

# Navigating the Grey Zones of Abortion Law in Sri Lanka: Clinical Case Narratives at the Intersection of Law, Ethics, and Reproductive Health

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## Policy Paper

### Abstract

**Introduction:** In Sri Lanka, abortion is legally permitted only to preserve the life of the woman. In routine obstetric and gynaecological practice, clinicians frequently encounter ethically complex and clinically high-risk situations that fall outside this narrow legal exception. Although unsafe abortion is no longer a leading direct cause of maternal mortality, it continues to contribute substantially to preventable maternal morbidity, psychological harm, and ethical distress within a highly restrictive legal framework.

**Objectives:** To describe recurrent clinical situations not accommodated by Sri Lanka's abortion law and to explore how clinicians navigate ethical decision-making under legal constraint using experience-based clinical case narratives.

**Methods:** Five anonymised clinical case narratives were purposively selected from long-term government obstetric and gynaecological practice to illustrate commonly encountered but legally unaddressed scenarios. A qualitative descriptive approach using thematic framework analysis was applied. Cases were examined across predefined grey-zone domains, including sexual violence, severe or lethal fetal anomalies, pregnancy in minors, impaired decisional capacity, and significant psychosocial vulnerability. Analysis was situated within statutory law, ethical principles, national clinical guidance, and relevant international human rights standards.

**Results:** Cross-case analysis revealed a consistent pattern of legal-ethical conflict arising from the absence of lawful options beyond the single ground of preserving the woman's life. Recurrent challenges included the inability to intervene even in the cases with despite lethal fetal prognosis, lack of legal recourse following rape or in minors, uncertainty in best-interest decision-making where decisional capacity was impaired, and constrained or delayed care in situations of profound psychosocial distress. Across all cases, the undefined legal threshold generated clinician uncertainty, moral distress, and a reliance on defensive or temporising management strategies.

**Conclusion:** These narratives illustrate how restrictive abortion law translates into ethical conflict and constrained clinical care in everyday practice. Clarification of legal standards and evidence-informed reform particularly in cases involving rape, severe fetal anomalies, minors, and marked vulnerability would better align law with ethical clinical practice, reduce preventable harm, and support clinicians in providing compassionate, professionally accountable care.

**Key Words:** Abortion law, unsafe abortion, clinical ethics, reproductive rights, qualitative case narratives, Sri Lanka

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## Introduction

Sri Lanka's primary legal framework governing abortion is contained in Sections 303–306 of the Penal Code [1]. Under these provisions, abortion is criminalised except when performed in good faith to save the life of the woman. The law further criminalises causing miscarriage, supplying or obtaining drugs or instruments for abortion, and self-induced abortion. Notably, the legislation does not define the scope of "saving the life of the woman," nor does it provide guidance for situations involving serious threats to mental well-being, severe fetal anomaly, sexual violence, or social vulnerability. As a result, Sri Lanka retains one of the most restrictive abortion laws globally.

Despite this restrictive legal environment, abortions continue to occur in Sri Lanka, largely outside the formal legal framework, reflecting unmet reproductive health needs [2]. While earlier national guidance, including the National Guidelines on Post-Abortion Care (2015), attributed a notable proportion of maternal deaths to unsafe abortion [3], more recent national surveillance data indicate a continued overall decline in maternal mortality in Sri Lanka. Unsafe abortion is no longer identified as a leading direct cause of maternal death, although abortion-related morbidity continues to place a burden on obstetric services [4]. Complications such as haemorrhage, sepsis, anaemia, genital tract injury, prolonged hospitalisation, and long-term reproductive morbidity remain well recognised in routine clinical practice following unsafe abortion.

These realities point to a persistent public health and ethical challenge that is insufficiently addressed by the current legal framework. Clinicians working in obstetrics and gynaecology frequently encounter

situations in which ethically appropriate, patient-centered care is constrained by the narrow legal exception permitting abortion only to save the woman's life. In such circumstances, healthcare professionals must navigate legal uncertainty while attempting to uphold core ethical principles, including autonomy, beneficence, non-maleficence, and justice.

In this article, the term "grey zones" refers to recurrent clinical situations that are not explicitly accommodated within Sri Lanka's abortion law but arise commonly in practice. These include pregnancies resulting from sexual violence, severe or lethal fetal anomalies, pregnancy in minors, pregnancy in women with significant intellectual disability or impaired decisional capacity, and situations of profound psychosocial or socio-economic vulnerability. Although these circumstances may carry substantial psychological, ethical, or clinical harm, they fall outside the sole legal ground of saving the woman's life.

