ISSUES OF SAFE ABORTIONS IN MALAYSIA

Reproductive Rights and Choice

Editors
Wah Yun Low
Wen Ting Tong
Veenah Gunasegaran

UNFPA
UNIVERSITY OF MALAYA
The Leader in Research & Innovation

ISSUES OF SAFE ABORTIONS IN MALAYSIA

Reproductive Rights and Choice

PROJECT REPORTS

Editors

Wah Yun Low

Wen Ting Tong

Veenah Gunasegaran

AUGUST 2013

Perpustakaan Negara Malaysia Cataloguing-in-Publication Data

Issues of safe abortions in Malaysia : reproductive rights and choice / editors
Wah Yun Low, Wen Ting Tong, Veenah Gunasegaran
Bibliography: p. 177
ISBN 978-967-11589-4-4
1. Abortion–Malaysia. 2. Reproductive rights–Malaysia. I. Low, Wah Yun.
II. Tong, Wen Ting. III. Gunasegaran, Veenah.
363.4209595

This publication was made possible with support from the United Nations Populaton Fund (UNFPA), Malaysia.

Low, Tong, Gunasegaran (eds.) 2013
Faculty of Medicine
University of Malaya
50603 Kuala Lumpur
Malaysia
Tel: 603 7967 4973 Fax: 603 7967 5769
Email: lowwy@um.edu.my

Designed by City Reprographic Services

Acknowledging Dr. Siti Norazah Zulkifli, for editing this report.

Printed in Malaysia

TABLE OF CONTENTS

FOREWORD

This publication is a significant contribution towards ensuring access to safe abortion in Malaysia.

The three studies contained herein are important insights into the perceptions, understanding and attitudes prevalent in society and the health system, which may create barriers for particularly poor, young and otherwise marginalized women who need access to these services.

The choice of the target group surveyed within each study has been both strategic and important in furthering the understanding of where the bottlenecks in service provision are located. The first study looks at prevailing knowledge and perceptions of medical students on abortion, the second on doctors' knowledge and attitudes, and the final one reviews the real life experiences of women who have undergone pregnancy termination. These studies are critical to understanding the challenges and formulating effective responses towards ensuring that the needs of women are met.

Unsafe abortion in Malaysia accounts for 1 in 5 maternal deaths over the period 1995 – 2006[1]. While data on the prevalence of abortions in Malaysia is not available, the contribution that unsafe abortions make to maternal deaths is significant both globally and nationally, and warrants serious attention in the face of last-mile issues in reducing the maternal mortality ratio towards achieving the Millennium Development Goal 5 target before 2015.

UNFPA commends the team of researchers involved in all three studies for their commitment, insight and strategic approach towards obtaining evidence on an area of research that is often neglected, namely human attitudes and perceptions, and the ways in which these influence the quality of services received by women across the country.

Saira Shameem
Programme Adviser
UNFPA Malaysia
Website: www.unfpa.org

[1]Hematram Y. Measuring maternal mortality in Malaysia. Journal of the University of Malaya Medical Centre (JUMMEC). 2006; 9(1): 30–4.

EXECUTIVE SUMMARY

The executive summary was prepared by Federation of Reproductive Health Associations Malaysia (FRHAM) in conjunction with the dissemination seminar for the three research studies contained in this publication. FRHAM conducted the dissemination seminar whereby a statement of resolution was proposed, revised and finalized with consensus from all those present at the seminar (refer to Resolutions).

THE ISSUE OF SAFE ABORTIONS IN MALAYSIA

Three studies were carried out in Malaysia on the issue of abortion with funding from the World Health Organisation, Western Pacific Region.

These are the resulting reports from the studies:

1. Survey on knowledge and perception of medical students on abortion
2. Study on medical doctors' knowledge, attitude and willingness to provide abortion related services as a reproductive right of women
3. Study on reproductive rights and choice: insights from women on pregnancy termination

Methodology

The "Survey on the Knowledge and Perception of Medical Students on Abortion" was carried out in two public universities for years 1, 3 and 5 students, and one private university for all year 3 and year 5 students (year 1 students were attending classes in a foreign campus) in Malaysia from March through May 2011. A total of 1060 students (705 from public universities and 355 from the private university) returned the questionnaires with complete information, giving an overall response rate of about 90%. The questionnaire was designed in consultation with medical professionals from the Ministry of Health, the Reproductive Advocacy Alliance of Malaysia and the Universities. The draft questionnaire was pre-tested on 30 year 2 students in one of the public universities selected for the survey.

The "Study on Medical Doctors' Knowledge, Attitude and Willingness to Provide Abortion-related Services as a Reproductive Right of Women" was carried out within a four month period from July to October 2011 at the Obstetrics & Gynaecology Departments of five public hospitals selected by zones. They included Hospital Sultanah Bahiyah (Alor Setar) representing the north, Hospital Sultanah Aminah (Johor Bahru) representing the south, Hospital Kuala Lumpur representing the central, Hospital Sultanah Nur Zahirah (Kuala Terengganu) representing the east, and Hospital Umum (Kuching) representing East Malaysia. A total of 279 respondents comprising three categories of medical staff i.e., O&G specialists, medical officers and house officers (who had been attached to the O&G Department for at least one and a half months), participated in the study. The same questionnaire in the above survey was used for this study.

The "Study on Reproductive Rights and Choice: Insights from Women on Pregnancy Termination" utilised a qualitative approach using face-to-face interview, unlike the above two

studies. A total of 31 participants aged 21-43 years old took part in the study with all the interviews carried out in one clinic located in Penang.

Findings:

Survey on medical students:

About 70% of medical students (respondents) were aware of safe abortion procedures, but less than one quarter were aware that the contraceptive prevalence rate (CPR) for modern methods in Malaysia is less than 40%.

Generally, respondents from the private university had a higher level of awareness on abortion issues and contraception compared to those from the public universities.

About 35% of them reported correctly that the first trimester is the gestation period beyond which menstrual regulation should not be performed.

About 54% of them knew the definition of abortion (i.e., termination of pregnancy before the foetus is viable, that is, when the pregnancy is 22 weeks).

Sixty percent of them were aware that abortion is permissible under certain conditions, while 22% were of the view that abortion is illegal under all circumstances in Malaysia.

More than 80% held the view that the foetus has the right to live (pro-life).

About 22% approved of pre-marital sex, and the majority stated that sex education (including contraceptive information) should be introduced in schools.

About 64% felt that contraceptive services should be provided to the unmarried.

Over 80% stated that they would provide contraceptive information to unmarried persons, and pre- and post-abortion counseling in their future practice, but less than 20% would provide medical or surgical abortion services.

About 90% agreed that there should be more training in general knowledge and legal aspects of abortion, including counseling.

Study on medical doctors:

Over 80% of doctors (respondents) have some understanding of abortion including what is a safe medical procedure, but have limited knowledge on contraceptive prevalence rate, abortion methods and their associated risk of complications.

Slightly more than one third of the doctors were able to identify the preferred methods for first-trimester and second trimester abortion.

Over 80% of doctors knew that abortion is legal under certain circumstances, but the majority of them either did not know or were unsure about whether abortion is allowed in cases of rape or foetal abnormalities.

Most of the medical doctors were conventional and “pro-life” in their attitudes towards sexuality and abortion.

The majority of them either remained neutral (33%) or would resist (41%) carrying out abortions under any circumstances when it is against their personal religious beliefs.

Over 80% of them were comfortable in giving pre- and post-abortion counseling, including on contraceptive use, whereas about half of them indicated that they would refer the women for safe abortion services.

Almost all of them indicated that some training in abortion related issues should be included in the existing medical curriculum.

Study on women who had undergone abortion:

The majority of the respondents have poor knowledge of sexual and reproductive health: inadequate contraception information (oral contraceptive pills and intrauterine contraceptive device are the most commonly known); unaware of the early signs of pregnancy; not knowing complications of abortion; lacking access to related knowledge and service provision.

Most of them viewed abortion as a sin and unacceptable on religious grounds, and that abortion is illegal. They also had mixed reactions and post-abortion emotions (relief/regret).

Financial constraints and large family size were cited as the main reasons leading to abortion, and medical abortion was preferred compared to dilation and curettage and manual vacuum aspiration.

Most of them tended to make their own decision to abort although joint decisions were made for some, particularly those who were married.

Their expressed needs include: more information on medical abortion; better understanding of sexual and reproductive health issues relating to unintended pregnancies and abortion related concerns; information on shelter facilities; and setting up of mutual agreement between pregnant women and prospective adopters.

The extent of the problem at an international and national level:

Of the 46 million abortions that take place each year worldwide, 20 million are considered unsafe, resulting in roughly 70 000 deaths and hundreds of thousands of disabilities. Almost all (95%) unsafe abortions occur in developing countries. Asia has the largest total number of unsafe abortions (roughly 10 million) and the highest number of deaths from unsafe abortions (34 000) per year.

Women across all age spans experience abortions. Most women who seek abortion are married and trying to limit their family size or to space births because of economic difficulties or other reasons.

Safe motherhood and reproductive health services are closely linked to several basic human rights, including the fundamental right to life, as well as the right to high quality health care, non-discrimination and reproductive self-determination. A number of important international policies and commitments, to which Malaysia is also a signatory, acknowledge these rights.

At the national level, laws and policies are important tools for assuring the provision of quality services, whether for safe abortion, post-abortion care or contraceptive provision.

Malaysian laws limit the legal rights to abortion to save the woman's life, to preserve physical health as well as to preserve mental health. It does not permit abortion on socio-

economic grounds. Neither does it allow it without restriction as to reason. An abortion rate of 38 per 1000 women aged 15-49 has been quoted for Malaysia (John, Stover & Willard, 1999). Myths that hinder women's access to abortion, for example, that the incidence of abortion will be lower if abortion is illegal or that abortion will no longer occur if women have access to family planning, should be addressed and post-abortion care should always be offered.

Research on healthcare issues are only meaningful if lessons can be learnt leading to appropriate policy changes. Interviews with abortion clients in the qualitative study revealed their awareness of the need for reliable contraception to avoid 'accidental' pregnancies but they lacked sufficient knowledge and confidence to adopt a suitable and reliable method themselves.

The women had little knowledge of the procedures or of the laws governing abortions in Malaysia even though they knew it is commonly practised from hearsay. Their own experience of rejections and negative attitudes by doctors and nurses to their abortion requests both from the public and private sector implied to them that abortions are probably illegal.

This is also a reflection of the poor attitudes and lack of knowledge of healthcare providers on the law and policies regarding abortions. Healthcare providers should also be made aware of the code of professional ethics especially in relation to conscientious objections to contraception and abortions.

Clearly, from the reasons given for seeking abortion, women are strongly motivated to limit family size or control the timeliness of childbearing, even after getting an unintended pregnancy.

The problems for women lie primarily in getting accurate information on available safe abortion services and at affordable fees. The lack of such services in public hospitals together with the general perception that abortions are illegal allows many private providers, of both safe and unsafe methods, to exploit the situation by charging exorbitant fees. It also encourages a judgmental attitude amongst providers to these clients, which is totally against healthcare ethics.

Any change of legal status will not bring changes without political commitment and clear directives to include abortions as an essential component of reproductive health services.

This will help to destigmatise the issue to enable universal access to safe abortions for all women a reality.

What is required? An action plan

These research findings should stimulate the following policy initiatives:

There is a need for the government to implement a comprehensive reproductive health policy to build on previous advances in this area, which are currently stagnated, as it is unlikely to achieve the MDGs without fresh strategies and greater political commitment.

Appropriate training in abortion, such as on general aspects, legal aspects, pre- and post-abortion counseling and abortion procedures, as well as safe abortion care, should be included and well integrated into the existing medical curriculum.

Medical students should be given (and encouraged to acquire) good knowledge of reproductive health, including family planning. This must not be derailed by the personal preferences and prejudices, if any, of the teachers.

There should be continuing professional development (CPD) programmes for all healthcare professionals which incorporate contemporary reproductive health issues.

The use of appropriate abortion technology and the availability of equipment, supplies, standards or technical guidelines and referral mechanisms should be made known to medical practitioners.

Policy changes are needed to address weaknesses in our school sexuality education programme, as well as, in the provision and promotion of comprehensive contraceptive services.

The MOH and other agencies should reinvigorate the previously existing mechanisms of coordination and provision of contraception to women at the ground level.

Healthcare managers should use contraceptive prevalence rates as their key performance indicators.

Women, as well as current and future health care providers, should be educated on the current status of the laws with regards to abortions in Malaysia.

There should be a review of the Ethical Codes of the regulatory professional bodies and national medical associations with regards to abortions so that current international frameworks on human rights and medical ethics are reflected in the guidance provided to registered medical practitioners in this country. Ethics will have to take into account the boundaries set by religious bodies of various faiths.

RESOLUTIONS

Of the Dissemination Seminar on Abortion studies supported by WHO and participating agencies.

FRHAM, Subang Jaya, 16 December 2011

At the Dissemination Seminar on Abortion studies, held on 16 December 2011, the following resolutions have been agreed upon:

- A consensus guideline on the provision of safe abortion services taking cognisance of the current medical and surgical developments should be formulated by all involved agencies led by the Ministry of Health, Malaysia.
- A comprehensive reproductive health policy taking into consideration fresh and effective strategies with greater political commitment should be adopted to enable Malaysia to achieve its MDG 5a & b targets and other international commitments.
- Appropriate training in abortion including legal and ethical aspects, pre- and post-abortion counselling, abortion technology and safe abortion care should be better integrated into the existing curriculum of all medical schools and healthcare providers in Malaysia.
- The training of healthcare providers should include good knowledge of sexual and reproductive health including family planning.
- Continuing professional development (CPD) programmes which inculcate contemporary reproductive health issues should be provided for all healthcare professionals.
- A review of the Ethical Codes of the regulatory professional bodies and national medical associations with regard to abortion should be conducted at the soonest possible instance.
- Policy changes are needed to address weaknesses in the education system's sexuality and reproductive health programme.
- There should be provision and promotion of comprehensive contraceptive information and services to all those in need, including addressing the fear of side effects.
- Efforts should be made to strengthen the engagement of boys and men in addressing abortion within the overall sexual and reproductive health concerns.

ABBREVIATIONS AND ACRONYMS

AIMST	Asian Institute of Medicine, Science and Technology University
CPR	Contraceptive Prevalence Rate
D&E	Dilation and Evacuation
FIGO	International Federation of Gynaecology and Obstetrics
FRHAM	Federation of Reproductive Health Associations, Malaysia
GH	General Hospital
ICPD	International Conference on Population and Development
ICPD POA	International Conference on Population and Development Programme of Action
IMU	International Medical University
IPAS	International NGO devoted to ending unsafe abortion
IPPF	International Planned Parenthood Federation
IUD	Intrauterine device
MDG	Millennium Development Goal
MMMC	Melaka Manipal Medical College
MOH	Ministry of Health
MREC	Medical Research Ethics Committee
MVA	Manual vacuum aspiration
O&G	Obstetrics and Gynaecology
RH	Reproductive Health
SPSS	Statistical Packages for Social Sciences
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Right
TFR	Total Fertility Rate
UKM	National University Malaysia
UM	University of Malaya
UMS	University Malaysia Sabah
UN	United Nations
UNIMAS	University Malaysia Sarawak
UNFPA	United Nations Population Fund
UPM	University Putra Malaysia
USM	University Science Malaysia
WHO	World Health Organisation

Survey on Knowledge and Perception of Medical Students on Abortion

Nai-Peng Tey, MSc
Wah-Yun Low, PhD
Siew-Yong Yew, PhD
Prachi Renjhen, MBBS, MD, DCAFC
Lela Su'ut, MD, PhD
Wen-Ting Tong, BSc (Hons)

STUDY TEAM

1. **Associate Professor Tey Nai Peng**
Faculty of Economics and Administration, University of Malaya, Kuala Lumpur, Malaysia

2. **Professor Dr. Low Wah Yun**
Faculty of Medicine, University of Malaya, Kuala Lumpur, Malaysia

3. **Dr. Yew Siew Yong**
Faculty of Economics and Administration, University of Malaya, Kuala Lumpur, Malaysia

4. **Associate Professor Dr. Prachi Renjhen**
Melaka Manipal Medical College, Melaka, Malaysia

5. **Associate Professor Dr. Lela Su'ut**
Faculty of Medicine and Health Sciences, University Malaysia Sarawak (UNIMAS), Sarawak, Malaysia

6. **Ms Tong Wen Ting**
Medical Education Research & Development Unit, Faculty of Medicine, University of Malaya, Kuala Lumpur, Malaysia

ACKNOWLEDGEMENTS

This research project is funded by World Health Organisation (Western Pacific Region).

This study was made possible by the guidance, support, cooperation and participation of many individuals/agencies/institutions who in one way or another have contributed to the smooth running and completion of the survey. We would like to acknowledge and thank the following:

- Dr. Corinne Capuano, WHO Representative in Malaysia, Brunei Darussalam and Singapore,
- Dr. Harpal Singh, WHO Technical Officer, WHO Representative Office for Brunei Darussalam, Malaysia and Singapore,
- UNFPA, who have kindly provided funding for the publication of this report,
- Ms Yeoh Yeok Kim, Executive Director, Federation of Reproductive Health Associations, Malaysia (FRHAM), Selangor, Malaysia,
- Dr. Choong Sim Poey, Klinik Rakyat, Penang, Malaysia,
- Dr. Ravichandran Jeganathan, Head of the Department of Obstetrics and Gynaecology, Hospital Sultanah Aminah, Johor Bahru, Malaysia,
- The Deans of the three medical schools/faculties where the survey was conducted,
- The Chairperson and members of the Medical Ethics Committee, University of Malaya Medical Centre, and,
- Our respondents - medical students who participated in the survey.

LIST OF TABLES

LIST OF FIGURES

INTRODUCTION

Induced abortion is a serious public health concern as it poses high risk to the health (both mental and physical) and life of women. In 2008, unsafe abortion made up about half of an estimated 44 million induced abortions worldwide, ranging from a negligible proportion in eastern Asia to 65% in south central Asia (Sedgh et al, 2012). About 60% of women of childbearing age live in countries with liberal abortion laws. Yet, safe abortion services are not readily available because few doctors are trained to provide such services. Many doctors are unaware of laws pertaining to abortion (Singh et al., 2009, Sedgh et al., 2011).

Despite the absence of data, there are indications that induced abortions are increasing in Malaysia. An indirect estimate using Bongaarts' model puts the abortion ratio at about 16 percent (Tey et al., 2012). This figure is considerably lower than the range of 20-26 percent reported for the Asia-Pacific Region (Sedgh et al., 2012).

The increase in induced abortions in the country can be inferred from various sources. The total fertility rate has declined from about 3.5 children per woman in the mid-1980s to about 2.3 today despite the stagnation in contraceptive prevalence rate at around 50 percent (33 percent based on modern methods) for the last two to three decades. While rising age at marriage may explain part of the inconsistency, the fertility inhibiting effect of abortion cannot be ruled out as the media has reported an increase in out-of-wedlock births and baby abandonment (Tey et al, 2012). Owing to marriage postponement, young people are exposed to the risk of unplanned and unwanted pregnancies for a longer period. Moreover, sexually active unmarried persons do not have access to contraceptive services from the clinics of the national programme. Unwanted pregnancies due to rape and incest (violence against women) are also increasing in Malaysia. In 2006, there were 2,431 reports of rape, up from 1,479 in 2003 (RRAAM, undated). This number is probably a gross under-estimate as many cases are not reported due to stigma and fear.

A survey among secondary school students showed that although only 2.4% admitted to have had sex, one in five respondents said they know of friends who have had premarital sex and illegitimate pregnancies, and 10% have friends who have undergone abortions (NPFDB, 1998).

Policy and Public Opinion on Abortion

Malaysia is moderately liberal with regards to abortion. In 1989, section 312 of Act 727 of the Penal Code was amended to permit abortion if a medical practitioner was of the opinion, formed in good faith, that the continuance of the pregnancy would risk the life of the pregnant woman, or injury to the mental or physical health of the pregnant woman, greater than if the pregnancy were terminated. The public, including some doctors and health professionals, are unaware of these conditions for abortion (RRAAM, 2007, RRAAM undated, Radhakrishnan, 2007).

Abortion is not openly discussed due to cultural and religious sensitivities, and its legality. There are many barriers and reluctance when it comes to medical practitioners' giving abortion services. Many mistakenly believe that abortion in Malaysia is illegal in all circumstances. Owing to a lack of awareness and public information, abortion services are not widely or openly offered and are not easily accessible, leading to exploitation by some doctors and illegal providers of abortion. Women who want to terminate their pregnancies may end up going to some clandestine untrained doctors or abortion providers who carry out unsafe procedures. As a

result of unsafe abortion, some women suffer massive bleeding, and only later seek treatment at government hospitals when private health care providers fail to handle the serious complications of abortion (Sedgh, 2012). Women without financial means are forced to use traditional abortion methods, such as pineapples and cola-cola (Siti Fathilah, 1998).

The stigma attached to abortion affects both the women and the abortion providers. Many private doctors and specialists are still hesitant to offer abortion services for fear of being stigmatized as being a murderer (Poey, 2010). For some, the act of abortion may be against their religion and cultural beliefs. A study by the Reproductive Rights Advocacy Alliance of Malaysia (RRAAM) found that out of 120 doctors and nurses, only 57% knew the legal status of abortion. Those from the government sector feel no empathy for women who are pregnant due to rape and disapprove them of having abortion for that reason (RRAMM, 2007). Low awareness or knowledge of abortion law, and the fear of going against it, is probably one of the main reasons for doctors not to provide abortion services.

As mentioned, many doctors in Malaysia do not, and are unwilling to, provide abortion services due to lack of knowledge about abortion (types of abortion services and the legality of abortion, etc.), fear of the stigma attached to abortion, and religious and personal beliefs towards abortion. Medical abortion, a safer alternative, is still unknown to many. A number of surveys have been carried out to ascertain students' and practitioner' attitudes toward abortion (Weiss, et al. 1998; Rosenblatt, et al. 1999; Ventura, 1999; Francom et al. 2000; Aiyer et al., 1999; Black, et al., 2001; Buga, 2002; Becker et al., 2002; Espey et al. 2004, 2005, 2008; Cessford, et al. 2011). These studies show a limited understanding of abortion among medical students and professionals despite their willingness to provide abortion services in their (future) practice. To date, no study has been carried out to determine the knowledge, attitudes and perceptions (KAP) of abortion among medical students in Malaysia. Given the increase in the number of abortions, it is appropriate and timely that such a study be conducted to determine their knowledge of and attitudes, as well as their personal beliefs and perceived future practice related to abortion so that the medical training curriculum can be revised appropriately. The study also aims to provide some inputs to the Government and relevant bodies to design and implement relevant policies and programmes, specifically, on the prevention of abortion and the provision of quality abortion services when needed.

Objectives

The objectives of the "Survey on Knowledge and Perceptions of Medical Students on Abortion" are to:

1. examine the knowledge of abortion (type and legality) among medical students,
2. determine the attitudes towards abortion among medical students,
3. assess the willingness of medical students to give different types abortion services in their future medical practice, and
4. provide input for the curriculum review of medical courses and the formulation of policies, programmes and strategies to improve reproductive health and to cope with the increasing trend in induced abortion.

Methodology

Sample selection

The survey was planned to cover two public universities and two private universities out of a total of 33 medical schools in Malaysia. The sampling design for this survey used a combination of stratified random sampling and single stage cluster sampling. The universities were stratified according to public and private universities. Two universities were randomly selected from each stratum, and it was decided that the survey be confined to Years 1, 3 and 5 students. University of Malaya (UM) and University Sarawak Malaysia (UNIMAS) were selected to represent the public universities. Out of two private universities selected, the survey was conducted only in Melaka Manipal Medical University (MMMC), which allowed the survey to be conducted.

Questionnaire design

Based on a review of past studies, and in consultation with medical professionals from the Ministry of Health and Reproductive Rights Advocacy Alliance of Malaysia and the Universities, the questionnaire was designed to collect information on students' knowledge on and attitudes toward induced abortion, and related reproductive health services, including contraceptive use. The questionnaire consisted of 26 items which included students' knowledge of abortion and reproductive health, attitudes toward abortion and abortion education, and intention to provide abortion services in future practice. The questionnaire also included 12 Likert scale statements on various conditions for abortion, such as on the grounds of rape, risk to women's health and life, their rights and socio-economic considerations, with responses from 1 for those who disagreed strongly (not pro-choice/pro-life) to 5 for those who agreed strongly (pro-choice). The classification variables include type of university (public and private), year of study, gender, ethnicity, and religion.

The draft questionnaire was pre-tested on 30 Year 2 students in a public university selected for the main survey. No modification was made to the questionnaire after the pre-test as the students were able to answer all the questions. The questionnaire is attached in Appendix 1.

Data collection, processing and analysis

The survey was carried out from March through May 2011. Research team members explained the objectives of the survey before distributing the questionnaires to the students for self-administration during lecture sessions of core courses. A total of 1,060 students returned the questionnaires, representing a response rate of about 90%.

Data from the survey were entered into the computer, processed and analyzed using SPSS for Windows version 19. Quality control measures included checking for data entry errors, missing data and inconsistencies. A pro-choice index was created by summing the responses to the 12 Likert scale statements, with values ranging from 12 to 60 (Cronbach's Alpha of 0.858). A pro-life index was created by summing the responses to seven Likert-scale statements, with values ranging from 7 to 35 (Cronbach's Alpha of 0.785). The respondent's feedback to each of the six questions relating to their intention to provide abortion counseling, referrals and services were recoded as 2 if the answer was "Yes", 1 if "Uncertain" and 0 if the

answer was "No". The scores were next added to form an index on willingness or intention to provide abortion services in future practice, with values ranging from 0 to 12 (Cronbach's Alpha of 0.755). Generally a Cronbach's Alpha value of between 0.7-0.8 indicates internal consistency for a reliable scale.

Frequency tables were run to show the distribution of the sample according to selected variables, and students' attitudes towards various types of abortion education. Cross-tabulations were run to compare the proportion of students agreeing or disagreeing with abortion education across the categories of selected variables.

Ethical considerations

The proposal to conduct the survey was endorsed in writing by the Medical Ethics Committee, University of Malaya Medical Centre, Kuala Lumpur. Permission was sought from the Deans of the three selected medical schools. All respondents have consented to participate voluntarily in the survey after being fully informed about the aims and objectives of the study.

Sample distribution

The largest number of respondents came from the University of Malaya (UM), followed by Melaka Manipal Medical College (MMMC), and University Sarawak Malaysia (UNIMAS). As mentioned above, Year 1 students in MMMC were not interviewed for the survey. Restricting the sample to Years 3 and 5 students, respondents from MMMC formed the largest group (355), followed by UM (295) and UNIMAS (142).

The smaller number of Year 1 students in our sample is due to the exclusion of Year 1 students from MMMC. A more detailed tabulation shows that the number of respondents from UM was rather evenly split across the year of study: Year 1 (n=163), Year 2 (n=142) and Year 3 (n=153). Reflecting the increasing intake in UNIMAS, Year 1 was the largest group (n=105), followed by Year 2 (n=79) and Year 3 (n=63). In MMMC, 241 respondents were from Year 5 while 114 were from Year 3.

The gender shift in tertiary education in favour of girls is also seen in medical schools. Female respondents made up close to two-thirds of the total, and tabulation by type of university shows that this is true in both public and private universities. The shift towards more females in medical schools is demonstrated by the increasing proportion from 63% among Years 3 and 5 students to 67% among Year 1 students.

By ethnicity, Malays comprised close to half of the respondents, followed by Chinese and Indians. Others were mainly the indigenous population in Sabah and Sarawak who made up about 6% of the respondents in UNIMAS. The distribution of respondents by religion followed closely that of ethnicity. All Malays are Muslim, 81% of the Indians are Hindu, two-thirds of the Chinese are Buddhist, and the remainder are mainly Christian. About 78% of the "Others" are Christian. As much as 95% of the respondents consider religion very important in their daily life.

Close to three quarters of the respondents came from towns rather than rural areas. This reflects partly the urban-rural differentials in academic performance and access to higher education, including medical education.

A little more than half of the respondents had two to three siblings while close to one third had four or more.

The most common field of specialization that students wished to pursue in the future was obstetrics and gynaecology (14.4%), followed by surgery (12.5%), pediatrics (11.9%) and medicine (9.3%), while 31.5% mentioned all others. About one in five still have not made up their mind.

