AN INVESTIGATIVE STUDY OF THE IMPACTS OF NOT LEGALIZING ABORTION IN SRI LANKA

KAHATAPITI PATHIRANNEHELAGE CHAMPIKA SUBHASHINI

B.Sc. Hon. in Chemistry, MA in Regional Development and Planning

STUDENT ID – 2213575

MASTER OF ARTS (WOMEN'S STUDIES)

RESEARCH PROJECT WMST 9017

COLLEGE OF ARTS, HUMANITIES AND SOCIAL SCIENCES

FLINDERS UNIVERSITY

ADELAIDE-SOUTH AUSTRALIA

05 DECEMBER 2020

Table of Contents

List of Tables **Page**

List of Figures **Page**

Thesis Summary/ Abstract

Unsafe abortion is a critical, yet barely noticed, reproductive health danger in the developing world. It affects women seeking abortions, their families and many others. The health system also suffers with the increased demand from women seeking care due to complications arising from unsafe abortion procedures. The issue of unsafe abortion has and will continuously lead to preventable mortality and morbidity consequences for millions of women in the world. Therefore, immediate, prompt measures must be taken to mitigate unsafe abortions and the associated consequences. This problem extends to Sri Lanka and will be the focus of this paper. Resolving the issue of unsafe abortion in Sri Lanka by reforming the current stringent abortion law is desperately necessary for the responsible agencies in the country. This research thesis has focused, analyzed, and synthesized previous studies on the topic in detail whilst expanding and further commenting upon key issues. It argues that the decriminalization of abortion alone will not provide proper provisions or long-term solutions for the abortion issue itself in Sri Lanka. Other changes including education and accessible health plans will also be required. This research thesis revises and scrutinizes the prevailing factors, which impact on the issue of essential, yet, unsafe abortions in third world countries. The situation for all females in Sri Lanka could be improved if all other associated factors of reproductive health, education, socio-economic, religious, political, legal, and gender norms and advocates came together for positive change and reform.

Declaration-

"I certify that this thesis:

1. does not incorporate without acknowledgment any material previously submitted for a degree or diploma in any university; and

2. to the best of my knowledge and belief, does not contain any material previously published or written by another person except where due reference is made in the text."

Signature of student

Acknowledgement

I would like to express my gratitude and immense appreciation to my supervisor Professor Sharyn Roach Anleu for her understanding, well-extended guidance and encouragement throughout this research process. Furthermore, a big thank for the editor Tristan Anleu, for his invaluable comments and eloquent editing. A special thanks to you Associate Professor Barbara Baird, Coordinator of the Women and Gender Studies major and postgraduate courses, for the extended support and precious advice. Doctor Laura Roberts you made a marvellous job, as a topic coordinator, and extended my heart-felt thank for the enormous support and coordination. My gratitude and pleasure towards the Australia Awards team and the government of Australia, including all the academic and non-academic staff of the Flinders University, South Australia, for being selected and offering of a such a wonderful scholarship for me to develop my knowledge and skills. All my thankfulness for the Government of Sri Lanka, especially, the authorities of the Ministry of Women and Child Affairs for granting me leave and providing necessary support and coordination to succeed in the academic task. Finally, from the bottom of my heart, I would appreciate my husband, my son, my daughter and my mother for their generous courage and extended support with bearing all my burdens throughout this journey.

1.0 Introduction

Crude abortion techniques used in developing countries, Sri Lanka in particular, is a dangerous health problem that requires solving. Abortion is defined as the 'termination of pregnancy before the independent survival of the foetus or removal of a foetus, prior to completion of gestation at any time of the pregnancy' (Thilakarathna 2018, p. 4). Abortion can either be organically or artificially induced, preferably by trained medical practitioners but it can happen in unhealthy, illegal ways and by improvised means. Most developing countries in the world, including Sri Lanka, have stringent abortion laws. Despite the restrictive laws, unsafe abortion and similar happenings are quite common in the world. Annually, approximately 22 million unsafe abortions take place around the world with 7 million related hospital admissions (WHO 2020). Further, each year 25% of all global pregnancies terminate as induced abortions, and 47,000 of maternal deaths (4.7% - 13.2%) are associated with the consequences of unsterile, unsafe abortions (WHO 2020). However, legalizing abortion in a country like Sri Lanka confronts deep-seated social, political, religious, medical, psychological, and economic factors. It includes how people identify and determine the benefits and consequences of legislative and social changes. Therefore, the purpose of this research is to critically examine the trouble of illegal, unsafe abortions while putting more attention towards the positive and negative social impacts of decriminalizing abortion in Sri Lanka. Further, the study predominantly analyses the deliberations and protestations among relevant stakeholders, prevailing social norms and challenges to eliminate the unsafe abortion issue. The study mainly synthesises the findings of previous research publications, grey literature, and secondary data to address the issue of unsafe abortion in Sri Lanka.

This research thesis will explore the question: what would be the social impacts - both positive and negative - of legalizing abortion in Sri Lanka? This is the ultimate question that will be answered at the end of the research. The next section discusses the demographic situation in Sri Lanka and describes the health care system. It then provides an overview of the legal context, the availability of legal abortion, and the various attempts to reform the law prohibiting abortion. Then, the research design is discussed and the examination of the empirical research on abortion in the context of Sri Lanka. The focus is then on the emerging themes from this literature which form

the findings of the research thesis. The thesis concludes by emphasising the need for reform of the colonial laws regarding abortion in Sri Lanka but recognises that this is a necessary but not sufficient change.

2.0 Demographic Factors and the Health System of Sri Lanka

Sri Lanka is a South Asian country that was upgraded to the upper-middle-income level as per the World Bank classifications in 2019. The country has a comparatively reflective human development index of 0.75 (HDI in a range 0-1) and ranking of 73 out of 187 countries (Annual Report of Central Bank of Sri Lanka 2019). Sri Lanka has a population of 21.41 million with a population density of 346 people per square kilometre (Human Development Report 2019). The annual registration of pregnant women is nearly 360,000 in the country. Over 99% of them acquire antenatal care, and 99.5% receive a skilled birth attendant at child delivery (Demographic Health Survey 2016). Sri Lanka is a multi-ethnic, multi-religious country and that nature has a direct correlation with the pregnancy, childbirth, maternal mortality rates and reproductive health consequences in the country. Sri Lanka has an all-inclusive traditional, allopathic, and western health care system, which can provide worthy preventive, curative and rehabilitative services universally, regardless of location (Samarage 2006). This health care system has been utilised as a model by the health care specialists from the era of 1980 in Sri Lanka (Rockefeller Foundation's report 1985 cited in Mukhopadhyay 2020).

Similarly, Sri Lanka has been identified as one of the countries that has guaranteed health care at a low cost (Rockefeller Foundation's report 1985: cited in Mukhopadhyay 2020). Thus, the wise decision of providing continuous free education and a health care system in parallel with the multiple free subsidies: food, housing, safe drinking water, sanitary facilities, health education, flexibility in social movements, immunisation, pre and post-natal care are the successes behind this social development (Hertz, Hebert & Landon 1994). Hertz, Hebert and Landon (1994) explain the value of having a free government health care system in the scenario of lessening the maternal mortality complications in Sri Lanka.

The table below shows the population, birth and mortality rates in Sri Lanka:

Table 1 Selected Demographic Features in Sri Lanka

Description	**Value**
Total population	21,413,249
Fertility Rate	2.194 live births per women
Adolescent Fertility Rate	32/1000
Life Expectancy at Birth	77.6 years (Male 74.3 years, Female 80.7 years)
Infant Mortality Rate	6.4 per 1000live births
Deaths under 5 years	7.3 per 1000 live births
Urban Population	18.3%
Population Density	346 km^{-2}
Total Land Area	67,710 km^2
Maternal Mortality Ratio	36 per 100,000 live births
GDP per capita	USD 3852
Gender Inequality Index (GII)	0.380
Human Development Index	0.749 Male 0.799 Female

Sources- Annual Health Bulletin 2017, Human Development Report 2019

Worldometers 02 July 2020, 11.00 a.m. Australian Time, <https://www.worldometers.info/coronavirus/#countries>.

Despite all these noteworthy gestures, Sri Lanka still has many issues in its health development that need to be addressed better. Sri Lanka is identified as one of the states in the region with high illegal abortion rates (Arulkumaran 2018). Illegal abortions bring about 35,000 reproductive health complications annually and are identified as one of the prevailing causes for death and disability among women in Sri Lanka (Arulkumaran 2018). Induced abortion is a global health burden, and annual occurrence is 42 million: 20 million inside the legal cover and 22 million without legal permission (Malwenna & Gunarathna 2016). Similarly, out of annual global illegal abortions a major share of 97% is happening in the developing region, and in every 8 minutes one women dies with unsafe abortion complications (WHO 2017). The Demographic and Health Survey (2016) revealed that there are nearly 658 abortions provided daily, which

approximately contribute to 240,170 abortions annually in Sri Lanka. One study among a sample of 365 abortion seekers has exposed that 73% of the women had unmet needs, and there was limited access to family planning in Sri Lanka (Malwenna & Gunarathna 2016). Correspondingly, an agonising burden to the country's economy is observable under the government health expenditure, which includes 79% out of total health cost as abortion complication management (Malwenna & Gunarathna 2016).

The recorded maternal mortality rate was 1694 per 100,000 live births in 1947 which ultimately has shown considerable improvement compared to the other South Asian countries in the region (Perera & Ranganathan 2019). The current annual maternal mortality rate in Sri Lanka is considerably low and recorded as 35 deaths per 100,000 live births in 2017 (Arulkumararn 2018). However, maternal mortality associated with unsafe abortions out of total maternal deaths in 2017 is 12.5% which is the second most common cause of maternal mortality in the country (Arulkumaran 2018). The fertility rate in Sri Lanka has drastically decreased from 5.3 to 2.3 from 1950 to 1970 (Wickramagamage 2004). Thus, this pregnancy reduction has resulted in 2.194 births per woman at present and is promoted by the government instead of pregnancy termination or abortion (Human Development Report 2019). Unwanted pregnancies - also known as unplanned, unexpected, or unintended pregnancies - happen when there is no desire for children at the time of pregnancy or beforehand at the onset of conception. The global estimated births were 213 million in 2016 and 40% of these fell under the unwanted category (Ranatunga & Jayaratne 2020). In Sri Lanka, 23.3% of total pregnancies fall under the unplanned category (Ranatunga & Jayaratne 2020). Unintended pregnancies are the main reason for abortions in any country and 50% of these pregnancies end up as induced abortions around the world (Ranatunga & Jayaratne 2020).

