals.

Quite interestingly, over ¾ of the abortion cases seen by the professionals were married women. A possible explanation for this situation would be that married abortion seekers than unmarried abortion seekers may consult skilled health professionals for medical attention at any stage of abortion procedure. On the other hand, it may also reflect the fact that the need for family planning among some married women may be fulfilled through the practice of abortion.

Table 7. Percentage distribution of health professionals in the survey according to their overall opinions on the most recently reported abortion case by the characteristics of women (N=110)

Characteristic	Categories of responses				
Approximate age	Under 20	21-30	31 - 40	Over 40	Unsure/ No answer
	7.3	53.7	30.9	2.7	5.4
Working status	Working		Not working		Unsure/ No answer
	33.6		52.8		13.6
Income status	Low	Middle		Upper	Unsure/ No answer
	30.0	50.9		6.4	10.7
Educational status	Uneducated	Had schooling		Highly educated	Unsure/ No answer
	6.4	78.2		6.4	9.1
Residential status	Urban		Rural		Unsure/ No answer
	64.5		29.2		6.3

With regard to the working status, over 50% of abortion cases were found among non-working women by the respondents. These data raise the speculation whether the use of contraceptives would be largely confined to the working women since they may have better opportunities than non-working women to the contraceptive sources.

Meanwhile, the respondents had reported a little over 50% of their most recent abortion cases were among the middle income group and, with regard to the educational status, over 78% of the respondents had found abortion cases among women have had some form of schooling. When the age factor is taken into consideration, over 50% of abortion cases were in the age category of 21-30 years. Finally, with regard to the residential status, the respondents held the opinion that the prevalence of induced abortions among urban women is high.

It is noteworthy that the data show only a small percentage of respondents (less than 5%) expressing their uncertainty with regard to the identification of marital status, age and residential status of the abortion seekers. However, the uncertainty is higher when the respondents were asked about the income, education and working status of their patients.

As the data were pertaining to a specific case of abortion, a cross-tabulation of the marital status of women by other characteristics allows further examination of broad patterns.

As Table 14 shows most unmarried women seeking induced abortion were younger, on average, than married women. Among the married women who seek induced abortion, the largest proportion was in the age group 21-30 years. This age group of married women probably points out the high demand for methods of fertility regulation particularly on the grounds of delaying their child bearing.

Notably, majority of abortion cases in both unmarried and married groups were not working, though living in urban areas and have had some level of schooling. The medium level of income is also associated largely with married women than unmarried women. The fact that the majority of abortion seekers are not working is particularly striking, because it is generally expected that women who are working and are living in an urban areas, would constitute an above average share of abortion seekers.

Table 8. Percentage distribution of health professionals according to the marital status of the most recent case of abortion that they were associated with professionally (N=110)

Profession	Marital status								
	Total			Unmarried		Married		Unsure/No answer	
	%	No.	%	No.	%	No.	%	No.	%
Obstetrician/	16.4	18	100		5.6	17	94.4	-	-
Gynecologist	7.2	08	100	01	25.0	06	75.0	-	-
Judicial Medical	6.4	07	100		57.1	02	28.6	01	14.3
Officer	9.1	10	100	02	10.0	09	90.0	-	-
Psychiatrist	5.5	06	100		16.6	04	66.7	01	16.6
Medical Officer of				04					
Health	35.5	39	100		10.3	31	79.5	04	10.3
District Medical Officer	12.7	14	100	01	28.6	09	64.3	01	7.1
and	7.2	08	100		12.5	07	87.5	-	-
Medical Officer In-			100	01	16.4	85	77.3	07	6.3
charge	100.0	110							
General Practitioner				04					
Senior Nursing Sister				04					
Senior Public Health				01					
Midwife				18					
Total									

The proportion of abortion-seeking women in urban areas considerably exceeds those in rural areas. Perhaps, this may be a reflection of the fact that abortion-seeking women in urban areas are more likely to contact professionals for health services than their rural counterparts. On the other hand, it may also be true that, self-induced methods may still be available in the rural areas. Also, these figures may have been influenced by the fact that Colombo district has more urban population than rural population.