Table 1: Sample Distribution by Selected Variables (n = 1060)

Variable	Category	n	%	Variable	Category	n	%
	Total	**1060**	**100.0**		**Total**	**1060**	**100.0**
University	UM	458	43.2	**Place of origin**	Urban	770	72.6
	UNIMAS	247	23.3		Rural	288	27.2
	MMMC	355	33.5		Total	1058	99.8
					Missing	2	0.2
Year of study	Year 1	268	25.3				
	Year 3	335	31.6	**No of siblings**	0	11	1.0
	Year 5	457	43.1		1	165	15.6
					2	291	27.5
Gender	Male	379	35.8		3	254	24.0
	Female	681	64.2		4	162	15.3
					5	74	7.0
Ethnicity	Malay	502	47.4		6+	95	9.0
	Chinese	388	36.6		Missing	8	0.8
	Indian	133	12.5				
	Other	37	3.5	**Intended field of specialization**	Medicine	99	9.3
					Obs & Gynae	150	14.2
Religion	Muslim	508	47.9		Pediatrics	126	11.9
	Christian	157	14.8		Surgery	133	12.5
	Buddhist	257	24.2		Others	334	31.5
	Hindu	109	10.3		Don't know	218	20.6
	Others	26	2.5				
	Missing	3	0.3				
Perceived importance of religion	Very	662	62.5				
	Important	334	31.5				
	Not	50	4.7				
	Not at all	9	0.8				
	Missing	5	0.5				

Knowledge of Abortion

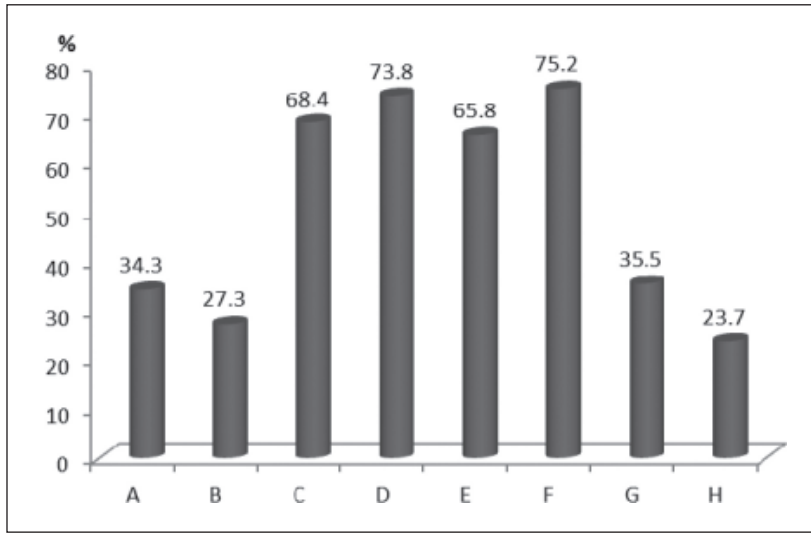
General knowledge of respondents on abortion and contraception

Many women around the world have little or no knowledge about abortion. A study in South Africa found that thirty-two percent of women did not know that abortion is currently legal. Among those who knew of legal abortion, few had knowledge of the time restrictions involved

(Morroni et al. 2006). Becker et al. (2002) found that Mexican youth had little knowledge of abortion law. The lack of knowledge on abortion was also common among medical students and professionals. In Malaysia, a survey found that abortion knowledge is also lacking among doctors and health professionals (RRAAM, 2007).

A rather high proportion of medical students had some misconceptions of abortion. The survey shows that only about a third knew that legally restricting abortion would not reduce the number of abortion, and less than a quarter were aware that the contraceptive prevalence rate for modern methods in Malaysia is less than 40%. However, about 70% were aware that abortion is a safe medical procedure when performed with proper equipment (68%), correct techniques (74%) and with sanitary standards (66%). About three-quarters knew that the total abortion rate decreases where effective contraceptive methods are available and widely used (Figure 1).

Figure 1: Percentage of Respondents with General Knowledge of Abortion and Contraception



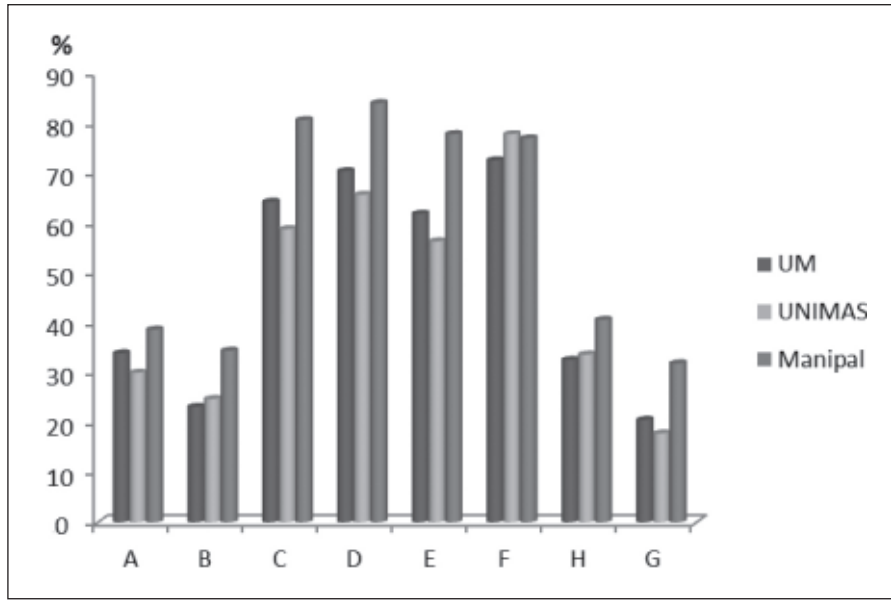
Legend

	Statement on Abortion Knowledge
A	Legally restricting abortion reduces number of abortion
B	The vast majority of women are likely to have at least one abortion by the time they are 45
C	Abortion is a safe medical procedure when performed with proper equipment
D	Abortion is a safe medical procedure when performed with correct technique
E	Abortion is a safe medical procedure when performed with sanitary standards
F	Where effective contraceptive methods are available and widely used, the total abortion rate decreases
G	If all contraceptive users were to use methods correctly all the time, there would not be any unintended or unwanted pregnancy
H	The proportion of women of reproductive age who are using modern contraceptive methods in Malaysia is less than 40%

The level of general knowledge on abortion and contraception was about the same for students from the two public universities. However, students from the private university had a higher level of awareness of abortion and contraception compared to those from the public universities. The differential was widest with respect to abortion being a safe procedure when performed with proper equipment, correct techniques and with sanitary standards. This could be due to differences in the curriculum (Figure 2).

As expected, senior students displayed more knowledge compared to younger ones, with the widest differential between Year 5 and Year 1 students. However, junior and senior students were equally aware that, where contraceptive methods are available and widely used, the total abortion rate decreases (Figure 3).

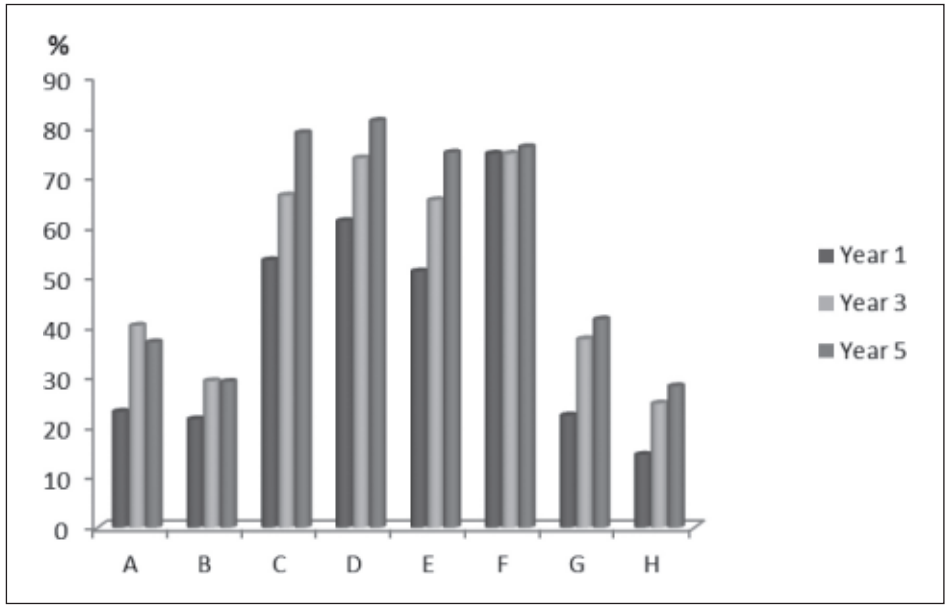
Figure 2: Percentage of Respondents with General Knowledge of Abortion and Contraception by University



Legend

	Statement on General Knowledge of Abortion and Contraception
A	Legally restricting abortion reduces number of abortion
B	The vast majority of women are likely to have at least one abortion by the time they are 45
C	Abortion is a safe medical procedure when performed with proper equipment
D	Abortion is a safe medical procedure when performed with correct technique
E	Abortion is a safe medical procedure when performed with sanitary standards
F	Where effective contraceptive methods are available and widely used, the total abortion rate decreases
G	If all contraceptive users were to use methods correctly all the time, there would not be any unintended or unwanted pregnancy
H	The proportion of women of reproductive age who are using modern contraceptive methods in Malaysia is less than 40%

Figure 3: Percentage of Respondents with General Knowledge of Abortion and Contraception by Year of Study



Legend

	Statement on Abortion and Contraception Knowledge
A	Legally restricting abortion reduces number of abortion
B	The vast majority of women are likely to have at least one abortion by the time they are 45
C	Abortion is a safe medical procedure when performed with proper equipment
D	Abortion is a safe medical procedure when performed with correct technique
E	Abortion is a safe medical procedure when performed with sanitary standards
F	Where effective contraceptive methods are available and widely used, the total abortion rate decreases
G	If all contraceptive users were to use methods correctly all the time, there would not be any unintended or unwanted pregnancy
H	The proportion of women of reproductive age who are using modern contraceptive methods in Malaysia is less than 40%

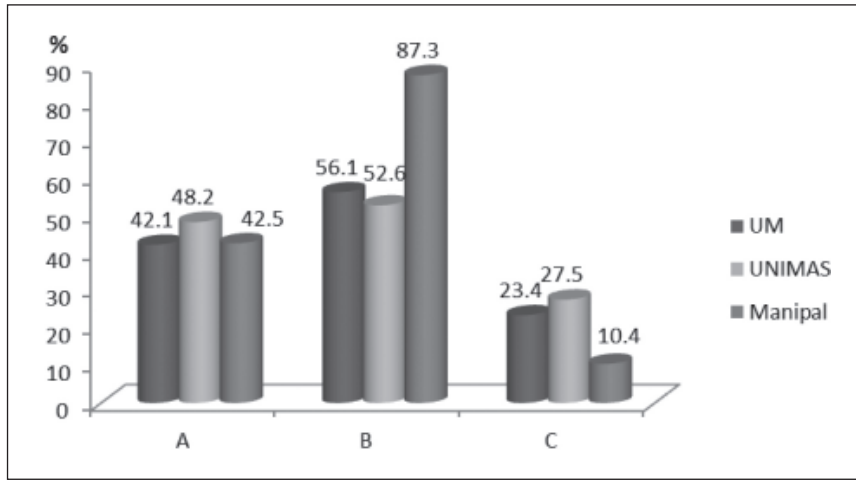
There was little difference in the level of general knowledge of abortion and contraception between male and female students, and between those coming from urban and rural areas. In terms of ethnic group, Indian students were relatively more knowledgeable on most aspects of general knowledge of abortion compared with the rest.

Knowledge of menstrual regulation

Many medical students were not aware that menstrual regulation is a surgical treatment for heavy menstrual bleeding of unknown cause (56.3%), regulating irregular menstrual cycles (34.3%) and early evacuation of the uterine cavity when pregnancy is not confirmed (80%).

Students from the private university were much more knowledgeable (87%) than those from public universities with regards to regulating irregular menstrual cycles (87% versus 53%–56%) but they were less knowledgeable on the other two aspects. Only about 10% of students from the private university were aware that menstrual regulation is a surgical treatment for early surgical evacuation of the uterine cavity when pregnancy is not confirmed compared to about 23%-28% among students from the public universities.

Figure 4: Percentage of Respondents with Knowledge of Menstrual Regulation as a Surgical Treatment by University



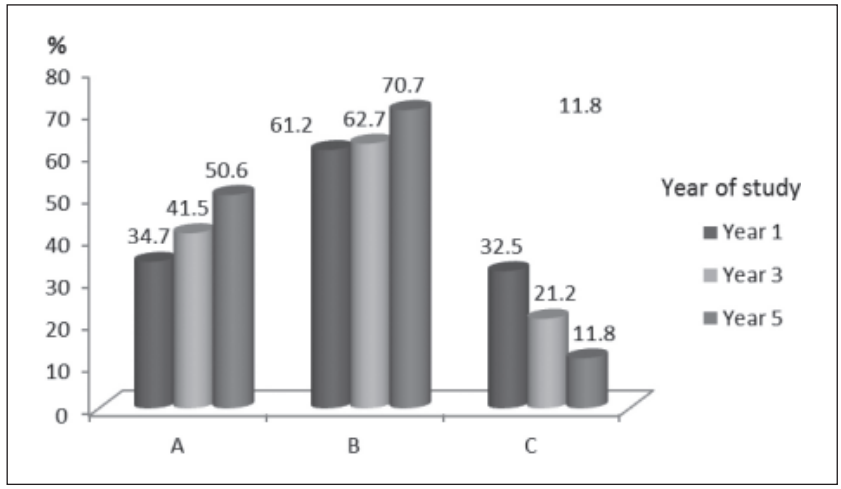
Legend

	Statement on Menstrual Regulation Knowledge
A	Menstrual regulation is a surgical treatment for heavy menstrual bleeding of unknown cause
B	Menstrual regulation is a surgical treatment to regulate irregular menstrual cycles
C	Menstrual regulation is a surgical treatment for early surgical evacuation of the uterine cavity when pregnancy is not confirmed

Senior students were more likely than their juniors to know that menstrual regulation is a surgical treatment for heavy menstrual bleeding of unknown cause, and to regulate irregular menstrual cycles. Contrary to expectation, only 11.8% of the seniors knew of menstrual regulation as a treatment for early surgical evacuation of the uterine cavity when pregnancy is not confirmed compared to 32% of Year 1 students and 21% of Year 2 students. There was little gender differential on all the three aspects of menstrual regulation discussed above.

Overall, only 43% of the respondents knew that the first trimester is the gestation period beyond which menstrual regulation should not be performed, ranging from 18.8% of UNIMAS students, 36.7% of MMMC students and 44.5% of UM students. It is to be noted that 22% of the respondents even reported that menstrual regulation could be performed up to the third trimester. Contrary to expectation, a higher percentage of Year 1 students gave the correct answer (47%) compared to Year 3 (40.7%) and Year 5 (41.5%) students.

Figure 5: Percentage of Respondents with Knowledge of Menstrual Regulation as a Surgical Treatment by Year of Study



Legend

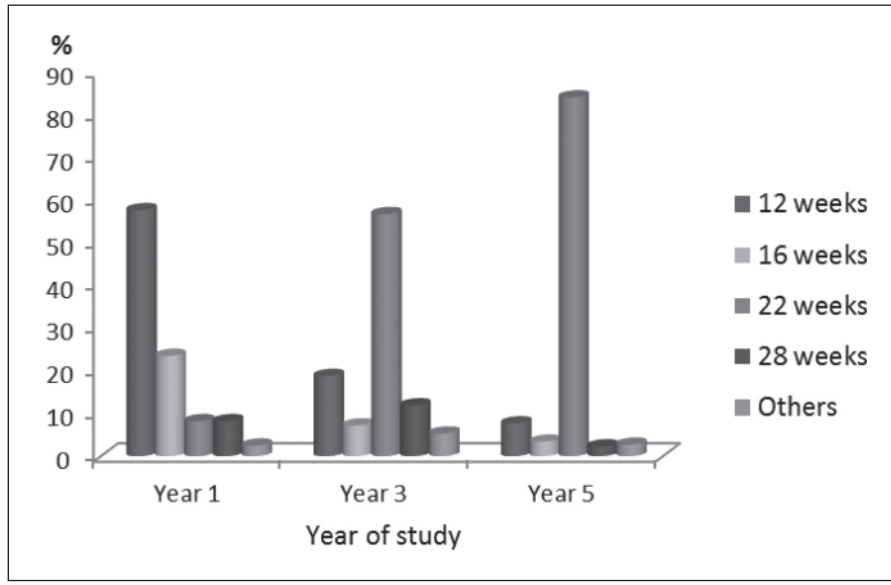
	Statement on Menstrual Regulation
A	Menstrual regulation is a surgical treatment for heavy menstrual bleeding of unknown cause
B	Menstrual regulation is a surgical treatment to regulate irregular menstrual cycles
C	Menstrual regulation is a surgical treatment for early surgical evacuation of the uterine cavity when pregnancy is not confirmed

Knowledge of foetal viability

The "age of viability" is the time at which a foetus obtains the capacity to survive outside the womb independently of its mother. There is no specific scientific or ethical consensus regarding the exact age of viability for a foetus. Depending on how one defines "viable," a foetus may pass this milestone any time between 21 weeks and 28 weeks of gestation. Advances in medicine have enabled a few newborns to survive even if they are born as early as 21 weeks into gestation (Russo, 2011). In this study, abortion is defined as terminating a pregnancy before the foetus becomes viable, and the foetus is regarded as viable when the pregnancy is 22 weeks. To the question "Abortion is defined as terminating a pregnancy before the foetus is viable; viability of a fetus is taken as when the pregnancy is ___ weeks?", 57.1% of the respondents gave 22 weeks as their response, ranging from 37.4% among students from UNIMAS, to 45.3% among UM students and 84.3% among MMMC students. However, including the shorter gestation periods (12 weeks, 16 weeks and 22 weeks) for terminating a pregnancy, about 90% of the students answered correctly, ranging from 80% among UNIMAS students to 94% among UM students.

Year 5 students were much more likely than their juniors to know of the viability of a foetus at 22 weeks of pregnancy. Figure 6 shows that 84% of Year 5 students gave the correct answer compared to 57% of Year 3 students and 8% of Year 1 students.

Figure 6: Percentage of Respondents by their Answer on the Gestation Period for the Viability of a Foetus by Year of Study



Knowledge of the preferred methods for abortion

The preferred methods for first trimester abortion are vacuum aspiration and mifepristone and misoprostol (Sarah Snow, 2009). Table 2 shows that only 25.2% and 34.6% of the respondents knew of vacuum aspiration and mifepristone and misoprostol, respectively, as the preferred methods. The level of knowledge of mifespristone and misoprostol as the preferred method for first trimester abortion is much higher among MMMC (private) students compared to those from the two public universities, but the reverse is true for vacuum aspiration. It should be noted that many students mentioned other methods, such as dilatation and curettage (51%, and higher among UM students at 55.9%), and dilatation and evacuation which was mentioned by about one third across all the three universities.

Table 2: Percentage of Respondents by the Preferred Methods Mentioned for First Trimester Abortion by University

Preferred Method for First Trimester Abortion	% of Respondents			
	UM	UNIMAS	MMMC	Total
Dilatation and curettage	55.9	49.0	46.0	51.0
Vacuum aspiration	27.5	29.6	19.5	25.3
Dilatation and evacuation	30.2	35.2	32.8	32.2
Mifepristone and misoprostol	23.2	28.7	53.4	34.6
Mifepristone and methotrexate	16.8	23.9	12.4	17.0

Surprisingly, Year 5 students were less likely than their juniors to mention vacuum aspiration and mifepristone and misoprotol, but a higher percentage mentioned other methods, namely, dilatation and curettage (60.3%) and dilatation and evacuation (36%) (Table 3).

Table 3: Percentage of Respondents by the Preferred Methods Mentioned for First Trimester Abortion by Year of Study

Preferred Method for First Trimester Abortion	% of Respondents			
	Year 1	Year 3	Year 5	Total
Dilatation and curettage	28.7	56.0	60.3	51.0
Vacuum aspiration	41.5	21.9	18.4	25.3
Dilatation and evacuation	29.4	29.3	36.0	32.2
Mifepristone and misoprostol	19.3	43.4	37.1	34.6
Mifepristone and methotrexate	22.0	15.9	14.9	17.0

The preferred methods for second trimester abortion were dilatation and evacuation, mifepristone and repeated doses of misoprostol, and vaginal prostaglandins (repeated doses) (Society of Family Planning, 2011). About 40% of respondents from all the three univeristies knew of dilatation and evacuation, but only between 20% and 31 % knew of the other two methods. In addition, about 40% of students from each of the three universities mentioned dilatation and curettage as the preferred method. UM students were a little more likely than the rest to mention vacuum aspiraton as a preferred method for second trimester abortion (Table 4).

Table 4: Percentage of Respondents by the Preferred Methods Mentioned for Second Trimester Abortion by University

Preferred Method for Second Trimester Abortion	% of Respondents			
	UM	UNIMAS	MMMC	Total
Dilatation and curettage	35.2	37.7	41.2	37.8
Vacuum aspiration	28.9	21.1	23.6	25.3
Dilatation and evacuation	39.3	38.1	43.2	40.3
Mifepristone and repeated doses of misoprostol	20.0	22.3	26.4	22.7
Vaginal prostaglandins (repeated doses)	22.7	30.8	20.5	23.8

Table 5 shows that Year 5 students were more likely than others to know of two of the preferred methods, but there is little variation between year groups on knowledge of the third method. Year 5 students were also more likely to mention dilatation and curettage which is not a preferred method.

Table 5: Percentage of Respondents by the Preferred Method Mentioned for Second Trimester Abortion by Year of Study

Preferred Method for Second Trimester Abortion	% of Respondents			
	Year 1	Year 3	Year 5	Total
Dilatation and curettage	23.0	41.1	44.0	37.8
Vacuum aspiration	34.3	26.4	19.1	25.3
Dilatation and evacuation	35.1	38.7	44.5	40.3
Mifepristone and repeated doses of misoprostol	22.3	18.0	26.4	22.7
Vaginal prostaglandins (repeated doses)	21.9	25.5	23.7	23.8

Knowledge of the risk of complications caused by abortion

Abortion involves various risks, including pelvic infection, infertility, uterine perforation, and post-operative bleeding needing hospitalization. Overall, only 40% to 54% of the students knew of these complications. Students from the two public universities were generally more likely than those from the private university to be aware of complications caused by abortion. It should be mentioned that 9% of the students were not aware of any these risks.

Senior students were generally more aware than their juniors of the risks of complications caused by abortion. However, 10.2% of Year 5 students were not aware of any of these risks (Table 7). Contrary to expectation, Year 1 students were more aware than their seniors of the risk of infertility caused by abortion (Table 7).

Table 6: Percentage of Respondents by their Knowledge of the Risks of Complications Caused by Abortion by University

Complication	% of Respondents			
	UM	UNIMAS	MMMC	Total
Pelvic infection	48.7	34.8	35.1	40.9
Infertility	48.2	38.9	31.1	40.4
Uterine perforation	59.4	53.8	46.9	53.9
Post-operative bleeding needing hospitalization	53.3	55.9	49.1	52.5
None of the above	4.6	8.1	15.4	9.0

Table 7: Percentage of Respondents by their Knowledge of the Various Risks of Complications Caused by Abortion by Year of Study

Complication	% of Respondents			
	Year 1	Year 3	Year 5	Total
Pelvic infection	32.3	40.4	46.4	40.9
Infertility	45.5	38.3	38.9	40.4
Uterine perforation	35.0	53.9	65.1	53.9
Post-operative bleeding needing hospitalization	39.1	61.7	53.6	52.5
None of the above	7.1	9.0	10.2	9.0

Knowledge of the legal aspects of abortion

Under the *Syariah* laws (*Fatwa*) issued by the National *Fatwa* Committee, abortion is not encouraged if the foetus is less than 40 days, but it is permissible if the foetus is found to be seriously abnormal within 120 days. However it is forbidden for the foetus to be aborted if it is more than 120 days old unless the mother's life was in danger.

Data show that 61.8% of the respondents were aware that abortion is allowed under certain conditions, yet 38.2% were unaware that there are provisions for abortion under the *Fatwa*. MMMC students were more aware of the *Syariah* laws on abortion than those from the two public universities. Years 3 and 5 students were also more aware than Year 1 students of this provision. In terms of ethnic group, the Malays were also much more aware of this provision than those from other ethnic groups (Table 8).

Table 8: Percentage of Respondents by their Knowledge of the Conditions (*Fatwa*) Permitting Abortion under *Syariah* Law (*Fatwa*) by Selected Variables

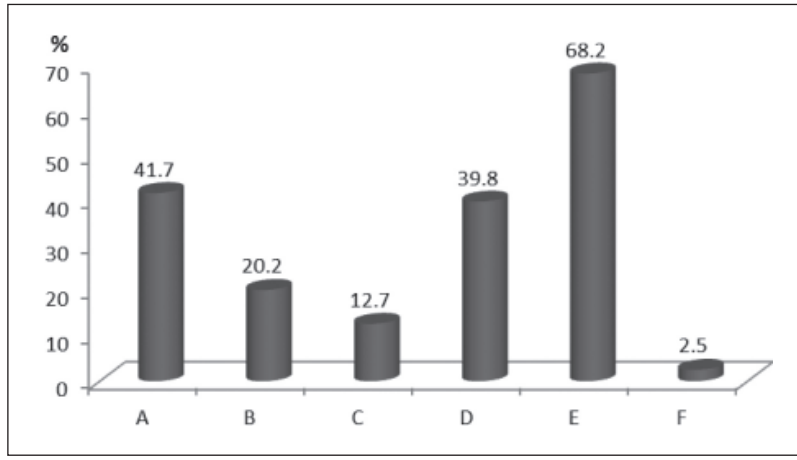
University	% of Respondents
UM	59.7
UNIMAS	60.2
MMMC	65.6
Year of Study	
Year 1	54.7
Year 3	64.5
Year 5	63.9
Ethnicity	
Malays	75.2
Chinese	52.4
Indians	39.5
Others	54.5

A little more than two-thirds of the respondents were aware that under the *Fatwa* abortion is permissible if continuing the pregnancy will endanger the woman's life, and 39.8% were aware of the provision for abortion if the foetus is found to be seriously abnormal. In terms of the age of the foetus, only 12.7% were aware that abortion is permissible up to 120 days. Only two percent, however, were aware that the *Fatwa* allows abortion on socio-economic grounds.

Under the Penal Code Amendment Act (Section 312, 1989), a registered medical practitioner is permitted to "terminate the pregnancy of a woman, if such medical practitioner is of the opinion, formed in good faith,that the continuance of the pregnancy would involve risk to the life of the pregnant woman, or injury to the mental and physical health of the pregnant woman" (Malaysia, 2006).

The survey shows that 22.4% of the medical students were unaware that abortion is legal under certain circumstances. Excluding the 7.5% who did not give a response to the question, the proportion increases to 24.2%.

Figure 7: Percentage of Respondents with Knowledge of the Conditions under which Abortion is Permitted



Legend

	Condition Permitting Abortion
A	If the foetus is under 40 days
B	If the foetus is under 100 days
C	If the foetus is under 120 days
D	If the foetus is found to be seriously abnormal
E	If continuing the pregnancy will endanger the woman's life
F	For socio-economic reasons

The proportion who hold the view that abortion is illegal under all circumstances in Malaysia was highest among UM students and lowest among UNIMAS students. Year 1 students were much more likely than Year 3 and Year 5 students to have this misconception, while female students were a little more likely than male students to do so. In terms of ethnic group, the highest proportion with this misconception were those categorized as 'Others', followed by Malays, Indians and Chinese (Table 9).

Under Malaysian law, abortion is allowed under the first three conditions listed in Table 10. The majority of the respondents (94.3%) were aware that abortion is allowed if it is performed to save the mother's life, but this decreases to 64% and 47% for preserving the woman's physical and mental health, respectively. Close to three-quarters gave the incorrect answer that abortion is allowed if there is serious foetal impairment (although this is allowed under the *Fatwa*), and 37.9% thought that abortion is allowed if the woman's pregnancy was the result of rape. Students from the public and private universities have about the same level of knowledge on these legal aspects of abortion.

Very few students reported that abortion is allowed for socio-economic reasons (6.4%), if an unmarried woman became pregnant and wanted to terminate the pregnancy, and if the woman became pregnant due to contraceptive failure. A rather sizable proportion of

Table 9: Percentage of Respondents with the Misconception that Abortion is Illegal under All Circumstances

Background Variable		% of Respondents
University	UM	30.21
	UNIMAS	17.04
	MMMC	20.94
Year of study	Year 1	35.37
	Year 3	19.87
	Year 5	20.82
Gender	Male	22.32
	Female	25.20
Ethnicity	Malay	28.67
	Chinese	17.55
	Indian	24.62
	Other	32.35

respondents were uncertain if abortion is permissible to preserve the woman's physical (16.9%) and mental health (28.1%), and if the woman's pregnancy was the result of rape (20.9%).