3.0 Legal Situation in Sri Lanka.

3.1 Prevailing Law in Sri Lanka and Legal Reforms in Other Countries.

The prevailing law in Sri Lanka imposes a strict prohibition on abortion; it only allows abortion with the condition of critical risk to the mother's life under medical recommendations (Arulkumaran 2018). The law on abortion is designed to save only the physical life of the mother and is assessed by two medical practitioners before any approval is given. According to section 303 of the Penal Code of Sri Lanka, the 'punishment for causing a miscarriage is a fine, and/or up to three years imprisonment' (Penal Code Ordinance No. 2 of Sri Lanka, p. 11/48). The Sri Lankan Penal Code was enacted during colonial rule under the British in 1883, and the laws relating to abortion remain untouched. However, most other sections of the Penal Code have already been revised over the years. Thus, section 303 criminalises abortion services and specifies the same penalties towards those who perform abortion as well as a 'woman who causes herself to miscarry' (Penal Code Ordinance No. 2 of Sri Lanka, p.11/48):

> ***Section 303 of the Penal Code***
> *"Whoever, voluntarily causes a woman with 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 fine."*

Similarly, section 304 of the Penal Code of Sri Lanka explains the situation in case of a death of such a woman and causing miscarriage without her consent. Then the responsible person for performing the abortion shall be penalized up to twenty years of imprisonment (Penal Code Ordinance No. 2 of Sri Lanka):

> ***Section 304 of the Penal Code***
> *"Whoever commits the offence defined in the last preceding section without the consent of the woman, whether the woman is quick with child or not, shall be punished with imprisonment with either description for a term which may extend to twenty years, shall also be liable to fine."*

Section 305 of the Penal Code

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

Explanation

It is not essential to this offence that the offender should know that the act is likely to cause death.

Section 306 of the Penal Code

"Whoever, 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."

Indeed, countries in Sri Lanka's locality have already loosened the abortion law, but Sri Lanka's 137 year old law of abortion has remained as it was written during the era of colonialism (Thilakaratna 2018). Ironically, the law changed even in England and Wales in 1967 that allowed doctors to accomplish abortions lawfully, with certain conditions fulfilled; this was the first country that relaxed the abortion law (Wickramagamage 2004; The Guardian 2017). Many of the world's jurisdictions allow abortion under several scenarios, and from 1968 to present a majority of countries have expanded and relaxed the legal reforms on abortion situations (Wickramagamage 2004; Thilakaratna 2018). According to recent research, 68 countries in the world have similar strict abortion laws to Sri Lanka (Finer and Fine 2013). The seven statutory grounds for abortion in the world as per the most strict to flexible are: to save the pregnant woman's life, to safeguard the physical wellbeing, to ensure her psychological wellbeing, with the pregnancies associated with 'rape or incest, in case of foetal impairment, for socio-economic reasons, and on request' (Sri Lanka Law Commission 2013, p.1). However, all these grounds on which abortion is permitted consider the age of gestation of the foetus, likely within the first trimester. For instance, fourteen to eighteen weeks of gestation has been anticipated as the humanitarian boundary to legal abortions in many abortion-permitting countries (Wickramagamage 2004). Supportive medical arguments promote early abortions which are as secure as childbirths for women. Therefore, that early foetal age has well-regarded both probable human life of the foetus as well as the

health of women who must face abortions in decriminalized countries (Wickramagemage 2004).

In general, the current abortion laws in Sri Lanka are vested in and continue to be imposed with colonial jurisprudence. The arguable reality is that most other colonial countries have already loosened the law despite the cultural, religious, and traditional nature of the society (Wickramagamage 2004). Similarly, even Islamic countries like Bangladesh and Indonesia have permitted the 'menstrual regulation,' which is a method of abortion during the early weeks of pregnancy that may be used without any legal barrier (Crane 1994 cited in Wickramagamage 2004). Therefore, within the previous five decades, the majority of commonwealth jurisdictions have undergone the global trend of loosening laws on abortion. (GJC & OMCT 2016) Sri Lanka is currently the only exception. Historically the attempts to revise the legal processes in Sri Lanka in favour of abortion seeking women and their families have failed, and for multiple reasons including the personal or political attitudes of those in power. Therefore, Sri Lankan's state health care system has been and continues to be unable to provide abortion services to women in need with the endorsed restrictive legal and policy framework (Kumar 2013).

3.2 The Application and Underperformances of the Ongoing Legacy

In general, abortions can be performed when the mother's life is threatened at government hospitals with the recommendation of two consultant obstetricians/ gynecologists (Kumar 2013). Thus, these restrictive state abortion services ultimately lead women to seek illegal, clandestine abortion services (Kumar 2013). Most women of high socio-economic status can follow the updating information to find and access illegal abortion service providers. Therefore, most women in urban sectors have the option of selecting private sector operated, safe but illegal abortion services, as opposed to unsafe, possibly improvised options (GJC & OMCT 2016). Yet despite the archaic and discriminatory quality of the current law, the 'number of abortion-related offences

processed by Sri Lankan police increased from 46 to 68' between 2012 and 2013 (GJC & OMCT 2016, p.3).

Despite increased processing, the reality is that judges and legal professionals in Sri Lanka tend to have positive, attitudes towards abortion services and are in favour of loosening the punishment for accused women (De Silva, Indralal & Sumanadasa 2014). Most of the judges are in a position to analyse individual cases in a sympathetic and humanitarian way and are often inclined to give suspended prison sentences to victimised women or they excuse as much as is possible as soon as they can (De Silva, Indralal & Sumanadasa 2014). Sometimes, judges mitigate punishment altogether - deviating from the law - while considering socioeconomic factors of victimised women who have undergone an illegal abortion (De Silva, Indralal & Sumanadasa 2014). Due to this and other reasons, the published data on recently successful punishment for illegal abortions is difficult to obtain. In general, the details of the penal code have created doubt on when and where abortion is lawful (De Silva & Indralal & Sumanadasa 2014). For example; if a woman gets pregnant after rape or incest, or if the possibility to develop serious traumatic stress is high, or if the chances of the mother suffering long-lasting psychological issues are high – which can and often do develop into suicidal ideation and behavioural tendencies. However, these sorts of mental health conditions are unexplained and are not recognised as a threat to the mother's life under the abortion law (De Silva & Indralal & Sumanadasa 2014) – despite suicide being life taking.

Similarly, the responsible authorities in Sri Lanka have taken almost all strict measures to enforce the law under section 303 but have done 'nothing to ensure that abortions are performed in a safe way' even though they remain illegal (GJC & OMCT 2016, p.3). The narrow provisions of the law do not allow state bodies provide legality or policy approval for abortions even at the risk of mother's life (GJC & OMCT 2016). So, it is risky to accept abortions under the absence of regulations, provisions, and specific guidelines on the qualifications of practitioners, minimum facilities, and the allowable categories of abortions (GJC & OMCT 2016). The restrictions and fear of prosecution can lead to discouragement of acquiring proper health care facilities for

women (GJC and OMCT 2016). Therefore, women in Sri Lanka tend to resort to illegal services in case of abortions, due to lack of accountability on women's health care facilities and the non-welcoming situation to obtain proper services.

3.3 Attempts at Abortion Law Reform

The only method to adjust the Penal Code of Sri Lanka is through change in legislation. There have been a few advancements made and milestones hit in regard to positively changing the abortion law: the inclusion of rape, incest, and, foetal abnormalities in the 1970s, 1995, and 2013; done through private member bills and cabinet papers (Suranga, Silva & Senanayake 2017). Similarly, women's groups have lobbied in Sri Lanka pushing for favourable law reforms, including to the abortion law for the past twenty-seven years. The Women's Charter, based on the Convention on the Elimination of all forms of Discrimination Against Women (CEDAW), was approved in 1993 by the Sri Lankan Parliament. Women's organisations were consulted in the process of Charter preparation; it effectively included 'women's right to control their reproductive function' under the chapter on health (Abeyesekera 1997, p. 87). Even though the Women's Charter and CEDAW ratification mandated the state to develop a law that facilitates a better system for women, the Charter was only a paper commitment until early 1997 (Abeyesekera 1997). As an obligation to the Charter, in 1995 the Ministry of Justice drafted a bill to amend the relevant sections of the Penal Code, in consultation with the Ministry of Women's Affairs (Abeyesekara 1997). Accordingly, members of women's NGOs also contributed to the initial discussions, however, the views that they expressed were not included in the drafted bill (Wickramagamage 2004).

In 1995 the Ministry of Justice offered an amended bill of the Penal Code to the Parliament. It included the relaxation of strict abortion law in 'cases of rape, incest, and congenital abnormalities of the foetus' (Abeyesekera 1997, P.88). The bill presented 'marital rape, sexual harassment (including verbal harassment) as criminal offences', and proposed to increase the penalties for rape, and incest, which was treated as an offence under marriage laws (Abeyesekara 1997 cited in Wickramagamage 2004,

p.33). The critical debate occurred in Parliament over two days and continued for six hours (Hansard 19 & 20 September 1995 cited in Abeyesekara 1997). Unfortunately, throughout the debate Members of Parliaments discussed their personal views, general thoughts, and attitudes towards women (Abeyesekera 1997). The amendment to section 306 of the Penal Code was unsuccessful and the bill itself was rejected. The strict abortion ban continued thereafter. In 1999 the women's NGO forum created a media campaign and public discussion on abortion in an attempt to further the conversation on legal change (Wickramagamage 2004). The NGOs intervention included an advertising campaign that used the "her body - her right" slogan to stimulate the more liberal views on abortion law. So far, no attempt has achieved any progress in generating a debate among the responsible parties or among individuals in power (Wickramagamage 2004).

As a consequence, a levonorgestrel based contraceptive pill, Postinor 2, became available as an over the counter drug in Sri Lanka. An extensive advertising campaign by the Family Planning Association and NGOs became prolific and the monthly sales of Postinor 2 increased from 400 packets in 1998 to 20,000 in 2003 (Senanayayaka 2004). The tablet is still marketed in Sri Lanka: the cost is approximately one Australian Dollar; however, it is not promoted as a continuous method of family planning for women. In December 2010, there was another unsuccessful attempt to regularise proper abortion medication, known as mifepristone and misoprostol in Sri Lanka. The Drug Regulatory Authority of Sri Lanka stalled registration of misoprostol, a drug which has been included in the WHO's Essential Medicines List (EML) since 2005. The Drug Regulatory Authority of Sri Lanka has the legislative power of registration, manufacturing, importing, transporting, selling, 'labelling, advertising, and distribution of medicines' under the Cosmetics, Drugs and Devices Act (Kumar 2012, p. 169). The drug evaluation sub-committee - which includes: clinical pharmacologists, physicians and representatives of professional medical bodies - makes the decisions on drug registrations. Then the review and evaluation of the decision of the subcommittee are forwarded to a Technical Advisory Committee.

This Technical Advisory Committee has the power to advise the Health Minister to make a final decision, which would then involve a number of policymakers, and members of the pharmaceutical industry (Kumar 2012). However, Misoprostol was included as a medication for: labour initiation, post-partum hemorrhage and miscarriage management, post-abortion and induced abortion treatments. Mifepristone is also used for medical abortion under favourable conditions and facilities and can work in conjunction with Misoprostol (Kumar 2012). The ban on the drugs has extensive and dire implications for many. Misoprostol is widely available and can be used with improper training, even among health professionals in Sri Lanka. However, this drug does exist in the country, and can be (and is) illegally prescribed by the medical practitioners and pharmacists; also, women often self-medicate (Kumar 2012). These drugs are legally available in the neighbouring country of India and can easily be smuggled into Sri Lanka. Most registered pharmacies in the country are inclined to break the law and sell the drug clandestinely (Kumar 2012). In the situation of strict criminalized law on abortion, the access and cost of Mifepristone and Misoprostol drugs can change drastically.