Table 9. Percentage distribution of health professionals according to the approximate age of the most recent case of abortion that they came across professionally (N=110)

Profession	Approximate age (years)												
	Total			Under 20		21-30		31-40		Over 40		Unsure/No answer	
	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Obstetrician/ Gynecologist	6.4	18	100	-	-	09	50.0	09	50.0	-	-	-	-
Judicial Medical Officer	7.2	08	100	02	25.0	04	50.0	02	25.0	-	-	-	-
Psychiatrist	6.4	07	100	04	57.1	01	14.3	01	14.3	-	-	01	14.3
Medical Officer of Health	9.1	10	100	01	10.0	06	60.0	02	20.0	01	10.0	-	-
District Medical Officer/ Medical Officer In-charge	5.5	06	100	-	-	04	66.7	-	-	-	-	02	33.2
General Practitioner	35.5	39	100	01	2.6	19	48.7	15	38.5	02	5.1	02	5.1
Senior Nursing Sister	2.7	14	100	-	-	11	78.6	02	14.3	-	-	01	7.1
Senior Public Health Midwife	7.2	08	100	-	-	05	62.5	03	37.5	-	-	-	-
Total	100	110	100	08	.3	59	53.7	34	30.9	03	2.7	06	5.4

Table 10. Percentage distribution of health professionals according to the working status of the most recent case of abortion that they came across professionally (N=110).

Profession	Working status								
	Total			Working		Not working		Unsure/No answer	
	%	No.	%	No.	%	No.	%	No.	%
Obstetrician/ Gynecologist	16.4	18	100	06	33.3	09	50.0	03	16.7
Judicial Medical Officer	7.2	08	100	01	12.5	05	62.5	02	25.0
Psychiatrist	6.4	07	100	02	28.6	04	57.1	01	14.3
Medical Officer of Health	9.1	10	100	05	50.0	05	50.0	-	-
District Medical Officer / Medical Officer In-charge	5.5	06	100	-	-	03	50.0	03	50.0
General Practitioner	35.5	39	100	17	43.6	17	43.6	05	12.8
Senior Nursing Sister	12.7	14	100	06	42.9	07	50.0	01	7.1
Senior Public Health Midwife	7.2	08	100	-	-	08	100.0	-	-
Total	100	110	100	37	3.6	58	52.8	15	13.6

Table 11. Percentage distribution of health professionals according to the income status of the most recent case of abortion that they came across professionally (N=110)

Profession	Total %	No.	%	Low No.	%	Middle No.	%	Upper No.	%	Unsure/No answer No.	%
Obstetrician/	6.4	18	100		27.8	08		03	6.7	02	11.1
Gynecologist	7.2	08	100	05	50.0	03	44.4	-	-	01	12.5
Judicial Medical	6.4	07	100		28.6	03		01	14.3	01	14.3
Officer	9.1	10	100	04	20.0	06	37.5	01	10.0	01	10.0
Psychiatrist	5.5	06	100		33.3	01		-	-	03	50.0
Medical Officer				02			42.9				
of Health	35.5	39	100		23.1	23		02	5.1	05	12.9
District Medical	12.7	14	100	02	35.7	08	60.0	-	-	01	7.2
Officer /	7.2	08	100		50.0	04		-	-	-	-
Medical Officer	100.0	110	100	02	30.0	56	16.7	07	6.4	14	12.7
In-charge											
General Practitioner				09			58.9				
Senior Nursing Sister				05			57.1				
Senior Public Health Midwife				04			50.0				
Total				33			50.9				

Table 12. Percentage distribution of health professionals according to the educational status of the most recent case of abortion that they came across professionally (N=110)

Profession	Total %	No.	%	Uneducated No.	%	Has had schooling No.	%	Highly educated No.	%	Unsure/No answer No.	%
Obstetrician/ Gynecologist	16.4	18	100	01	5.6	16	88.8	-	-	01	5.6
Judicial Medical Officer	7.2	08	100	-	-	07	87.5	01	12.5	-	-
Psychiatrist	6.4	07	100	01	14.3	05	71.4	-	-	01	14.3
Medical Officer of Health	9.1	10	100	-	-	07	70.0	02	20.0	01	10.0
District Medical Officer / Medical Officer In-charge	5.5	06	100	01	16.7	04	66.6	-	-	01	16.7
General Practitioner	35.5	9	100	03	7.7	30	79.9	02	5.1	04	10.3
Senior Nursing Sister	12.7	14	100	01	7.1	10	71.4	02	14.3	01	7.1
Senior Public Health Midwife	7.2	08	100	-	-	07	87.5	-	-	01	12.5
Total	00	110	100	07	6.4	86	78.2	07	6.4	10	9.1

Reasons for having abortion

The respondents were given the opportunity of ranking a set of reasons as to why women seek induced abortion, in the order of importance. This approach was expected to provide a more comprehensive picture. The data in Table 15 and Diagram 3 give the percentage distribution of health professionals by their ranking of these reasons.