Table 10: Percentage of Respondents by their Knowledge on the Various Circumstances under which Abortion is allowed by Law

Circumstance	% of Respondents		
	Yes	No	Do not know
To save the woman's life	94.5	3.1	2.4
To preserve the woman's physical health	64.2	18.8	16.9
To preserve the woman's mental health	47.3	24.6	28.1
For socio-economic reasons (e.g. low family income, limited living space)	6.4	81.6	12
Due to serious foetal impairment	73.9	15.3	10.8
An unmarried woman became pregnant and wanted to terminate the pregnancy	6.5	84.3	9.2
The woman's pregnancy was the result of rape	38.1	40.9	20.9
The woman became pregnant due to contraceptive failure	7.2	84.6	8.2

The majority of students from all the three universities were correct when they reported that abortion is allowed to save a woman's life; this ranges from 91.9% among UM students to 97.2% among MMMC students. UM students were slightly more likely than students from the other two universities to report that abortion is allowed if it is performed to save the physical and mental health of the women. A high proportion of students, ranging from 68% among UM students to 78% among the others, had the misconception that abortion is allowed due to serious foetal impairment. Many students also had the misconception that abortion is

allowed if the woman's pregnancy was the result of rape (ranging from about 27-29% among students from the two public universities to 58.9% among MMMC students). Most students from all the universities were aware that abortion is not allowed under the circumstances listed in Table 10. However, it must be noted that 15.3% of the students from MMMC incorrectly thought that abortion is allowed if the woman became pregnant due to contraceptive failure.

Table 11: Percentage of Respondents by the various Circumstances Permitting Abortion Reported by University

Permissible Circumstance for Abortion	% of Respondents		
	UM	UNIMAS	MMMC
To save the woman's life	91.9	95.5	97.2
To preserve the woman's physical health	66.1	60.7	64.3
To preserve the woman's mental health	53.7	35.5	47.2
For socio-economic reasons (e.g. low family income, limited living space)	6.4	5.7	6.8
Due to serious foetal impairment	68.0	78.0	78.4
An unmarried woman became pregnant and wanted to terminate the pregnancy	7.0	4.1	7.4
The woman's pregnancy was the result of rape	26.8	29.0	58.9
The woman became pregnant due to contraceptive failure	3.5	2.4	15.3

Data show that most students, regardless of the year of study, knew of the law that permits abortion to save the woman's life. However, Year 3 students were a little less knowledgeable than other year groups about the other two conditions. About three-quarters of students from Years 1, 3 and 5 incorrectly gave foetal impairment as a permissible reason for abortion. Unexpectedly, senior students were more likely than junior students to have the misconception that abortion is allowed if the woman's pregnancy was the result of rape.

Table 12: Percentage of Respondents by the various Circumstances Permitting Abortion Reported by Year of Study

Permissible Circumstance for Abortion	% of Respondents		
	Year 1	Year 3	Year 5
To save the woman's life	89.9	96.7	95.6
To preserve the woman's physical health	65.5	59.2	67.2
To preserve the woman's mental health	54.0	41.0	48.0
For socio-economic reasons (e.g. low family income, limited living space)	10.9	6.3	3.7
Due to serious foetal impairment	73.8	73.3	74.3
An unmarried woman became pregnant and wanted to terminate the pregnancy	10.6	4.8	5.3
The woman's pregnancy was the result of rape	25.8	39.8	44.1
The woman became pregnant due to contraceptive failure	4.5	8.1	8.1

Attitudes towards Abortion and Sexuality

Attitudes towards Abortion

Abortion is seen as a taboo subject, and not publicly discussed. However, the use of of self-administered questionnaires may encourage students to disclose their frank opinions. Students' opinions may be influenced by socio-cultural factors, and exposure to abortion and social issues. This section presents the differentials in students' opinions on abortion in terms of gender, ethnicity and place of origin.

Opinions were assessed using a total of 19 Likert-scale statements, with the score from 1 to 5 (5 - strongly agree, 4 - agree, 3 - neutral, 2 - disagree, 1 - strongly disagree). Agreement with the first 12 statements listed in Table 13 is regarded as being pro-choice, and agreement with the remaining 7 statements is regarded as being pro-life. It is possible that a student who agrees with a pro-choice statement also agrees with a pro-life statement.

Table 13 shows the percentage distribution of respondents' level of agreement and disagreement with each statement. The mean value is shown to facilitate comparison. Generally, students tended to be more likely to agree to statements on providing general information, and on the rights of women to decide on abortion for health reasons, but were least likely to agree that a woman should have an abortion if she thinks that the birth of the child will jeopardize her future. For instance, while 67.1% of the students agreed that information on abortion should be made available to the public (mean score 3.8), only 8% agreed that it is ok to abort because a foetus is not a life until it is born (mean score 1.8), 9.8% agreed that abortion should be made legal for economic/social reasons (mean score 2.1), 12% agreed that a woman should have an abortion if she thinks that the birth of the child will jeopardize her future (mean score 2.1). Students were also relatively more likely to endorse abortion for health reasons as 45.5% and 38.5% agree that abortion should be carried out if the pregnancy will result in the birth of a child with physical and mental defects (mean score 3.3 and 3.1) respectively. About 30% of the students agreed that abortion should be legalized on demand as a woman's reproductive right to choose, and should be made available to the public.

More than 94% of the respondents were of the view that a foetus has the right to live as it is a potential human being, and a large proportion also agreed that a woman who is having an unwanted pregnancy should still give birth to the child because life is precious, and that abortion is like taking a life as life begins at conception (Table 13).

Pro-life sentiments appeared to be relatively stronger than pro-choice among respondents, as indicated by the mean scores of 3.9 to 4.3 for four out of the seven pro-life statements. As shown in Table 13, 94.4% of the respondents agreed that the foetus has the right to live as it is a potential human being, 76.5% agreed that abortion can affect the future fertility of a woman, 68.3% agreed that a woman who is having an unwanted pregnancy should still give birth to the child because life is precious, and 66.8% agreed that abortion is like taking a life as life begins at conception. A little more than a third of the respondents did not agree with abortion under any circumstance as it goes against their personal religious beliefs. These findings show the importance of religion in influencing students' attitudes toward abortion.

As mentioned earlier, a composite index on pro-choice was obtained by summing up the responses to the first 12 items, and a composite on pro-life was obtained by summing the remaining seven items listed in Tables 13-18. The mean score indicates that MMMC students were relatively more pro-choice but less pro-life than those from UM and UNIMAS. Table 14

Table 13: Percentage of Respondents by their Attitudes towards Abortion

Statement on Abortion	Strongly agree	Agree	Neutral	Disagree	Strongly disagree	Mean
Abortion should be legalized on demand as a woman's reproductive right to decide	8.3	18.1	22.2	25.4	26.0	2.6
Abortion services should be easily accessible	5.4	15.4	21.4	32.2	25.6	2.4
Abortion services should be easily affordable	5.6	16.1	29.3	26.1	22.9	2.6
Information on abortion should be made available to the public	34.7	32.4	18.9	7.0	6.9	3.8
Abortion services should be made available to the public	10.9	20.2	27.5	25.5	15.9	2.8
Abortion should be carried out if the pregnancy will result in the birth of a child with physical defects	17.3	28.2	28.0	19.1	7.4	3.3
Abortion should be carried out if the pregnancy will result in the birth of a child with mental defects	15.7	22.9	30.9	21.6	8.9	3.1
A woman should have abortion if she thinks that the birth of the child will jeopardize her future	4.4	7.6	19.1	35.1	33.8	2.1
Women should be given the right to decide for themselves whether or not to carry on with the pregnancy	8.4	24.9	27.6	19.8	19.3	2.8
It is ok to abort because a foetus is not a life until it is born	3.2	4.8	12.3	25.7	54.1	1.8
Abortion should be made legal for women who become pregnant as a result of rape or incest	26.9	28.9	26.1	10.9	7.2	3.6
Abortion should be made legal for economic/ social reasons	3.3	7.5	23.6	31.7	33.9	2.1
A woman who is having an unwanted pregnancy should still give birth to the child because life is precious	36.2	32.1	23.0	5.8	2.8	3.9
Abortion is like taking a life as life begins at conception	31.7	35.7	22.8	6.9	2.9	3.9
Foetus has the right to live as it is a potential human being	45.2	39.2	13.2	1.2	1.2	4.3
Abortion can affect the future fertility of a woman	27.8	48.7	17.3	4.2	2.0	4.0
Abortion providers are sinful	13.7	15.8	42.2	19.0	9.2	3.1
Women who have abortion are sinful	10.8	15.8	42.2	19.8	11.4	2.9
Having or performing abortions under any circumstances, goes against my personal religious beliefs	15.7	19.8	33.8	21.3	9.4	3.1

Table 14: Percentage of Respondents Agreeing with Statements on Abortion by University

Statement	UM	UNIMAS	MMMC	Total
Pro-choice (Mean score based on composite index)	*32.4*	*31.4*	*35.1*	*33.1*
Abortion should be legalized on demand as a woman's reproductive right to decide	27.3	21.1	28.7	26.3
Abortion services should be easily accessible	22.1	15.0	23.1	20.8
Abortion services should be easily affordable	20.7	15.8	26.8	21.6
Information on abortion should be made available to the public	61.8	67.2	72.4	66.6
Abortion services should be made available to the public	32.3	21.1	35.5	30.8
Abortion should be carried out if the pregnancy will result in the birth of a child with physical defects	36.7	48.6	53.8	45.2
Abortion should be carried out if the pregnancy will result in the birth of a child with mental defects	35.2	38.5	42.8	38.5
A woman should have abortion if she thinks that the birth of the child will jeopardize her future	11.1	7.3	16.3	12.0
Women should be given the right to decide for themselves whether or not to carry on with the pregnancy	29.5	30.4	40.0	33.2
It is ok to abort because a foetus is not a life until it is born	9.0	6.1	7.6	7.8
Abortion should be made legal for women who become pregnant as a result of rape or incest	46.3	49.0	71.8	55.5
Abortion should be made legal for economic/social reasons	9.2	7.7	14.9	10.8
Pro-life (Mean score based on composite index)	*25.5*	*26.5*	*23.6*	*25.1*
A woman who is having an unwanted pregnancy should still give birth to the child because life is precious	71.0	74.1	60.0	68.0
Abortion is like taking a life as life begins at conception	65.5	72.1	65.4	67.0
Foetus has the right to live as it is a potential human being	83.4	87.4	82.5	84.1
Abortion can affect the future fertility of a woman	77.5	82.6	69.6	76.0
Abortion providers are sinful	32.1	38.9	18.9	29.2
Women who have abortion are sinful	29.5	36.0	16.1	26.5
Having or performing abortions under any circumstances, goes against my personal religious beliefs	36.2	42.9	29.0	35.4

shows that a higher proportion of MMMC students than those from the two public universities agreed with all the pro-choice statements. Conversely, a lower proportion of MMMC students than UM and UNIMAS students agreed with all the 7 pro-life statements. The comparison between UM and UNIMAS students' attitudes toward abortion is not consistent – UM students were more likely than UNIMAS students to agree on some statements but the reverse is true for other statements. The highest proportion agreeing with each of the 7 pro-life statements, however, was among the UNIMAS students (Table 14). By and large, students were rather consistent in their responses. Groups that were more pro-choice tend to be less pro-life.

Table 15 shows that senior students were more pro-choice than their juniors, with a mean score ranging from 31.1 among Year 1 students to 32.7 among Year 3 students and 34.4 among Year 5 students. The final year students have the highest proportions agreeing to 10 out of 12 pro-choice statements. Year 1 students have the lowest proportions agreeing with nine of the pro-choice statements. The widest differential by student year group in the attitudes toward abortion is on whether abortion should be made legal for women who become pregnant as a result of rape or incest – only 36.2% of Year 1 students agreed with this compared to around 62% of Year 3 and 5 students.

Clearly, Year 1 students were more pro-life compared to their seniors, with a mean score of 27.0 compared to 25.2 for Year 3 students and 23.9 for Year 5 students. For example, Year 1 students were much more likely than their seniors to hold the view that abortion providers are sinful, women who have abortion are sinful, and having or performing abortion under any circumstances goes against their personal religious beliefs (Table 15).

Abortion directly affects women, and pro-choice feminism views the right to an abortion as integral to a women's right to sovereignty. However, our findings show that female students were less likely to be pro-choice compared to the male students (mean score 32.2 versus 34.5). Table 16 shows that the proportion agreeing with all the 12 pro-choice statements is lower among female compared to male students. Contrary to expectation, female students were less likely than male students to agree to legalizing abortion on demand as a woman's reproductive right to decide; allowing abortion if the birth of the child will jeopardize her future, making it legal for women who become pregnant as a result of rape or incest and that women should be given the right to decide for themselves whether or not to carry on with the pregnancy.

Consistent with being less pro-choice, female students tended to be a little more pro-life than their male counterparts (mean score 25.6 versus 24.2). That is, female students were more likely than the male students to agree on all seven pro-life statements (Table 16).

The multi-ethnic composition of Malaysia provides an interesting setting to study the attitudes of various socio-cultural and religious groups living in one country. Table 17 shows pronounced ethnic differentials on attitudes toward abortion. The Malays who adhere to Islamic teaching, were the least pro-choice and most pro-life. Table 17 shows that the pro-choice score is much lower for the Malays (28.7) than those of Chinese (37.0) and Indians (38.0). All those categorized under "Others', the majority of whom are Christians, were also less pro-choice.

On the other hand, Malays and "Others" were more likely to be pro-life, with a mean score of 26.8 and 25.8, respectively, compared to 23.9 for the Chinese and 22.2 for the Indians. A very high proportion of Malay and "Others" students held the view that the foetus has the right to live as it is a potential human being; and that a woman who is having an unwanted pregnancy should still give birth to the child because life is precious (Table 17).

Table 15: Percentage of Respondents Agreeing with Statements on Abortion by Year of Study

Statement	Year 1	Year 3	Year 5
Pro-choice (Mean score based on composite index)	*31.1*	*32.7*	*34.4*
Abortion should be legalized on demand as a woman's reproductive right to decide	23.5	23.6	30.0
Abortion services should be easily accessible	14.6	20.9	24.3
Abortion services should be easily affordable	15.7	19.7	26.5
Information on abortion should be made available to the public	57.1	64.8	73.5
Abortion services should be made available to the public	29.9	28.7	32.8
Abortion should be carried out if the pregnancy will result in the birth of a child with physical defects	42.9	41.8	49.0
Abortion should be carried out if the pregnancy will result in the birth of a child with mental defects	39.2	38.2	38.3
A woman should have an abortion if she thinks that the birth of the child will jeopardize her future	6.7	12.2	14.9
Women should be given the right to decide for themselves whether or not to carry on with the pregnancy	26.1	32.2	38.1
It is ok to abort because a foetus is not a life until it is born	7.5	8.4	7.7
Abortion should be made legal for women who become pregnant as a result of rape or incest	36.2	61.8	62.1
Abortion should be made legal for economic/social reasons	9.3	11.6	10.9
Pro-life (Mean score)	*27.0*	*25.2*	*23.9*
A woman who is having an unwanted pregnancy should still give birth to the child because life is precious	77.2	71.6	60.0
Abortion is like taking a life as life begins at conception	73.5	66.6	63.5
Foetus has the right to live as it is a potential human being	88.4	83.0	82.3
Abortion can affect the future fertility of a woman	74.3	78.8	75.1
Abortion providers are sinful	41.4	31.0	20.8
Women who have abortion are sinful	37.7	28.7	18.4
Having or performing abortions under any circumstances, goes against my personal religious beliefs	49.3	36.7	26.3

Table 16: Percentage of Respondents Agreeing with Statements on Abortion by Gender

Statement	Male	Female
Pro-choice (Mean score based on composite index)	*34.5*	*32.2*
Abortion should be legalized on demand as a woman's reproductive right to decide	31.9	23.2
Abortion services should be easily accessible	27.7	16.9
Abortion services should be easily affordable	29.6	17.2
Information on abortion should be made available to the public	71.8	63.7
Abortion services should be made available to the public	34.0	28.9
Abortion should be carried out if the pregnancy will result in the birth of a child with physical defects	47.5	43.9
Abortion should be carried out if the pregnancy will result in the birth of a child with mental defects	42.0	36.6
A woman should have an abortion if she thinks that the birth of the child will jeopardize her future	14.8	10.4
Women should be given the right to decide for themselves whether or not to carry on with the pregnancy	35.6	31.9
It is ok to abort because a foetus is not a life until it is born	11.1	6.0
Abortion should be made legal for women who become pregnant as a result of rape or incest	61.7	52.0
Abortion should be made legal for economic/social reasons	13.7	9.1
Pro-life (Mean score based on composite index)	*24.2*	*25.6*
A woman who is having an unwanted pregnancy should still give birth to the child because life is precious	66.0	69.2
Abortion is like taking a life as life begins at conception	60.7	70.5
Foetus has the right to live as it is a potential human being	78.9	86.9
Abortion can affect the future fertility of a woman	74.1	77.1
Abortion providers are sinful	25.1	31.6
Women who have abortion are sinful	20.3	30.0
Having or performing abortions under any circumstances goes against my personal religious beliefs	28.5	39.2

Table 17: Percentage of Respondents Agreeing with Statements on Abortion by Ethnicity

Statement	Malays	Chinese	Indians	Others
Pro-choice (Mean score based on composite index)	*28.7*	*37.0*	*38.0*	*31.3*
Abortion should be legalized on demand as a woman's reproductive right to decide	11.4	41.5	41.4	16.2
Abortion services should be easily accessible	12.5	29.4	29.3	10.8
Abortion services should be easily affordable	13.9	27.6	31.6	27.0
Information on abortion should be made available to the public	58.4	75.8	71.4	64.9
Abortion services should be made available to the public	31.3	29.4	36.1	18.9
Abortion should be carried out if the pregnancy will result in the birth of a child with physical defects	31.1	58.0	62.4	40.5
Abortion should be carried out if the pregnancy will result in the birth of a child with mental defects	20.9	54.1	60.9	32.4
A woman should have abortion if she thinks that the birth of the child will jeopardize her future	8.4	14.4	20.3	5.4
Women should be given the right to decide for themselves whether or not to carry on with the pregnancy	15.1	50.0	53.4	29.7
It is ok to abort because a foetus is not a life until it is born	5.6	9.5	11.3	8.1
Abortion should be made legal for women who become pregnant as a result of rape or incest	35.5	73.2	81.2	48.6
Abortion should be made legal for economic/social reasons	5.8	14.4	19.5	8.1
Pro-life (Mean score based on composite index)	*26.8*	*23.9*	*22.2*	*25.8*
A woman who is having an unwanted pregnancy should still give birth to the child because life is precious	83.3	56.2	42.9	75.7
Abortion is like taking a life as life begins at conception	71.1	63.7	59.4	73.0
Foetus has the right to live as it is a potential human being	90.8	78.4	72.9	91.9
Abortion can affect the future fertility of a woman	73.3	82.0	68.4	78.4
Abortion providers are sinful	42.6	18.0	14.3	18.9
Women who have abortion are sinful	39.2	16.2	10.5	18.9
Having or performing abortions under any circumstances goes against my personal religious beliefs	42.8	29.4	21.8	45.9

Table 18: Percentage of Respondents Agreeing with Statements on Abortion by Place of Origin

Statement	Town	Village
Pro-choice (Mean score based on composite index)	*33.9*	*30.8*
Abortion should be legalized on demand as a woman's reproductive right to decide	28.4	20.8
Abortion services should be easily accessible	21.9	17.4
Abortion services should be easily affordable	23.2	17.0
Information on abortion should be made available to the public	68.4	61.5
Abortion services should be made available to the public	32.5	26.4
Abortion should be carried out if the pregnancy will result in the birth of a child with physical defects	48.4	36.5
Abortion should be carried out if the pregnancy will result in the birth of a child with mental defects	42.6	27.8
A woman should have an abortion if she thinks that the birth of the child will jeopardize her future	12.1	11.8
Women should be given the right to decide for themselves whether or not to carry on with the pregnancy	36.6	24.3
It is ok to abort because a foetus is not a life until it is born	6.8	10.8
Abortion should be made legal for women who become pregnant as a result of rape or incest	59.0	46.2
Abortion should be made legal for economic/social reasons	11.4	9.0
Pro-life (Mean score based on composite index)	*24.7*	*26.2*
A woman who is having an unwanted pregnancy should still give birth to the child because life is precious	66.8	71.2
Abortion is like taking a life as life begins at conception	68.1	63.9
Foetus has the right to live as it is a potential human being	83.2	86.1
Abortion can affect the future fertility of a woman	75.7	76.7
Abortion providers are sinful	25.2	39.6
Women who have abortion are sinful	23.6	34.0
Having or performing abortions under any circumstances goes against my personal religious beliefs	31.8	44.8

Place of origin also plays a part in one's attitudes towards a host of issues, including abortion. Table 18 shows that those who come from urban areas were more pro-choice than those from rural areas (mean score of 33.9 versus 30.8), but the reverse is true for pro-life (24.7 versus 26.2).

Students from urban areas were more likely than those from rural areas to agree on 11 out of the 12 pro-choice statements but were less likely to agree with the pro-life statements. Students from urban areas were also much more likely than their rural counterparts to agree that abortion should be carried out if the pregnancy will result in the birth of a child with

mental defects. Compared to students from urban areas, those with rural backgrounds were much more likely to view abortion providers and women who have abortions as being sinful, and that it is against their personal religious beliefs to perform an abortion under any circumstances (Table 18).

Attitudes toward Sexuality

Besides eliciting information on students' attitudes toward abortion, the survey also collected information on their attitudes toward sexuality in general, including their opinions on pre-marital sex, censoring of pornographic materials on the Internet, introduction of sex education and contraceptive information in primary and secondary schools.

The survey shows that 22.1% of students disapproved of pre-marital sex, and about two-thirds wanted the government to censor pornographic materials from the internet. The majority opined that sex education should be introduced and contraceptive information provided in secondary schools. However, only 44.9% of the students felt that sex education should be introduced in primary, and 36.1% felt that contraceptive information should be provided in primary schools.

There is little variation in the attitudes toward pre-marital sex among students from the three universities. However, wide differentials in the attitudes toward pre-marital sex can be observed by year of study, gender, ethnicity and place of origin. The ethnic variable provides the sharpest differentials on this aspect – only 2.8% of Malay student approved of pre-marital sex compared to about 40% of Chinese and Indians (see Table 19). Generally, those opposed to pre-marital sex were more likely to want government censorship of pornography on the internet. For instance, female students were less likely than male students to approve of pre-marital sex, and they were more likely to want the government to censor pornographic materials from the internet.

Students from the different universities also did not differ much in their attitudes toward sex education and providing contraceptive information in schools. Malay students and those from the rural areas, however, were less likely to approve of these.

Willingness to Provide Abortion Services in Future Practice and Attitudes toward Abortion Education

Willingness to provide abortion services in future practice

In Malaysia, the national family planning programme does not provide contraceptive services to unmarried persons. However, some private practitioners do provide such services. Contraceptive supplies, in particular condoms, are sold in supermarkets, medical shops, sundry shops such as 7-Eleven. In this survey, respondents were asked about their willingness to provide various kinds of contraceptive and abortion services in their future practice.

The survey findings show that 80.7% of the respondents stated that they will provide contraceptive information to unmarried persons, but only 64.1% will provide them contraceptive services. A high proportion (about 80%) will provide pre- and post-abortion counselling. Three-quarters will pursuade the client to keep the pregnancy, and about 46% to 55% will either make referrals, remain neutral or give written support to a request for an abortion. Less than 20% will provide medical or surgical abortion as part of their future practice (Table 20).

Table 19: Respondents' Attitudes toward Sexuality

University	Pre-marital sex	Censor pornographic materials	Sex education in primary school	Sex education in secondary school	Contraceptive information in primary school	Contraceptive information in secondary school
Total	22.1	67.9	44.9	93.3	36.1	88.9
University						
UM	21.7	66.7	46.1	93.8	39.9	86.8
UNIMAS	20.6	74.8	41.6	91.9	30.7	85.8
MMMC	23.6	64.6	45.8	93.7	35.0	93.7
Year of study						
Year 1	15.7	73.7	45.7	90.2	40.8	86.5
Year 3	22.8	67.0	34.3	93.3	25.8	88.0
Year 5	25.3	65.2	52.2	95.2	40.8	90.9
Gender						
Male	34.6	52.5	47.6	93.6	40.5	91.7
Female	15.0	76.6	43.5	93.2	33.7	87.3
Ethnicity						
Malays	2.8	86.6	26.6	87.4	21.1	79.4
Chinese	40.8	48.7	65.1	98.7	53.8	98.2
Indians	38.9	56.1	54.3	98.5	39.7	97.0
Others	27.0	56.8	52.9	100.0	44.1	91.9
Place of origin						
Urban	25.1	64.9	47.0	94.5	37.3	90.5
Rural	13.9	76.0	39.8	90.2	33.2	84.4

Table 20: Percentage of Respondents by their Willingness to Provide Contraceptive and Abortion Services in Future Practice

Statement on Service Provision	Yes	No	Uncertain	Total
Contraceptive information to unmarried persons	80.7	11.5	7.9	100.0
Contraceptive services to unmarried persons	64.1	24.0	11.9	100.0
Give pre-abortion counselling	80.8	11.0	8.2	100.0
Try to persuade the client to keep the pregnancy	76.7	4.8	18.5	100.0
Remain neutral, leaving the client to make her own decision	54.7	25.1	20.2	100.0
To give post-abortion counselling on future contraceptive use	80.2	7.1	12.7	100.0
To endorse or give written support to a request for an abortion provided, I am convinced that the client had been fully informed when she made her request	50.4	18.6	31.0	100.0
To make referrals for a woman who is seeking abortion services	45.8	24.6	29.6	100.0
To provide medical abortion as part of my practice	19.1	49.4	31.5	100.0
To provide surgical abortion as part of my practice	18.0	50.7	31.3	100.0

Table 21: Percentage of Respondents by their Willingness to Provide Various Contraceptive and Abortion Services in Future Practice

	Contraceptive information	Contraceptive services	Pre-abortion counselling	Post-abortion counselling on future contraceptive use	To make referrals	Provide medical abortion	Provide surgical abortion
Total	80.7	64.1	80.8	80.2	45.8	19.1	18.0
University							
UM	78.2	67.0	79.6	77.3	47.5	21.5	20.6
UNIMAS	80.6	57.1	75.5	74.8	39.2	7.7	8.9
MMMC	83.9	65.3	86.2	87.8	48.2	23.9	20.8
Year of study							
Year 1	73.0	51.7	71.9	63.8	39.6	16.1	15.0
Year 3	78.6	59.0	80.4	84.6	44.4	19.8	17.7
Year 5	86.7	75.0	86.4	86.7	50.3	20.4	20.0
Gender							
Male	85.7	70.9	83.3	81.4	54.2	24.5	22.4
Female	77.9	60.3	79.4	79.6	41.0	16.1	15.5
Ethnicity							
Malays	67.5	46.2	76.2	74.9	36.5	15.1	13.7
Chinese	95.1	84.4	87.0	88.0	56.9	24.9	23.3
Indians	88.0	72.9	83.2	80.8	51.9	20.3	20.5
Others	83.8	62.2	70.3	69.4	32.4	8.1	10.8
Place of origin							
Urban	83.6	67.6	82.3	81.8	47.2	19.9	18.4
Rural	72.9	54.4	76.7	76.0	41.6	17.0	17.0

Of the three universities in this survey, UNIMAS students were least likely to provide contraceptive and abortion services in their future practice, but they were just as willing as the rest to provide information and counselling on contraception and abortion. Students from MMMC were a little more likely than UM students to provide abortion counselling and medical abortion services in their future practice (Table 21).

By year group, senior students were more likely than their juniors to express their willingness to provide contraceptive and abortion services in their future practice. This is to be expected as the seniors are about to start their practice sooner. Table 21 further shows that male students were more likely than female students to provide contraceptive and abortion information, counselling and services in their future practice, especially in contraceptive services, making referrals for women who want an abortion, as well as medical and surgical abortion services.

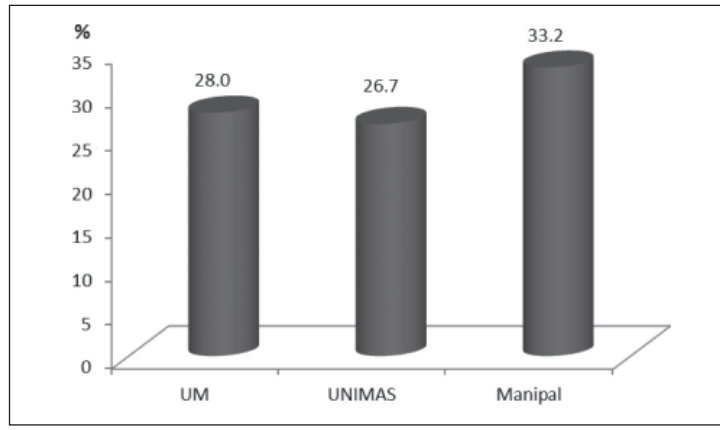
As mentioned above, Malay students in this sample tended to be more pro-life than pro-choice, and most of them did not approve of abortion under various circumstances. Hence, as expected, Malay students were least likely to provide to provide contraceptive and abortion services in their future practice. Students from rural areas were also less likely than those from the urban areas to provide such services. However, the urban-rural differential is not as pronounced as the ethnic differentials. Students' willingness to be involved in abortion provision

was related to their views on abortion, as found in a study in United Kingdom (Gleeson et al, 2008). Those who are pro-choice tended to be more likely to want to provide contraceptive and abortion services, and the reverse was true for those who are pro-life (Table 21).