In 2011 the five-year National Action Plan of Human Rights embraced the goal of legalizing abortion for rape, incest and major congenital abnormalities (Arulkumaran 2018). The abortion debate was initiated and was advanced by the Minister of Child Development and Women's Affairs who highlighted the necessity of abortion law reform to the parliament. Before developing a draft bill, the Law Commission of Sri Lanka collaborated and consulted with the Ministry of Child Development and Women's Affairs and the Ministries of Health and Justice (Kumar 2013). The Law Commission also conferred with medical professionals from the 'medical council, Sri Lanka's College of Obstetricians and Gynecologists, and the Sri Lanka College of Psychiatrists' and conducted a series of discussions beforehand to draft the bill in 2013 (Sri Lanka Law Commission 2013, p.2). In advising the law reform, the law commission considered all possible aspects of the procedure to follow the medical termination of pregnancy. The commission proposed and identified rape and serious foetal impairment as the grounds for termination and submitted an all-inclusive, well-thought-out draft bill, which was again rejected by the parliament in 2013 (Arulkumaran 2018). Then, in 2016, a joint shadow report of the Global Justice Centre

(GJC) and World Organization Against Torture (OMCT) explained the anti-abortion law of Sri Lanka as condoning torture of women and girls (GJC & OMCT 2016). GJC and OMCT have strongly urged the Committee Against Torture (CAT) to insist the government of Sri Lanka repeal the abortion law without any delay, and to review all existing legislative, administrative and policy-level interventions which hinder women's and girl's access to reproductive services (GJC & OMCT 2016).

In September 2016, a favourable campaign to decriminalize abortion under three scenarios was headed by the 'Sri Lanka College of Obstetricians and Gynaecologists', which was 'endorsed by the Family Planning Association of Sri Lanka' (Arulkumaran 2018, p. 2). The three scenarios are listed as: 'severe congenital abnormalities in the foetus incompatible with life up to 22 weeks of pregnancy, pregnancy resulting from rape, and pregnancy resulting from incest up to 20 weeks' of gestation (Arulkumaran 2018, p. 3). Then, in 2017, Justice Aluvihare's special committee made recommendations on abortions in cases of rape, incest, pregnancy in a child below 16 years of age, and with foetal impairments. The proposed law reform based on committee recommendation initially appeared to be successful without any challenge (Arulkumaran 2018). Drafting of the bill was placed on hold due to President Maithripala Sirisena's consultation with religious leaders (Arulkumaran 2018). The most recent initiative of the responsible state authorities to legalize abortion has ended up only with discussion, and not a decision (Thilakarathna 2018). However, in the end, this proposal either not been discussed by the cabinet or had not been put forward to the Ministry of Health. Finally, the Minister of Christian Affairs - after consultation with the Prime Minister - was reported to have said that abortion would not be legalised in Sri Lanka (Arulkumaran 2018).

All efforts toward getting legal permission for abortion were unproductive, largely due to religious, political, and social struggles in Sri Lanka. Historically all proposed interventions have been followed by severe condemnation in the media and other environments including parliamentarians and religious parties. Even though the proposed amendments are not enough to mitigate all unsafe abortions in the country, they do provide some flexibility for women. However, the influence from the Ministry

of Health alone to diminish the practice of unsafe abortions is not realistic (Kumar 2013). For instance, the reduction of abortion-related maternal mortality is a one set objective even in the five-year National Strategic Plan on Maternal and Newborn Health (2012-2016). Thus, there should be many novel ideas to reduce unsafe abortion in the five-year strategic plan ; however, the utmost priority was given to traditional activities, such as increasing contraceptive prevalence rates and reproductive awareness programs (Kumar 2013). The three main religions in Sri Lanka: Buddhism, Christianity and Islam have categorised abortion as taboo, due to the elimination of a live body (Arulkumaran 2018). Though, the open support from sensible priests while explaining inevitability and unsafe risk of illegal abortion towards women is not entirely enough to change the law.

According to the media and activists, the religious groups opposition is the central reason to stall the decriminalizing proposals. The balance between morality and immorality of decriminalization is greatly influenced by the Church. Only 6% of the population is Catholic, but this minority in the population has always loudly protested against the legalisation of abortion (Thilakaratna 2018). 'Marie Stopes', an International NGO provided specialized sexual and reproductive services which included abortion services in Sri Lanka but was banned in 2007 following the strong influence of the Catholic Church (Thilakaratna 2018). Despite having a tight relationship with Catholic clergy and the Catholic doctors' professional organisation, the Archbishop of Colombo, Malcolm Ranjith has declared his disapproval for the decriminalization of abortion (Arulkumaran 2018). The government initiatives on decriminalizing abortion had to backtrack again and again due to campaigns against abortions, various views, and opinions from the people who oppose abortions. Children's rights leaders in Sri Lanka are also among the leading groups that are against abortions and putting more emphasis towards child rights and highlighting the right to life of the child rather than women's rights (Samath 2020). Nonetheless, most people who oppose the decriminalization of abortion, have a positive attitude of legalizing abortion under the conditions of rape, sexual assault, or incest. However, people who support the abortion are contrary: the leader of the NGO "Women's Centre", explained that Sri Lanka is a 'traditional country within which the mindset of the people does not allow to leave a legacy of abortion' (Ladly 2020). Indeed, most of the abortion

supporters highlighted and recommended decriminalization given the risks and complications to a woman following an unsafe abortion.

The "Women and Media Collective" also have positive thoughts on abortion; it highlights that because of the taboo and legal status of abortion, much of the general public harbour feelings of shame around the life-defining reproductive health process causing it to appear mysterious and dubious (Ladly 2020). The Secretary of the General Service's Employees Union also voiced a positive, nuanced and favourable view on abortion in order to create justice towards socio-economically disadvantaged free trade zone garment trade worker girls. Since this group is highly vulnerable to sexual exploitation and often become pregnant. In the meantime, some girls have committed suicide due to the negative social stigma surrounding the abortion process. Sometimes an unmarried pregnant woman can be made to feel an outsider who is inadequate for the society and family (Ladly 2020). Similarly, there is a clear negative attitude, and some misbeliefs towards abortion even among urban communities (Suranga, Silva & Senanayake 2017; Rowlands 2011). A sample study reveals that most people living in urbanised areas also prefer abortion legalization only in situations of the rape, incest and foetal abnormalities (Suranga, Silva & Senanayake 2017). But an argument made by the senior advisor to the Sri Lanka Women's Lawyers Association highlights that poverty is one of the main reasons for women to want to have an abortion in Sri Lanka. Thus far, despite the legal framework, the process of accessing the illegal abortion providers and abortion-inducing drugs is quite easy in Sri Lanka (Ladly 2020).

However, the legal grey zone and social opinion act as a barrier to obtaining the real facts and figures concerning unsafe abortions in Sri Lanka. The current ruling party in the country is Sri Lanka Podujana Peramuna (SLPP) whose support base is Sinhala-Buddhist, and there will be a little hope of decriminalizing abortion in Sri Lanka, during this regime (Ladly 2020). Reproductive rights were clarified and endorsed internationally in the Conference on Population and Development (ICPD) and were reaffirmed at the Beijing Conference and other international agreements following Beijing (United Nations Population Fund (UNFPA) 2013). Hence, many national laws have been enacted while enabling the right to decide the number, timing, and spacing

of children (UNFPA 2013). Some argue that the inclusion of the last condition of "rights of men and women to have access to safe, effective, affordable and acceptable methods of family planning" is not a violation of the law. Even though Sri Lanka had not shown the demanding need for legalizing abortion in line with international attempts, the country has recognized the necessity of government intervention for the population control at a very early stage (Wickramagamage 2004). Thus, the massive campaign of family planning during the period of 1960s to 1970s has resulted in small families and has familiarized birth control measures to the public (Wickramagamage 2004).

4.0 Research Design: Examining Research on Abortion in Sri Lanka

This thesis provides a synthesis and analysis of qualitative and quantitative secondary data from previously conducted research studies on abortion, and allied fields. A selection of articles published in the last twelve years especially from Sri Lanka and other local regions is the core criterion. Access to the Ministry of Health's website - as well as other related Ministries - contain data and information regarding the prevalence of contraception, family planning methods, legal and illegal abortion, as well as health consequences related to maternal mortality. As well, analyses of relevant government bodies, legal drafts, the current situation and background reports have been conducted and information has been gathered. A thorough search of recent demographic health data and household survey data has been analyzed to get more accurate facts and figures that are relevant. Peer-reviewed articles on the subject are used in combination with grey literature to expand the field of study. Similarly, a number of unpublished or non-peer-reviewed sources have been collected through emails from the research conducting institutions and examined.

All articles, peer-reviewed publications, and journals are reviewed initially to find and organize the data and information and then a summary sheet of the referred articles is provided (see Appendix 1). The positive and negative consequences of legalizing abortion in the sense of social, family, and individual implications will then be reviewed. The collected information will be synthesized according to the pre-designed

standardized form. For instance, pregnancies after incest, rape, and teenage, foetal abnormalities, unsafe abortions among married couples with the negligence of proper family planning methods will be further considered and analyzed. Further, maternal mortality and other health consequences associated with unsafe abortions, social and cultural barriers to prevention of unwanted pregnancies, gaps and shortfalls in the existing health care system and revised improvement measures also will take into consideration.

5.0 Findings and Discussion

5.1 Implication of Unsafe Abortions: A Hidden Burden

The study explores both negative and positive aspects of legalizing abortion in Sri Lanka. It also shows that the decriminalization of abortion in Sri Lanka is problematic and difficult, but it does not entirely solve the issue of unsafe abortion. A structured, multifaceted solution will be necessary to overcome the issue and will need the involvement of the whole system, especially the areas of education, health, legal, religious and other socio-cultural aspects. The limited number of studies on abortion conducted in the past, hinder the proper decision-making on decriminalization due to lack of accurate and reliable data, therefore, it is necessary to rethink and reframe all the findings of previous researches. For instance, there are only a small amount of analyses based on primary data collection on the effects and consequences of illegal abortion. The sensitivity of the issue and the strict legal framework hinder data collection and the accumulation of accurate findings from clandestine abortion providers and seekers. Most previous researchers have made conclusions using limited and potentially erroneous findings and have argued on the basis that the majority of abortion-seeking women are married. It is very difficult to prove the marital status of women at the time of obtaining an abortion service. Some women may mislead the service provider or researcher due to shame and fear. The identification of abortion is like an iceberg: many more abortions are occurring in the country than are seen and known about. Unlawful, unsafe abortions play a severe health burden in Sri Lanka, which can cause deadly or devastating socio-economic and family consequences (Kumar 2013; Gerdts, Vohra & Ahern 2013).

Subsequently, the issues of abortion have been neglected in Sri Lanka for years within which has resulted in overwhelming impact in the country's health system. According to the WHO (2019) women's abortion choices should not be constrained by imposing strong restrictions. At the same time, bearing a child or removing a foetus from a woman's womb is a decision that should be entirely based on the pregnant woman and is a basic human right (Finer and Fine 2013). Thus, a long-term solution with a progressive attitudinal change on family planning, sexual and reproductive education is not visible among the Sri Lankan community. Loi et al. (2015) highlight the direct correlation of rate of unsafe abortions and the gross inability to provide post-abortion care, follow up services, and counselling. This lack of determination by health care providers toward this critical public health issue in the country is unsatisfactory and problematic for many. A detailed, well-researched and rigorous study on the hidden burden and danger of the prevalence of illegal abortion, as well as the depth and breadth of illegal abortion is missing in the Sri Lankan based studies. Undeniably, most arguments are contradictory and difficult to support the proper outcome through the identified mandate of expected legal permission.