This article aims to explore these grey zones through experience-based clinical case narratives, illustrating how legal restrictions shape clinical decision-making, generate ethical conflict, and contribute to moral distress among healthcare professionals. By situating these cases within the broader legal, ethical, and reproductive health context, the paper seeks to highlight gaps between law, clinical reality, and ethical practice, rather than to quantify prevalence or establish causality.

An established body of peer-reviewed scholarship has examined abortion law and policy in Sri Lanka, with particular attention to the Penal Code's narrow life-saving exception and its public health consequences. Prior analyses have

documented the persistence of unsafe abortion in a legally restrictive setting and the continued burden of post-abortion morbidity managed within the formal health system, despite Sri Lanka's overall decline in maternal mortality [5-7]. Other academic work has approached abortion restriction through ethical and human-rights frameworks, highlighting its impact on women's autonomy, vulnerability, and access to reproductive healthcare, as well as ongoing debates around legal reform in cases such as rape, incest, and severe fetal anomaly [8-10]. Taken together, this body of work has clarified the legal architecture governing abortion in Sri Lanka and its broader public health and rights-based implications.

However, comparatively less attention has been paid to how this legal framework and its inherent ambiguities are translated into everyday clinical decision-making within obstetric and gynaecological practice. Much of the existing scholarship operates at the level of law, policy, population-based outcomes, or normative ethical analysis, with limited examination of how clinicians navigate ethically complex cases under legal constraint at the bedside. This article supplements existing work by using experience-based clinical case narratives to illustrate recurrent "grey zones" encountered in routine practice and to analyse the mechanisms through which restrictive abortion law shapes clinical choices, generates ethical conflict, and contributes to moral distress among healthcare professionals. By foregrounding clinicians' perspectives, the paper provides a practice-level lens that complements legal, public health, and human-rights analyses.

## **Methodology**

### **Study Design**

This study adopts a qualitative descriptive design using experience-based clinical case narratives. The purpose of this analysis is to illustrate recurrent clinical and ethical dilemmas ('grey zones') encountered in obstetric and gynaecological practice that are not accommodated within Sri Lanka's current abortion law.

### **Case Source and Clinical Context**

The case narratives are drawn from the lead author's longitudinal clinical experience spanning over two decades in government obstetric and gynaecological services in Sri Lanka, including ward-based care, outpatient clinics, and emergency presentations. Cases were not drawn from a defined time-bound cohort or from medical records, but from accumulated professional experience of recurrent clinical scenarios encountered in routine practice.

### **Case Selection Strategy**

Cases were selected using purposive sampling, appropriate for qualitative descriptive inquiry. Selection was guided by the study objective: to identify clinical situations that repeatedly generate legal ambiguity or ethical conflict under the sole legal exception of saving the woman's life. Cases were included if they illustrated one or more of the following predefined grey zones: (1) Ambiguity in applying the legal threshold of "saving the life of the woman", (2) Pregnancy resulting from sexual violence, (3) Severe or lethal fetal anomalies, (4) Pregnancy in minors, (5) Pregnancy in women with significant intellectual disability or impaired decisional capacity,

(6) Situations of profound psychosocial or socio-economic vulnerability Cases that did not raise a legal or ethical dilemma related to abortion law were excluded. Because cases were selected purposively from experiential recall rather than identified through systematic record screening, a formal screening log or flow diagram was not applicable.

### **Case Construction and Data Sources**

The narratives were constructed retrospectively from clinician recall, informed by typical clinical encounters. No Bed Head Tickets, hospital records, electronic databases, referral letters, imaging reports, or patient interviews were accessed for the purpose of this manuscript. The cases are therefore illustrative rather than documentary and are intended to represent common patterns rather than specific patient trajectories.

To enhance clarity and consistency, each case was summarised using a structured narrative format describing clinical context, legal constraints, ethical considerations, and decision-making challenges.

### **Analytic Approach**

A thematic framework analysis was applied. Case narratives were examined across predefined analytic domains corresponding to the identified grey zones. Cross-case comparison was used to identify recurrent patterns in: (1) Legal ambiguity and uncertainty, (2) Ethical conflict and moral distress, (3) Constraints on clinical decision-making, (4) Reliance on temporising or defensive management strategies. The analysis focused on mechanisms by which legal restriction shapes clinical practice, rather than on outcome measurement or causal inference.