Attitudes towards abortion education

The final section of the survey elicited information on students' attitudes toward abortion education, with the purpose of making some recommendations for curriculum review based on their feedback. Our survey findings show that a higher proportion of students in MMMC compared to the two public universities thought that the existing curriculum covers the topics on abortion adequately, as shown in Figure 8.

Figure 8: Percentage of Respondents by their opinion that the existing curriculum has dealt with topics on abortion adequately by University



Close to 90% of the students agreed that there should be more training in general knowledge and legal aspects of abortion, and pre- and post-abortion counselling. A lower proportion agreed with training on surgical abortion techniques and medical abortion while 21.7% and 17.3%, respectively, were neutral on the need for more training in each of these. Only a small number of students disagreed with having more training on the various types of abortion education, including surgical abortion techniques and medical abortion, in the medical curriculum (Table 22).

Table 22: Percentage of Respondents by their Opinion on Whether Medical Students should be given more Training on Various Aspects of Abortion

Aspects	Strongly agree	Agree	Neutral	Disagree	Strongly disagree	Total
General Knowledge on abortion	47.3	45.5	6.8	0.2	0.2	100.0
Surgical abortion techniques	32.2	43.9	21.4	1.8	0.7	100.0
Medical abortion	34.3	46.8	17.0	1.4	0.5	100.0
Legal aspects of abortion	48.2	40.7	9.1	1.2	0.9	100.0
Pre- and post-abortion counselling	44.3	42.5	11.4	1.1	0.7	100.0

Table 23: Percentage of Respondents Agreeing to the Inclusion of Various Types of Abortion Education in the Curriculum by Selected Variables

Variable	General knowledge	Surgical techniques	Medical abortion	Legal aspects	Pre-& post-abortion counselling
Total	*92.5*	*75.8*	*80.7*	*88.4*	*86.3*
University					
UM	89.3	77.7	80.6	84.9	84.1
UNIMAS	94.7	70.0	76.5	91.1	87.0
MMMC	94.9	77.2	83.7	91.0	88.7
Year of study					
Year 1	89.2	72.8	76.1	81.3	82.8
Year 3	93.1	72.5	80.6	90.7	86.3
Year 5	93.9	79.9	83.4	90.8	88.4
Gender					
Male	91.8	75.5	81.3	89.2	87.1
Female	92.8	75.9	80.3	88.0	85.9
Ethnicity					
Malay	90.8	74.3	78.9	87.8	83.5
Chinese	93.6	78.6	83.8	89.9	89.4
Indian	94.0	76.7	79.7	86.5	88.0
Other	97.3	62.2	75.7	86.5	86.5
Place of origin					
Town	93.0	76.5	82.3	89.1	88.2
Village	91.0	73.6	76.0	86.5	81.6
Pro-choice score					
Below 29	91.5	68.9	73.0	88.7	81.8
29-36	93.0	74.2	81.7	88.7	88.4
37+	93.4	83.0	86.5	88.5	89.1
Pro-life score					
Less than 23	90.1	75.7	80.5	86.0	85.3
23 to 27	93.2	78.5	82.8	91.3	89.1
More than 27	93.9	72.5	79.2	89.0	85.0
Willingness to provide abortion service score					
Less than 6	90.5	64.7	68.3	84.9	77.0
6 to 9	92.6	76.2	82.6	88.1	88.1
10+	94.6	86.8	89.9	93.4	94.2

The survey shows that a high proportion of students from all the three universities (between 84% and 95%) wanted more training on the general knowledge of abortion, the legal aspects of abortion and pre- and post-abortion counselling. However, a lower proportion of UNIMAS students compared to those from UM and MMMC wanted more training on surgical abortion techniques and medical abortion (Table 23).

Male and female students did not differ significantly in their opinion on any type of abortion education. However, year of study was significantly associated with students' attitudes toward more training on surgical and medical abortion and the legal aspects of abortion. Year 5 students were much more likely than their juniors, especially Year 1 students, to want more training on abortion education. The differential can be explained by the fact that senior students have better knowledge on and exposure to various aspects, including the curriculum, compared to their juniors.

There was no significant ethnic differential in attitudes toward more training in general knowledge, surgical and medical abortion and the legal aspect. However, Chinese and Indian students were more likely than Malays to want more training on pre- and post-abortion counselling. Students from urban areas were also more likely than those from rural areas to want more training in abortion.

Pro-choice students were much more likely than those less pro-choice to want more training on surgical and medical abortion, and pre-and post-abortion counselling. However, students who are more pro-life were a little less likely to want more training on surgical abortion techniques compared to those who are less pro-life, but they did not differ much on other aspects of abortion education.

As expected, the desire for abortion education was higher among students who are more likely to provide abortion service in future practice. Clearly, students who intend to provide abortion services need to be trained before starting their own practice.

Discussion and Conclusion

There is ample evidence that abortion is on the rise in Malaysia, yet safe abortion services are not readily available because doctors are not trained to provide such services. Moreover, many doctors are unaware of laws pertaining to abortion. Our survey found a sizeable proportion of medical students who are also unaware of abortion laws. As future doctors, medical students may have attitudes toward abortion that will affect the provision of safe abortion, yet little is known about their attitudes to abortion. A number of studies on students' attitudes to abortion have been conducted in the West. To our knowledge, there has been no such study in Malaysia.

Pace et al. (2008) argued that that early clinical experiences with abortion and family planning can impact medical students' knowledge, attitudes and intentions to provide abortions and ability to counsel patients, thereby, potentially improving women's access to comprehensive reproductive health care in the future. They also suggested that improving medical students' training in abortion could help abate this public health crisis. Shotorbani et al. (2004) concluded that although it may not be possible to require abortion training for every future health care provider, making abortion a standard part of clinical training would provide opportunities for future physicians and advanced clinical practitioners, and would likely ameliorate the abortion provider shortage.

Medical students in Malaysia have some knowledge of reproductive health and abortion, but there is still a gap in knowledge on certain aspects due to the lack of attention on abortion education in medical schools. It is important to note that a very high proportion (between 40 and 60 percent) are unaware of the various risks and complications caused by abortion, and an even higher proportion have no knowledge of the preferred methods for first and second trimester abortion.

Our survey found that medical students are both pro-choice and pro-life. Generally, students would approve of abortions that are allowed under the law, i.e., to save the life of the mother and to preserve her physical/mental health. However, students' attitudes toward abortion for other reasons tend to vary widely across different sub-groups. There is a need to have a more in-depth analysis on the perception of normative beliefs among peers and society which would have an impact on attitudes towards abortion. For instance, a cross-country study in Norway and Northern Ireland showed significant differences in students' attitudes to abortion, reflecting differences in religious, legal and educational experiences (Steele, 2009).

This survey found that the majority of students are in favour of more training on various aspects of abortion, and eight out of ten express an intention to provide some form of abortion services in their future practice. Hence, there is a need to equip medical students with skills and knowledge to meet the increasing demand for safe abortion. The need to integrate appropriate training in abortion, including legal and ethical aspects, pre- and post-abortion counselling, abortion technology and safe abortion care into the existing curriculum of all medical schools and health care providers' training in Malaysia was unanimously endorsed by participants of a national seminar held to discuss the findings from this survey and two other related surveys. Abortion education may be incorporated along with family planning into the existing reproductive health module to circumvent any opposition that may arise. Curriculum reform to improve abortion education would result in improved reproductive health care for women, and enable them to exercise their reproductive rights (Tey et al., 2012b).

WHAT YOU CAN DO TO ADDRESS THE ISSUES AND MISCONCEPTIONS:

HEALTH PROFESSIONALS

- Take more time as a doctor, nurse, midwife or family planning worker to accurately inform and educate women on the need for contraception and on the various methods, especially if they have previously had an unwanted pregnancy or an abortion.
- Provide legal, compassionate, non-judgemental and affordable quality abortion services to women of low income on a sliding scale according to their financial circumstances. Refer women to others if you do not provide the service.
- Respect the law and women's and young peoples' needs and rights, setting aside your own personal beliefs and religious views if they differ from your clients, thus, acting professionally and ethically.

NGOS, COMMUNITY LEADERS AND POLITICIANS

- Advocate for all women's right to access quality, affordable reproductive health services, including contraception and legal abortion.
- Advocate for the evaluation and improvement of contraceptive services in order to increase contraceptive use and meet women's unmet needs for contraception.
- Know and publicise which government hospitals and private clinics offer quality, affordable and women-centred contraceptive services and legal abortion services.

EVERYONE

- Demand that the government be held accountable to implement international commitments which greatly affect women's health.
- Allow women themselves to be the main decision maker about whether or not an unwanted pregnancy is injurious to their physical and mental health, if they need contraception or an abortion and what methods they prefer.
- Be open to listening to women's feelings, circumstances and health concerns about contraception and unwanted pregnancies and be supportive.
- Listen respectfully to young people and be understanding and supportive of their sexual and reproductive health needs and decisions.
- Be courageous and speak out on these reproductive health and rights issues in your NGO, hospital, clinic, family and in the media.
- Lobby policy makers and the public for the implementation of sexuality education in schools.

REFERENCES

Aiyer AN, Ruiz G, Steinman A & Ho GY. Influence of physician attitudes on willingness to perform abortion. Obstetrics & Gynecology. 1999; 93(4): 576–80.

Becker D, Garcia SG & Larsen U. Knowledge and opinions about abortion law among Mexican youth. International Family Planning Perspectives. 2002; 28(4): 205–23.

Black G, Hunter A & Heasley N. A survey of attitudes to abortion law in Northern Ireland amongst obstetricians, gynecologists and family planning doctors. Journal of Family Planning and Reproductive Health Care. 2001; 27(4): 221–2.

Buga GA. Attitudes of medical students to induced abortion. East African Medical Journal. May 2002; 79(5): 259–62.

Cessford TA & Norman W. Making a case for abortion curriculum reform: A knowledge-assessment survey of undergraduate medical students. Journal of Obstetrics and Gynaecology Canada. January 2011; 33(1): 38–45.

Espey E, Ogburn T & Dorman F. Student attitudes about a clinical experience in abortion care during the obstetrics and gynecology clerkship. Academic Medicine. 2004; 79(1): 96–100.

Espey E, Ogburn T, Chavez A, Qualls C & Leyba M. Abortion education in medical schools: a national survey. American Journal of Obstetrics & Gynecology. 2005; 192(2): 640–3.

Espey E, Ogburn T, Leeman L, Nguyen T & Gill G. Abortion education in the medical curriculum: a survey of student attitudes. Contraception. 2008; 77(3): 205–8.

Francom C & Freeman E. British General practitioners attitudes towards abortion. Family Planning Perspectives. 2000; 32(4): 189–91.

Gleeson R, Forde E, Bates E, Powell S, Eadon-Jones E & Draper H. Medical students' attitudes towards abortion: a UK study. Journal of Medical Ethics. 2008; 34(11): 783–7.

Malaysia. 2006. The Commissioner of Law Revision, Malaysia. Laws of Malaysia – Act 574 Penal Code.

Morroni C, Myer L & Tibazarwa K. Knowledge of the abortion legislation among South African women: a cross-sectional study. Reproductive Health. 2006; 3: 7.

NPFDB (National Population and Family Development Board). Ministry of Women, Family and Community Development. Report of the National Study on Reproductive Health and Sexuality 1994/1995. Kuala Lumpur: National Population and Family Development Board; 1998.

Pace L, Sandahl Y, Backus L, Silveira M & Steinauer J. Medical students for choice's reproductive health externships: impact on medical students' knowledge, attitudes and intention to provide abortions. Contraception. 2008 Jul; 78(1): 31–5.

Poey CS. Opinion: Stay committed to help women. The Star. 8 July 2010. N43.

Radhakrishnan, S. The Legal Dimensions. Paper presented at the Seminar on 'Reproductive Health, Reproductive Rights and Miscarriages: Problems and Solutions', July 3rd 2007, Hospital Tua´anku Jaafar, Seremban, Negri Sembilan, Malaysia.

RRAAM (Reproductive Rights Advocacy Alliance of Malaysia) (Undated). Speaking out on Malaysian women's access to contraception and abortion services.

RRAAM (Reproductive Rights Advocacy Alliance Malaysia). Survey Findings of Knowledge and Attitudes of Doctors and Nurses on Abortion by the Reproductive Rights Advocacy Alliance Malaysia. (2007). http://www.rraam.org/about.html. Accessed on 31 July 2011.

Rosenblatt RA, Robinson KB, Larson EH & Dobie SA. Medical students' attitudes toward abortion and other reproductive health services. Family Medicine. 1999 Mar; 31(3): 195–9.

Russo J. When is the Age of Viability for a Fetus?. http://voices.yahoo.com/when-age-viability-fetus-7678400.html?cat=52. Accessed on 16 November 2011.

Sedgh G, Singh S, Henshaw SK & Bankole A. Legal abortion worldwide in 2008: levels and recent trends. International Perspectives on Sexual and Reproductive Health. 2011 Jun; 37(2): 84–94.

Sedgh G, Henshaw SK, Bankole A, Shah IH & Ahman MA. Induced abortion: incidence and trends worldwide from 1995 to 2008. The Lancet. 2012; 379(9816): 625–32.

Shotorbani S, Zimmerman FJ, Bell JF, Ward D & Assefi N. Attitudes and intentions of future health care providers toward abortion provision. Perspectives on Sexual and Reproductive Health. Mar-Apr 2004; 36(2): 58–63.

Singh S, Wulf D, Hussain R, Bankole A & Sedgh G. Abortion Worldwide: A Decade of Uneven Progress. New York: Guttmacher Institute, 2009.

Siti Fathilah K. Urban Malaysian women's experiences of abortion: Some implications for policy. Kajian Malaysia (Journal of Malaysian Studies). 1998; XVI (2): 53–77.

Snow S. What Abortion Methods Are Used in the First Trimester of Pregnancy? (2009). http://ezinearticles.com/?What-Abortion-Methods-Are-Used-in-the-First-Trimester-of-Pregnancy?&id=1892953. Accessed on 1 December 2011.

Society of Family Planning. Clinical Guidelines for Labor induction abortion in the second trimester. SFP Guideline 2011.

Steele R. Medical students' attitude to abortion: a comparison between Queen's University Belfast and the University of Oslo. Journal of Medical Ethics. 2009; 35(6): 390–4.

Tey NP, Ng ST & Yew SY. Proximate determinants of fertility in peninsular Malaysia. Asia-Pacific Journal of Public Health. 2012a; 24(3): 489–99.

Tey NP, Yew SY, Low WY, Su'ut L, Renjhen P, et al. Medical Students' Attitudes toward Abortion Education: Malaysian Perspective. PLoS ONE. 2012b; 7(12): e52116. doi:10.1371/journal.pone.0052116

Ventura MJ. Ethics on the job: Where nurses stand on abortion? Registered Nurse Journal. 1999; 62(3): 44–7.

Weiss P & Zverina J. Factors affecting the attitudes of the Czech population towards induced abortion. Ceska Gynekologie / Ceska Lekarska Spolecnost J. Ev. Purkyne. Oct 1998; 63(5): 411–3.

World Health Organization (WHO). Unsafe abortion: global and regional estimates of the incidence of unsafe abortion and associated mortality in 2008. Geneva: World Health Organization, 2011.

APPENDICES

Appendix A – Questionnaire

Knowledge and Perception of Medical Students on Abortion

	Section A: Socio-Demographic Background
1.	**University** ☐ University of Malaya ☐ UNIMAS ☐ Manipal Medical College ☐ IMU **Year of study** ☐ Year 1 ☐ Year 3 ☐ Year 5
2.	**Gender:** ☐ Male ☐ Female
3.	**Race:** ☐ Malay ☐ Chinese ☐ Indian ☐ Others: _____
4.	**Religion:** ☐ Muslim ☐ Christian ☐ Buddhist ☐ Hindu ☐ Others: _____
5.	**How important is religion in your daily life?** ☐ Very important ☐ Important ☐ Not important ☐ Not important at all
6.	**Did you grow up in a town/city or kampung?** ☐ Town/city ☐ Kampung
7.	**How many brothers and sisters do you have, NOT including yourself?** _____
8.	**What field of specialization would you pursue in the future?** _____

Section B: Knowledge of Abortion

9. Please tick (✓) "True" or "False" as it applies to the following statements on abortion. If you are unsure with the answer, please (✓) tick Unsure.

No	Statement	True	False	Unsure
a.	Legally restricting abortion reduces the number of abortions.			
b.	The vast majority of women are likely to have at least one abortion by the time they are 45 years old.			
c.	Abortion is a safe medical procedure when performed with proper equipment.			
d.	Abortion is a safe medical procedure when performed with correct technique.			
e.	Abortion is a safe medical procedure when performed with sanitary standards.			
f.	Where effective contraceptive methods are available and widely used, the total abortion rate decreases.			
g.	If all contraceptive users were to use methods correctly all the time, there would not be any unintended or unwanted pregnancies.			
h.	The proportion of women of reproductive age who are using modern contraceptive methods in Malaysia is less than 40%.			

10. Menstrual regulation is a treatment for *(Please tick (✓) all that apply)*

☐ Heavy menstrual bleeding of unknown cause.

☐ To regulate irregular menstrual cycles.

☐ Early surgical evacuation of the uterine cavity when pregnancy is not confirmed.

11. What is the gestation period beyond which menstrual regulation should not be performed?

☐ 1st -trimester ☐ 2nd -trimester ☐ 3rd -trimester

12. Abortion is defined as terminating a pregnancy before the foetus is viable; viability of a foetus is taken as when the pregnancy is

☐ 12 weeks ☐ 16 weeks ☐ 22 weeks ☐ 28 weeks

☐ Others, please specify: _____

13. The preferred methods for first trimester abortion are *(Please tick (✓) all that apply)*:

☐ Dilatation and curettage
☐ Vacuum aspiration
☐ Dilatation and evacuation
☐ Mifepristone and misoprostol
☐ Mifepristone and methotrexate

14. The preferred methods for second trimester abortion are *(Please tick (✓) all that apply)*:

☐ Dilatation and curettage
☐ Vacuum aspiration
☐ Dilatation and evacuation
☐ Mifepristone and repeated doses of misoprostol
☐ Vaginal prostaglandins (repeated doses)

15. What are the risks of the following complications caused by 1st-trimester induced abortion performed in a sterile setting? *(Please tick (✓) all that apply)*

☐ Pelvic infection
☐ Infertility
☐ Uterine perforation
☐ Post-operative bleeding needing hospitalization
☐ None of the above

16. Under Syariah laws (Fatwa) issued by the National Fatwa Committee, is abortion permissible under certain conditions?

☐ Yes [please go to 16 (a) and (b)]
☐ No [please go to question

a) In terms of age of the foetus, it is permissible if *(Please tick (✓) all that apply)*

☐ the foetus is under 40 days
☐ the foetus is under 100 days
☐ the foetus is under 120 days

b) In terms of the reasons for wanting to abort, it is permissible *(Please tick (✓) all that apply)*

☐ if the foetus is found to be seriously abnormal.
☐ if the continuance of the pregnancy will endanger the woman's life.
☐ for socio-economic reasons.

17. Is abortion illegal under all circumstances in Malaysia?

☐ Yes ☐ No

18. Is abortion legal under the following circumstances in Malaysia?

No.	Conditions permissible under present laws.	Yes	No	Do not know
a.	If it is performed to save the woman's life.			
b.	If it is performed to preserve the woman's physical health.			
c.	If it is to performed preserve the woman's mental health.			
d.	If it is performed for socio-economic reasons (e.g. low family income, limited living space).			
e.	If it is performed due to serious foetal impairment.			
f.	If an unmarried woman became pregnant and wanted to terminate the pregnancy.			
g.	If the woman's pregnancy was the result of rape.			
h.	If the woman became pregnant due to contraceptive failure.			

Section C: Attitudes towards abortion and sexuality

19. Do you agree or disagree with the following statements?

	Statements	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
a.	Abortion should be legalized on demand as a woman's reproductive right to decide.					
b.	Abortion services should be easily accessible.					
c.	Abortion services should be easily affordable.					
d.	Information on abortion should be made available to the public.					
e.	Abortion services should be made available to the public.					
f.	Abortion should be carried out if the pregnancy will result in the birth of a child with physical defects.					
g.	Abortion should be carried out if the pregnancy will result in the birth of a child with mental defects.					

	Statements	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
h.	A woman should have abortion if she thinks that the birth of the child will jeopardize her future.					
i.	Women should be given the right to decide for themselves whether or not to carry on with the pregnancy.					
j.	It is ok to abort because a foetus is not a life until it is born.					
k.	A woman who is having an unwanted pregnancy should still give birth to the child because life is precious.					
l.	Abortion is like taking a life as life begins at conception.					
m.	Fetus has the right to live as it is a potential human being.					
n.	Abortion can affect the future fertility of a woman.					
o.	Abortion should be made legal for women who become pregnant as a result of rape or incest.					
p.	Abortion should be made legal for economic/social reasons.					
q.	Abortion providers are sinful.					
r.	Women who have abortion are sinful.					
s.	Having or performing abortions under any circumstances, goes against my personal religious beliefs.					

20. Do you approve of couples having pre-marital sex?

☐ Yes ☐ No

21. Do you think that the Government should censor pornographic materials from the internet?

☐ Yes ☐ No

22. Do you think sex education should be introduced

a) In primary schools? ☐ Yes ☐ No

b) In secondary schools? ☐ Yes ☐ No

23. Do you think contraceptive information should be provided

a) In primary schools? ☐ Yes ☐ No

b) In secondary schools? ☐ Yes ☐ No

Section D: Willingness to provide abortion services in future practice

24. Would you provide the following services in your future practice?

No	Services	Yes	No	Unsure
a.	Contraceptive information to unmarried persons.			
b.	Contraceptive services to unmarried persons.			
c.	Give pre-abortion counselling.			
d.	Try to persuade the client to keep the pregnancy.			
e.	Remain neutral, leaving the client to make her own decision.			
f.	To give post-abortion counselling on future contraceptive use.			
g.	To endorse or give written support to a request for an abortion provided, I am convinced that the client had been fully informed when she made her request.			
h.	To make referrals for a woman who is seeking abortion services.			
i.	To provide medical abortion as part of my practice.			
j.	To provide surgical abortion as part of my practice.			

Section E: MBBS Curriculum on abortion

25. Do you think the existing MBBS curriculum has dealt with the topics on abortion adequately?

☐ Yes ☐ No

26. Do you think medical students should be given more training in abortion in terms of:

No.	Statements	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
a.	General Knowledge on abortion.					
b.	Surgical abortion techniques.					
c.	Medical abortion.					
d.	Legal aspects of abortion.					
e.	Pre- and post-abortion counselling.					

Thank you very much for your cooperation.

For any enquiries regarding the information presented in this study,
please contact the principal investigator:

Associate Prof. Tey Nai Peng
Faculty of Economics and Administration
University of Malaya
50603 Kuala Lumpur
Malaysia
Tel: 603 7967 3667 Fax: 603 7967 3738
Email: teynp@um.edu.my

Study of Medical Doctors' Knowledge, Attitudes and Willingness to Provide Abortion Related Services as a Reproductive Right of Women

Mary Soo-Lee Huang, PhD
Ravindran Jegasothy, MBBS, FRCOG
Shiang-Cheng Lim, MSc

STUDY TEAM

1. Assoc. Prof. Dr. Mary Huang Soo Lee
Department of Nutrition and Dietetics, Faculty of Medicine and Health Sciences, University Putra Malaysia, Selangor, Malaysia.

2. Dato' Dr. Ravindran Jegasothy
Department of Obstetrics and Gynaecology, Kuala Lumpur General Hospital, Malaysia.

3. Ms Lim Shiang Cheng
Institute of Gerontology, Faculty of Human Ecology, University Putra Malaysia, Selangor, Malaysia.

ACKNOWLEDGEMENTS

This study would not have been possible without the guidance and support of several individuals/agencies who in one way or another contributed and extended their invaluable assistance in the preparation and completion of the work. The Study Team would like to express gratitude and acknowledge the following:

- Dr Corinne Capuano, WHO Representative in Malaysia, Brunei Darussalam and Singapore,
- Dr Harpal Singh, WHO Technical Officer, WHO Representative Office for Brunei Darussalam, Malaysia and Singapore,
- Ms Yeoh Yeok Kim, Executive Director, Federation of Reproductive Health Associations, Malaysia (FRHAM), Subang, Malaysia,
- UNFPA, who have kindly provided funding for the publication of this report,
- Dr. Choong Sim Poey, Klinik Rakyat, Penang, Malaysia,
- Dr. Wan Abu Bakar b. Yusof, Head of the Department of Obstetrics and Gynaecology, Hospital Sultanah Nur Zahirah, Kuala Terengganu, Malaysia,
- Dr. Ravichandran Jeganathan, Head of the Department of Obstetrics and Gynaecology, Hospital Sultanah Aminah, Johor Bahru, Malaysia,
- Dr. Mohd Rushdan b. Md Noor, Head of the Department of Obstetrics and Gynaecology, Hospital Sultanah Bahiyah, Alor Setar, Malaysia, and,
- Dr. Haris Njoo Suharjono, Head of the Department of Obstetrics and Gynaecology, Hospital Umum Sarawak, Kuching, Sarawak, East Malaysia.

LIST OF TABLES

INTRODUCTION

Background

Globally, unsafe abortion is one of the main causes of maternal deaths accounting for 13% of maternal deaths (WHO, 2011). The number of unsafe abortions has also increased from 19.7 million in 2003 to 21.6 million in 2008 with almost all occurring in developing countries. However, in Malaysia, there is no official published source of data on abortion despite the fact that Contraceptive Prevalence Rate (CPR) has remained low and Total Fertility Rate (TFR) has declined. Furthermore, access to abortion services is also unclear. The International Conference on Population and Development (ICPD) Third Country Report of Malaysia and the Millennium Development Goals (MDGs) Progress Report in 2010 both indicate an urgent need for evidence-based data on abortion, including access to safe abortion services, in order to understand the reasons for the low TFR in the midst of stagnated CPR and to further reduce maternal mortality in Malaysia (Ang, Huang & Lee, 2010; Government of Malaysia & UNDP, 2010).

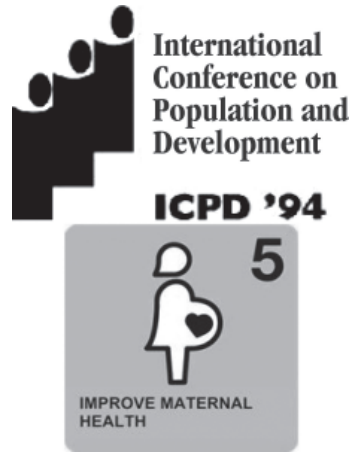
In view of the above, the study on "Medical Doctors' Knowledge, Attitude and Willingness to Provide Abortion Related Services as a Reproductive Right of Women" was initiated and supported by the World Health Organization (WHO). The study was carried out within a four month period from July to October 2011 at public hospitals in five zones, namely, Alor Setar General Hospital (GH) to represent the North zone, Johor Bahru GH representing the South, Kuala Lumpur GH the Central zone, Kuala Terengganu GH the East Coast zone and, finally, Kuching GH for East Malaysia. The study focused on the doctors' knowledge on abortion, including the techniques, complications and laws of abortion, their attitudes on sexuality and abortion, willingness to provide abortion related services and current training on abortion, in order to understand their perspectives and their need for capacity building. Through the study findings, it is hoped that the barriers/red tape that prevent women from accessing safe abortion services can be reduced, thus, enabling them to realize their reproductive rights, and indirectly contribute to the national efforts to reduce maternal mortality rate as well as to achieve Malaysia's commitment to the ICPD Plan of Action and the MDGs by 2015.

Fulfilling ICPD and MDGs' Commitments

Unsafe abortion and its consequences are regarded as a critical public health issue and attention to it has been called for in two important international documents; the ICPD Programme of Action (PoA) and the MDGs.

The ICPD PoA in 1994, urged "all governments and relevant intergovernmental and non-governmental organizations to strengthen their commitment to women's health, to deal with the health impact of unsafe abortion as a major public health concern and to reduce the recourse to abortion through expanded and improved family planning services" (para 8.25). It also further declared that "In circumstances in which abortion is not against the law, such abortion should be safe." The ICPD PoA called attention to women's needs on safe abortion and reiterated that access to abortion related services is part of women's reproductive rights. In 1999, the United Nations' five-year review of POA implementation strengthened this call to action by saying that "In circumstances where abortion is not against the law, health systems

should train and equip health-service providers and should take other measures to ensure that such abortion is safe and accessible."