"Unwanted pregnancy" was ranked first by nearly a 2/3 of the respondents as the most important reason for having induced abortion. The commonly held opinion by the respondents that unwanted pregnancy is the major reason why women have abortions is consistent with the changing patterns of fertility preferences in Sri Lanka as confirmed by the Demographic and Health Survey in 1993. A comparison of the total fertility rate of 2.3 children in 1993, with the total wanted fertility rate of 1.8 children, suggests that women in Sri Lanka are having more children than they wanted.

Table 13. Percentage distribution of health professionals according to the residential status of the most recent case of abortion that they came across professionally (N=110)

Profession	Residential Status							
	Total			Urban		Rural		Unsure/No answer
	%	No.	%	No.	%	No.	%	No.	%
Obstetrician/ Gynecologist	16.4	18	100	13	72.2	05	27.8	-	-
Judicial Medical Officer	7.2	08	100	05	62.5	03	37.5	-	-
Psychiatrist	6.4	07	100	04	57.1	02	28.6	01	14.3
Medical Officer of Health	9.1	10	100	06	60.0	03	30.0	01	10.0
District Medical Officer/ Medical Officer In-charge	5.5	06	100	01	16.7	03	50.0	02	33.3
General Practitioner	35.5	39	100	32	82.0	05	12.8	02	5.2
Senior Nursing Sister	12.7	14	100	07	50.0	06	42.9	01	7.1
Senior Public Health Midwife	7.2	08	100	03	7.5	05	62.5	-	-
Total	100	110	100	71	64.5	32	29.2	07	6.3

Furthermore, nearly one out of three women who had a birth in the last 12 months reported that their last birth was unwanted either because the birth was not wanted at the time or not wanted at all. Also, 34% of currently married women, of whom 25% were in need of family planning, were not using any contraceptive method and, a further 22% relied on traditional methods. Under such circumstances in Sri Lanka, the chances are high that many married women will face unwanted pregnancy and, that many of them will choose to have an abortion (Sri Lanka Department of Census and Statistics 1995).

Being an 'unmarried mother' as a reason for seeking abortion was ranked second by nearly 1/3 of the respondents and first by about 17% of them. Meanwhile, 'young age of mother' was ranked sixth according to the responses. Although being too young and being single are expected to operate in combination, the ranking of these two reasons in the study was not similar. These responses of the health professionals' may point to the fact that most unmarried mothers who seek induced abortions may not necessarily by young.

'Contraceptive failure was placed third in the ranking, while 'pure socio economic reasons' and 'sexual relationships outside marriage' were ranked as the fourth and fifth reasons respectively. Quite interestingly, the respondents gave low priority to some of the highly sensitive reasons for abortion such as rape and incest, which are frequently being reported in the media.

Purely health reasons such as 'maternal illness' and the 'abnormal fetus' were given the lowest ranking by the health professionals. Also a sizeable proportion of the respondents gave "no answer" to these health reasons.

Pregnancy as a risk to maternal health is apparently a less important reason for women to have abortions in many developed countries and in Latin America (24). Despite the fact that the pregnancy may be a threat to the maternal health, and it may provide a moral and social justification for having abortion, this reason seems to be perceived as less important by the respondents.

The respondents have not considered the potential risk for the unborn child as an important reason probably due to the fact that such health problems are not being identified extensively, or may be due to the low actual incidence of birth defects. In many countries in the developing world, advanced testing for birth defects may not be widely available and may not be performed regularly.

A large dispersion in the responses of health professionals with regard to the reasons for having induced abortion indicates the fact that many of these respondents have perceived the priorities of these reasons quite differently. According to the data given in Table 15, a higher variation in the ranking is seen for all reasons, except in the 'unwanted pregnancy' where a moderate variation is seen.