### **Ethical Considerations and Governance**

The manuscript is based on anonymised, experience-based clinical narratives and does not involve identifiable patient data, record extraction, or direct patient participation. No interventions were performed for research purposes, and no additional information was sought from patients. Because the narratives are derived from professional experience rather than from identifiable medical records or human-participant research, formal institutional ethics review and individual patient consent were not sought. This approach is consistent with accepted standards for reflective clinical scholarship and experience-based qualitative analysis. Safeguards were applied to protect confidentiality, including omission or alteration of non-essential demographic details. The case narratives are the intellectual work of the authors and are based on professional clinical experience. No third-party datasets or unpublished institutional data were accessed or used.

## **Results**

### **Case Narratives**

#### **Case 1: Lethal Fetal Anomaly in an Adolescent**

A young adolescent primigravida was diagnosed during the second trimester with a severe congenital anomaly incompatible with postnatal survival. Despite clear counselling regarding the uniformly fatal prognosis and the expressed wish of the patient to end the pregnancy, the prevailing legal framework offered no lawful option for abortion in the absence of an immediate threat to preserve the life of the woman. The pregnancy therefore continued under legal constraint, and the patient subsequently developed significant psychological distress requiring mental health support.

**Case 2: Pregnancy Resulting from Sexual Violence in a Minor**

A young minor presented during pregnancy with a history of sexual violence resulting in conception. The pregnancy arose from an act constituting statutory rape under Sri Lankan law. Given the patient’s age and physical immaturity, the pregnancy required careful obstetric management, including operative delivery. At no stage was a lawful option for abortion available to clinicians, despite the circumstances of sexual violence and the patient’s vulnerability.

**Case 3: Pregnancy in a Woman with Significant Intellectual Disability**

An adult woman with a longstanding intellectual disability, requiring substantial support for daily living, was identified during routine clinical assessment to be pregnant. She was assessed as lacking decisional capacity to understand pregnancy, childbirth, or the responsibilities of parenthood. Under the prevailing legal framework, no lawful option for abortion existed in the absence of an immediate threat to her life. The pregnancy therefore continued under legal constraint, with postnatal arrangements necessitating involvement of social protection services.

**Case 4: Pregnancy in the Context of Social Vulnerability**

A young woman experiencing significant social and economic vulnerability presented with an unplanned pregnancy in early gestation. The pregnancy occurred in the context of unstable living arrangements, limited social support, and financial insecurity. Concern regarding social stigma, loss of employment, and future economic hardship led her to repeatedly request an abortion. Following counselling regarding the legal limitations on abortion, she developed significant emotional distress requiring supportive intervention.

**Case 5: Pregnancy in the Context of Financial and Caregiving Burden**

A multiparous woman with substantial caregiving responsibilities presented with an unplanned pregnancy despite prior use of contraception. She described significant financial strain, limited family support, and concern regarding her capacity to meet the needs of her existing children. She repeatedly requested an abortion; however, in the absence of an immediate threat to preserve the life of the woman, clinicians were unable to offer abortion within the current legal framework.

**Table 1. Summary of Clinical Case Narratives Illustrating Legal-Ethical Grey Zones in Abortion Care in Sri Lanka**

Case	Grey-zone domain	Presenting context	Core legal-ethical dilemma	Clinician response under legal constraint	Observed pathway / immediate impacts
1	Lethal fetal anomaly	Prenatal diagnosis of a lethal congenital anomaly incompatible with postnatal survival	No legal provision for abortion despite uniformly fatal fetal prognosis and significant psychological harm	Continuation of pregnancy mandated; counselling and mental health referral	Prolonged psychological distress; reactive mental health support rather than preventive intervention

(Continued)

Case	Grey-zone domain	Presenting context	Core legal-ethical dilemma	Clinician response under legal constraint	Observed pathway / immediate impacts
2	Sexual violence in a minor	Pregnancy following rape/statutory rape	Absence of lawful abortion option and lack of a best-interests framework for minors	Pregnancy continued under legal constraint; social services engaged	Psychological trauma; reliance on social protection mechanisms rather than reproductive healthcare
3	Impaired decisional capacity	Limited capacity to consent or make reproductive decisions	No legal mechanism for substituted or best-interest decision-making in abortion care	Conservative management; involvement of caregivers without legal clarity	Ethical uncertainty; delayed or non-definitive care; caregiver burden
4	Socio-economic vulnerability	Severe socio-economic hardship with foreseeable psychosocial harm	Socio-economic and psychosocial harms excluded from legal grounds for abortion	Counselling and surveillance only; no definitive intervention	Ongoing distress; social disruption; delayed mitigation through non-medical pathways
5	Financial and caregiving burden	Existing caregiving responsibilities and financial strain	Non-recognition of contraceptive failure and cumulative burden as legally relevant factors	Continuation of pregnancy mandated; supportive counselling	Increased economic stress; psychological strain; absence of preventive reproductive choice