On the other hand, although the MDGs adopted by 193 United Nations member states in September 2000 are generally viewed as the path to ending poverty by 2015, the UNFPA pointed out that the goals can only be achieved by promoting women's reproductive rights and protecting maternal and newborn health (United Nations Population Fund, 2000). Of the spectrum of action required for reducing maternal mortality and accessing reproductive health services, greater attention is required on access to the effective practice of family planning, the prevention of unintended pregnancies and unsafe abortions and the management of abortion complications. The latest policy articles by the Guttmacher Institute in June 2011 also recognises that unsafe abortion is the missing link in global efforts to improve maternal health and the key global players, including the United States, are urged to support safe abortion as part of efforts to combat maternal deaths and disability (The Guttmacher Institute).

Various technical documents related to safe abortion have been developed in order to support and increase the accessibility to safe abortion. These include: Safe abortion: technical and policy guidance for health systems (WHO 2012); Medical and Service Delivery Guidelines: for sexual and reproductive health services (International Planned Parenthood Federation, 2004); A Guide to Providing Abortion Care (Ipas, 2002); and Ethical Issues in Obstetrics and Gynecology (International Federation of Gynecology and Obstetrics (FIGO), 2009). FIGO's guidelines point out that women have the right to access legal, safe, effective, acceptable and affordable methods of contraception and safe abortion services.

UNSAFE ABORTION AROUND THE WORLD – OVERVIEW

Global and regional estimates of the incidence of unsafe abortion and associated mortality

Each year, an estimated 210 million women throughout the world become pregnant and about 75 million pregnancies end in stillbirths, or spontaneous or induced abortions (WHO, 2011). The likelihood of a woman to have an abortion was 29 per 1000 women (aged 15 – 44 years) in 2003 (Sedgh et. al, 2007). The estimated number of induced abortions in 2003 was 42

million, which works out as one in five pregnancies, 48% of which were unsafe (The Guttmacher Institute and WHO, 2007).

The World Health Organization defines unsafe abortion as a procedure for terminating an unintended pregnancy carried out either by persons lacking the necessary skills or in an environment that does not conform to minimal medical standards, or both (WHO, 1992). Between 1995 and 2003, the proportion of unsafe abortions increased from 44% to 47% despite the overall decrease in abortion rates (Sedgh et. al, 2007). Globally, over 80% of the unsafe abortions occur in developing countries. More than half (55%) of the abortion procedures carried out in developing countries are unsafe, in comparison to only 8% in developed countries.

Globally, the proportion of maternal deaths due to unsafe abortion remains at 13% in 2008, or 47,000 per year with most of the deaths taking place in developing countries (Sedgh et. al, 2007). Worldwide, the risk of death due to unsafe abortion is 30 per 100,000 live births whereas for developing countries, the risk is 40 per 100,000. In addition, abortion-related complications remain one of the main consequences of unsafe abortions. An estimated five million women are hospitalized worldwide each year for treatment of haemorrhage and sepsis related to unsafe abortion procedures. Furthermore, the costs of treating these medical complications constitute a significant financial burden on the public health care systems, especially in the developing world. A study in Africa and Latin America found that the cost of post-abortion services to the health care system ranged from USD159 million to USD476 million per year (Vlassoff et. al, 2009). Nevertheless, abortion-related deaths also cause about 220,000 children worldwide to lose their mothers every year (The Guttmacher Institute and WHO, 2007). Other important consequences of unsafe abortion are loss of productivity, stigma and long-term health problems, such as infertility.

Legal Context of Abortion and Barriers to accessing Safe Abortion Services

Globally, abortion is permitted in 98% of countries if it is conducted to save a woman's life (The Guttmacher Institute and WHO, 2007). However, it differs from one country to another for the other conditions under which abortion is legally permitted, such as to preserve physical or mental health, rape or incest, foetal impairment and economic or social reasons. Nevertheless, abortion upon request is only allowed in 28% of the countries.

The common belief is that the legalisation of abortion policies will increase the incidence of abortion. However, this is not the case according to a review by the Guttmacher Institute (The Guttmacher Institute, 2009). In fact, the relationship between abortion legality and abortion incidence is very small but there is a strong connection between abortion legality and abortion safety. According to WHO, the legal context of abortion plays an important role in shaping the path taken by a woman with an unplanned pregnancy (towards a safe or an unsafe abortion) (The Guttmacher Institute, 2009). Restrictive laws will not stop women from ending an unwanted pregnancy as most of these women are determined to seek an abortion regardless of its legal status. Indeed, it drives women to go underground for unregulated and unsafe abortions. Studies show that countries with abortion policies that are less restrictive and which permits the conduct of abortion on broad grounds are generally able to offer safe abortion services in comparison to countries with stricter legislations, where unsafe abortion is more prevalent (Cohen, 2009). The prevalence of unsafe abortions remains the highest in the 82 countries with the most restrictive legislations.

Apart from restrictive laws on abortion, women have also experienced other barriers in accessing safe abortion services. These barriers include personal barriers, such as lack of information and financial problems, structural barriers, such as lack of trained providers and health facilities, not forgetting social and cultural barriers.

Generally, women still have limited access to sexual and reproductive health information. According to UNFPA, 900 million young women over the world lack access to the information, opportunities or services that they need, including information on sexual and reproductive health (UNFPA, 2011). Most women are unaware of SRH information and services, including abortion, and they do not know about the circumstances under which abortion is legal in their country. Many women, especially those who are poor and cannot afford a safe abortion, resort to ending their unwanted pregnancy themselves or go for unsafe abortions (UNFPA, 2011).

On the other hand, there are also structural barriers like inadequately trained service providers and poor health infrastructures, including a lack of the latest and safer abortion technologies or procedures to provide quality safe abortion services. In many countries, the availability of and accessibility to safe abortion services are still limited even though the country's laws on abortion have become more liberalized. Furthermore, the judgmental attitude and lack of empathy among service providers can also discourage women from seeking safe abortion services.

Apart from that, the stigma on abortion that exists due to social and cultural beliefs is another challenge to accessing abortion services. For most women with unintended pregnancies, procuring an abortion service is kept a secret due to the fear of social condemnation. The social disapproval will cause unsafe abortion procedures to prevail.

OVERVIEW OF UNSAFE ABORTION IN MALAYSIA

Generally, the lack of data on and related to abortion in Malaysia increases the gaps in our understanding of the issue. Firstly, Malaysia does not have the most recent documented figure on the abortion rate because information on the incidence of abortion is not readily available in this country. Secondly, Malaysia has no documented data on complications related to induced abortion, which serves as one of the indicators on whether safe or unsafe abortions are more commonly practised in this country. Thirdly, the actual number of cases of surviving clients living with morbidity or negative health outcomes due to unsafe abortion is also not officially documented.

According to the WHO report on Health in Asia and Pacific, "38 out of every 1,000 women aged between 15 and 49 years old had undergone an abortion in Malaysia" (World Health Organization Regional Offices for South-East Asia and the Western Pacific, 2008). On the other hand, the Asia Safe Abortion Partnership's website reveal that the abortion rate in Malaysia is estimated to be approximately one in every five pregnancies after considering the low contraceptive prevalence of 48% for all methods (but only 32% for modern methods), and the low total fertility rate of 2.5 children (Asia Safe Abortion Partnership, 2008). In addition, the New Straits Times on 13 February 2011 reported that not only unmarried women seek abortion services but married women also, especially women aged 40 and above (New Straits Times, 2011). In fact, the National Population and Family Survey (2004) reported that the unmet need for family planning was highest among women forty years and above (National

Population and Family Development Board, 2004). It is therefore not surprising that a study of women who had been for an abortion revealed that these women tended to use abortion as a means of contraception (Kamaluddin, 2010).

In Malaysia, abortion is permitted under The Penal Code Amendment Act (Section 312, 1989) with certain conditions. It allows a registered medical practitioner to "terminate the pregnancy of a woman if such medical practitioner is of the opinion, formed in good faith, that the continuance of the pregnancy would involve risk to the life of the pregnant woman or injury to the mental and physical health of the pregnant woman greater than if the pregnancy were terminated" (The Commissioner of Law Revision Malaysia, 2006).

With regards to the provision on abortion under *Syariah* laws, the Department of Islamic Development Malaysia's website points out that abortion is *makruh* (not encouraged) for up to 40 days, *harus* (permissible) for up to 120 days if there is foetal impairment or is a threat to the woman's life and *haram* (forbidden) beyond 120 days except to save the life of the mother. This is in accordance with the *fatwa* (a ruling on a point of Islamic law given by a recognized authority) that was developed by the National *Fatwa* Council (*Muzakarah Jawatankuasa Fatwa Majlis Kebangsaan)* (Mohamad, 2010).

Although abortion is permitted under certain conditions in Malaysia, most people, including healthcare professionals are uninformed of the legal framework for abortion and have conservative opinions on this issue. In Kamaluddin's study (2008) of abortion clients, 41% of respondents did not know the legal conditions of abortion (Mohamad, 2010). In addition, a survey of 120 doctors and nurses found that only 57% correctly knew the law. Furthermore, 38% of them said that women who became pregnant from being raped should continue their pregnancy to term instead of having an abortion (Reproductive Rights Advocacy Alliance Malaysia (RRAAM), 2007). The judgmental attitudes and lack of empathy of health professionals for women who seek abortion services may also be one of the barriers for women to access safe abortion services (Dalvie et. al, 2010).

Although abortion services are available in both public and private healthcare facilities, there is no official guideline from the Ministry of Health and abortion services in private hospitals are also not monitored and regulated by any government authority (Dalvie *et. al,* 2010). As such, the quality and fees for abortion services may vary for different hospitals. The cost of abortion can be as high as USD800 depending on gestation, size, and ambulatory or in-patient treatment. On the other hand, training on termination of pregnancies for doctors or other healthcare providers is limited and dismal, and modern technologies, such as manual vacuum aspiration and medical abortions, are also not available. The current most common methods in Malaysia are surgical methods, such as dilation and evacuation (D&E), and manual vacuum aspiration (MVA). Uterine evacuation procedures are also provided in government hospitals as treatment for spontaneous and incomplete abortions.

Nonetheless, the views of medical practitioners on abortion and their needs for capacity building are unclear as most of them keep a very low profile and choose not to discuss it due to ignorance of the present law or a general reference to religious beliefs or the Hippocratic Oath. Healthcare service providers' knowledge, attitudes and willingness to provide abortion-related services remain missing gaps and need to be addressed if Malaysia wishes to strengthen her commitment to women's health, reduce the health impact of unsafe abortion and maternal mortality rate as well as achieve the ICPD's POA and the MDGs by 2015.

Objectives

The project "Study on Knowledge, Attitudes and Willingness of Doctors to Provide Abortion Related Services as a Reproductive Right of Women" objectives are to:

1. determine their knowledge on abortion, including:
   a) Abortion Law in Malaysia
   b) Medical and Surgical Abortions as well as safe and unsafe abortions
   c) Abortion-related complications,
2. determine respondents' attitude towards abortion,
3. determine the level of respondents' commitment towards the issue of abortion as a sexual right of women,
4. identify those factors associated with knowledge, attitude and commitment towards the issue of abortion and sexual rights, and to
5. provide some input into the training of medical doctors in the area of abortion and reproductive rights.

METHODOLOGY

The study was conducted using a structured questionnaire similar to the one used in the study on medical students conducted at Universiti Malaya, Universiti Malaysia Sarawak (UNIMAS) and Melaka Manipal Medical College (MMMC). The questionnaire is divided into five sections to gather information on the socio-demographic background of respondents, knowledge on abortion, attitudes towards abortion and sexuality, willingness to provide abortion-related services and their opinions on abortion in the medical curriculum.

A coordination meeting was initiated by the Federation of Reproductive Health Associations, Malaysia (FRHAM) on 28 January 2011. The meeting was attended by the researchers, representatives from FRHAM, Dr. Harpal Singh (WHO) and Dato' Dr. Ravindran Jegasothy (Senior Consultant and Head of the Department of O&G at Hospital Kuala Lumpur). At this meeting, the main public hospitals in five zones (Johor, Kedah, Kuala Lumpur, Terengganu and Sarawak) of the country were identified as the study locations. The five public hospitals included Hospital Kuala Lumpur, Hospital Sultanah Bahiyah, Alor Setar, Hospital Sultanah Aminah, Johor Bahru, Hospital Sultanah Nur Zahirah, Kuala Terengganu and Hospital Umum Sarawak, Kuching. A total of 279 medical doctors from the O&G Departments of these hospitals form the respondents. This number does not represent all the medical doctors who were serving in the O&G department of the various hospitals but rather those who responded to our invitation to participate in the study. They included specialists, medical officers (qualified doctors but not specialists) and house officers (doctors in the first two years after qualification from a medical school) who had completed at least one and half months of their attachments in the O&G Department.

The recruitment of respondents was assisted by Dato' Dr. Ravindran Jegasothy who facilitated the participation of the Heads of O&G Departments from the identified hospitals. A coordinator was appointed by the Head of the O&G Department in each hospital to distribute and collect the questionnaires from the respondents. The questionnaire was self-administered by the respondents. Data was collected within a time frame of one and a half months (July to

August 2011). Data from the questionnaire were analyzed by using the Statistical Packages for Social Sciences (SPSS) for window, version 18.0.

Ethical considerations

The study proposal and the questionnaires were submitted to the Ministry of Health Medical Research Ethics Committee (MREC) for review and approval was obtained prior to commencement of the study (Appendix 1). Since the principal researcher was from Universiti Putra Malaysia, ethical clearance was also sought from the university's Medical Research Ethics Committee (Appendix 2).

STUDY FINDINGS

Socio-Demographic Characteristics of Respondents

By the end of August 2011, a total of 279 respondents from 5 public hospitals in Johor, Kedah, Kuala Lumpur, Sarawak and Terengganu had participated in the study. More than one third of the respondents (35.8%) were recruited from Hospital Kuala Lumpur, followed by 20.1% from Hospital Umum Sarawak, Kuching, 17.9% from Hospital Sultanah Bahiyah, Alor Setar, 16.1% from Hospital Sultanah Aminah, Johor Bahru and 10.1% from Hospital Sultanah Nur Zahirah, Kuala Terengganu. The study population comprised three groups, which included O&G Specialists (37 or 13.3%), Medical Officers (56 or 20.0%) and House Officers (186 or 66.7%) who had completed at least one and half months of their O&G attachment.

Table 1 shows that slightly more than one third of the respondents obtained their medical degrees from local public universities, such as University Malaya (UM), University Science Malaysia (USM), National University Malaysia (UKM), University Putra Malaysia (UPM), University Malaysia Sarawak (UNIMAS) and University Malaysia Sabah (UMS). A third of the respondents graduated from universities overseas, namely from Ukraine, Ireland, Russia and Indonesia. Meanwhile, 18.6% received their degrees from local private colleges or universities, including the Asian Institute of Medicine, Science and Technology (AIMST) University, International Medical University (IMU), Melaka Manipal Medical College (MMMC) and Penang Medical College. Compared to the specialists and medical officers, more house officers had studied in local (25.3%) or overseas (34.9%) private colleges or universities for their medical degrees. This reflects the recent increase in access to medical education in Malaysia.

In view of the fact that house officers made up of two thirds of the respondents, it was not surprising that majority of the respondents (74.2%) were below 30 years. For respondents who are O&G specialists, the majority of them were between 31 to 50 years (83.8%) and for medical officers, most of them were between 21 to 40 years. A small number (6.8%) of respondents did not disclose their ages in this study.

As shown in Table 1, more than two-thirds of the respondents (63.4%) were women, especially among the medical officers and house officers. However, with the specialists, slightly more than half of them (56.8%) were men while 43.2% were women.

Nearly half (45.9%) of the respondents were Malays, followed by 29.4% Chinese, 21.8% Indians, and 2.9% other ethnic groups (Punjabi, Kadazan, etc.). By religion, the majority of the respondents (48.0%) were Muslims, followed by Hindu (20.1%), Buddhists (15.4%) and

Table 1: Socio-Demographic Background of Respondents by Selected Variables

Socio-Demographic Background	Specialists N = 37 (%)	Medical Officers N = 56 (%)	House Officers N = 186 (%)	Total N = 279 (%)
Source of Respondents				
Hospital Kuala Lumpur	12 (32.5)	28 (50)	60 (32.3)	100 (35.8)
Hospital Sultanah Bahiyah, Alor Setar	5 (13.5)	6 (10.7)	39 (20.9)	50 (17.9)
Hospital Sultanah Aminah, Johor Bahru	9 (24.3)	11 (19.6)	25 (13.4)	45 (16.1)
Hospital Sultanah Nur Zahirah, Kuala Terengganu	2 (5.4)	8 (14.3)	18 (9.7)	28 (10.1)
Hospital Umum Sarawak, Kuching	9 (24.3)	3 (5.4)	44 (23.7)	56 (20.1)
Source of Respondents' Medical Degree				
Local Public Universities – (UKM, UM, UNIMAS, UPM, USM, etc)	14 (37.8)	23 (41.1)	66 (35.5)	103 (36.9)
Local Private Colleges/ Universities – (IMU, AIMST, MMMC, Penang Medical College, etc)	0	5 (8.9)	47 (25.3)	52 (18.6)
Overseas Private Colleges/Universities – (Indonesia, Ukraine, Russia, Ireland, etc)	5 (13.5)	18 (32.1)	65 (34.9)	88 (31.5)
Data unavailable	18 (48.7)	10 (17.9)	8 (4.3)	36 (13.0)
Age Group (Years)				
21 – 30	0	31 (55.4)	176 (94.7)	207 (74.2)
31 – 40	16 (43.2)	17 (30.4)	1 (0.5)	34 (12.2)
41 – 50	15 (40.6)	2 (3.6)	0	17 (6.1)
> 50	2 (5.4)	0	0	2 (0.7)
Data unavailable	4 (10.8)	6 (10.6)	9 (4.8)	19 (6.8)
Gender				
Male	21 (56.8)	19 (33.9)	62 (33.3)	102 (36.6)
Female	16 (43.2)	37 (66.1)	124 (66.7)	177 (63.4)
Ethnicity				
Malay	16 (43.3)	28 (50.0)	84 (45.2)	128 (45.9)
Chinese	4 (10.8)	14 (25.0)	64 (34.4)	82 (29.4)
Indian	14 (37.8)	14 (25.0)	33 (17.7)	61 (21.8)
Others	3 (8.1)	0	5 (2.7)	8 (2.9)
Religion				
Muslim	19 (51.4)	28 (50.0)	87 (46.8)	134 (48.0)
Christian	3 (8.1)	5 (8.9)	23 (12.4)	31 (11.1)
Buddhist	1 (2.7)	10 (17.9)	32 (17.2)	43 (15.4)
Hindu	13 (35.1)	12 (21.4)	31 (16.6)	56 (20.1)
Taoist/Confucianism	0	1 (1.8)	5 (2.7)	6 (2.2)
Others	1 (2.7)	0	8 (4.3)	9 (3.2)
Importance of Religion in Daily Life				
Very important	29 (78.4)	34 (60.7)	106 (57.0)	169 (60.6)
Important	8 (21.6)	19 (33.9)	73 (39.2)	100 (35.8)
Not important	0	3 (5.4)	5 (2.7)	8 (2.9)
Not important at all	0	0	2 (1.1)	2 (0.7)
Place where respondents come from				
Town/City	32 (86.5)	41 (73.2)	148 (79.6)	221 (79.2)
Village	5 (13.5)	15 (26.8)	38 (20.4)	58 (20.8)
Number of Siblings				
No sibling	0	0	3 (1.6)	3 (1.1)
1 – 3	19 (51.4)	36 (64.3)	135 (72.6)	190 (68.1)
4 – 6	11 (29.7)	13 (23.2)	37 (19.9)	61 (21.9)
> 7	7 (18.9)	5 (8.9)	11 (5.9)	23 (8.2)
Data unavailable	0	2 (3.6)	0	2 (0.7)
Desired field of specialization in the future (for house officers only)				
O&G			21 (11.3)	
Other fields			151 (81.2)	
Unsure			14 (7.5)	

Christians (11.1%). For the remaining respondents, 2.2% practised Taoism or Confucianism and 3.2% respondents claimed that they either practised other religions or none at all.

The majority of the respondents reported that religion plays a very important (60.6%) or important (35.8%) role in their daily lives, especially the specialists, all of whom expressed the fact that religion plays an important (21.4%) or very important (78.6%) role in their lives. Only very few respondents (3.6%), mostly house officers, claimed that religion is not important in their daily life.

In this study, more than three quarters (79.2%) of the respondents came from towns or cities, regardless of whether they were specialists, medical officers or house officers. Only about one fifth (20.8%) of the doctors said they grew up in villages.

With regards to the number of siblings, about two-thirds (68.1%) of the respondents reported having one to three brothers or sisters while 21.9% said that they had four to six siblings. Only a few respondents (8.2%) reported more than seven siblings and three respondents (1.1%) were the only child in their families. As shown in Table 1b, more specialists grew up in bigger families compared to medical officers and house officers. About three quarters (72.6%) of the house officers only had one to three brothers or sisters.

When the house officers were asked about the field of specialization that they wished to continue in the future, only 11.3% of them said that they would like to be in O&G. The majority of respondents (81.2%) would like to specialize in other fields, such as cardiology, family medicine, medical, ophthalmology, orthopaedics, paediatrics, pathology, psychiatrics, radiology, surgery, etc., while 7.5% had not decided.

General Knowledge of Respondents on Contraception, Menstrual Regulation and Abortion including Abortion Methods and Risk of Complications (Table 2)

In this section, respondents were asked to answer True or False to a series of questions on contraception, menstrual regulation and abortion methods and risks. Less than half (46.6%) of the respondents were aware of the contraceptive prevalence rate (CPR) for modern methods in Malaysia while 53.4% of them either did not know anything or were unsure. Generally, the O&G specialists (83.8%) had better knowledge of CPR than medical officers and house officers.

For the second statement that the total abortion rate will be reduced if effective contraceptive methods were available and widely used, the majority of the respondents (82.1%) provided the correct answer, and most of them (55.2%) also believed that there would be no unintended or unwanted pregnancies if all contraceptive users used the methods correctly all the time. However, it should be noted that none of the modern contraceptive methods provide 100% effectiveness and protection. In fact, the rates of unintended pregnancies per 100 women range from 0.05 (for implants) to 0.6 (for copper bearing IUD) even if the methods are used consistently and correctly (WHO, Johns Hopkins Bloomberg School of Public Health & USAID, 2007).

According to IPPF, menstrual regulation refers to the "Evacuation of the uterus of a woman who has missed her menstrual period by 14 days or fewer, who previously had regular periods and who has been at risk of conception" (IPPF, Glossary). In this instance, only 31.5% to 49.5% of the respondents answered correctly the statements on menstrual regulation as a surgical treatment for heavy menstrual bleeding of unknown cause or to regulate irregular menstrual cycles, and as an early surgical evacuation of the uterine cavity when pregnancy cannot or has not been confirmed.

Table 2: General Knowledge on Contraception, Menstrual Regulation and Abortion

Statement on Abortion	Number (%) of respondents who answered correctly			
	Specialists N = 37 (%)	Medical Officers N = 56 (%)	House Officers N = 186 (%)	Total N = 279 (%)
The proportion of women of reproductive age who are using modern contraceptive methods [or contraceptive prevalence rate (CPR) for modern methods] in Malaysia is less than 40%. (T)	31 (83.8)	29 (51.8)	70 (37.6)	130 (46.6)
Where effective contraceptive methods are available and widely used, the total abortion rate decreases. (T)	35 (94.6)	46 (82.1)	148 (79.6)	229 (82.1)
If all contraceptive users were to use methods correctly all the time, there would not be any unintended or unwanted pregnancies. (F)	20 (54.1)	29 (51.8)	76 (40.9)	125 (44.8)
Menstrual regulation is a surgical treatment for heavy menstrual bleeding of unknown cause. (T)	12 (32.4)	28 (50.0)	98 (52.7)	138 (49.5)
Menstrual regulation is a surgical treatment to regulate irregular menstrual cycles. (T)	8 (21.6)	25 (44.6)	88 (47.3)	121 (43.4)
Menstrual regulation is an early surgical evacuation of the uterine cavity when pregnancy cannot or has not been confirmed. (T)	16 (43.2)	14 (25.0)	58 (31.2)	88 (31.5)
The gestation period beyond 1st-trimester, menstrual regulation should not be performed. (T)	17 (45.9)	17 (30.4)	72 (38.7)	106 (38.0)
Legally restricting abortion reduces the number of abortions that occur. (F)	20 (54.1)	24 (42.9)	92 (49.5)	136 (48.7)
The vast majority of women are likely to have at least one abortion by the time they are 45 years old. (T)	18 (48.6)	35 (62.5)	93 (50.0)	146 (52.3)
Abortion is defined as terminating a pregnancy before the foetus is viable; viability of a foetus is taken as when the pregnancy is 22 weeks. (T)	24 (64.9)	42 (75.0)	142 (76.3)	208 (74.6)
Abortion is a safe medical procedure when performed by trained health-care providers. (T)	35 (94.6)	51 (91.1)	156 (83.9)	242 (86.7)
Abortion is a safe medical procedure when performed with proper equipment. (T)	34 (91.9)	51 (91.1)	152 (81.7)	237 (84.9)
Abortion is a safe medical procedure when performed with correct technique. (T)	34 (91.9)	51 (91.1)	162 (87.1)	247 (88.5)
Abortion is a safe medical procedure when performed with sanitary standards. (T)	32 (86.5)	46 (82.1)	147 (79.0)	225 (80.6)

T = True **F = False**

As for general knowledge on abortion, slightly more than half (51.3%) believed that legally restricting abortion reduces the number of abortions that occur while 48.7% of them correctly thought otherwise. With regards to the prevalence of abortion in the reproductive lifetime of women, only 52.3% of the respondents correctly answered that the vast majority of women are likely to have at least one abortion by the time they are 45 years old.

However, the majority of the respondents were able to define what abortion is and understood that abortion is a safe medical procedure when performed by trained healthcare providers, with proper equipment, correct technique and sanitary standards (over 80% provided the correct answers for these four statements). Compared to house officers, O&G specialists and medical officers had slightly better knowledge in this area.

Generally, most of the respondents were not familiar with abortion methods and its risk of complications. Only slightly more than one third identified vacuum aspiration (34.4%), and mifepristone and misoprostol (38.0%) as the preferred methods for first trimester abortion. For second trimester abortion, 25.1% and 39.1% of the respondents recognized dilatation and evacuation and mifepristone and misoprostol (repeated doses) as the preferred methods. Finally, slightly more than half (59.1%) of the respondents recognized vaginal prostaglandins (repeated doses) as another preferred method for second-trimester abortion.

With regards to the question on risks of complications caused by first trimester induced abortions performed in a sterile setting, the majority of the respondents correctly identified uterine perforation (81%) and post-op operative bleeding (58.1%) as two of the risks. However, for other risks, such as pelvic infection (<1%) and infertility (<0.1%), only about one-fifth of the respondents were aware that these are possible complications caused by abortion.

Overall, Table 3 also shows that O&G specialists were more familiar with abortion methods and its risk of complications while house officers had the least knowledge.

Table 3: Knowledge on Abortion Methods and Risk of Complications

Preferred Methods for Abortion and Risk of Complication	Number (%) of respondents who answered correctly			
	Specialists N = 37 (%)	Medical Officers N = 56 (%)	House Officers N = 186 (%)	Total (%)
Preferred Methods for First trimester Abortion				
Dilatation and curettage (F)	17 (45.9)	12 (21.4)	29 (15.6)	58 (20.8)
Vacuum aspiration (T)	27 (73.0)	20 (35.7)	49 (26.3)	96 (34.4)
Dilatation and evacuation (F)	18 (48.6)	36 (64.3)	117 (62.9)	171 (61.3)
Mifepristone and misoprostol (T)	20 (54.1)	27 (48.2)	59 (31.7)	106 (38.0)
Mifepristone and methotrexate (F)	35 (94.6)	53 (94.6)	158 (84.9)	246 (88.2)
Preferred Methods for Second trimester Abortion				
Dilatation and curettage (F)	35 (94.6)	46 (82.1)	128 (68.8)	209 (74.9)
Vacuum aspiration (F)	37 (100.0)	52 (92.9)	147 (79.0)	236 (84.6)
Dilatation and evacuation (T)	5 (13.5)	11 (19.6)	54 (29.0)	70 (25.1)
Mifepristone and repeated doses of misoprostol (T)	22 (59.5)	26 (46.4)	61 (32.8)	109 (39.1)
Vaginal prostaglandins (repeated doses) (T)	27 (73.0)	44 (78.6)	94 (50.5)	165 (59.1)
Risks of the complications caused by 1st-trimester induced abortion performed in a sterile setting				
Pelvic Infection <1%.	15 (40.5)	9 (16.1)	37 (19.9)	61 (21.9)
Infertility <0.1%.	12 (32.4)	9 (16.1)	18 (9.7)	39 (14.0)
Uterine perforation.	35 (94.6)	48 (85.7)	143 (76.9)	226 (81.0)
Post-op operative bleeding needing hospitalization.	22 (59.5)	31 (55.4)	109 (58.6)	162 (58.1)

T = True **F = False**

General Knowledge of Respondents on Legal Context of Abortion

The majority of respondents (87.8%) indicated that they knew that abortion is legal under certain circumstances in Malaysia. Almost all (92.8%) mentioned that abortions are permitted in Malaysia to save the life of the mother, 71% of the respondents said it was permitted to "avoid negative effects on the woman's physical health" and over two-thirds (64.5%) were aware that "abortion is permissible to "preserve the woman's mental health". In addition, most of them (more than 80%) were also aware that abortion is not permissible for socio-economic reasons, contraceptive failure or upon request. In contrast, the majority of doctors either did not know or were unsure about whether abortion is allowed in cases of rape or foetal abnormalities. Less than half (47.3%) correctly stated that abortion is not permissible when the pregnancy is a consequence of rape, whilst far fewer (14.3%) correctly stated that it is not allowed when there is serious foetal impairment.