Consequently, this suggests a methodological limitation on the validity of responses given by the health professionals. The dispersion suggests that the understanding of reasons for having induced abortion through the opinions of health professionals require further attention in future research.

Table 14. Percentage distribution of reported abortion cases cross tabulated by marital status with other characteristics (N=110)

Marital status	Working status			
	Working	Not working	Unsure/ No answer	All
Unmarried	5.5	9.1	1.8	16.4
Married	28.2	42.7	6.4	77.3
Unsure/No answer	-	0.9	5.4	6.3
All	33.7	52.7	13.6	100.0

Marital status	Residential status			
	Urban	Rural	Unsure/No answer	All
Unmarried	9.1	6.4	0.9	16.4
Married	52.8	21.8	2.7	77.3
Unsure/No answer	2.7	0.9	2.7	6.3
All	64.6	29.1	6.3	100.0

Marital status	Approximate age (years)					
	<20	21-30	31-40	Over 40	Unsure/ No answer	All
Unmarried	5.5	10.9	-	-	-	16.4
Married	1.8	41.0	30.9	2.7	0.9	77.3
Unsure/No answer	-	1.8	-	-	4.5	6.3
All	7.3	53.7	30.9	2.7	5.4	100.0

Marital status	Income status				
	Low	Medium	Upper	Unsure/ No answer	All
Unmarried	9.1	6.4	0.9	-	16.4
Married	19.9	43.6	5.5	8.3	77.3
Unsure/No answer	0.9	0.9	-	4.5	6.3
All	29.9	50.9	6.4	12.8	100.0

Marital status	Educational status				
	Uneducated	Has had schooling	Highly educated	Unsure/ No answer	All
Unmarried	0.9	11.9	1.8	1.8	16.4
Married	4.5	64.7	4.5	3.6	77.3
Unsure/ No answer	0.9	1.8	-	3.6	6.3
All	6.3	78.4	6.3	9.0	100.0

Conclusions and policy recommendations

It may be concluded that these opinions may provide better information on the profile of abortion seekers as well as on reasons for having abortions. Also, the approach is more appropriate in the illegal context. The self-administered questionnaire ensured the respondents' complete anonymity and, also permitted them to respond to the questions in a secluded environment. Our assumption was that a self-administered questionnaire filled by the respondents at their leisure would have accurate and valid responses especially because all the respondents were at a higher level of their professional status. It was also expected that the answers would be honest since the respondents were guaranteed complete anonymity.

Table 15. Percentage distribution of health professionals by their ranking of reasons of seeking abortion N=119

Reasons	Rank									No answer
1.Unwanted pregnancy	**63.9**	11.8	11.	3.4	0.8	0.8	-	0.8	-	6.7
2.Unmarried mother	16.8	**31.9**	11.	13.	7.6	2.5	5.0	0.8	-	10.1
3.Contraceptive failure	3.4	16.8	**26.**	13.	7.6	9.2	4.2	3.4	3.4	11.8
4.Pure socio-economic reasons	8.4	11.8	16.	**21.**	10.1	9.2	5.0	2.5	5.0	10.9
5.Sexual relationships outside marriage	5.9	10.9	7.6	17.	**19.3**	10.9	9.2	2.5	6.7	9.2
6.Young age of mother	1.7	3.4	4.2	7.6	13.4	**15.1**	12.6	12.6	14.	15.1
7.Rape/incest	5.0	5.9	4.2	7.6	7.6	13.4	**16.0**	15.1	10.	15.1
8.Maternal illness	4.2	1.7	5.9	4.2	8.4	13.4	16.8	**18.5**	8.4	26.9
9.Abnormal fetus	3.4	4.2	2.5	2.5	6.7	10.9	11.8	17.6	**19.**	21.0

Note: The bold figures indicate the highest percentages in each rank

In view of the complexity of the questions asked on the characteristics of abortion seekers and the reasons for having abortions, it would be easier to respond to such questions on a self-administered basis, since they could refer to the patients' files if necessary.

However, the self- administered questionnaires on abortion conducted in countries where abortion is illegal and also where the relevant populations of health professionals or service providers are not large enough, usually face the risks of either receiving low response rates or deriving relatively smaller sample sizes. However, if a study is able to overcome at least one of these two challenges, the results may be considered worthwhile. For example, although a study conducted in Nigeria had approached a very small sample of health professionals (76 doctors, nurses, midwives and chemists), the response rate achieved was very high, 88 % (Makinwa-Adebusoye et al. 1997).