There are, at present, many negative sexual and reproductive health issues prevailing among women in Sri Lanka; unintended pregnancies, unsafe abortions, spontaneous abortions, complications of pregnancies, and sexually transmitted diseases are widespread (WHO 2018). Unsafe, illegal abortions are important since the pregnancy tragedies are preventable, but the ability to do so has not been made legal. The use of self-help, nasty, unsanitary practices, alternative medicines, and clandestine services are common as induced abortion methods among women in Sri Lanka. Indeed, some of these practices may have occurred for centuries without any change (Thilakarathna 2018). However, as explained by Ban, Kim and De Silva (2002) the socio-cultural, and legal framework associated with illegal abortion has hindered the efforts of collecting data on abortion through community surveys and demographic health surveys in Sri Lanka. Correspondingly, the collection of data from the hospitalized cases of post-abortion may not depict the reality of illegal abortion since it only signifies serious post-abortion complications. Therefore, the most reliable and accurate way to collect the data is through the clandestine abortion clinics, however, the process is very difficult and needs proper negotiation with the service providers (Ban, Kim & De Silva 2002).

Similarly, the sensitivity of the issue and the strict legal framework hinder much data collection and finding more accurate information from Sri Lankan clandestine abortion providers and seekers.

The most clandestine services are staffed with trained medical practitioners to supervise procedures, but that alone does not guarantee a safe outcome (Ban, Kim & De Silva 2002). The illegal abortion service provision centres are operating under the guise of gynecological and family planning clinics in Sri Lanka. They provide induced abortion services, as well as well-functioning informal women's information networks provides continuous clients for the centres (Ban, Kim & De Silva 2002). As cited in Ban, Kim and De Silva (2002), clandestine abortion centres basically use the method of menstrual regulation to terminate the pregnancies within the first trimester. According to the sample survey of 356 abortion seeking clients in two clandestine clinics, less than 3% of clients were nineteen years of age or younger (Ban, Kim & De Silva 2002). The same research reveals that less than 2% stated being unmarried, in contrast almost 90% responded as married (Ban, Kim & De Silva 2002). A survey of hospitalized women after abortion-related complications in 2014 proves that unqualified persons are performing over 50% of unsafe abortions (GJC & OMCT 2016). Similarly, the major share of abortions takes place in unsterile, unspecified places; these practices can include transvaginal procedures (GJC & OMCT 2016). According to Ministry of Health estimations, '16% of hospital admissions' are owed to 'post-abortion complications' out of all female hospitalizations in the year 2014 (GJC & OMCT 2016, p. 3). There are both safe and unsafe abortion services in Sri Lanka; but all are technically illegal.

5.2 Factors Contributing to Unwanted Pregnancies

Unwanted pregnancies are the main reason for illegal abortions. This is directly linked with inappropriate knowledge on contraception, the inability to access or use adequate contraception, improper use of proper contraceptive methods among sexually active heterosexual couples. This is the case worldwide. The use of appropriate contraceptive methods can safely prevent unwanted pregnancies. The concept of smaller family size

among married couples and a tendency towards a young start to sexual relations are significant factors leading to unwanted pregnancies. As cited by Arulkumaran (2018) the main reasons behind induced abortions among married couples are unexpected pregnancies with a little gap in between previous birth, economic hardships, and/or intention of foreign employment. Similarly, the modern familial transitions cause higher levels of divorce and the cohabitation of heterosexual unions outside of marital boundaries. These changes may or may not be directly visible and are probably unforeseen in the society. The vulnerable groups are at risk of having to obey family planning methods and planned pregnancies within the strict social restrictions. Law and policy must update to cater to the shift of reflective social changes which includes: an early start to sexual relations, multiple and shifting partners throughout the reproductive lifecycle of modern-day women (Warriner and Shah 2006).

The scarcity of research has been unable to prove the prevalence of sexual intercourse outside marriage and this may be the main reason for abortions associated with unintended pregnancies. Similarly, Warriner and Shah (2006) cited that it is probably common for intercourse to occur before the age of marriage. Research findings by Warriner and Shah (2006) express that unmarried couples or those married at a later stage makes the risk of unwanted pregnancies high, potentially resulting in many out-of-wedlock births. Therefore, empowerment for women to access the appropriate services to manage these happenings while overcoming and bearing the socio-cultural stigma related to these issues is essential. Heterosexual relationships among unmarried teenagers are becoming more common in Sri Lanka. Some are not willing to conceive and bear children within the traditional socio-cultural framework. To ensure and protect the right of those men and women in the society, there needs to be a system put in place that provides proper family planning and/or abortion services. Many factors that contribute to unwanted pregnancies among married couple that include: the postponement of first pregnancy, high parity, low birth intervals, lack of social support, and poverty all contribute.

Unwanted pregnancies may have negative effects on the mother and the foetus, as well as other children in -and members of- the family. The type of unwanted pregnancy that

is mostly associated with induced illegal abortions in Sri Lanka is a discomfort that causes bladder and urinary tract infections, post-partum stress and depression, anemia and preeclampsia, chronic pelvic inflammations, infertility and ectopic pregnancies (Warriner & Shah 2006). Mothers with unwanted pregnancies may skip antenatal clinic visits; they are vulnerable and may not take the required amount of supplementary and micronutrients. Poor maternity care and illegal abortion attempts may lead to maternal mortality among mothers with unwanted pregnancies (Ranatunga & Jayaratne 2020). Gerdts, Vohra and Ahern (2013) describe unsafe abortion-related maternal mortality as a true global burden, and they recommend an objective and systematic way of reporting. Sri Lanka needs to reduce the number of maternal deaths to less than 10 per 100,000 live births to achieve the Sustainable Development Goals (SDGs) by the year 2030. Every single possibility of maternal death is important and needs to be eliminated for Sri Lanka's women to prosper (Perera & Ranganathan 2019). Further, if an unwanted pregnancy continues, adverse pregnancy outcomes and post-natal and infant deaths may occur. High prevalence of low birth weight, stillbirths, neonatal deaths, behavioural problems, preterm births, small size for the gestational age, and substance abuse tendencies are the common issues for the foetus or new-born as a result of unwanted pregnancy (Ranatunga & Jayaratne 2020).

5.3 The Adolescent Health and Risk factors

Similarly, there are a considerable number of reproductive health issues among youth and adolescents in Sri Lanka. Out of the total Sri Lankan population, 22% of illegal abortions are undertaken by adolescents, a further 19% occur among the youth in 15-25-year age category (Agampodi, Piyaseeli & Agampodi 2008). The factors that lead to a start to sexual life can include early marriages and teenage curiosity, both often resulting in pregnancy. In Sri Lanka these drives are often linked to a humble socio-economic background, family disputes, living with single parents, incest, rape and sexual abuse, lack of care and protection from parents, poor educational achievement including reproductive knowledge, poverty, and mother's migration (Ranatunga & Jayaratne 2020). Reproductive education within school curricular is limited and the accessibility to sexual and reproductive services by sexually active adolescents are very

low in Sri Lanka, this is mainly due to strong socio-cultural, and religious barriers. Several unsuccessful collaborative attempts by the responsible Ministries with Parliamentarians to incorporate reproductive and sexual education into school curricular have yet to be implemented in the country. The reality is that most female teachers are reluctant to even talk about reproductive health with school children, as well most parents try to keep secret the reproductive matters, sexual, hormonal and bodily changes from their children (Agampodi, Piyaseeli & Agampodi, 2008).

The use of contraceptives among married adolescents is only 65%, however, the use of contraceptives among unmarried adolescent is unclear due to data scarcity (Agampodi, Piyaseeli & Agampodi, 2008). Regardless of marital status and age sexual relations seem to be significantly high in the country. For an instance, 10.2% of school children and 22.2% of non-schooling children are engaged in sexual relationships (Agampodi, Piyaseeli & Agampodi 2008). The rate of teenage pregnancies varied from 5-8% and the reported adolescent fertility rate is at 32 per 1000 (WHO 2018). However, this rate of teenage pregnancy in Sri Lanka is much lower compared to the other South Asian countries. The 'legal age of marriage in Sri Lanka is 18 years', however, 2% of females younger than 15 years, and 12% of females younger than 18 years cohabit with their partners (WHO 2018, p.3). This early age of reproduction and living together are not proper symbols or vehicles to solve the unsafe abortion problem in Sri Lanka and reducing cases. Sexual consent is allowed at 16 years of age under Sri Lankan common law, however, in contrast, the customary Muslim Marriage and Divorce Act has no specific age limit for marriage (GJC & OMCT 2016). In fact, young cohorts receive improper anatomical/bodily knowledge and sexual education by outside insecure sources, which can lead to the exploitation and abuse of children. Therefore, the very first recommendation is to incorporate proper sexual and reproductive education into the school curriculum and increase focus on parental education to enhance child awareness and protection and provide appropriate guidance on how to care for children.

Yet adolescents encompass a substantial proportion of unsafe abortion seekers in the country, and most are vulnerable to serious health consequences or mortality, future childbearing issues and severe mental, physical, emotional and spiritual side effects.

This high vulnerability occurs with the inability to recognize pregnancy at early gestation, inability to reach affordable existing care and services and can lead to high susceptibility of using unsafe, traditional and extremely ineffective methods of abortion. As cited by Warriner and Shah (2006) adolescent sexual relations are increasing incrementally and occur without appropriate family planning amenities. This too often results in unwanted pregnancies. The situations of adolescent abortion seekers are mostly understood, but the social networks and protection from family need to increase in this sense. As cited by Agampodi, Piyaseeli and Agampodi (2008) reproductive service provisions in Sri Lanka are inappropriate and inadequate to cater for confidential, youth -friendly self-confident amenities to adolescents. The adolescent stage is more important and needs proper care and guidance since the child experiences a biological, psychological and cognitive transformation which is necessary for the future reproductive capability. Household harmony and protection from both parents are highly valuable for the adolescent well-being. The traditional gender ideologies and roles of: male breadwinner and female housewife have been confronted and in some ways, reversed with the onset of women's paid work and foreign migration.

Larger-scale migrant labour is regarded as one of the main foreign income earning sectors in Sri Lanka. The government has stimulated and facilitated unskilled domestic worker migration to the Middle East, European Union, and far East Asian countries as a remedy to unemployment and poverty (Annual Report of Central Bank of Sri Lanka 2019). Unskilled labour migration in Sri Lanka is mainly targeted at women in the reproductive age. Most socially and economically disadvantaged women in the country tend to want to migrate. The reason behind migration among Sri Lankan women is to create a better future for the family. However, by the time of migration, if women are pregnant then they may try to seek the option of illegal abortion services. At present there are 1.9 million Sri Lankan workers overseas, contributing over $7 billion (USD) of yearly worker export remittances which is equivalent to 9.6% of the country's GDP (Jayasuriya & Opeskin 2015). The highest recorded number of departures for women in just the year of 2012 is 282,000. This in turn creates significant demographic, health and reproductive consequences in the country (Jayasuriya & Opeskin 2015). Migrant married women with children represented 90% of total women migrations from Sri Lanka in 2012 (Rathnayaka 2013). A mother's migration has led to physical and

psychological abandonment for more than one million children in Sri Lanka (Rathnayaka 2013). In the absence of mothers, most young daughters must satisfy the fatherly or male relative's sexual desires, resulting in about 50% of all incest incidents reported among the left-behind children (Rathnayaka 2013). A considerable percentage of children in the age range of 15-18 who are left behind by migrant mothers have been confronted with rape, attempt to rape and or sexual abuse (Rathnayaka 2013).