As shown in Table 4, house officers had the least knowledge of abortion laws compared to the O&G specialists and medical officers. More than 40% of the house officers were not aware that abortion is permissible if it is performed to preserve the woman's mental health and over 80% of them believe that it is allowed in case of foetal impairment.

Table 4: Knowledge of Laws on Abortion

Statement on Abortion Laws	Number (%) of respondents who answered correctly			
	Specialists N = 37 (%)	Medical Officers N = 56 (%)	House Officers N = 186 (%)	Total N = 279 (%)
Abortion illegal under all circumstances in Malaysia (F)	35 (94.6)	52 (92.9)	158 (84.9)	245 (87.8)
Abortion is permissible if it is performed to save the woman's life. (T)	36 (97.3)	54 (96.4)	169 (90.9)	259 (92.8)
Abortion is permissible if it is performed to preserve the woman's physical health. (T)	30 (81.1)	41 (73.2)	127 (68.3)	198 (71.0)
Abortion is permissible if it is performed to preserve the woman's mental health. (T)	32 (86.5)	40 (71.4)	108 (58.1)	180 (64.5)
Abortion is permissible if it is performed for socio-economic reasons (e.g., low family income, limited living space). (F)	34 (91.9)	47 (83.9)	161 (86.6)	242 (86.7)
Abortion is permissible if it is performed due to serious foetal impairment. (F)	9 (24.3)	2 (3.6)	29 (15.6)	40 (14.3)
Abortion is permissible if an unmarried woman became pregnant and wanted to terminate the pregnancy. (F)	32 (86.5)	50 (89.3)	157 (84.4)	239 (85.7)
Abortion is permissible if the woman's pregnancy was the result of rape. (F)	14 (37.8)	25 (44.6)	93 (50.0)	132 (47.3)
Abortion is permissible if the woman became pregnant due to contraceptive failure. (F)	32 (86.5)	51 (91.1)	163 (87.6)	246 (88.2)

T = True **F = False**

Table 5: Knowledge of *Syariah* Laws on Abortion

Conditions Under *Syariah* Law (*Fatwa*) issued by the National *Fatwa* Committee	Number (%) of respondents who answered correctly			
	Specialists N = 37 (%)	Medical Officers N = 56 (%)	House Officers N = 186 (%)	Total N = 279 (%)
It is permissible to allow abortions under certain conditions: (T)	33 (89.2)	43 (76.8)	144 (77.4)	220 (78.9)
▪ if the foetus is under 40 days (T)	20 (54.1)	26 (46.4)	78 (41.9)	124 (44.4)
▪ if the foetus is under 100 days (T)	17 (45.9)	14 (25.0)	44 (23.7)	75 (26.9)
▪ if the foetus is under 120 days (T)	16 (43.2)	11 (19.6)	30 (16.1)	57 (20.4)
▪ if the foetus is found to be seriously abnormal (T)	23 (62.2)	34 (60.7)	118 (63.4)	175 (62.7)
▪ if the continuance of the pregnancy will endanger the woman's life (T)	33 (89.2)	45 (80.4)	136 (73.1)	214 (76.7)
▪ for socio-economic reasons (T)	2 (5.4)	2 (3.6)	5 (2.7)	9 (3.2)

T = True **F = False**

When asked about the conditions under which abortion was permitted according to *Syariah* laws, the majority of respondents were uncertain. Only 20.4% of the respondents were aware that abortion is permissible if the foetus is less than 120 days. On the other hand, more than two-thirds of the respondents were aware that abortion is allowed to be performed if the foetus is found to be seriously abnormal (62.7%) or if the pregnancy would endanger the woman's life (76.7%). However, almost all respondents (96.8%) did not realize that *Syariah* laws also permit abortion for health and social reasons conditionally depending on the time of ensoulment which is usually around 120 days.

Attitudes towards Sexuality

Table 6 shows that seven in ten (70.6%) respondents, irrespective of whether they are specialists, medical officers or house officers, disapproved of pre-marital sex. In addition, two-thirds (66.3%) of them were of the opinion that the government should censor pornographic materials from the internet.

Although the majority of respondents disapproved of sexual activity among the unmarried, their attitudes concerning the provision of sex education and contraceptive information to adolescents and youth were rather positive. Almost all respondents felt that sex education (92.5%) and contraceptive information (87.5%) should be introduced in secondary schools. On the other hand, most of the respondents were more conservative in their perceptions regarding the provision of sex education and contraceptive information in primary schools. In this instance, only 49.8% of them agreed that we should expose primary school students to sex education, and even fewer (39.1%) approved of providing contraceptive information in primary schools. The differences among O&G specialists, medical officers and house officers regarding their views on sexuality and provision of sex education and contraceptive information for young people were moderate; however, more positive attitudes were expressed by O&G specialists as shown in Table 6.

Table 6: Attitudes towards Sexuality

Statement on Sexuality	Number (%) of respondents			
	Specialists N = 37 (%)	Medical Officers N = 56 (%)	House Officers N = 186 (%)	Total N = 279 (%)
Approve of couples having pre-marital sex				
Yes	10 (27.0)	18 (32.1)	44 (23.7)	72 (25.8)
No	27 (73.0)	36 (64.3)	134 (72.0)	197 (70.6)
Unsure	0	2 (3.6)	8 (4.3)	10 (3.6)
Government should censor pornographic materials from the Internet				
Yes	25 (67.6)	37 (66.1)	123 (66.1)	185 (66.3)
No	11 (29.7)	18 (32.1)	57 (30.7)	86 (30.8)
Unsure	1 (2.7)	1 (1.8)	6 (3.2)	8 (2.9)
Sex education should be introduced in primary schools				
Yes	24 (64.9)	30 (53.6)	85 (45.7)	139 (49.8)
No	13 (35.1)	24 (42.8)	94 (50.5)	131 (47.0)
Unsure	0	2 (3.6)	7 (3.8)	9 (3.2)
Sex education should be introduced in secondary schools				
Yes	37 (100.0)	54 (96.4)	167 (89.8)	258 (92.5)
No	0	1 (1.8)	15 (8.0)	16 (5.7)
Unsure	0	1 (1.8)	4 (2.2)	5 (1.8)
Contraceptive information should be provided in primary schools				
Yes	17 (45.9)	24 (42.8)	68 (36.6)	109 (39.1)
No	20 (54.1)	30 (53.6)	109 (58.6)	159 (57.0)
Unsure	0	2 (3.6)	9 (4.8)	11 (3.9)
Contraceptive information should be provided in secondary schools				
Yes	34 (91.9)	52 (92.8)	158 (84.9)	244 (87.4)
No	3 (8.1)	3 (5.4)	23 (12.4)	29 (10.4)
Unsure	0	1 (1.8)	5 (2.7)	6 (2.2)

Attitudes towards Abortion

Overall, fewer than one third of the respondents strongly agreed (9.3%) or agreed (19.4%) that abortion should be legalized in order to make it available on demand as a woman's reproductive right in contrast to 43.4% who either disagreed or strongly disagreed with the statement. In addition, more than two-thirds (67.7%) opposed the legalization of abortion for socio-economic reasons. On the other hand, in the circumstances of women who are pregnant as a result of rape or incest, the majority (59.5%) were of the opinion that abortion should be made legal.

In view of the fact that most respondents disagreed that "abortion to be legalized for socio-economic reasons or upon request", it was not surprising that they also felt that: abortion services should not be:

- easily accessible (48.4%),
- affordable (39.4%) and
- made available (40.2%) to the public.

However, with regards to providing abortion information, more than two thirds (67.0%) either agreed or strongly agreed that it should be made available to the public. It should be noted that, as shown in Table 7a and 7b, about 20% to 30% of the respondents remained neutral and did not express their views on legalization of abortion and provision of abortion information and services to the public. In addition, Tables 7a and 7b also show that O&G specialists have more supportive attitudes than medical and house officers towards the provision of accessible and affordable abortion services to the public.

Table 7b also presents the respondents' views on the circumstances under which abortion should be carried out. Most doctors, regardless of whether they are specialists, medical officers

Table 7a: Attitudes towards Abortion

Statement on Abortion	Number (%) of respondents			
	Specialists N = 37 (%)	Medical Officers N = 56 (%)	House Officers N = 186 (%)	Total N = 279 (%)
Abortion should be legalized on demand as a woman's reproductive right				
Strongly Agree	6 (16.2)	5 (8.9)	15 (8.1)	26 (9.3)
Agree	9 (24.3)	8 (14.3)	37 (19.9)	54 (19.3)
Neutral	7 (19.0)	11 (19.6)	60 (32.2)	78 (28.0)
Disagree	9 (24.3)	17 (30.4)	44 (23.7)	70 (25.1)
Strongly Disagree	6 (16.2)	15 (26.8)	30 (16.1)	51 (18.3)
Abortion should be made legal for economic and social reasons				
Strongly Agree	3 (8.1)	1 (1.8)	7 (3.8)	11 (3.9)
Agree	5 (13.5)	11 (19.6)	22 (11.8)	38 (13.6)
Neutral	5 (13.5)	14 (25.0)	50 (26.9)	69 (24.7)
Disagree	18 (48.7)	21 (37.5)	61 (32.8)	100 (35.8)
Strongly Disagree	6 (16.2)	9 (16.1)	46 (24.7)	61 (22.0)
Abortion should be made legal for women who become pregnant as a result of rape or incest				
Strongly Agree	15 (40.6)	12 (21.4)	48 (25.8)	75 (26.9)
Agree	9 (24.3)	24 (42.9)	58 (31.2)	91 (32.6)
Neutral	6 (16.2)	14 (25.0)	50 (26.9)	70 (25.1)
Disagree	6 (16.2)	5 (8.9)	17 (9.1)	28 (10.0)
Strongly Disagree	1 (2.7)	1 (1.8)	13 (7.0)	15 (5.4)
Abortion services should be easily accessible				
Strongly Agree	7 (18.9)	2 (3.6)	8 (4.3)	17 (6.1)
Agree	11 (29.7)	12 (21.4)	33 (17.7)	56 (20.1)
Neutral	7 (18.9)	10 (17.8)	54 (29.0)	71 (25.4)
Disagree	10 (27.0)	23 (41.1)	60 (32.3)	93 (33.3)
Strongly Disagree	2 (5.5)	9 (16.1)	31 (16.7)	42 (15.1)
Abortion services should be easily affordable				
Strongly Agree	9 (24.3)	3 (5.4)	6 (3.2)	18 (6.5)
Agree	12 (32.4)	10 (17.8)	34 (18.3)	56 (20.0)
Neutral	7 (19.0)	20 (35.7)	68 (36.5)	95 (34.1)
Disagree	8 (21.6)	16 (28.6)	55 (29.6)	79 (28.3)
Strongly Disagree	1 (2.7)	7 (12.5)	23 (12.4)	31 (11.1)

7b: Attitudes towards Abortion

Statement on Abortion	Number (%) of respondents			
	Specialists N = 37 (%)	Medical Officers N = 56 (%)	House Officers N = 186 (%)	Total N = 279 (%)
Information on abortion should be made available to the public				
Strongly Agree	14 (37.8)	12 (21.4)	46 (24.7)	72 (25.8)
Agree	14 (37.8)	22 (39.3)	79 (42.5)	115 (41.2)
Neutral	6 (16.2)	8 (14.3)	40 (21.5)	54 (19.4)
Disagree	3 (8.2)	12 (21.4)	16 (8.6)	31 (11.1)
Strongly Disagree	0	2 (3.6)	5 (2.7)	7 (2.5)
Abortion services should be made available to the public				
Strongly Agree	9 (24.3)	4 (7.1)	15 (8.1)	28 (10.0)
Agree	8 (21.6)	9 (16.1)	40 (21.5)	57 (20.4)
Neutral	9 (24.3)	14 (25.0)	59 (31.7)	82 (29.4)
Disagree	10 (27.1)	22 (39.3)	50 (26.9)	82 (29.4)
Strongly Disagree	1 (2.7)	7 (12.5)	22 (11.8)	30 (10.8)
Abortion should be carried out if the pregnancy will result in the birth of a child with physical defects				
Strongly Agree	12 (32.4)	13 (23.2)	43 (23.1)	68 (24.4)
Agree	9 (24.3)	19 (33.9)	62 (33.3)	90 (32.2)
Neutral	5 (13.5)	16 (28.6)	45 (24.2)	66 (23.7)
Disagree	11 (29.8)	7 (12.5)	33 (17.8)	51 (18.3)
Strongly Disagree	0	1 (1.8)	3 (1.6)	4 (1.4)
Abortion should be carried out if the pregnancy will result in the birth of a child with mental defects				
Strongly Agree	12 (32.5)	10 (17.9)	43 (23.1)	65 (23.3)
Agree	7 (18.9)	15 (26.8)	49 (26.3)	71 (25.4)
Neutral	7 (18.9)	18 (32.1)	54 (29.1)	79 (28.3)
Disagree	11 (29.7)	11 (19.6)	35 (18.8)	57 (20.5)
Strongly Disagree	0	2 (3.6)	5 (2.7)	7 (2.5)
A woman should have abortion if she thinks that the birth of the child will jeopardize her future				
Strongly Agree	1 (2.7)	3 (5.4)	11 (5.9)	15 (5.4)
Agree	5 (13.5)	4 (7.1)	12 (6.5)	21 (7.5)
Neutral	7 (19.0)	14 (25.0)	46 (24.7)	67 (24.0)
Disagree	18 (48.6)	22 (39.3)	68 (36.6)	108 (38.7)
Strongly Disagree	6 (16.2)	13 (23.2)	49 (26.3)	68 (24.4)

or house officers, stated that abortion should be carried out if the pregnancy will result in the birth of a child with physical defects (56.7%) and mental defects (48.7%), while about one-fifth of them disagreed or strongly disagreed with it. Conversely, only 12.9% of the respondents viewed abortion as an appropriate option in cases where a woman feels that the birth of the child will jeopardize her future.

The study shows that most of the respondents were more pro-life than pro-choice (Table 7c). In general, pro-choice refers to individuals who support abortion as a private matter involving a woman's personal choice, whereas pro-life refers to individuals who believe that

Table 7c: Attitudes towards Abortion

Statement on Abortion	Number (%) of respondents			
	Specialists N = 37 (%)	Medical Officers N = 56 (%)	House Officers N = 186 (%)	Total N = 279 (%)
Abortion is equivalent to taking a life as human life begins at conception				
Strongly Agree	5 (13.5)	13 (23.2)	33 (17.7)	51 (18.3)
Agree	17 (46.0)	25 (44.7)	72 (38.7)	114 (40.9)
Neutral	8 (21.6)	10 (17.8)	53 (28.5)	71 (25.4)
Disagree	6 (16.2)	8 (14.3)	21 (11.3)	35 (12.5)
Strongly Disagree	1 (2.7)	0	7 (3.8)	8 (2.9)
Foetus is not a person until it is born out from the mother's womb				
Strongly Agree	1 (2.7)	1 (1.8)	4 (2.2)	6 (2.2)
Agree	2 (5.4)	5 (8.9)	11 (5.9)	18 (6.5)
Neutral	12 (32.4)	5 (8.9)	32 (17.2)	49 (17.5)
Disagree	16 (43.3)	17 (30.4)	63 (33.9)	96 (34.4)
Strongly Disagree	6 (16.2)	28 (50.0)	76 (40.8)	110 (39.4)
Foetus has the right to live as it is a potential human being				
Strongly Agree	6 (16.2)	18 (32.1)	55 (29.6)	79 (28.3)
Agree	20 (54.1)	27 (48.2)	86 (46.2)	133 (47.7)
Neutral	8 (21.6)	9 (16.1)	35 (18.8)	52 (18.6)
Disagree	3 (8.1)	2 (3.6)	8 (4.3)	13 (4.7)
Strongly Disagree	0	0	2 (1.1)	2 (0.7)
A woman who is having an unwanted pregnancy should still give birth to the child as life is precious				
Strongly Agree	6 (16.2)	7 (12.5)	49 (26.3)	62 (22.2)
Agree	16 (43.3)	21 (37.5)	65 (35.0)	102 (36.5)
Neutral	10 (27.0)	19 (33.9)	51 (27.4)	80 (28.7)
Disagree	4 (10.8)	8 (14.3)	15 (8.1)	27 (9.7)
Strongly Disagree	1 (2.7)	1 (1.8)	6 (3.2)	8 (2.9)
Women should be given the right to decide for themselves whether or not to carry on with the pregnancy				
Strongly Agree	6 (16.3)	6 (10.7)	11 (5.9)	23 (8.2)
Agree	9 (24.3)	9 (16.1)	55 (29.6)	73 (26.2)
Neutral	10 (27.0)	19 (33.9)	54 (29.0)	83 (29.7)
Disagree	9 (24.3)	12 (21.4)	45 (24.2)	66 (23.7)
Strongly Disagree	3 (8.1)	10 (17.9)	21 (11.3)	34 (12.2)

foetus has the right to life. Almost two-thirds (59.2%) of the respondents believed that abortion is equivalent to taking a life as human life begins at conception. In addition, three-quarters (76%) of the respondents had the same opinion that the foetus has the right to live as it is a potential human being, hence, the majority of them (73.8%) disagreed or strongly disagreed with the statement that the "Foetus is not a person until it is born out from the mother's womb". As such, almost half of the respondents (48.8%) stated that women with an unwanted

Table 7d: Attitudes towards Abortion

Statement on Abortion	Number (%) of respondents			
	Specialists N = 37 (%)	Medical Officers N = 56 (%)	House Officers N = 186 (%)	Total N = 279 (%)
Abortion can affect the future fertility of a woman				
Strongly Agree	4 (10.8)	3 (5.4)	24 (12.9)	31 (11.1)
Agree	21 (56.8)	37 (66.1)	92 (49.5)	150 (53.7)
Neutral	6 (16.2)	11 (19.6)	43 (23.1)	60 (21.5)
Disagree	3 (8.1)	4 (7.1)	25 (13.4)	32 (11.5)
Strongly Disagree	3 (8.1)	1 (1.8)	2 (1.1)	6 (2.2)
Abortion providers are sinful				
Strongly Agree	2 (5.4)	5 (8.9)	18 (9.7)	25 (9.0)
Agree	2 (5.4)	15 (26.8)	11 (5.9)	28 (10.0)
Neutral	19 (51.4)	14 (25.0)	77 (41.4)	110 (39.4)
Disagree	7 (18.9)	13 (23.2)	51 (27.4)	71 (25.5)
Strongly Disagree	7 (18.9)	9 (16.1)	29 (15.6)	45 (16.1)
Women who have abortion are sinful				
Strongly Agree	2 (5.4)	5 (8.9)	15 (8.1)	22 (7.9)
Agree	2 (5.4)	12 (21.4)	13 (7.0)	27 (9.7)
Neutral	19 (51.4)	20 (35.7)	78 (41.9)	117 (41.9)
Disagree	5 (13.5)	9 (16.1)	51 (27.4)	65 (23.3)
Strongly Disagree	9 (24.3)	10 (17.9)	29 (15.6)	48 (17.2)
Having or performing abortions under any circumstances goes against my personal religious beliefs				
Strongly Agree	1 (2.7)	8 (14.3)	18 (9.6)	27 (9.7)
Agree	8 (21.6)	10 (17.8)	28 (15.1)	46 (16.5)
Neutral	7 (19.0)	18 (32.1)	67 (36.0)	92 (33.0)
Disagree	13 (35.1)	17 (30.4)	52 (28.0)	82 (29.4)
Strongly Disagree	8 (21.6)	3 (5.4)	21 (11.3)	32 (11.4)

pregnancy should still give birth to the child as life is precious, and some of them (35.9%) did not agree that women have the right to decide whether she wants to keep her pregnancy.

As shown in Table 7d, about two-thirds (64.9%) of the respondents believed that having an abortion could affect the future fertility of a woman. On the other hand, about two-fifths (41.5%) disagreed that abortion providers are sinful and another two fifths (39.4%) were neutral on the statement. The study also found similar results when the respondents were asked to express their views on women who have had an abortion. In this instance, 40.5% of them did not think that these women have committed sin while 41.9% remained neutral. Although most respondents did not feel that service providers who perform abortions are sinful, only about a quarter of them (26.2%) reported that they would perform abortions under any circumstances, even though it was against their personal religious beliefs. The majority of the respondents, however, either remained neutral (33%) or would refuse (40.9%) to carrying out abortions under any circumstance.

Willingness to Provide Abortion-Related Services in the Future

Table 8 indicates the types of abortion-related services which the medical officers were willing to include as part of their services. The majority of respondents cited that they would provide contraceptive information (88.9%) and services (77.8%) to unmarried persons. This is especially so among the O&G specialists. On the other hand, over 80% of respondents also indicated that they were comfortable giving pre- and post-abortion counseling, including counseling on contraceptive use. With regards to the types of pre-abortion counseling, the responses by respondents are contradictory. On the one hand, 66.3% stated that they would try to persuade the client to keep the pregnancy but, on the other hand, about the same number of respondents (61.6%) said that they would remain neutral and leave the client to make her own decision. Therefore, what is evident is that about one-third of the medical officers were themselves not certain if they would let the woman herself (without interference from the medical officer) choose what she wants to do with her pregnancy.

Table 8a: Willingness to Provide Abortion-related Services in their Future Medical Practice

Abortion Related Services	Number (%) of respondents			
	Specialists N = 37 (%)	Medical Officers N = 56 (%)	House Officers N = 186 (%)	Total N = 279 (%)
Provide contraceptive information to unmarried persons				
Yes	36 (97.3)	52 (92.8)	160 (86.0)	248 (88.9)
No	1 (2.7)	3 (5.4)	13 (7.0)	17 (6.1)
Unsure	0	1 (1.8)	13 (7.0)	14 (5.0)
Provide contraceptive services to unmarried persons				
Yes	30 (81.1)	45 (80.4)	142 (76.3)	217 (77.8)
No	4 (10.8)	6 (10.7)	30 (16.2)	40 (14.3)
Unsure	3 (8.1)	5 (8.9)	14 (7.5)	22 (7.9)
Give pre-abortion counselling				
Yes	29 (78.4)	47 (83.9)	158 (84.9)	234 (83.9)
No	6 (16.2)	3 (5.4)	15 (8.1)	24 (8.6)
Unsure	2 (5.4)	6 (10.7)	13 (7.0)	21 (7.5)
Give post-abortion counselling on future contraceptive use				
Yes	34 (91.9)	50 (89.3)	169 (90.9)	253 (90.7)
No	3 (8.1)	0	6 (3.2)	9 (3.2)
Unsure	0	6 (10.7)	11 (5.9)	17 (6.1)
Provide medical abortion				
Yes	11 (29.7)	7 (12.5)	45 (24.2)	63 (22.6)
No	19 (51.4)	30 (53.6)	89 (47.8)	138 (49.5)
Unsure	7 (18.9)	19 (33.9)	52 (28.0)	78 (27.9)
Provide surgical abortion				
Yes	12 (32.4)	12 (21.4)	41 (22.0)	65 (23.3)
No	19 (51.4)	29 (51.8)	94 (50.5)	142 (50.9)
Unsure	6 (16.2)	15 (26.8)	51 (27.5)	72 (25.8)

Table 8b: Willingness to Provide Abortion-related Services in their Future Practices

Abortion Related Services	Number (%) of respondents			
	Specialists N = 37 (%)	Medical Officers N = 56 (%)	House Officers N = 186 (%)	Total N = 279 (%)
Try to persuade the client to keep the pregnancy				
Yes	22 (59.5)	35 (62.5)	128 (68.8)	185 (66.3)
No	8 (21.6)	4 (7.1)	17 (9.1)	29 (10.4)
Unsure	7 (18.9)	17 (30.4)	41 (22.1)	65 (23.3)
Remain neutral, leaving the client to make her own decision				
Yes	21 (56.8)	31 (55.4)	120 (64.5)	172 (61.6)
No	13 (35.1)	15 (26.8)	42 (22.6)	70 (25.1)
Unsure	3 (8.1)	10 (17.8)	24 (12.9)	37 (13.3)
To endorse or give written support to a request for an abortion provided, I am convinced that the client had been fully informed when she made her request				
Yes	17 (46.0)	28 (50.0)	86 (46.2)	131 (47.0)
No	16 (43.2)	14 (25.0)	48 (25.8)	78 (28.0)
Unsure	4 (10.8)	14 (25.0)	52 (28.0)	70 (25.0)
To make referrals for a woman who is seeking abortion services				
Yes	29 (78.4)	25 (44.7)	72 (38.7)	126 (45.2)
No	5 (13.5)	18 (32.1)	73 (39.2)	96 (34.4)
Unsure	3 (8.1)	13 (23.2)	41 (22.1)	57 (20.4)

When asked about the types of abortion services that they would provide, only a small group of respondents cited that they would include medical abortion (22.6%) and surgical abortion (23.3%) in their future practices. However, a quarter of respondents stated that they were unsure whether they would provide medical and surgical abortion in the future. Among the three groups of service providers, the proportion of O&G specialists who indicated that they would offer medical or surgical abortion was slightly higher compared to medical officers and house officers.

Despite the majority's reluctance to provide abortion services, almost half of the respondents cited that they would provide women seeking abortion an endorsement, written support (47.0%) or referral (45.2%).

Views of Medical Curriculum on Abortion

In this study, more than three quarters (78.8%) of the respondents, irrespective of medical staff category, stated that the existing medical curriculum does not cover the topic of abortion adequately. Almost all respondents stated that training on abortion, such as general knowledge (92.2%), legal aspects (94.2%) and pre- and post-abortion counseling (92.1%), should be included. In addition, over 80% of the respondents also felt that the techniques and methods to perform a safe abortion, whether surgical or medical, should also be included in the training of medical students (Table 9).

Table 9: Views of the Medical Curriculum on Abortion

Curriculum on Abortion	Number (%) of respondents			
	Specialists N = 37 (%)	Medical Officers N = 56 (%)	House Officers N = 186 (%)	Total N = 279 (%)
Existing curriculum has dealt with the topics on abortion adequately				
Yes	6 (16.2)	14 (25.0)	39 (21.1)	59 (21.2)
No	31 (83.8)	42 (75.0)	146 (78.9)	219 (78.8)
Training on general knowledge of abortion				
Strongly Agree	19 (51.4)	30 (53.6)	89 (47.9)	138 (49.4)
Agree	16 (43.2)	21 (37.5)	82 (44.1)	119 (42.7)
Neutral	2 (5.4)	5 (8.9)	14 (7.5)	21 (7.5)
Disagree	0	0	1 (0.5)	1 (0.4)
Strongly Disagree	0	0	0	0
Training on surgical abortion techniques				
Strongly Agree	17 (46.0)	20 (35.7)	70 (37.6)	107 (38.4)
Agree	14 (37.8)	29 (51.8)	89 (47.8)	132 (47.3)
Neutral	4 (10.8)	6 (10.7)	23 (12.4)	33 (11.8)
Disagree	2 (5.4)	1 (1.8)	4 (2.2)	7 (2.5)
Strongly Disagree	0	0	0	0
Training on medical abortion				
Strongly Agree	18 (48.7)	21 (37.5)	73 (39.2)	112 (40.1)
Agree	13 (35.1)	30 (53.6)	92 (49.5)	135 (48.4)
Neutral	5 (13.5)	5 (8.9)	18 (9.7)	28 (10.1)
Disagree	1 (2.7)	0	3 (1.6)	4 (1.4)
Strongly Disagree	0	0	0	0
Training on legal aspects of abortion				
Strongly Agree	19 (51.4)	33 (58.9)	94 (50.5)	146 (52.3)
Agree	16 (43.2)	21 (37.5)	80 (43.0)	117 (42.0)
Neutral	1 (2.7)	2 (3.6)	11 (6.0)	14 (5.0)
Disagree	0	0	0	0
Strongly Disagree	1 (2.7)	0	1 (0.5)	2 (0.7)
Training on pre- and post-abortion counseling				
Strongly Agree	18 (48.7)	26 (46.4)	89 (47.8)	133 (47.7)
Agree	14 (37.8)	26 (46.4)	84 (45.2)	124 (44.4)
Neutral	4 (10.8)	4 (7.2)	12 (6.5)	20 (7.2)
Disagree	1 (2.7)	0	1 (0.5)	2 (0.7)
Strongly Disagree	0	0	0	0

Discussion

In Malaysia, there is no official published source of data on abortion. Generally, unsafe abortion is not assumed to be a public health issue because there are very few maternal deaths attributed to complications of abortion in the country, including unsafe abortion. There is also no research or study that can shed light on the actual situation of abortion on the ground, namely, mortality and morbidity due to unsafe abortions, the availability, accessibility and affordability of safe abortion services, and the needs and gaps of service providers in providing safe abortions. As such, this study is the first of its kind in Malaysia to compare knowledge and attitudes among doctors from public hospitals regarding abortion, specifically to examine their needs and willingness to provide such services in the future.