Similarly, an abortion study conducted in several countries in South Central and South East Asia had achieved a moderate response rate of 62 %. The size of the selected sample was, however, 374 health professionals (Singh et al.1997).

The overall moderate response rate of our study (48%) may be partly a result of the legal constraints imposed on abortion. Also, the shorter time period given to the respondents to return the questionnaires may be another factor. In a similar study, conducted in the United Kingdom using a sample of 396 gynecologists had achieved a response rate of 87%. These respondents were given the opportunity of more than four months to answer the questionnaire (Francome and Savage 1992), while in our case, the respondents were given about two months.

While, over 92% of the respondents acknowledged that they were involved with abortion cases in their entire professional career, there were only 67% of them who acknowledged abortion cases in the last three months. As such, some professionals may have been prevented in answering the questions on the characteristics of abortion seekers by the selection of three-month recall period.

Also, for some professionals the recall period may be too long, if the most recent case was not really 'recent'. When the three-month period was concerned, some of them may find difficulties in recalling the characteristics of such abortion cases.

How well will health professionals be able to assess the profile and reasons for women to have induced abortions?

The low proportion of "don't know" and "no answer" responses for many questions possibly indicate the fact that the respondents are giving accurate information.

Furthermore, since almost all respondents were highly qualified, experienced professionals and many of them were holding senior positions in their respective fields of specialisation, they are obliged ethically and officially to maintain appropriate medical histories of their patients. It is assumed, therefore, that when answering the questionnaire, the respondents may have referred to the medical histories of the particular abortion case.

The data shows that a high proportion of abortion cases are reported to be married, and this may be possibly because many unmarried abortion seekers may contact unskilled professionals. Although the

unskilled and unqualified professionals are believed to be frequent providers of abortion services, they were not included in the present study mainly because of the non-availability of valid and complete lists of their names and addresses. The sources mentioned earlier in this study do provide information only on the qualified professionals. No such compilation of information what so ever available about quacks who provide unsafe abortion services.

With regard to the profile of abortion seekers, these data were derived indirectly from the opinions of service providers and, therefore, the validity of the results are to be measured after analysing the characteristics of the direct information obtained from the abortion seekers. Arising from this, the opinions of the health professionals are basically 'approximations', and, therefore, may be subject to some errors. One way of minimising such errors are to direct the attention of respondents to a particular case of abortion rather than asking the opinions on the general population. This was done in the this study and, it may be concluded that these opinions provide better information on the profile of women seeking abortion and, the approach is more appropriate in the context of illegal and sensitive nature.

When the responses on the characteristics of abortion cases were cross-tabulated by the categories of health professionals, it raises some of the differentials in the responses.

Such differences can be seen among several categories of respondents. For example, psychiatrists have seen a higher proportion of unmarried abortion cases than other categories of health professionals. On the other hand, the abortion cases, reported to the obstetricians/gynecologists comprise a large proportion of married women.

Meanwhile, many abortion cases referred to the Judicial Medical Officers are found to be in the category of low income, showing the relationship between the low income of the abortion seeker and the adverse quality of the abortion services available to such women.

The level of education of the abortion cases shows some consistency. Over 2/3 of the abortion cases seen by the all health professionals are among the category of women who have had some schooling.

With regard to the residential status of abortion cases, general practitioners have seen a large proportion of abortion cases living in urban areas. This may be due to the fact that most general practitioners provide their services at urban centers. Similarly, obstetricians/gynecologists have reported many abortion cases among urban women, possibly indicating their establishments are close to the urban centers.

The differences in the characteristics of abortion cases that existed in relation to the professional status of the respondents may reflect the fact that the degree of involvement of professionals with abortion cases may have some influence on their responses.

The fact that the proportion of abortion-seeking women in urban areas exceeds considerably those in rural areas may be because abortion services are more readily available in the urban areas.

The data clearly indicated that there may be several circumstances, not merely for seeking abortion procedures, under which abortion seekers would come into contact with the respondents. These circumstances may vary from seeking safe abortion services by women themselves to the abortion seekers who were referred by the police or judiciary for medical examination of suspected induced abortion or autopsy investigation.

Note

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