The next risk factor of unsafe abortion among women in developing countries is a high vulnerability to be swept up in the commercialized sex industry. The phenomenon of prostitution is increasing in Sri Lanka with an estimated 40,000 women involved in prostitution in the year 2019 (Jordal & Öhman & Wijewardene 2020). Exploitation, sexual, emotional and physical violence, harassment, unintended pregnancies, and unsafe illegal abortions are commonplace in sex work (Jordal & Öhman & Wijewardene 2020). Commercialized sex industry is another hidden avenue that can attract adolescents either girls or boys in the country. This is a tragedy that exposes youngsters to unsafe penetrative sex - often without condoms - that can result in unwanted pregnancies. Reproductive health issues among youth groups in Sri Lanka are commonly linked with inappropriate, immature knowledge. The existing reproductive health services are mainly targeted to married couples in the country since it traditionally incorporated with the family health program. Most adolescents are not covered. There are only a small number of youth-friendly health services in major hospitals in Sri Lanka; similarly, those who desperately require the services may face issues and hindrances in service access (Agampodi, Piyaseeli and Agampodi 2008). Recent high school graduates tend to be vulnerable to unsafe sex-related problems, however, family-integrated health care programs are also non-effective due to socio-cultural issues (Agampodi, Piyaseeli and Agampodi 2008). Therefore, proper in-depth solutions that have compassion for the needs and want of adolescents is a must in the country in order to mitigate the unsafe abortion issue among teenagers.

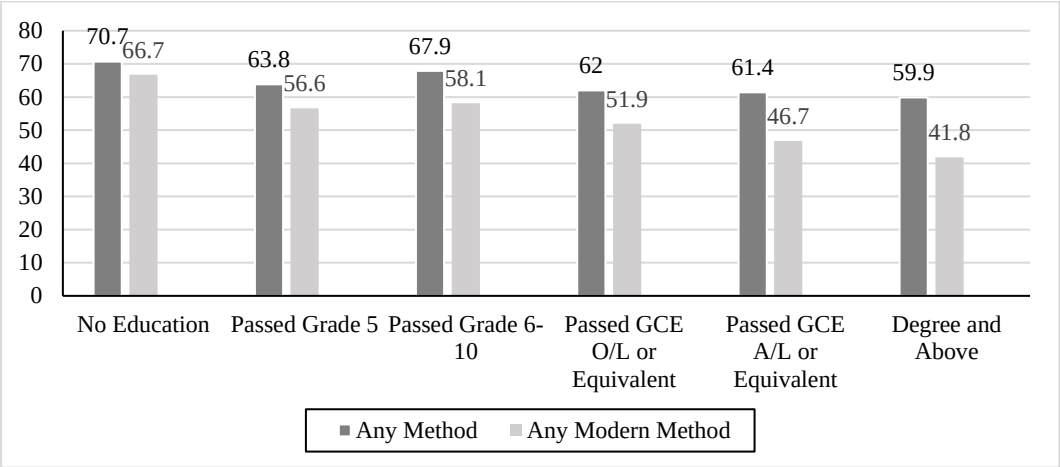
5.4 Family Planning and the Use of Contraceptives

Modern and traditional family planning methods stress the delay of childbearing. According to the Demographic Health Survey (2016), the reproductive health knowledge and awareness of traditional and modern methods in the Sri Lankan community is in an appropriate condition. Indeed, a Demographic Health Survey undertaken in 2016 revealed that regardless of the level of education, 98% of eligible couples know about any method of contraception in the country, but the contraceptive prevalence rate was 70%. According to the Demographic Health Survey (2016) out of the total demand (72%) of family planning, 90% of the demand has fulfilled within which includes 74% of modern methods. In Sri Lanka, provision of family planning services is mainly directed and facilitated by government-run organisations. Preventive health care systems; including maternal, child health, and family planning services are comprised of a well-trained primary health care worker team (Demographic Health Survey 2016).

At present, oral contraceptive pills and condoms are available over the counter at any pharmacies in the country. All other temporary and permanent modern methods of contraception are available island-wide either government or private. So far, unsafe abortions and the resulting consequences are practically avoidable as it originates mainly due to unmet needs of family planning, shortfalls on contraceptive methods, and an incomplete knowledge of the use of contraceptives. Even though the knowledge of contraception in the country is widespread and available, the practice of unprotected sex leading to pregnancy continues. Therefore, within this circumstance, the emphasis should be on inspiring people to practice the modern methods of family planning. World Health Organization (2018) explains the necessity of collaborative efforts to mitigate the unwanted pregnancies and unsafe abortions at all levels, especially through policies, individuals, community, families as well as the health systems. According to the findings of the Demographic Health Survey done in 2016, the higher the level of education actually lowers the use of contraceptives among Sri Lankan women.

Figure- 1 below shows the level of education among women is inversely proportionate with the use of modern methods of contraceptives, though, the high probability for traditional methods specifically, rhythm (Demographic Health Survey 2016).

Figure 1 - Current use of Contraceptive Methods by Level of Education among Sri Lankan Women.



Source- Demographic Health Survey 2016

The unmet needs of family planning - which is 7.3% in Sri Lanka as per the Demographic Health Survey (2016) - are an important parameter, which denotes the percentage of sexually active women without any proper contraceptive method. This category is either expecting the following child in the next two years or does not know the exact date of their next child. As per the standard definitions, a woman is supposed to be in family planning if she is married or is cohabitating with a heterosexual male partner - if she is fertile - is encouraged to postpone childbearing. This sidesteps the need for family planning altogether (Demographic Health Survey 2016). Emergency contraceptive pills could have been better off to manage unwanted pregnancies up to some extent; however, the Demographic Health Survey (2016) reveals that only 53.1% of the Sri Lankan population is aware of the emergency contraceptive pill. Since the issue of unwanted pregnancy-related consequences is very sensitive in nature, there should be equity in the reproductive and family planning service provision throughout the country. The concurrent investigation made by the Thalagala (2012) suggested

family planning as a noteworthy approach rather than legal restrictions for unsafe abortions.

Negligence and irresponsibility among married couples, and power imbalances between husband and wife may be one of the main reasons for many unwanted pregnancies. Research findings by Arulkumaran (2018) show that a high percentage of women seeking abortion are married and above 30 years of age and they already have had one or two children. The high prevalence of illegal, abortion among married couples is sometimes associated with physical and sexual violence from the intimate partner, low birth interval, and lack of knowledge on emergency contraceptive methods (Ranatunga & Jayaratne 2020). For instance, many women experience difficulties in adequately expressing their thoughts and feelings with men or their partner about their sexual and reproductive desires and fears is a significant problem. An effect of the long-lasting patriarchal system has created a subordinate position among women in society. The instances of forced sexual intercourse within marriage (marital rape), which may include the inability to negotiate condom use, and that can - and often does - ultimately result in an unwanted pregnancy. Gender stereotyping and gender roles continue to exist in Sri Lanka while unfairly empowering male superiority in relation to the enduring traditional patriarchal culture. As cited by the WHO in 2018, over-aggressive and toxically antagonistic attitudes regarding intimate partner violence, marital rape, and gender imbalances in developing countries may also lead to lifelong health damages to women, this –unfortunately- may also be true with the reproductive decision-making power of women in Sri Lanka.

Therefore, in contrast to freely available, efficient precautions for family planning in the country, unsafe sex associated problems are the main risks to disability, disease, and death among women in Sri Lanka (Ranatunga & Jayaratne 2020). Thus, it is necessary to improve family planning services as a remedy to reduce the unsafe abortion-related consequences. As cited by Ranatunga and Jayaratne in 2020, a cross-sectional sample of 349 women who delivered at the government hospitals has had 40.9% of the traditional or natural method of family planning or never use any family planning method at the onset of conception. The prevention strategies mostly

propagation of family planning must extend with maximum effort to eliminate the unwanted pregnancies (Thalagala 2012). At the same time, continuation of well-informed counselling and reliable service provision is a must for women with unwanted pregnancies to eliminate the need for an illegal abortion and future unplanned conceptions. Besides the situation of women, those who are totally engaged in household chores are most vulnerable to helplessness and poverty. Most married women in Sri Lankan families are not engaged in paid work and struggle with financial insecurity. As per the World Bank Report 2019, only 44.56% of Sri Lankan women have paid work, which is low in value and has remained unchanged for several years.

The society has moved basically from an extended to nuclear family status, and maintenance of the family and work-life balance is another considerable factor among married couples. The situation does not welcome new births soon after marriage; especially with the issues of caretakers, financial barriers, and higher expectation of materialistic life among newly married couples. However, total childbearing and caring responsibilities are in the hands of rural Sri Lankan mothers; if they unexpectedly get pregnant, then there is no option that is available other than unsafe abortion. Thus, despite the secured status quo of family planning, the need for abortions is still a realistic health problem in Sri Lanka. Similarly, some working women in Sri Lanka also have the problem of being unable to access childcare facilities, the situation is worse within nuclear families. If a woman has had one or two children already, they often develop the idea that they have enough children, however, they are often still reluctant to use proper permanent methods of family planning (Thalagala 2012). Decades-long strong family planning campaign in the country has created a two-child policy, which restricts a family unit to one or two children, three are rarely allowed (Demographic Health Survey 2016).

Indeed, misunderstanding of natural family planning among married women may also link to unexpected pregnancies - some take place just after the afterbirth, postpartum stage. For instance, some women tend to think that they may not get pregnant during the period of breastfeeding or until the normal monthly menstrual cycle restarts. Similarly, socio-economic factors in the society have transformed the lifestyle and

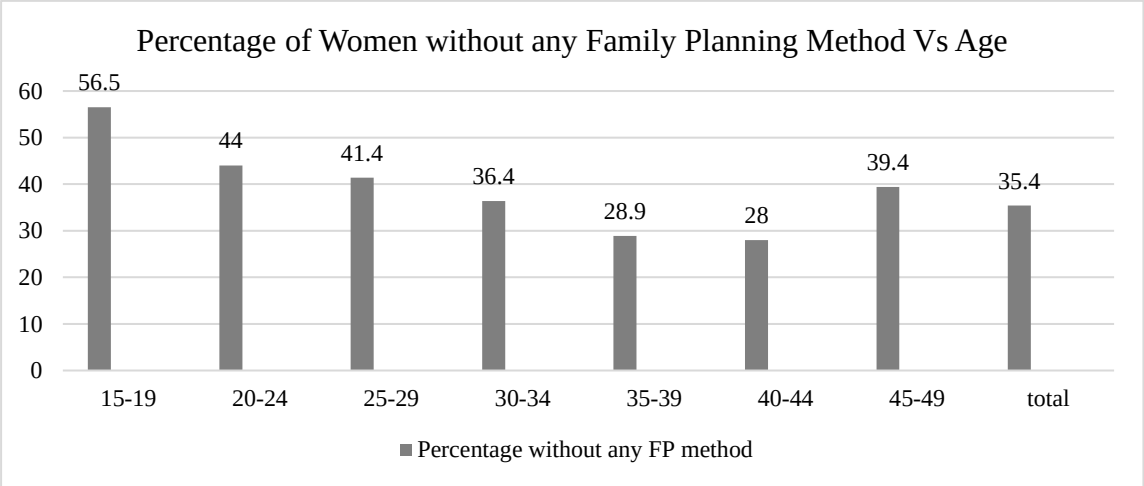
social values of Sri Lankan women and men (Ranatunga & Jayaratne 2020). If used properly, modern contraceptives are very effective. However, negative attitudes towards modern methods, poor communication skills, inadequate support from partners and peers, and some side effects of the methods are the factors that link with interruption of expected practice of modern methods of family planning in Sri Lanka. Thus, most newly married couples prefer to have their first childbirth after acquiring all their materialistic wants, however, they are not keen to adhere to effective contraceptive methods. Therefore, reducing the number of unsafe, illegal abortions among married couples is of great anxiety for the Sri Lankan government. Table-3 and Figure-2 below illustrate the negligence of family planning among married couples in Sri Lanka, which denotes a total of 35.4% of currently married women that do not use any contraceptive method (Demographic Health Survey 2016).