### **Thematic Analysis**

Analysis of the five clinical case narratives (Table 1) revealed a consistent pattern of legal-ethical conflict arising from the narrow statutory ground permitting abortion solely to preserve the life of the woman. Each case corresponded to a distinct but overlapping “grey zone” in which clinically and ethically significant circumstances were not accommodated within the legal framework.

Across cases, four recurrent analytic themes were identified.

#### **Legal ambiguity and uncertainty**

The undefined threshold of “preserving the life of the woman” created uncertainty regarding when, if ever, clinicians could lawfully intervene. In all cases, the absence

of explicit legal guidance resulted in conservative, risk-averse decision-making.

#### **Ethical conflict and moral distress**

Clinicians experienced tension between ethical obligations to respect autonomy, prevent harm, and act in patients’ best interests, and the requirement to comply with restrictive legal provisions. This conflict was particularly pronounced in cases involving minors, women lacking decisional capacity, and pregnancies complicated by lethal fetal anomalies.

#### **Constraints on clinical decision-making**

Legal restriction translated into constrained clinical options, including the inability to offer abortion despite foreseeable psychological, social, or clinical harm. Management strategies were frequently

limited to counselling, surveillance, or supportive interim measures rather than definitive intervention.

### **Translation of legal restriction into patient harm**

In all cases, the legal framework indirectly contributed to patient distress, prolonged suffering, or secondary harms, including psychological morbidity and social disruption, with reliance on reactive social protection or mental health interventions rather than timely, preventive healthcare.

Taken together, these findings demonstrate how recurrent and predictable grey zones, sexual violence, lethal fetal anomaly, impaired decisional capacity, and socio-economic vulnerability fall outside Sri Lanka's sole legal ground for abortion. The analysis illustrates how legal constraints shape clinical practice, generate ethical conflict, and contribute to moral distress among healthcare professionals, thereby directly addressing the stated objectives of the study.

## **Discussion**

This study demonstrates how Sri Lanka's restrictive abortion law generates recurrent and predictable legal-ethical grey zones in routine obstetric and gynaecological practice. Using reconstructed clinical case narratives, the analysis illustrates how the narrow statutory ground permitting abortion solely to preserve the life of the woman fails to accommodate a range of clinically and ethically significant circumstances. These situations, lethal fetal anomaly, sexual violence in minors, impaired decisional capacity, and profound socio-economic vulnerability are not exceptional, but arise systematically at the intersection of law, ethics, and clinical care.

### **Legal Ambiguity and Clinical Uncertainty**

Sri Lanka's Penal Code permits abortion only when performed in good faith to preserve the life of the woman, yet provides no definition of what constitutes such a threat. The absence of statutory or judicial clarification creates substantial uncertainty for clinicians managing pregnancies in which harm is foreseeable but not immediately life-threatening. As illustrated by cases involving lethal fetal anomaly and impaired decisional capacity, clinicians are often compelled to adopt conservative interpretations of the law, defaulting to continuation of pregnancy despite profound ethical concern [1].

Although Sri Lankan law criminalises sexual violence and recognises the need for child protection, it offers no reproductive remedies for pregnancies resulting from rape, including statutory rape. Similarly, fetal anomalies, contraceptive failure, and severe socio-economic hardship remain legally invisible. The absence of appellate jurisprudence interpreting these provisions further entrenches defensive practice, leaving clinicians without authoritative guidance in complex cases [1,11,12].

### **Ethical Conflict and Moral Distress**

The findings highlight persistent tension between clinicians' ethical obligations and legal constraints. Professional standards emphasise respect for autonomy, beneficence, non-maleficence, and acting in the patient's best interests. However, the legal framework frequently prevents clinicians from honouring these principles. In cases involving minors, women lacking decisional capacity, or those facing profound psychosocial harm, clinicians are required to acknowledge foreseeable suffering while being legally prohibited

from offering termination unless the woman's life is imminently threatened.

This misalignment generates moral distress, erodes professional autonomy, and encourages risk-averse decision-making. Rather than supporting ethical deliberation, the legal framework constrains clinical judgment and places health-care professionals in ethically untenable positions [15,22].