The study covered five different zones with diverse socio-economic and cultural backgrounds across the country. These included Johor Bahru from the Southern Zone, Kedah from the Northern Zone, Kuala Terengganu from the East Coast Zone, Kuala Lumpur from the Central Zone and Kuching from East Malaysia. The respondents of this study comprised three categories, i.e., O&G specialists, medical officers and house officers who had been attached with the O&G Department for at least one and a half months.

The majority of the respondents recruited were house officers, between 21 to 30 years old, mostly female, and from urban areas. It was not surprising that there were more female than male doctors in public hospitals, especially among the house officers, as there are always a higher number of girls in universities than boys. The latest statistics show that male students made up only about 35% of the overall intake of local universities in 2011. The study showed that two-thirds of the respondents obtained their first medical degree from private universities, either local or overseas, while one-third of them graduated from local public universities. However, over three-quarters of the respondents stated that none of the existing medical curricula covered the topic of abortion adequately. Furthermore, almost all of them held the view that the existing medical curriculum should include training on abortion, including general knowledge, legal aspects, pre- and post-counseling and abortion techniques.

Nearly half of the respondents were Malays and Muslims. Apart from respondents who were Muslims, most of the other respondents with different religious backgrounds also claimed that religion played an important role in their daily lives. In view of their religious influences, it was understandable that most respondents in this study were rather conservative and pro-life when they expressed their views towards abortion as their values, decisions and willingness to perform abortion (Turner & Page, 2008).

With regards to the respondents' general knowledge on contraception and abortion, one of the most surprising findings of this study was the lack of knowledge on contraception among the doctors, especially house officers. The study found that although most of the respondents were aware that the increased use of effective contraception was associated with a decline in abortion, the majority of them were unaware that Malaysia has a low Contraceptive Prevalence Rate (CPR) and high unmet need for family planning among women. The CPR for all methods has stagnated at around 50% and for modern methods was only about 33% in 2004 (Government of Malaysia and UNDP, 2010). As a consequence, the rate and need for abortion may increase as some women use abortion as a means to control their fertility and plan their family (Peng, 2008). On the other hand, most of the doctors in this study also had some misconceptions on contraceptive methods as they believed that all the contraceptive methods provides 100% protection if used correctly all the time. In fact, the consistency of

contraceptive use would only reduce the rates of contraceptive failure so unintended pregnancies among women can still occur (Peng, 2008). According to Kamaluddin's study on a follow-up profile of 28,605 women who had sought pregnancy terminations in a clinic in urban Malaysia from 1998 to 2005, 85% of these women had used contraception in the past (Kamaluddin, 2010).

In this study, more than half of the respondents were unaware of menstrual regulation as an alternative term for abortion and were unsure of the procedures for menstrual regulation. According to Potts et al., menstrual regulation is just another term to describe abortion. Technically, it is also a procedure that evacuates the uterus after one or more missed menstrual periods. The term "menstrual regulation", emotionally, is more easily accepted by women who need it, and ethically, it is also less challenging for doctors to perform as the pregnancy may not be confirmed yet at the time the procedure is carried out (Potts, Diggory & Peel, 1977). In Malaysia, the practice of menstrual regulation was introduced in 1970 as a way to circumvent the law as well as to coincide with the development of surgical and medical methods for early uterine evacuation (Potts, Diggory & Peel, 1977). However, there is no official data or study on the current practice of menstrual regulation in Malaysia. In view of the fact that most doctors in this study were unable to provide the correct answers regarding menstrual regulation, it can be assumed that menstrual regulation is not easily available in public hospitals.

In Malaysia, many people, including policy makers and healthcare providers, tend to neglect termination of pregnancy and are not interested in making abortion accessible and safer due to fear that addressing it might be construed as promoting abortion. Therefore, it is not surprising that the study showed that the majority of the doctors were not well equipped with general knowledge on abortion and not familiar with abortion methods and its risk of complications. However, avoiding discussion of abortion does not eliminate its causes or incidence. In fact, the majority of women all over the world are likely to have at least one abortion by the time they are 45 years old, hence, legally restricting abortion would not reduce the number of abortions. Restrictive laws that criminalize abortion would only increase the mortality and morbidity risks for women seeking unsafe abortions. In reality, the countries with abortion policies that are less restrictive, and which permit the conduct of abortion on broad grounds, are generally able to offer safer abortion services as well as reduce maternal mortality and morbidity rates (Potts, Diggory & Peel, 1977). According to WHO, abortion is one of the safest medical procedures and risks of complications, such as infection, uterine perforation, haemorrhage, etc., rarely occur if the abortion is properly performed by trained health care providers with proper equipment, correct technique and sanitary standards (WHO, 2003).

With regards to the legal context of abortion in Malaysia, the study found that the only misconception among the doctors was that most of them thought abortion was allowed in case of rape or foetal abnormalities. The majority were aware of the other conditions under which abortion is allowed under laws, such as to save a woman's life and preserve women's physical and mental health. In addition, they were also aware that abortion was not permitted upon request and for socio-economic reasons. Although most of the doctors had some understanding of the legal status of abortion in the country, most of them had a rather conservative view in interpreting the law because abortion is categorized under the Penal Code and the health practitioner can be charged if the law is broken (WHO, 2003). Furthermore, the laws also do not provide for any protection for the practitioner in case of a patient's death in the course of abortion.

Apart from the restrictive abortion legislation under national laws, the legal context of abortion is more complicated as Malaysia practises a unique dual justice system incorporating secular laws (criminal and civil) and *Syariah* (Islamic) laws. Basically, *Syariah* laws are developed based on the Quran and the *Sunnah* (the collection of acts and statements made by the prophet Mohammed). However, although there is no specific guidance on abortion from these two primary sources of Islamic law, it is generally believed that abortion is allowed before ensoulment, the time at which a foetus gains a soul which is most often viewed as occurring 120 days into a pregnancy (Boonstra, 2001). In view of that, it is not surprising that the majority of the respondents in this study were unsure about the conditions of abortion that is permitted within the *Syariah* law as there is no clear guidance. Nevertheless, there is a "*fatwa*" (ruling) on abortion issued by the National Council for *Fatwa* Islamic Religious Affairs Malaysia *(Muzakarah Jawatankuasa Fatwa Majlis Kebangsaan)* stating that abortion is permissible up to 120 days if there is foetal impairment or if continuance of the pregnancy is a threat to the woman's life. It should be noted that the *fatwa* is just an opinion of the *fatwa* committee; it is not a verdict in accordance with the law and not binding by the state.

Although there is no clear guidance on abortion under Islamic laws, the religious, cultural and societal norms are extremely influential in shaping people's attitudes and values towards sexuality and abortion (Boonstra, 2001). In this study, as the majority of respondents cited that religion plays an important role in their daily lives, it is understandable that most of them revealed conservative views and attitudes towards premarital sex and abortion. Since most of the doctors disapproved of premarital sex, opposed legalization of abortion, were pro-life and believed that abortion is equivalent to taking a life, it should be cautioned that these personal morals or beliefs can be translated into conscientious objections in their profession as healthcare providers, and result in their refusal to perform a legal role (abortion) or responsibility. In fact, only a quarter of the doctors in this study said they would perform abortions under any circumstances even though it might be against their personal religious beliefs. Furthermore, less than a quarter of the respondents indicated they would provide medical or surgical abortion, and less than half them cited that they would endorse or give written support and refer women for abortion services. Clearly, conscientious objection by doctors to providing safe abortion services will affect women's access to safe abortion and put them at risk of unsafe abortion and other complications that may result. Therefore, laws and professional guidelines on conscientious objection to abortion must balance the respect for an individual's beliefs against the well-being of the general public.

In addition to the study findings that more doctors were "pro-life" than "pro-choice", the study further shows that most of the doctors would not support women in making their own choice and decision in all areas of reproduction. Yet, reproductive choice is central to women's right to control their lives and also to their development and empowerment. Furthermore, the right of women to safe abortion is recognized as part of their reproductive rights embodied in human rights (Marie Stopes International (MSI) and Ipas, 2009). According to ICPD PoA in 1994, women have the right to attain the highest standard of sexual and reproductive health, including abortion services and the right to make decisions concerning reproduction free of discrimination, coercion and violence. In order for women to exercise these rights, certain elements need to be in place, including full and correct information and education on contraception, sexuality and abortion and health systems should be made available in circumstances where abortion is not against the law (United Nations, 1994).

Nevertheless, the study revealed the contrasting fact that many medical officers wanted abortion training to be included as a standard part of the medical curriculum as most of them expressed reservations towards abortion. The positive attitudes of the respondents in proposing that training on abortion, including general knowledge, legal aspects, pre- and post-abortion counseling and abortion procedures, be included in the existing medical curriculum is indeed a good starting point towards making safe abortion as a woman's right in the country.

CONCLUSIONS AND RECOMMENDATIONS

Conclusion

Although unsafe abortion is generally not assumed to be a major public health problem in Malaysia, it does not mean that maternal deaths from complications of unsafe abortions should be overlooked. In fact, the problem of unsafe abortion can extend far beyond official statistics; women who have unwanted pregnancies will be forced to risk their health and life to undergo an unsafe abortion if safe abortion services are not available or accessible. It should be noted that while unsafe abortion is one of the most common causes of maternal deaths, it is also the most easily preventable through the provision of, and access to, safe abortion services and care.

The study of "Medical Doctors' Knowledge, Attitude and Willingness to Provide Abortion Related Services as a Reproductive Right of Women" has given us some insights into the possibility of accessing abortion services (as a reproductive right of a woman) at public hospitals in Malaysia. The study found that the majority of the doctors have some understanding of abortion, such as what abortion is and that abortion is a safe medical procedure when performed properly as well as its legal status in Malaysia. However, their knowledge on contraceptive prevalence rate, menstrual regulation, abortion methods and its risk of complications are limited.

The attitudes of the medical doctors towards sexuality and abortion were conventional and "pro-life". They expressed their beliefs that abortion should not be legalized for social-economic reasons or upon request, that the foetus has the right to live and they will not perform abortions under any circumstances when it is against their personal religious beliefs. As such, most doctors were quite reluctant to provide abortion services but, what is even more discouraging is that only about half of them indicated that they would even refer women for safe abortion services. Nonetheless, the study has provided a platform for the respondents to express their views towards abortion, to identify their gaps on abortion knowledge and to indicate their needs. Almost all of the respondents stated that they hoped to be trained in abortion (general knowledge, legal aspect, pre- and post-abortion counseling and abortion procedures to be included in the existing medical curriculum). This feedback is quite encouraging as this may be the first step in making abortion more accessible.

Recommendations

In order to address the barriers that have been identified by this study, a rights-based approach is required. First of all, the rights of women to access quality healthcare, including safe abortion, must be recognized as part of their reproductive rights. A woman has the fundamental right

to decide whether and when to have a child and the right to have access to abortion in circumstances where abortion is not against the law, according to the ICPD PoA in 1994. By recognizing women's reproductive rights, it means that there is a need to protect all women from unprotected sex, unwanted pregnancies and unsafe abortion through building on their own strengths and empowerment.

Secondly, to ensure women's access to comprehensive sexual and reproductive health services and further reduce the rate of maternal mortality and morbidity in the country requires concerted efforts from all the stakeholders to develop norms, processes and institutions to systematically address safe abortion care as part of the SRH services. Policy-makers, programme planners and service providers must recognize that restrictive laws or access to safe abortion do not stop women from obtaining abortions but only increase women's risk for unsafe abortion. These policy makers and programme planners should be from all sectors of government, including those involved in medical education, and should be privy to the evidence-base, including the findings of this survey to facilitate corrective measures.

Making safe, effective and acceptable abortion services available and accessible is a critical component to meeting women's healthcare needs and reducing the causes or incidence of unsafe abortions. In the context of Malaysia where contraceptive prevalence is only 34% for modern methods, making safe abortion a women's right may also reduce the number of babies abandoned after birth (United Nations, 1994).

"Abortion care" is more than the abortion procedure itself. It is a comprehensive approach comprising counselling and services for safe abortion, contraceptive counselling and method provision as well as other reproductive health services, or links to such services, such as diagnosis and treatment of STIs or gender-based violence (McInerney *et. al*, 2001). By integrating safe abortion care into existing SRH services, it protects women from unsafe abortion, unintended or unwanted pregnancy and abortion, thus, dealing with many issues related to contraception and sexual health and reduce stigma and discrimination. In addition, the provision of safe abortion services also reduces the health-system costs for treating serious complications and post-abortion infertility due to unsafe abortion and reduces the income lost from society and individuals due to death or disability resulting from unsafe abortions (WHO, 2010).

In order to provide and support high-quality abortion care, several aspects of services need to be addressed, namely, the skills required, including clinical or technical competence, as well as soft skills, including the service providers' comfort or emotional capability in providing the service. Training on comprehensive abortion care including pre- and post-abortion counselling, legal aspects of abortion, and safe abortion methods should be included in the medical curriculum and continuing professional development (CPD) programmes for all healthcare professionals to continuously improve their knowledge, understanding and enhancement of competency and skills. In addition, sensitization workshops or training on value clarification on abortion should also be conducted for public health policymakers and healthcare providers to help them explore, question, clarify and affirm their values and beliefs about abortion in the context of sexual and reproductive health and rights. As such, it can help them distinguish and separate their personal beliefs from their professional roles and responsibilities appropriately and increase their awareness, acceptance, support and advocacy for comprehensive abortion care and related sexual and reproductive health care and rights.

Finally, it is essential to ensure the delivery of comprehensive abortion care addresses both the issues of "what to deliver" and "how to deliver". The use of appropriate abortion technology and the necessary equipment, supplies, standards or technical guidelines and referral mechanisms need to be made available. The service delivery system should also address other issues, such as affordability and acceptability of the services, quality of care, additional support, such as couple counselling on safe sex, family planning, unwanted pregnancy, consequences of unprotected sex and unsafe abortion, and legal grounds for safe abortion.

Malaysia is a signatory to the ICPD PoA in which women's right to reproductive health, including safe abortion, is enshrined. The MDG 5 Goal on maternal health and targets for universal access to sexual and reproductive health and rights also address this same right of women. The country is also on the verge of being recognized as a developed nation. To this end, it is imperative that the country enters this new phase with a renewed commitment to meet the reproductive health and rights of women. Women should not be allowed to die from unsafe abortion in a country which is often looked upon as the forerunner of the Safe Motherhood programme.

REFERENCES

Ang ES, Huang MSL & Lim SC. ICPD+15: ICPD Third Country Report of Malaysia: NGO Perspectives. 2010. Federation of Reproductive Health Associations, Malaysia (FRHAM) and United Nations Population Fund (UNFPA).

Boonstra H. Islam, Women and Family Planning: A Primer. The Guttmacher Report on Public Policy December 2001. Guttmacher Institute. 2001; 4(6).

Cohen, SA. Facts and Consequences: Legality, Incidence and Safety of Abortion Worldwide. New York: The Guttmacher Institute, 2009.

Country Profile on Abortion. Asia Safe Abortion Partnership. http://www.asap-asia.org/country-profile-malaysia.htm

Dalvie S, Barua A, Choong S, Chin O & Ramasami S. A Study of Knowledge, Attitudes and Understanding of Legal Professionals about Safe Abortion as a Women's Right. The Asia Safe Abortion Partnership. 2010.

Facts on Induced Abortion Worldwide. The Guttmacher Institute and World Health Organization (WHO). 2007.

Family Planning: A Global Handbook for Providers - Contraceptive Effectiveness. World Health Organization (WHO) and Johns Hopkins Bloomberg School of Public Health & USAID. 2007. http://www.ippf.org/NR/rdonlyres/22249F1F-E396-420C-B6F6-D6C8C2976458/0/319332.pdf. Accessed on 28 August 2011.

Government of Malaysia and United Nation Development Programme (UNDP). Malaysia (2010) Malaysia 2010 MDG Report. 2010.

International Conference on Population and Development (ICDP): Summary of the programme of action. United Nations. 1994. http://www.un.org/ecosocdev/geninfo/populatin/icpd.htm. Accessed on 15 October 2011.

International Planned Parenthood Federation (IPPF). Glossary. http://www.ippf.org/en/Resources/Glossary.htm?g=M. Accessed on 24 August 2011.

Kamaluddin SF. A Follow-up Profile of Women Seeking Pregnancy Terminations in a Clinic in Urban Malaysia: 1998-2005. Jurnal Sains Kesihatan Malaysia. 2010; 8(1): 5-11.

Linking ICPD and MDG. United Nations Population Fund (UNFPA). 2000.

Malaysia. 2006. The Commissioner of Law Revision, Malaysia. Laws of Malaysia – Act 574 Penal Code.

Marie Stopes International (MSI) & Ipas. For women's lives and health: Report of the Global Safe Abortion Conference. Whose right? Whose choice? Who cares? 23-24 October, 2007. London, England. London and Chapel Hill, NC: MSI and Ipas, 2009.

McInerney T, Baird TL, Hyman, AG & Huber AB. A guide to providing abortion care. Technical Resources for Abortion Care. Chapel Hill, NC: Ipas, 2001.

Mohamad, A. Islamic views on Abortion Content. Fatwa Management Division, Department of Islamic Development Malaysia. http://www.e-fatwa.gov.my/artikel/pandangan-syarak-mengenai-pengguguran-kandungan, Accessed on 19 December 2011.

National Population and Family Development Board, Ministry of Women, Family and Community Development. National Population and Family Survey. 2004.

New Straits Times. Married women want it, too. 2011. http://www.nst.com.my/nst/articles/13lppkn-2/Article/index_html. Accessed on 16 January 2012.

Potts M, Diggory P and Peel J. Abortion. Cambridge University Press, London, 1977.

Reproductive Rights Advocacy Alliance Malaysia (RRAAM). Survey Findings of Knowledge and Attitudes of Doctors and Nurses on Abortion by the Reproductive Rights Advocacy Alliance Malaysia. 2007. http://www.rraam.org/about.html. Accessed on 2 August 2011.

Sedgh G, Henshaw S, Singh S, Åhman E & Shah IH. Induced abortion: rates and trends worldwide. Lancet. 2007; 370 (9595): 1338–45.

Singh S, Wulf D, Hussain R, Bankole A & Sedgh G. Abortion Worldwide: A Decade of Uneven Progress. New York: Guttmacher Institute, 2009.

Tey NP. Contraceptive Use and Unmet for Contraception in Peninsular Malaysia. Paper presented at FFPAM RRAAM. Consultation Increasing Access to The Reproductive Right to Contraceptive Information and Services; Monitoring Progress since 1994 ICPD Agreements, 21 October, 2008, Subang Jaya, Selangor, Malaysia.

The Guttmacher Institute. Unsafe Abortion: The Missing Link in Global Efforts to Improve Maternal Health. 2011. http://www.guttmacher.org/pubs/gpr/14/2/gpr140224.pdf. Accessed on 5 September 2011.

Turner KL & Page KC. Abortion attitude transformation: A values clarification toolkit for global audiences. Chapel Hill, NC: Ipas, 2008.

United Population Fund (UNFPA). Unleashing the Power of Women and Girls: A 7 Billion Actions Special Event. 2011.

Vlassoff M, Walker D, Shearer J, Newlands D & Singh S. Estimates of Health Care System Costs of Unsafe Abortion In Africa and Latin America. International Perspectives on Sexual and Reproductive Health. Sep 2009; 35(3): 114-21.

World Health Organization. Package of Interventions for Family Planning, Safe Abortion care, Maternal, Newborn and Child Health. Geneva: World Health Organization, 2010.

World Health Organization. Safe abortion : technical and policy guidance for health systems. Geneva: World Health Organization, 2003.

World Health Organization. The prevention and management of unsafe abortion: Report of a Technical Working Group. Geneva: World Health Organization, 1992.

World Health Organization. Unsafe abortion: global and regional estimates of the incidence of unsafe abortion and associated mortality in 2008. Geneva: World Health Organization, 2011.

World Health Organization Regional Offices for South-East Asia and the Western Pacific (WPRO). Health in Asia and the Pacific quoting a study: "J. Ross J, Stover J, Adelaja. Profiles for family planning and reproductive health programs (116 countries). [2nd ed]. Washington DC: Futures Group". 2005.

APPENDICES

Appendix A – Questionnaire approval

UPM
UNIVERSITI PUTRA MALAYSIA
BERILMU BERBAKTI

QUALITY SYSTEM SIRIM
STANDARDS MALAYSIA
MS ISO 9001 : 2000 REG. NO. AR 4256

FAKULTI PERUBATAN DAN SAINS KESIHATAN
FACULTY OF MEDICINE AND HEALTH SCIENCES

Ruj. Kami : UPM/FPSK/PADS/T7-MJKEtikaPer/F01(LECT(JPD Mac(11)11)
Tarikh : 9 September 2011

Kepada Sesiapa yang Berkenaan

Tuan/Puan,

PROJEK PENYELIDIKAN:

MEDICAL OFFICER'S KNOWLEDGE, ATTITUDE AND WILLINGNESS TO PROVIDE ABORTION RELATED SERVICES AS A REPRODUCTIVE RIGHTS OF WOMEN

PENYELIDIK : PROF. MADYA DR. MARY HUANG SOO LEE

Jawatankuasa Etika Penyelidikan Perubatan, Fakulti Perubatan dan Sains Kesihatan telah meneliti cadangan penyelidikan di atas dan dengan ini bersetuju bahawa tidak terdapat sebarang isu melibatkan etika di dalam cadangan penyelidikan tersebut.

Fakulti tidak akan bertanggungjawab terhadap sebarang tindakan yang dilakukan oleh penyelidik semasa menjalankan penyelidikan selepas kelulusan ini diberikan.

Sekian, terima kasih.

"BERILMU BERBAKTI"

Yang benar,

PROFESOR DR. NORLIJAH OTHMAN
Pengerusi
Jawatankuasa Etika Penyelidikan Perubatan
Fakulti Perubatan dan Sains Kesihatan
Universiti Putra Malaysia

s.k Fail Induk – Etika

Appendix B – Ethics Approval

PEJABAT TIMBALAN KETUA PENGARAH KESIHATAN
OFFICE OF THE DEPUTY DIRECTOR-GENERAL OF HEALTH
(PENYELIDIKAN & SOKONGAN TEKNIKAL)
(RESEARCH & TECHNICAL SUPPORT)
KEMENTERIAN KESIHATAN MALAYSIA
MINISTRY OF HEALTH MALAYSIA
Aras 12, Blok E7, Parsel E, Presint 1
Level 12, Block E7, Parcel E, Precinct 1
Pusat Pentadbiran Kerajaan Persekutuan
Federal Government Administrative Centre
62590 PUTRAJAYA

Tel : 03 88832543
Faks : 03 88895184

JAWATANKUASA ETIKA & PENYELIDIKAN PERUBATAN
KEMENTERIAN KESIHATAN MALAYSIA
d/a Institut Pengurusan Kesihatan
Jalan Rumah Sakit, Bangsar
59000 Kuala Lumpur

Ruj. Kami : (2) dlm.KKM/NIHSEC/08/0804/P11-316
Tarikh : 14 Jun 2011

Prof. Dr. Mary Huang Soo Lee
Jabatan Pemakanan dan Dietetik
Fakulti Perubatan Dan Sains Kesihatan
Universiti Putra Malaysia

Puan,

NMRR-11-213-8466
Medical Officers Knowledge, Attitude and Willingness to Provide Abortion Related Services as a Reproductive Right of Women

Lokasi Projek: Universiti Putra Malaysia / Hospital Kuala Lumpur / Hospital Sultanah Nur Zahirah, Terengganu / Hospital Sultanah Aminah, Johor Bahru / Hopital Sultanah Bahiyah, Kedah / Hospital Umum Sarawak, Sarawak

Dengan hormatnya perkara di atas adalah dirujuk.

2. Jawatankuasa Etika & Penyelidikan Perubatan (JEPP), Kementerian Kesihatan Malaysia (KKM) tiada halangan, dari segi etika, ke atas pelaksanaan kajian tersebut. JEPP mengambil maklum bahawa kajian tersebut tidak mempunyai intervensi klinikal ke atas subjek dan hanya melibatkan pengumpulan data melalui borang soal selidik.

3. Segala rekod dan data subjek adalah SULIT dan hanya digunakan untuk tujuan kajian dan semua isu serta prosedur mengenai *data confidentiality* mesti dipatuhi. Kebenaran daripada Pengarah hospital di mana kajian akan dijalankan mesti diperolehi terlebih dahulu sebelum kajian dijalankan. Puan perlu akur dan mematuhi keputusan tersebut.

4. Laporan tamat kajian dan sebarang penerbitan dari kajian ini hendaklah dikemukakan kepada Jawatankuasa Etika & Penyelidikan Perubatan selepas tamatnya kajian ini.

Sekian terima kasih.

BERKHIDMAT UNTUK NEGARA

Saya yang menurut perintah,

(DATO' DR CHANG KIAN MENG)
Pengerusi
Jawatankuasa Etika & Penyelidikan Perubatan
Kementerian Kesihatan Malaysia

For any enquiries regarding the information presented in this study, please contact the principal investigator:

Associate Prof. Dr. Mary Huang Soo Lee
Faculty of Medicine and Health Sciences
University Putra Malaysia
43400 Serdang
Selangor, Malaysia
Tel: 603 8947 2471 Fax: 603 8942 6769
Email: huang@medic.upm.edu.my

Project Report

Reproductive Rights and Choice: Insights from Women on Pregnancy Termination

Wah-Yun Low, PhD
Yut-Lin Wong, DrPH
Sim-Poey Choong, MBChB, FRCA (Eng)
Ravindran Jegasothy, MBBS, FRCOG
Wen-Ting Tong, BSc (Hons)

STUDY TEAM

1. **Professor Dr. Low Wah Yun**
Faculty of Medicine, University of Malaya, Kuala Lumpur, Malaysia

2. **Associate Professor Dr. Wong Yut Lin**
Department of Social and Preventive Medicine, University of Malaya, Kuala Lumpur, Malaysia

3. **Dr. Chong Sim Poey**
Klinik Rakyat, Penang, Malaysia

4. **Dato' Dr. Ravindran Jegasothy**
Department of Obstetrics & Gynaecology, Kuala Lumpur General Hospital, Kuala Lumpur, Malaysia

5. **Ms. Tong Wen Ting**
Medical Education Research and Development Unit, Faculty of Medicine, University of Malaya, Kuala Lumpur, Malaysia

ACKNOWLEDGEMENTS

This research is funded by World Health Organisation (Western Pacific Region).

We would like to express our heartfelt gratitude to staff members of the research clinic who have rendered their time and resources to ensure that the entire research process was executed smoothly.

Last but not least, our utmost appreciation goes to all the women who were willing to be interviewed and spend their time in this study. Their co-operation, thoughts and opinions certainly have given us new insights into understanding womens' perception, knowledge and experiences of pregnancy termination in Malaysia.

We would like to acknowledge and thank the following:

- Dr. Corinne Capuano, WHO Representative in Malaysia, Brunei Darussalam and Singapore,
- Dr. Harpal Singh, WHO Technical Officer, WHO Representative Office for Brunei Darussalam and Singapore, and
- UNFPA, for providing the funding for the publication of this report.
- Dr. Siti Norazah Zulkifli, for editing this whole report.

LIST OF TABLES

INTRODUCTION

Since Independence, Malaysia's policies in social development has vastly improved women's access to education and employment opportunities. However, there are still weaknesses in the area of women's reproductive health and rights. Despite the establishment of the National Family Planning Board in 1966, and a relatively permissive abortion law in 1989 (Penal code, section 312) (IPPF ESEAOR, 2011), knowledge and practice of contraception remain low and access to abortion remains limited.

As in the rest of Asia, the topic of reproductive health for women remains controversial in a conservative cultural environment prescribing norms of moral behaviour for women. Despite evidence of it as a common practice for women faced with unintended pregnancies, abortion remains the most contentious (Dickens, 2009).

There are many reasons how and why women experience unintended pregnancies despite the availability of modern contraception. This is supported by surveys worldwide in 2008 indicating that, in South East Asia on average, for every 12 pregnancies, six are unintended of which two are born and four are aborted; in other words, almost 1/3 of all pregnancies are aborted (Susheela Singh et al., 2009). Furthermore, more than 90% of abortions are induced.