Table - 2 Percentage of Families without any Method of Contraception along with Number of Children

Number of Children	**Percentage of Families without any Method of Contraception.**
0	84.3
1-2	33.8
3-4	20.1
5+	28.7

Source- Demographic Health Survey 2016

Figure-2 Percentage of Currently Married Women Without Any Method of Family Planning.



Source – Demographic Health Survey 2016

Similarly, alcohol or other substance abuse among sexual partners, can also negatively affect the reproductive health of women, including the negotiation of the use of temporary contraceptives such as condoms or the pill. A study revealed that 17% of married women in Sri Lanka have experienced intimate partner violence (DHS 2016 cited in WHO 2018). The statistics from the department of police revealed that more than 33,000 cases of domestic violence reported to the police are related to women and children between 2005 and 2016 (Abeynaike & Shajehan 2017). Therefore, sexual and gender-based violence (SGBV) is a leading consequence to remedy in the country; up to 96% of perpetrators are known to the victim (Abeynaike & Shajehan 2017). There is a 40% increase of rape and incest recorded in the decade between 2006 and 2016. Most occurrences of incest and rape were forced upon girls below 16 years of age (Abeynaike & Shajehan 2017). In 2016, 2036 child rape and incest incidents were reported to police in Sri Lanka, but the recorded numbers are assumed to be much lower than actual figures (Abeynaike & Shajehan 2017). The Grave Crime Abstract report by the department of Sri Lanka Police (2019) exposes 1779 of recorded male-on-female rape cases for the whole year 2019.

Consequently, unlawful abortion attempts with pregnancies that occur after rape or incest are common among all females especially, among disabled women in Sri Lanka. The sexual abuse of physically or mentally disabled females is another highly prevalent phenomenon that affects much of the world (Griffin 2006). The situation may be similar in Sri Lanka; however, low reported facts and figures may mislead and inappropriately address the wide-ranging health issues among women with disabilities. There may be barriers to access the family planning and reproductive services by the disabled people especially in countries like Sri Lanka. A study in other countries reveals that there are social, physical and attitudinal barriers to access the services by disabled women as of health workers and community wrongly assume disabled people are sexually inactive (Smith 2004 cited in Griffin 2006). The possibility of getting pregnant after rape or incest of disabled children is higher than usual, and the aftereffects would be worse than with other children not facing those challenges. Indeed, the eventual situation of raising an unwanted child as a result of rape or incest by a poor, single disabled mother is an unethical consequence.

However, the country is free from dowry-related deaths, female foeticide, neglect of female children or honour killings and female infanticide (WHO 2018). As per the UNFPA estimations, 25% of women Sri Lanka have been subjected to sexual abuse by the time they reach 18 years of age (CRC Alternative Report 2017). Regardless of social class and culture, child sexual abuse is one of the major global health burdens with the prevalence rate of 11.8% in the world (CRC Alternative Report 2017). However, studies have shown a much higher prevalence (21.9%) of adolescent sexual abuse in Sri Lanka (CRC Alternative Report 2017). When victims do report acts of violence to the police or other agencies, the existing legal and organisational situation in Sri Lanka is ill-equipped to maintain statistics and comprehensive reports. A low national reporting rate of child abuses (only 0.15%) 'indicates a lack of self-confidence in the protection and judicial structures and does not reflect the true magnitude or prevalence of violence, abuse and exploitation' (UNICEF 2020, p.1). Therefore, effective systems, mechanisms and hard and fast rules must necessarily be developed to reduce the perpetrators of child abuse, and rape in Sri Lanka. 'Victims of such abuse and violence' merely do not have proper 'access to rehabilitation and support services' in many areas of the country (UNICEF 2020, p.1). 'Even where cases are reported and

brought to the court, they are often delayed or mishandled, which further' loosens the public's trust of the legal system (UNICEF 2020, p.1). The situation is worse for poor, socio-economically deprived victims of child abuse, rape, and incest.

5.5 Cultural, Religious and Social Measures

In developing countries, export-processing/free trade zones generate career pathways for girls; however, they may have a high vulnerability towards to sexual abuse, teenage pregnancies, rape, trafficking and cheating (Jordal et al. 2015). The same situation can be observed in export-processing zones in Sri Lanka where many clandestine abortion service centres function to facilitate the needs of young girls (and their employers). The export processing zone garment factories initiated in late 1970's, and up to date cater for the 80% of female employees (Jordal et al. 2015). Altogether there are 300 thousand women in the direct apparel sector and another 600 thousand engaged indirectly in the sector (Institute of Policy Studies 2019). Most rural, unmarried women migrate to urbanized areas especially as garment industry workers, and they are highly vulnerable to heterosexual relationships and premarital unsafe sex. Premarital sex is highly discouraged by Sri Lankan culture; however, women in free trade zones tend to obey the destructive gender power relations and asserted pressure due to poverty and to protect their jobs and they are often victims of unknown or recently known men (Jordal et al. 2015). Finally, the functional illegal abortion centres close to free trade zones cater to the demands for abortion of these women.

Premarital sex is a result of love and attraction, which occurs naturally among a couple after together for some time. This situation of arousing sex is a natural phenomenon and perhaps the most powerful biological instinct; however, the social disrespect and rejection lead couples to keep their relationship - and everything that comes with it- secret among themselves. The virginity of unmarried girls is strongly admired by the Sri Lankan society and therefore, virginity is an important factor for them to be respected in a family and the society. As explained by Jordal et al. (2015) women in the South Asian context need to keep control and deactivate their sexual desires because of this attitude. Thus, the reality is that women may not be able to get required family

planning and if a pregnancy is initiated, then the desire to seek illegal abortions peaks, in order to avoid the social disrespect. Women should have equal rights for sexual pleasure; it is a natural and positive part of being human, the necessity of accepting an attitude of sexuality regardless of the marital state is a future generational shift to rethink.

Consequently, despite having an advanced health care system in the country, more can be done to ensure the safe motherhood initiatives, including eliminating unsafe abortions, in the least intrusive ways possible. Henceforth, the situation must change with the proactive, modern approach of prevention of unwanted pregnancies or early abortions, rather than the more intrusive removal of foetus, which may incur many penalties towards pregnant women and the service providers. Indeed, substantial solutions other than complete legalization, such as proper reproductive awareness measures and education, access to services, updated attitudes and socio-cultural measures in support of women are to be reinforced with continuous attempts, and substantial backing. Thus, WHO (2019) advocates for approachable and effective contraception, and safe abortion facilities in each country to protect all females from serious life consequences. Sexual and reproductive education is certainly an important factor, which is relatively primitive in the Sri Lankan consciousness. As ‘children grow older, they must be educated to understand their own basic rights and be empowered and encouraged to speak up or seek assistance when they need’ it (UNICEF 2020, p.1). It is also ‘critical that the families and communities have the same knowledge, so that children can be brought up in caring, secure environments where they can be helped and supported if they find themselves in danger’ (UNICEF 2020, p.1).

Further, up until all of the unsafe abortion facilities in Sri Lanka are discontinued and eliminated, the associated consequences still remain; therefore, it is necessary to get a clear picture of factors behind the perseverance of unsafe abortion. Similarly, it is necessary to recognise prevailing barriers, occasions and possible emerging solutions to mitigate the issue. Thus, to reduce the high prevalence of unsafe abortion practices, there should be ‘a great need for safe, affordable and simple abortion methods' in Sri Lanka (Warriner & Shah 2006). Despite the strict law, women in need somehow seek

abortion services, however, the women in rural areas may not be able to access the safe services due to legislative barriers (Kumar 2012). Altogether 83% of people live in Sri Lanka's rural areas (WHO 2017). The significant variation in urban-rural demarcation sees a major share of deprivation towards this rural majority, including access to health services. Women in urban areas have better access to wealth and the power to get proper, safe abortion services, while rural poor women use primitive unsafe, nasty methods to abort. The damages to the health and wellbeing of women's life after unsafe, unhealthy abortions are very harsh.

Further, some women may suffer lifelong damages to their reproductive systems including permanent sterilization. Some may lose their life due to septicemic conditions and after abortion effects like multiple organ failure (Kumar 2012). Undoubtedly, unsafe abortion associated consequences create very many penalties even towards the already existing children in the family. Sometimes, loss of mothers at very early stage of life is another social burden in the country. Without imposing a strict ban on medical abortions, there is a need to overview the positive impact of proper medical abortions. In most countries having legal provisions and permissions to perform abortions are still practising medical abortions since the method is inexpensive, simple to handle, easy to accumulate, no need for highly skilled providers and sterile surgical facilities. As cited by Warriner and Shah in 2006 the provision of medical abortion under supervision could be achieved 95% success rate, and the method is much safer than unsupervised, self-help nasty methods of abortion like insertion of physical objects or caustic matters to vagina. Therefore, Sri Lanka must rethink about the proper use of Mifepristone and Misoprostol drugs with the critical needs of abortions at least. However, wrong dosages of the Mifepristone and Misoprostol drugs may cause incessant bleeding of the vagina, and so must be administered strictly under approved conditions (Kumar 2012).

Universal access to sexual and reproductive health is a global commitment to sustainable development goals. The situation in Sri Lanka after intended abortion is different and totally unwelcoming for clients (GJC & OMCT 2016). The findings emphasised by Loi et al. (2015) demonstrate the discrimination and unwelcoming situation towards women who seek post-abortion care, counselling, and follow-up

services after an unsafe abortion. Indeed, Loi et al. (2015) highlight the unsafe abortions and the inability to provide post-abortion care services by health care providers as a critical public health burden and a key human right violation. As cited by Warriner and Shah (2006), when abortion is totally against the state law, then it would be unsafe, and women must have quality post-abortion care services for the complication management as well as to mitigate the reoccurrences of abortions. However, the attitude of health care workers in Sri Lanka does not accept illegal post-abortion care even though health care workers doubtfully treat the women with spontaneous abortion too. Similarly, the situation on succeeding unplanned pregnancies and post-abortion contraception has not yet been thoroughly measured in Sri Lanka. According to Warriner and Shah (2006), women who obtained proper counselling and contraceptive awareness during post abortion treatment has resulted in a fewer number of successive unplanned pregnancies than those who not obtained proper post-abortion services.