### ***Constrained Clinical Decision-Making and Systemic Contradictions***

Legal restriction translates directly into constrained clinical options. National maternal care guidelines recognise adolescent pregnancy, pregnancy following sexual violence, mental health vulnerability, and social instability as high-risk conditions requiring careful management. Yet these clinical classifications do not confer legal authority to permit termination. Consequently, clinicians are often limited to counselling, surveillance, and supportive interim measures rather than definitive intervention [16].

This contradiction is further underscored by Sri Lanka's endorsement of comprehensive Post-Abortion Care (PAC). While clinicians are authorised to manage complications of unsafe abortion using evidence-based interventions, they are prohibited from using the same tools to prevent harm through timely, safe abortion. This paradox reflects a broader disjunction between public health practice and legal regulation, shifting care from prevention to crisis response [3,22].

### ***Legal Restriction as a Determinant of Patient Harm***

Across cases, legal restriction functioned as a structural determinant of harm.

Women experienced prolonged psychological distress, social disruption, and secondary harms as a consequence of being compelled to continue pregnancies under adverse circumstances. Rather than preventing harm, the legal framework displaces it onto mental health services, social protection mechanisms, and emergency care.

Sri Lanka's international human rights commitments further illuminate this gap. Treaty bodies have repeatedly expressed concern regarding restrictive abortion laws, particularly in cases involving rape, minors, and severe fetal anomalies. Despite these obligations, domestic abortion law has remained largely unchanged, sustaining a disconnect between global standards and clinical realities [17-21].

### ***Comparative and Policy Implications***

Comparative experience from neighbouring India illustrates that a more balanced legal approach is feasible. India's Medical Termination of Pregnancy framework provides clearly defined indications, procedural safeguards, and gestational thresholds that allow clinicians to manage complex pregnancies within a regulated system. This demonstrates that reform need not equate to unrestricted access, but can provide structured pathways that align medical ethics, patient welfare, and public health [25,26].

In Sri Lanka, reform has been impeded by legal ambiguity, fear of prosecution among healthcare professionals, socio-cultural resistance, and political reluctance. These factors have contributed to prolonged stagnation despite sustained evidence of harm and continued professional advocacy.

## Conclusion

Sri Lanka's abortion law produces recurrent and predictable grey zones that constrain clinical practice, generate ethical conflict, and translate legal restriction into patient harm. By grounding analysis in clinician-facing case narratives, this study demonstrates how legal rigidity shapes everyday decision-making and contributes to moral distress among healthcare professionals.

Clearer legal guidance and evidence-based reform are urgently needed, particularly in cases involving rape, severe fetal anomalies, minors, women lacking decisional capacity, and profound psychosocial vulnerability. Aligning national law with contemporary clinical realities, ethical principles, and international obligations would improve patient safety while supporting clinicians to deliver compassionate, ethical, and accountable care.

## Ethical Approval

The manuscript is based on anonymised, experience-based clinical narratives and does not involve identifiable patient data, record extraction, or direct patient participation. No interventions were performed for research purposes, and no additional information was sought from patients. Because the narratives are derived from professional experience rather than from identifiable medical records or human participant research, formal institutional ethics review and individual patient consent were not sought. This approach is consistent with accepted standards for reflective clinical scholarship and experience-based qualitative analysis. Safeguards were applied to protect confidentiality, including omission or

alteration of non-essential demographic details. The case narratives are the intellectual work of the authors and are based on professional clinical experience. No third party datasets or unpublished institutional data were accessed or used.

## External Funding

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## Conflicts of Interest

The authors declare no conflicts of interest.

## Data Availability Statement

No datasets were generated or analysed during the current study. The manuscript is based on anonymised, experience-based reconstructed clinical narratives and publicly available legal, policy, and human rights documents.

## Use of Artificial Intelligence

Artificial intelligence tools were used to assist with language refinement and editorial clarity during manuscript preparation. All substantive content, analysis, interpretation, and conclusions are the responsibility of the authors.

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## Author Contribution Statement

Dr. Dias H G D C was responsible for conceptualisation, drafting of the manuscript, and the legal and ethical analysis.

Dr. J Jeyamaruthy contributed through critical revision of the manuscript, validation of content, editorial input, and final approval of the version to be published.

### Disclaimer

The views expressed in this article are those of the authors and do not necessarily reflect the views of their affiliated institutions.

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