Similarly, after counselling services women tend to use highly effective family planning methods (Warriner & Shah 2006). Therefore, post-abortion care policies and programs must be incorporated in the countries that have strict abortion laws, in conjunction with women's reproductive and health care plans. Indeed, proper post-abortion care necessitates urgent care for women in need after an incomplete abortion to prevent maternal mortality, provide family planning services and counseling that accommodate further consultations relevant to reproductive health (Warriner & Shah 2006). Post-abortion complications are multifaceted and serious in nature and require quality updated health care facilities even in rural areas of the country to handle the bleeding, infections, injuries to the reproductive system and much more. Therefore, in order to mitigate the repeated induced abortions, proper post-abortion facilities are a must. Warriner and Shah (2006) list some strategies to improve and reorganize the quality of post-abortion care which includes the assurance of safe and humane service provisions, enhanced clinical services, male partner involvement, provision of proper family planning services, expand and comprehensive post-abortion service provision. The best option of family planning education is before discharge the hospital at the time of post-abortion care, but lack of time of health care providers may hinder the service provision.

Most Catholic and Buddhist priests argue that forceful abortion is a sin and they oppose the decriminalisation of abortion, similarly some people who oppose the decriminalization of abortion suggest to simply put unwanted children up for adoption (Arulkumaran 2018). However, decriminalization and or child adoption are not the only solution. Many women and men in Sri Lanka, even outside of religion, tend to think of abortion as a sin; similarly, most feel guilty for taking that strong decision. Most mothers who have given their child away for adoption due to financial, social, or cultural reasons may suffer with regret following the decision. Similarly, women who have undergone or have selected the option of abortion may be considered and treated as wrongdoers. However, most scientific research has proven that the early removal of a foetus does not create any pain or sensation to it. Rowlands (2011) explains the misbeliefs of abortion, reconnects and resolves the wider spread of misinterpretation and distortion of scientific information on abortion. Rowlands (2011) especially rejects the foetal sensation of pain during abortion with clear facts and figures. As cited by Rowlands (2011) neurobiological connections, which need to perceive such stimulation, do not get developed until after 24 weeks of gestation. According to Rowlands (2011) the foetus is not conscious until birth. This means the bodily environment of the uterus keeps the foetus sedated. Thus, the key argument from the religious leaders who oppose abortion law in Sri Lanka is the foetal sensation and these studies disregard that argument. However further studies are needed prove the condition of the baby is required, since the ability to change the mindsets and attitudes of people with deep religious and cultural backbones is not easy; and historical attempts have literally started wars.

Even though the situation is not entirely conclusive as there are many influences that support the legal approach to abortion in Sri Lanka. Kumar (2013) stresses the undesirable realities of clandestine illegal abortion methods, the prevalence, and the outcomes of unwanted pregnancies. The WHO report (2019) reveals supportive arguments and elaborates on the inability of reducing the number of abortion choices of individuals by imposing strong restrictions on abortion. Similarly, illegal abortion providers get the real benefits of inflexible law (Arulkumaran 2018). This argument is entirely convincing with the explanation given in WHO (2019) which exemplifies the

importance of having legal policy and financial level commitments within a country to prevent unintended pregnancies and unskilled abortions. Women impregnated via rape, abused women, or a victim of incest may not be physically and mentally able to bear and raise a child. The pregnancy after such a disaster is not healthy for mother or an unborn baby; therefore, it is vital to rethink and update the strong decisions on abortion. Thus, the nourishment of a foetus or delivering a healthy baby after rape, incest, or abuse is a devastating situation for a victimized female. Similarly, the ability to evaluate or judge the depth and breadth or the penalties of the lives of victimized women and girls is impossible (Warriner & Shah 2006). Even though the religious and cultural background of the country is still not welcoming to the victims of rape or incest, or abuse, any situation with an unlawful child is devastating. Therefore, the shame and fear associated with unnecessary pregnancy may a create double burden on the lives of victims.

As stressed by most abortion supportive people the right of taking decision of someone's own body should be in the hands of themselves. Thus, a long-term solution with a positive and modern attitudinal change on family planning, sexual and reproductive education is far behind among the Sri Lankan community. The process of decision making to terminate an unwanted pregnancy is not an easy task for any woman, and as cited by Rowlands (2011) it is massively and intensely emotional. The decision to terminate a pregnancy is prejudiced with individual consequences as well as the systematic and dynamic determinants (Warriner & Shah 2006). According to Warriner and Shah (2006) these systematic factors include service factors, social factors, economic factors and religious and political factors. Accordingly, any shortfalls of these factors may lead to worsen the women's psychological condition, morbidity and mortality factors. The service factors include quality and access to safe abortion services, provider's skill and training, incurred cost, accuracy of the information and mainly the honesty and trustworthiness of the service (Warriner & Shah 2006). Similarly, social factors which influence a decision to terminate a pregnancy are disagreement of partner or other members in a family unit and community influences, lack of caretakers, social and patriarchal norms. Then, economic factors include level of income, employment, lack of childcare and protection system, inability to bring up child, and poverty associated other factors (Warriner & Shah 2006). Devotion and

faithfulness towards religious opinion and belief is another parameter, which determines the abortion behaviour of women. Finally, the policy level factors include whether abortion is legalized or not in the country, policies and programs for the family planning (Warriner & Shah 2006).

6.0 Conclusion

This research concludes that not legalizing and supporting abortion in Sri Lanka has created many social and health problems to the Sri Lankan community. The prevailing law in Sri Lanka strictly prohibits abortion unless the life of the mother is in danger. However, high percentages of women in the country are practising traditional, unsafe methods or are seeking clandestine abortion services. Research investigations and analyses regarding illegal abortions and the consequences are very limited, and actual figures on unsafe abortions have not existed in the country due to strict legislative measures. The study suggests enhancing the prevention of unexpected pregnancies while ensuring proper effective contraceptive usage among sexually active heterosexual couples. The burden of rape, incest and sexual abuse may be reduced with proper sexual and reproductive education among children. Similarly, religious leaders, and those who oppose abortion must be more aware of the prevailing situation of unintended pregnancies among victims of rape, or incest.

Responsible authorities must intervene at least to get approval for medical abortion to mitigate the life-threatening situation for women and girls in the country of Sri Lanka. The country's health system is set up so women continuously suffer from unsafe abortion-related consequences and will continue to until unsafe abortions are no longer required and therefore eradicated. Unfortunately, only those who suffer from unwanted pregnancies can realize the burden. Pregnancies after rape and incest must be considered as a human rights matter and taken seriously for women to prosper safely. The decision of having to terminate a pregnancy is always a difficult one, regardless of whether the pregnancy results from rape or is otherwise unwanted. Unsafe abortion grants temporary relief to a victim; however, psychological and social disrespect remain. There are many more consequences and systems to be improved in Sri Lanka

to eradicate issue of unsafe abortion. Finally, it is obvious that strict abortion law itself not enough to manage the unsafe abortion burden in the country but the most appropriate way to control is fulfilling the unmet needs for family planning and decreasing the rate of unwanted pregnancies. Research on unsafe abortions and the consequences of the undertaking of such a procedure are multi-layered in nature. The difficulty of getting accurate data tends to delineate the wrong picture of the situation with the strict legal background. Therefore, this paper urges further empirical research with more primary data to envisage the scope and gravity of the real issue in Sri Lanka.

Bibliography

Abeynaike, R, Shajehan, R 2017, New Police Database Documents Violence against Women and Children in Sri Lanka, *INASIA, weekly insights and analysis*, The Asia Foundation, viewed 5 May 2020, <asiafoundation.org/2017/1>.

Abeyesekera, S 1997, Abortion in Sri Lanka in the Context of Women's Human Rights, *Reproductive Health Matters*, vol.5, no.9, pp.87-93, <DOI: 10.1016/S0968-8080(97)90009-4>.

Agampodi, SB, Agampodi, TC and Piyaseeli, UKD 2008, 'Adolescents Perception of Reproductive Health Care Services in Sri Lanka', *BMC Health Services Research*, vol. 8, no. 98, viewed 12 March 2020, <https://doi.org/10.1186/1472-6963-8-98>.

Annual Report Central Bank of Sri Lanka, 2019 <https://www.cbsl.gov.lk/en/publications/economic-and-financial-reports/annual-reports/annual-report-2019>.

Arulkumaran S, 2018, Abortion; Where Is Sri Lanka On The Spectrum?, Gender, Healthcare, Human Rights, *Featured Image Courtesy* Paulo Nunos Des Santos/The New York Times, viewed 30 April 2020,<Https://Groundviews.Org/2018/09/02/Abortion-Where-Is-Sri-Lanka-On-The-Spectrum/>.

Ban, DJ, Kim, J, De Silva, WI 2002, Induced Abortion in Sri Lanka: Who Goes to Providers for Pregnancy Termination?, *J. biosoc. Sci*, vol. 34, pp.303-315.

CRC Alternative Report 2017, Protecting Environment and Children Everywhere: Alternative Report for the examination of Sri Lanka's State Party's Fifth and Sixth Combined Periodic Report under Article 44 of the Convention on the Rights of the Child to the Committee on the Rights of the Child Session 77, *PEaCE/ECPAT Sri Lanka and ECPAT International*, <https://www.ecpat.org/wp-content/uploads/2017/09/2017-%E2%80%93-Sri-Lanka-CRC-Alternative-Report.pdf>.

Demographic and Health Survey on Fertility, Family Planning, Maternal and Child Health, Nutrition and awareness of HIV/AIDS, 2016, *Department of Census and Statistics*, viewed 5 May 2020, <http://www.statistics.gov.lk/social/DHS_2016a/Chapter9.pdf>.

De Silva, WI, Sumanadasa, WADJ 2014, Decriminalization of Abortion in Sri Lanka: An Appraisal, *National Centre for Advanced Studies in Humanities and Social Sciences, Annual Research Symposium Proceedings.*

Finer, L and Fine, JB 2013, Abortion law around the world: progress and pushback. *American journal of public health*, vol.*103*, *no.*4, pp.585–589. <https://doi.org/10.2105/AJPH.2012.301197>.

Gerdts, C, Vohra, D, and Ahern, J 2013, 'Measuring Unsafe Abortion-Related Mortality: A Systematic Review of the Existing Methods'. *PloS one*, vol.8, no.1, viewed 10 March 2020, < https://doi.org/10.1371/journal.pone.0053346>.

Grave Crime Abstract for The Year 2019 For Whole Island From 01.01.2019 To 31.12.2019, *Department of Police, Sri Lanka.*

Hertz, E, Hebert, JR and Landon J, 1994, Social and Environmental Factors and Life Expectancy, Infant Mortality, and Maternal Mortality Rates: Results of A Cross-National Comparison, *Social Science Medicine,* vol. 39, no. 1, pp. 105- 114.

Human Development Report, 2019 <hdr.undp.org/sites/default/files/hdr2019.pdf>.

Jayasuriya, R, Opeskin, B 2015, The Migration of Women Domestic Workers from Sri Lanka: Protecting the Rights of Children Left Behind, *Cornell International Law Journal,* vol. 48, pp. 580-590.

Jordal, M, Wijewardena, K, Öhman, A, Essén, B,Olsson, P 2015, 'Disrespectful Men, Disrespectable Women': Men's Perceptions on Heterosexual Relationships and Premarital Sex in A Sri Lankan Free Trade Zone – A Qualitative Interview Study, BMC International Health and Human Rights, vol.15, no.3, <DOI 10.1186/s12914-015-0040-4>

Jordal, M, Öhman, A, Wijewardene, K 2020, Respectability and rights, Sexual and reproductive health and rights of Sri Lankan women formerly involved in prostitution, *Contemporary South Asia,* vol.28, no.1, pp.28-42, <DOI: 10.1080/09584935.2019.1667301>.

Kumar, R 2013, 'Abortion in Sri Lanka: The Double Standard', *American Journal of Public Health, vol.*103, no. 3, pp. 400-404, viewed 11 March 2020,<https://doi.org/10.2105/AJPH.2012.301154>.

Kumar, R 2012, Misoprostol and the Politics of Abortion in Sri Lanka, *Reproductive Health Matters*, vol. 20, no. 40, <166-174, DOI: 10.1016/S0968-8080(12)40652-8>.

Ladly, MD 2020, 'Sri Lanka's Abortion Laws are among The World's Most Restrictive, Yet Hundreds of Women Risk Their Lives Every Day with Illegal Terminations',The Telegraph, < https://www.telegraph.co.uk/global-health/women-and-girls/sri-lankas-backstreet-abortions-hundreds-women-take-daily-risks/> .

Loi, UR, Gemzell-Danielsson, K, Faxelid, E and Klingberg-Allivin, M 2015, 'Health Care Providers' Perceptions of and Attitudes Towards Induced Abortions in Sub-Saharan Africa and Southeast Asia: A Systematic Literature Review of Qualitative and Quantitative Data', *BMC Public Health,* vol.15, no.139, viewed 11 March 2020,< https://doi.org/10.1186/s12889-015-1502-2>.

Malwenna, LI, Gunarathna, NKC, 2016, Unmet Need for Family Planning; Global and National Trends and Challenges, *Sri Lanka Journal of Medicine,* vol. 25 No.2, *<Doi: http://dx.doi.org/10.4038/sljm.v25i2.22>*.

Mukhopadhyay, A 2020, Made for Minds; How Sri Lanka Successfully Curtailed the Coronavirus Pandemic, *DWs Newsletter; Top Stories World for Asia,*18 May, <https://www.Dw.Com/En/How-Sri-Lanka-Successfully-Curtailed-The-Coronavirus-Pandemic/A-53484299> .

Panel Code Ordinance No.2 of 1883 Sri Lanka; Section 303-308. *<https://www.ilo.org/dyn/natlex/natlex4.detail?p_isn=67628&p_lang=en>*.

Perera, BJC, Ranganathan, SS 2019, National Maternal Death Surveillance and Response: Sri Lankan Scenario, Ceylon Medical Journal, vol. 64, No.1,pp.1-3, DOI< http://doi.org/10.4038/cmj.v64il.8822> .

Ranatunga JC, Jayaratne K 2020, Proportion of Unplanned Pregnancies, their Determinants and Health outcomes of Women Delivering at a Teaching Hospital in Sri Lanka.Research Square <+https://doi.org/10.21203/rs.2.13205/v2+>.

Rathnayaka, M 2013, Sri Lanka's Missing Mothers; A working paper on Effects of Mother Migration on Children, *Research Gate,* <10.13140/RG.2.2.16754.81608>.

Rowlands, S 2011, 'Misinformation on Abortion', *The European Journal of Contraception & Reproductive Health Care,* vol.16, no.4, pp. 233-240, viewed 11 March 2020, < 10.3109/13625187.2011.570883>.

Samarage, SM 2006, Health Care System: Sri Lanka, Migration and Human Resources for Health: From Awareness to Action, *CICG Geneva*, viewed 27 May 2020, <https://www.iom.int/jahia/webdav/site/myjahiasite/shared/shared/mainsite/microsites/IDM/workshops/mhrh23240306/abstract_samarage.pdf>.

Samath, F 2020, 'Rights-Sri Lanka: Women's Right To Abortion Debete Reopens', Asia-Pacific, Development and Aid, Headlines, Health, Human Rights, Inter Press Service.

Senanayake, H 2004, Induced abortion in Sri Lanka, *The Ceylon medical journal,* vol. 49. pp. 1-4, <10.4038/cmj.v49i1.3274>.

Suranga, S, Silva, KT and Senanayake, L 2017, 'Access to Information and Attitudes towards Induced Abortion: A Community-Based Study Among Adults in the City of Colombo, Sri Lanka', *Physicians of Sri Lanka*, viewed 8 March 2020, <jccpsl.sljol.info>.

Sri Lanka Law Commission 2013, 'Medical Termination of Pregnancy - Proposals of the Law Commission of Sri Lanka', < https://lawcom.gov.lk / web/images/stories/reports/medical_termination_of_pregnancy_proposals_of_the_law_commission_of_sri_lanka.pdf>.

Sri Lanka GJC & OMCT 2016, Submission to the Committee against Torture in Relation to its examination of the Sri Lanka's Fifth State Party Report.

Thilakarathna, KAAN 2018, Point of View Liberalizing Abortion Laws in Sri Lanka; Prospects and Challenges, *Sri Lanka ournal of Forensic Medicine, Science and Law*, vol. 9, no.2.

Thalagala, N 2012, 'Unsafe Abortions in Sri Lanka, Facts and Risk Profile', *Journal of the College of Community Physicians of Sri Lanka,* Vol. 15, No. 1, pp. 1-12, viewed on 10 March 2020 <http://doi.org/10.4038/jccpsl.v15il4934>.

The Guardian 2017, Fifty Years on, the Abortion Act should be Celebrated-and Updated <www.google.com/amp/s/amp.the guardian.com>

UNFPA 2013, ICPD and Human Rights*, Centre for Reproductive Rights,* pp.1-23.

UNICEF Sri Lanka 2020, Child protection in middle childhood, *Children need knowledge and support to stay protected from all forms of violence,* Viewed 18 November 2020, <https://www.unicef.org/srilanka/child-protection>.

Warriner IK, Shah IH, 2006, *Preventing Unsafe Abortion and its Consequences: Priorities for Research and Action*, New York: Guttmacher Institute.

WHO 2020, Sexual and Reproductive Health, Preventing Unsafe Abortion; Human Reproductive Programme, viewed 26 August 2020, <https://www.who.int/reproductivehealth/topics/unsafe_abortion/hrpwork/en/> ?

WHO 2019, viewed 30 April 2020, <https://www.who.int/news-room/detail/28-09-2017-worldwide-an-estimated-25-million-unsafe-abortions-occur-each-year>.

WHO Sri Lanka 2018, Country Profile on Gender Based Violence in Sri Lanka, World Health Organization, Country Office for Sri-Lanka,< https://apps.who.int/iris/handle/10665/273193>

Wickramagamage, C 2004, 'Her Body, Her Right'?: Interrogating the Discourse on Abortion in Sri Lanka', *Sri Lanka Journal of Social Sciences*, vol. *27*, no.1&2, pp.17-59.

Zamberlin, N, Romero, M and Ramos, S 2012, Latin American women's experiences with medical abortion in settings where abortion is legally restricted, *Reproductive Health*, vol. 9, no. 34, <http://www.reproductive-health-journal.com/content/9/1/34>.

Appendix-I

Research Topic- AN INVESTIGATIVE STUDY OF THE IMPACTS OF NOT LEGALIZING ABORTION IN SRI LANKA

Reference List Summary-

Article Number	Women's Right	Law	Primary data Survey	Ethics Approval	Other
01.Abeynaike & Shajehan 2017	√	√			√ (Facts and Figures on Rape and Incest)
02.Abeyesekera 1997	√	√			√ (legal Attempt and Parliamentary Debate in 1995)
03. Agampodi, Piyaseeli & Agampodi 2008			√	√	√ (Issues and shortfalls on Adolescent Health)
04.Annual Central Bank Report 2019					√ (Data and information)
05.Arulkumaran 2018	√	√			√ (Maternal Death and Health Effects on Abortion)
06.Ban, Kim & De Silva 2002		√	√	√	√ (Collected Data Prior to the Termination of Pregnancy)
07.CRC Alternative Report 2017		√			√ (Child Sexual Exploitation, Prostitution)
08.DHS 2016					√ (Relevant Data on Reproductive Health)
09.De Silva, Indralal & Sumanadasa 2014	√	√	√	√	√ (Judgers perception on Abortion)
10.Finer & Fine 2013	√	√			√ (Comparison with other Countries)
11.Gerdts, Vohra & Ahern 2013					√ (Maternal Mortality and Abortion)
12.Grave Crime Abstract 2019					√ (Data on Crimes)
13.Hertz, Herbert & London 1994					√ (A Cross National Comparison of Maternal Mortality)
14.HDR 2019					√ (Data and Information on Human Development Indices)
15.Jayasuriya& Opeskin 2015		√			√ (Women Migration and Child Rights)
16.Jordal et al. 2015			√	√	√ (Free-trade zone women and disrespectful men)
17.Jordal, Öhman & Wijewardena 2020	√		√	√	√ (Formal Prostitutes in Sri Lanka)
18.Kumar 2013	√	√			√ (Push for Legal Reform)

19.Kumar 2012	√	√			√ (Misoprostol Drug)
20.Ladly 2020		√			√ (Various Opinions on Abortion)
21.Loi et al. 2015	√	√			√ (Health Care Providers Attitude & Perception)
22.Maiwenna & Gunarathna 2016			√	√	√ (Unplanned Pregnancy and Outcome)
23. Mukhopodbyay 2020					√ (Advance Health System in Sri Lanka)
24.Penal Code Ordinance 1883	√	√			√ (An Ordinance to Provide General Penal Code for Ceylon in 1883)
25.Perera & Ranganathan 2019					√ (Maternal Mortality Facts and Figures)
26.Ranatunga & Jayaratne 2020			√	√	√ (Unwanted Pregnancy and Outcome Hospital Based)
27.Rathnayake 2013	√				√ (Sexual Exploitation and Consequenes)
28.Rowlands 2011	√				√ (Myths and Misbeliefs on Abortion)
29.Samarage 2006					√ (Facts on Migration)
30.Samath 2020	√	√			√ (MediaArticle on Bortion Perception)
31.Senanayake 2004		√			√ (Induced Abortions and Consequences based on Hospital Data)
32.Suranga, Silva & Senanayake 2017		√	√	√	√ (Perception on Abortion)
33.Sri Lanka Law Commission 2013	√	√			√ (A Proposed Law Reform for Medical Termination of Pregnancy)
34.Sri Lanka GJC & OMCT 2016	√	√			√ (Critique on Legal Framework in Sri Lanka)
35.Thalagala 2012			√	√	√ (Family Planning and Unmet Need)
36.The Guardian 2017	√	√			√ (Abortion Law and History of Change)
37.Thilakarathna 2018	√	√			√ (Unwanted Pregnancy)
38.UNFPA 2013	√	√			√ (Family Planning and Rights)
39.UNICEF 2020		√			√ (Child Abuse and Reporting)
40.Warriner & Shah 2006	√	√			√ (Unsafe Abortion, Family Planning),
41.WHO 2020					√ (Relevant Data)
42.WHO 2019	√	√			√ (Precautionary Measures and World Trend)
43.WHO 2018	√	√			√ (Country Profile on GBV)
44.Wickramagamage 2004	√	√			√ (Abortion Facts Comparison with Other Countries)