Advances in the medical technology for abortions have made such services both safer and cheaper. Manual vacuum aspiration (MVA) under local anaesthesia and medical abortion (MA) with drugs alone are methods which are well established but still not widely used in Malaysia. After the International Conference on Population and Development(ICPD) 1994 in Cairo, there is increasing international consensus that access to information and services to enable all women to regulate their reproductive function is a woman's right. Unfortunately, abortion services in government health facilities are still very limited while the private sector keeps a very low profile on such services because of the stigma attached. This makes access to information and services difficult for many women. It is thus appropriate and timely that a study on the availability and practice of abortion be undertaken. The current study also seeks to clarify the circumstances faced by women seeking an abortion in Malaysia.

OBJECTIVES

The project, "Reproductive Rights and Choice: Insights from Women on Pregnancy Termination" objective is to study, explore the knowledge, perceptions and practices related to abortion among women. Findings of this study should act as a guide towards formulating policies and programmes to promote safe abortion.

METHODOLOGY

A qualitative approach was utilized for the study. The approach was selected for several reasons. First, abortion is generally not acceptable in Malaysian society and its practice among women remains largely undisclosed, sometimes even to the spouse. Secondly, despite being legal, abortion services are not publicized by healthcare providers and are not offered widely or openly. Thirdly, the inconsistent classification of abortion episodes, e.g., as menstrual regulation or miscarriage, under-reports its prevalence and, hence, provides unreliable data. Fourthly, to carry out a survey (quantitative method), a very large sample of women would have to be canvassed to capture a sufficient sample of women who have experienced abortion,

not to mention potentially poor respondent reliability (the issue of whether women would, in the first instance, admit to it). Thus, these anticipated problems and limited resources necessitated a focussed qualitative approach to this study.

The advantages of a qualitative enquiry are the following (Ulin et al 2002; Sacket & Wennberg 1997; Dickerson 1997; Allen-Meures & Lane 1990):

1. elicits in-depth information from respondents that may uncover unanticipated causal factors, and reveal new research questions (exploratory, emergent and iterative processes),
2. provides the opportunity for respondents to speak about and discuss issues pertaining to the study with less constraint than a structured questionnaire, i.e., respondents are active participants rather than subjects, and
3. adds to the content and quality of data collected via a quantitative (survey) approach via a more in-depth understanding of actions and behaviours.

This study utilised face-to-face in-depth interviews (IDIs). The primary reason for this choice was the sensitivity of the focus of enquiry. As such, it was expected that individual interviews would have a better chance of gaining respondents' participation compared to a group interview method, namely, Focus Group Discussion. The IDIs were conducted individually and each IDI took between one and a half hours.

Respondent Recruitment

The women were recruited in an urban setting in a private clinic based in Penang, Malaysia. A list of women who fulfilled the criteria for participation, namely aged 21 years and above who have had an abortion (medical and/or surgical) was obtained and telephone calls were made to invite them for the study. Respondents from multi-cultural backgrounds who had visited the clinic were recruited. Out of a total of 45 calls made, only 31 were willing to take part in the study. Those who declined to participate gave the following reasons: they did not wish to share information on the topic, time constraints, unavailability, disapproval by husband and concerns over confidentiality. A small token of appreciation was given to the participants after the interview.

This clinic is owned by one of the researchers (SPC). This clinic was purposively chosen as it is a family planning clinic that openly provides abortion services and has a very high turnover of clients who have experienced surgical or medical abortions. All interviews were carried out in the clinic and confidentiality and privacy was ensured.

Participants were also informed that participation was entirely voluntary and the interviews would be recorded for analysis purposes. Withdrawal from the study was allowed at any time. Due to the sensitivity of the subject matter, all information was kept in strictest confidence and all interviews were anonymous. An interview guide constructed by researchers was used in the interview process (Appendix A). As respondents from various ethnic backgrounds were selected, IDIs were conducted in three languages, namely Malay, English and Chinese, depending on the respondents' first language (mother tongue). All interviews were conducted by the female researchers.

With permission from the respondents, digital recordings of all the interviews were carried out strictly for transcribing purposes. Once the transcripts were done, all the recordings were

destroyed in view of its confidentiality. All recordings were transcribed verbatim for data analysis. Malay and Chinese transcripts were translated into English. The transcripts were analysed using QRS NVivo qualitative software (QRS International Pty Ltd, Doncaster, Victoria, Australia) and open, axial and selective coding (Strauss & Corbin, 1998) were carried out during analysis. During the coding process, themes and concepts were produced.

As required by our agreement with our respondents on total anonymity in the report, the quotes only provide their socio-demographic characteristics as abbreviated in the table below:

Age (in years)	Ethnicity	Education level	Marital status	Profession
Specific age of the women	M = Malay	Primary	Single	Specific profession of the women
	C = Chinese	Secondary	Married	
	I = Indian	Tertiary	Divorced/Separated	

For example: This quote is cited by a 29 year old Malay married woman, with secondary level education who works as an operator:

> "Like we say in Islam, it's definitely wrong to have an abortion"
> **[29_M_SECONDARY_MARRIED_OPERATOR]**

Ethical Considerations

Ethical approval for the study was obtained from the University of Malaya Medical Centre Ethics Committee. The verbal informed consent was obtained from all participants prior to the study (Appendix B).

STUDY FINDINGS

Socio-Demographic Characteristics of Respondents

A total of 31 in-depth interviews were conducted from May to June 2011 in the said clinic. All the women had their last abortion between January 2010 and May 2011.

The average age of the women interviewed was 30 years, ranging from 21 to 43 years old. Half of the respondents were Malays (50%), followed by Chinese (30%) and Indians (20%). The majority had secondary level education (74%, n=23). Only 19% (n=6) achieved tertiary education and two women (7%) only received primary level education. Most (80.6%, n=25) of the women were married, five (16.1%) were single and one (3.2%) was separated from her partner.

Out of the 31 women, 24 were working while seven were housewives. Almost all the working women earned a low income of less than RM2000 (92%, n=22) monthly while the remaining (8%, n=2) earned a monthly personal salary of RM3001-RM4000 and RM4000-RM5000, respectively. However, in terms of monthly household income, there was an equal (35.5%, n=11) distribution among those earning between RM1000-RM2000 and RM3001-RM4000. Five (16.1%) women had a monthly household income of RM4001-RM5000, two (6.5%) had less than RM1000, and one (3.2%) each in the RM2000-RM3000 and RM5001-RM6000 bracket, respectively.

There were equal (22.6%, n=7) proportions of women who were clerical support workers, service and sales workers, and housewives. The rest were plant & machine operators & assemblers (16.1%, n=5), technicians & associate professionals (6.5%, (n=2) and three (9.7%) were self-employed or doing freelance work.

Table 1: Socio-demographic background of respondents (n=31)

Characteristics		
Age (years)		
Range	21-43	
Mean ± sd	30.16 ± 6.41	
Characteristics	n	Percent (%)
Race		
Malay	16	51.6
Chinese	10	32.3
Indian	5	16.1
Religion		
Islam	16	51.6
Buddhist/Taoist	10	32.3
Hindu	5	16.1
Education level		
Primary	2	6.5
Secondary	23	74.2
Tertiary	6	19.4
Marital status		
Single	5	16.1
Married	25	80.6
Divorced/Separated	1	3.2
Monthly Personal Income[1] (US$1 = Ringgit Malaysia RM3.10)		
< RM 1000	7	29.2
RM1000 – RM2000	15	62.5
RM3001 – RM4000	1	4.2
RM4001 – RM5000	1	4.2
Monthly Household Income		
< RM 1000	2	6.5
RM1000 – RM2000	11	35.5
RM2001 – RM3000	1	3.2
RM3001 – RM4000	11	35.5
RM4001 – RM5000	5	16.1
RM5001 – RM6000	1	3.2
Occupational group[2]		
Technicians &associate professionals	2	6.5
Clerical support worker	7	22.6
Service and sales worker	7	22.6
Plant & machine operators & assembler	5	16.1
Self-employed/freelance	3	9.7
Housewife	7	22.6

1 N=24. Total is less as 7 women are housewives with no personal income

2 Based on Malaysia Standard Classification of Occupations 2008, Ministry of Human Resource, Malaysia

Obstetrics History of Women

Among the 31 women, seven of them did not have any children at the time of the abortion. The mean number of children for the others was 1.9 (±1.35), ranging from one to five. The women averaged 4.29 pregnancies in their lifetime ranging from 1 to 11 pregnancies (±2.5). They had an average of 2.16 (±1.37) abortions ranging from one to eight for one participant.

Table 2: Obstetrics history (n=31)

Obstetric information	
Para	
Range	0-5
Mean ± sd	1.9 ± 1.35
Median	2
Mode	3
Gravida	
Range	1-11
Mean ± sd	4.29 ± 2.5
Median	5
Mode	5
Number of induced abortion	
Range	1-8
Mean ± sd	2.16 ± 1.37
Median	2

Perceptions on Abortion among Respondents

General Views on Abortion

Many respondents viewed abortion negatively. Although they themselves have had abortions, many still considered it a sin, as the taking of life, based on their religious beliefs and convictions.

> "I am in Buddhism. Every single thing has a soul. Although it hasn't taken shape, yet it is also a life. We are taking a life away"
>
> **[29_C_SECONDARY_SINGLE_ADMIN CLERK]**

> "Legally, I am not sure. But, in Islam, it is against abortion. What I know is especially for those pregnancies out of wedlock, it is not allowed"
>
> **[26_M_TERTIARY_MARRIED_CLERK]**

Yet, some felt that abortion is a common phenomenon and that a lot of people have it done.

> "I think there are many people doing it [abortion]"
>
> **[38_C_PRIMARY_MARRIED_FACTORY QA]**

> "Yes, very common already, a lot of people doing it"
>
> **[25_C_SECONDARY_SINGLE_HAIRSTYLIST]**

Some also felt that having an abortion is better than having to abandon a baby or bringing up a baby without love or a conducive environment, i.e., without financial means.

> "If the situation is affordable and in good condition, then we keep the baby. But, if the situation cannot be allowed, then when the baby comes out then suffering"
>
> **[25_C_TERTIARY_MARRIED_HOUSEWIFE]**

Also, some felt that abortions were done because the pregnancy was unplanned or because couples were not ready to have a baby. Some felt really sorry and guilty talking about abortions. Abortion is perceived to be a personal and sensitive matter and, thus, not many people talk about it.

> "But I think bringing him [the baby] out [to this world], if we cannot really give him the best, it's no point to have him [the baby] because it can cause harm to the baby"
>
> **[26_C_SECONDARY_MARRIED_SALESPERSON]**

> "Um...personally...abortion actually for me is not ok. But to do it [abortion] surely there must be a reason. Why do you do it? If you are ready, you won't do it. That's it. If you are ready to have a baby, you won't go for an abortion"
>
> **[38_M_TERTIARY_MARRIED_HR OFFICER]**

There were also misconceptions about the dangers of abortion.

> "I heard people said it will spoil the kidney. Sometimes, the ovary will come down. Like us ladies, when we give birth, the ovaries must be strong. Then, when you have abortion, the ovary will be very low, make you tired, cause pain, all these things happened. A lot of effects"
>
> **[42_I_SECONDARY_SEPARATED_PRODUCTION OPERATOR]**

Acceptable Reasons for Abortion

The study also revealed the respondent's personal views on the acceptable reasons or circumstances in which abortion should or can be allowed. The accepted reasons were mainly economic instability, unmarried status, foetal abnormalities, mothers' health risk, doctor's recommendation, unplanned or mistimed pregnancies affecting the mother or couple, relationship issues, and having completed their family.

> "Some kids took too much medicine. If you don't want to abort, you'll bear a child with retardation. How to raise a kid like this? Right?"
>
> **[42_C_PRIMARY_MARRIED_CLERK]**

> "It can be accepted for those who are not married yet. But for those who are married, there must be reasons why they go for abortion. Also, having too many children is a problem because the cost is high"
>
> **[29_M_SECONDARY_MARRIED_OPERATOR]**

> "I think one of the reasons is being unmarried. If married, very few people want to abort without reason"
>
> **[32_M_SECONDARY_MARRIED_FACTORY LINE LEADER]**

> "Maybe they [couples] are not ready to have children…and they did not plan, so…"
>
> **[29_M_SECONDARY_MARRIED_OPERATOR]**

> "Sometimes, we are not capable of looking after so many children. Some people have too many babies. Low salary, so forced to abort, so we got to accept it. So I cannot say it's illegal. You cannot say we are against the law. It depends on individual's income, right?"
>
> **[35_M_SECONDARY_MARRIED_CLERK]**

Among others, the financial situation was mentioned as another factor that justifies an abortion.

> "Sometimes it's because of economic problem. Therefore, don't want to give birth to so many children. Then, some people not married, they don't want to become an unmarried mother. Or, some like relationship between couple is not good. If the relationship is not good, they tend not to have kids too, as it will cause lot of problems"
>
> **[38_C_PRIMARY_MARRIED_FACTORY QA]**

> "All want to have abortion because of financial problems"
>
> **[22_M_SECONDARY_MARRIED_HOUSEWIFE]**

> "Can't afford"
>
> **[25_C_SECONDARY_SINGLE_HAIRSTYLIST]**

Some women perceived abortion by unmarried women as unjustified.

> "Misuse of abortion by those who are not married. Easy for them to just go for abortion. They do not know the risk. When married later on, not sure whether they can have children. That's the consequence. Like those young ones [teenagers], they like to play around, then easy to go for abortion, then this is not good"
>
> **[32_M_SECONDARY_MARRIED_FACTORY LINE LEADER]**

One said that abortions may be medically recommended.

> "Like if the mother has got medical problem, the doctor will suggest to go for abortion. If the mother got pregnant and got problem, so between mother and child, got to pick one, then maybe, doctor will ask to abort the baby"
>
> **[29_M_SECONDARY_MARRIED_OPERATOR]**

It is interesting to note that when the pregnancy is early, abortion is more acceptable because of the unformed foetus.

> "…because when you got just one month only (pregnancy), not too shape [formed], so you can do it [abortion]"
>
> **[25_C_SECONDARY_SINGLE_HAIRSTYLIST]**

Although there are acceptable reasons for abortion, even strong religious objections are abandoned in desperate situations.

> "It's definite that in Islam, abortion cannot be done, unless in desperate situation"
>
> **[29_M_SECONDARY_MARRIED_OPERATOR]**

Perceived Barriers to Abortion

The perceived barriers faced by the respondents in seeking abortion include the following: financial constraints, accessibility and availability, lack of information, and uncertainty over the legal status of abortion.

> "No I didn't go anywhere. Because if go to government [hospital], need to give birth to the baby. Cannot have abortion in government hospital, because they are government, very strict, conservative, very traditional mind, say abortion is illegal"
>
> **[29_C_SECONDARY_SINGLE_ADMIN CLERK]**

> "If let's say people are rich, it's ok for them. If poor means cannot afford, so there is problem, so abort baby"
>
> **[38_I_SECONDARY_MARRIED_HOUSEWIFE]**

> "Maybe not everyone knows [about abortion services]. Maybe they also asked other people where to get abortion"
>
> **[24_M_SECONDARY_MARRIED_HOUSEWIFE]**

> "Finance. Because if you want to have sex, it can be anywhere. But, when it comes to abortion, it's more expensive than having a one night stand, you see. So, it's probably financial"
>
> **[29_I_TERTIARY_MARRIED_SUPPORT SPECIALIST]**

> "Some people want to abort, but have no money. Some families don't want to abort. Sometimes the husband also doesn't want to abort. So, maybe these are some of the obstacles"
>
> **[35_M_SECONDARY_MARRIED_CLERK]**

Reasons for Choosing Medical Abortion

Personal reasons for choosing medical abortion were also revealed. The main reasons given were lower cost, on doctor's recommendation, convenience, and ease of use.

"It was the doctor who suggested it. Doctor said slight wash only. You only take medicine. He taught me how to take the medicine and so I took it accordingly"

[42_C_PRIMARY_MARRIED_CLERK]

"I'm scared to have induced abortion and it is more expensive. So err…take medicine and it's also much cheaper"

[26_C_SECONDARY_MARRIED_SALESPERSON]

"Main motivator is it's easy, no pain at all. Only take medicine. Easy, no need to wash, no suction, no digging"

[29_M_SECONDARY_MARRIED_OPERATOR]

"I take pills. Because first time I washed, nearly RM500. Take pills cheaper"

[38_I_SECONDARY_MARRIED_HOUSEWIFE]

"Much cheaper than induced abortion. Take medicine will be lesser cost"

[26_C_ SECONDARY _MARRIED_ECONOMIC RICE SELLER]

Knowledge about Abortion

Methods of Abortion

Almost all know the traditional methods, namely eating unripe pineapples with Coca-cola and Panadol, considered as a 'caustic' concoction or *'tajam'* in Malay.

"Yeah. Coca-Cola, some more…pineapple. Yeah, unripe pineapple you know…"

[38_I_SECONDARY_MARRIED_HOUSEWIFE]

"(laugh) That means, er… pineapple. Er, cuka. Er, mix dengan water kot. And then, because cuka kita guna buat macam barang makanan. Just little kita put dalam tu. Er, so, kita makan dengan pineapple, cuka dan tapai. Yes. Tapai ah tawas. Tawas, er, apa dia…er, air lah, like macam cuka juga. Er, minum"

"(laugh) That means, er…pineapple. Er, vinegar. Er, mixed with water. And then, because the vinegar is those we use to prepare food, we put little inside. So, we eat with pineapple, vinegar and tapai [fermented tapioca beverage]. Yes. Tapai ah tawas. Tawas, er, what is that…er, water, is like vinegar also. Er, drink"

[25_M_SECONDARY_MARRIED_CLERK]

"Air cola tu tajam. Nenas pun tajam juga"

"The cola drink [carbonated drink] is caustic. Pineapple is caustic also"

[35_M_SECONDARY_MARRIED_NASI LEMAK SELLER]

"Dia banyak…makan nanas, panadol, air coke…"

"There are a lot…who eat pineapple, panadol [paracetamol], coke [carbonated drink]…"

[21_M_SECONDARY_SINGLE_PROMOTER]

"Ya. (laughs) Eat so many pineapples. And then eat…pineapple and drink coke. They mixed together…"

[25_C_TERTIARY_MARRIED_HOUSEWIFE]

"Doklah macam dalam buku...adalah dia macam...macam setengah setengah kes kan? Macam dia cerita macam dia nak gugurkan kandungan tu macam dia... macam dia makan bende bende yang macam tajam tajam tu I pun I try lah jugok macam nanas apa semua..."

"Like those in book...there are such as...like some cases right? Like how they tell how she wants to abort the pregnancy. Eats things that are caustic, I also tried pineapple all that…"

[29_M_SECONDARY_MARRIED_OPERATOR]

Malays also mentioned '*jamu*', i.e., herbs prepared by traditional midwives either locally or from Indonesia, as a method of abortion.

"Ah, jamu yang panas. Panas punya Indonesia. Macam jamulah, kedai indonesia kan dia ada jamu kan."

"Ah, the *jamu* is 'heaty'. From Indonesia. In Indonesian shops, they have *jamu*"

[32_M_SECONDARY_MARRIED_FACTORY LINE LEADER]

"Mmm… Kedai ubat cina saja. Lepas tu… jamu Indonesia pun ada... dia kata"

"Mmm...Chinese medicinal shops. Or...Indonesian *jamu* also got she said"

[24_M_SECONDARY_MARRIED_HOUSEWIFE]

Another popular method was consuming herbal abortifacients from the traditional Chinese medicine shop.

"I cuma... Haritu I pernah cuba sekali sebelum I mari sini. I makan itu ubat cina. Kaedah ubat cina"

"That day I tried once before coming here. I took the Chinese medicine. Chinese medicine methods"

[22_M_SECONDARY_MARRIED_HOUSEWIFE]

"Selalu yang kawan-kawan I tanya um… mana ada ubat ar boleh kasi gugur? Ah semua mau pergi itu klinik cina punyakan. Semua selalu banyak tanya ubat punyalah. Biji itu kedai cina jual punya kan…"

"My friends always asked where to get medicine for abortion? All want to go to the Chinese clinic. They all usually asked about the medicine. The tablets that the Chinese shop sell"

[24_M_SECONDARY_MARRIED_HOUSEWIFE]

"For what… and then they got…use the Chinese herbs…"

[25_C_TERTIARY_MARRIED_HOUSEWIFE]

However, it was also generally agreed that these methods are not very effective and the 'caustic' ingredients may have very bad side effects. Only one respondent mentioned the insertion of stalks into the cervix as a method but admitted that it is very dangerous.

"Inside, kita punya dalam… akan rasa pedih, panas, sakit. Kalau kita ambil cuka, tawas, ha, that's one benda tajam, memang tak bolehlah"

"Inside our [body], we feel stinging, hot and pain. If we take the vinegar, '*tawas*' [fermented tapioca beverage], those are caustic, shouldn't do that"

[25_M_SECONDARY_MARRIED_CLERK]

"Oh, kalau yang tu, yang saya tau, kalau dekat kampung, dia ambil satu serai. Dia bagi… ha, dia jolok. Tapi yang itu boleh bawa maut sikit lah."

"Oh, if those, what I know, if it is in the village, they will take the lemon grass stalk. They will give...ha, they will thrust [into the vagina]. But it can cause death"

[21_M_SECONDARY_SINGLE_PROMOTER]

"Yang tu pun tak yakin la kan. Traditional kalau makan nenas tu kalau badan dia lemah dia tak kuat dia boleh turun juga lah."

"That one also not very convincing. Traditional, eventhough eat pineapples, if the body is weak…not strong, it will still come down [bleeding following induced miscarriage]"

[35_M_SECONDARY_MARRIED_NASI LEMAK SELLER]

"Klinik ubat cina lah.. mau beli makan, kita kata eh jangan lah, takut. Bahayakan… kita tak tahu ubat tu macam mana. Pergilah klinik ini."

"The Chinese medicinal shop…want to buy and eat [for abortion], we said 'eh, don't do that'. It's scary. Dangerous and we don't know how the medicine is like. Better to go to this clinic"

[24_M_SECONDARY_MARRIED_HOUSEWIFE]

"Pineapple dengan, er, tapai, that's one OK, diorang cakap. Tapi I tak biasa try lah, sebab I… kalau I try benda tu, dalam akan rosak, sakit, lebih baik I datang ke klinik, I ambil ubat, dah sekali pun I dapat lagi kaunseling semua, bagi ubat tahan sakit, memang I tau benda dalam dah memang boleh clean, boleh"

> "Pineapple with, 'tapai' [fermented tapioca beverage] people said it's ok. But I am not used to trying because if I try those things, inside [internal body] will be damaged, painful. So is better I come to the clinic. I take the medicine, and I also get counseling as well. They give pain killers. I knew that all the things [foetus] inside will be clean [complete abortion]"
>
> **[25_M_SECONDARY_MARRIED_CLERK]**

Many mentioned taking western medication as an abortifacient but it was not clear whether they were referring to Norcolut (progestagen), a hormone often given to induce menstrual bleeding in delayed menses, or to modern medical abortion with Cytotec. Norcolut works only for non-pregnant women as periods can often be delayed by anxiety and Norcolut often initiates the menstrual bleed, hence, women mistake it for an abortifacient effect. Surgical abortion was referred to as an 'operation', sometimes as D&C or as suction procedure or vacuum.

> *"Ha, yang tahu itu, D&C. Sebelum yang tahu yang itu saja lah. Lepas tu yang second ni baru tahu kata ada ubat"*
>
> "What I know is D&C. All I know is that before. After that I knew of medical abortion"
>
> **[29_M_SECONDARY_MARRIED_OPERATOR]**

Availability of Services

Generally, the respondents were aware that abortions are available at some private clinics but certainly not in government hospitals 'because they are very strict'. Some knew that they do it for 'bleeding during pregnancy' only, i.e., clinically termed 'threatened' or 'incomplete' abortions.

> *"Klinik kerajaan kalau macam kita sendiri nak buat tak boleh lah. Kalau macam masalah kesihatan tu, depa buat lah."*
>
> "In government clinic, we cannot request for abortion. If it's for health problems, then they will do it [abortion]"
>
> **[29_M_SECONDARY_MARRIED_OPERATOR]**
>
> "Because last time when I tried government clinic, they said cannot."
>
> **[38_I_SECONDARY_MARRIED_HOUSEWIFE]**
>
> *"Er, takda, kerajaan takkan. Memang takda. Sebab diorang strict, terus. Kerajaan…more than, er, malay kan, so, diorang memang tak accept kes untuk keguguran. Tak terima langsung"*
>
> "Er, no, government won't. They really won't. Because they are strict. Government…more Malay right, so, they won't accept cases for abortion. Won't accept at all"
>
> **[25_M_SECONDARY_MARRIED_CLERK]**

Where it is available, they perceived it is an illegal clandestine service *'macam sembunyi-sembunyi'*. Some sensed that the researcher's clinic is 'official' and, therefore, legal. Some knew from personal experience of refusals after seeking help at different hospitals and clinics but mostly they knew this from hearsay.

> "Here should be legal one (laugh), because…because very long ago ma"
>
> **[43_C_SECONDARY_MARRIED_HOUSEWIFE]**

> *"Dia orang buat ni memang salah lah, melalui undang-undang. Lagipun diorang tak cakap benda ni erm, secara terbuka. Diorang buat secara private saja. Ha. Daripada depan kita tengok klinik untuk, er, sakit ringan. Front side. Dalam diorang buat untuk ini lah. I rasa ini secara sembunyi-sembunyi lah"*

> "They do all this it's illegal, in terms of law. Furthermore, they don't talk about all this openly. They only do it privately. From the front, we look at the clinic, it's for general sickness. Front side. Inside, they all do abortion. I think this one is clandestine"
>
> **[25_M_SECONDARY_MARRIED_CLERK]**

Ease of getting information depends on their social environment. Obviously, this subject gets talked about more than others. Thus, some expressed it was 'easy' to get correct information, while others found it difficult after a few rejections. Cost, generally quoted as over RM1,000, was an issue in having abortions at private hospitals.

> *"Mm, rasanya tak senang, susah jugalah. Sebab, adalah, dulu juga pi tanya klinik kan, klinik setengah tu ada yang tak, takda perkhidmatan macam ni? Ah, kira banyak klinik lah juga pi tanya? So, last tanya member, member dah rekomen. Dan so, yang ni sajalah yang I tau."*

> "Mm, it's not that easy, it's quite hard also. Because, I asked around last time, in clinics, some clinics don't offer services [abortion service] like that right? Ah, there are quite a number which I have asked. So, at last, I asked my friend, my friend recommended me. And so, I only know this one [clinic]"
>
> **[31_M_TERTIARY_MARRIED_CLERK]**

> "Hospital, only one. Already asked…already asked. It is expensive so I did not go there."
>
> **[36_C_SECONDARY_MARRIED_BEAUTICIAN]**

Side Effects

There was a belief in the generally 'weakening effects' of abortions on women, and more specifically, on the womb which is thought to 'drop down' (by which they mean a prolapse), and also that the walls of the womb get thinner each time an abortion is done.

> "This is very ordinary. Everyone says that after abortion, how the body become worse. Weak or what"
>
> **[43_C_SECONDARY_MARRIED_HOUSEWIFE]**

"Ahhh...mungkin lah...tak tak semua lah akan jadi macam tu. Dia kata sebab kita pernah...ahh gugur. Dia kata mungkin...kita punya rahim tu dah jadi macam...tak ok lah...jadi macam duduk kedudukan dia tu macam dah tak ok...dia kata mungkin masa kita nak mengandung pulak nanti mungkin uri tu akan ke bawah lah kira dia cakap...tak tahu lah yang tu je lah yang i tahu pun..."

"Ahh…maybe lah…not everyone will be like that. He [doctor] said because we had abortion before. He said maybe our womb is not in a good condition [prolapsed]. So, he said maybe when we want to get pregnant in the future, our placenta will go down. He said like that…don't know lah. This is the one that I know of…"

[29_M_SECONDARY_MARRIED_OPERATOR]

"Mm, I pernah dengar orang kata macam, rahim tu lah, nanti jatuh lah, macam luka kan, ah, yang tu je lah yang I tau. Macam, kedudukan rahim tu lah. Berubah ah, macam, kadang-kadang setengah tu kan, macam dia orang cakap rahim jatuh, macam just, bawah ari kita macam sakit kan?"

"Mm, I have heard that people said that the womb will descend [prolapse], and get injured. This is the only one I have heard of. Like, the womb will be displaced [prolapse]. Change, like ah, sometimes some people right, like they said the womb will descend, like down there [womb] we will feel pain right?"

[31_M_TERTIARY_MARRIED_CLERK]

However, from doctors' counselling, they recalled their great concern over the possible risk of infection causing subsequent infertility despite being informed that there is less than 1% risk of this happening.

"Ada macam sini pun depa habaq…kalau macam...apa sebab ada yang 99.9% tu kemungkinan tak boleh mengandung kan? Tak boleh mengandung balik lah…"

"Even here they told that if like…there is a 99.9% chance that there's possibility cannot get pregnant right? Cannot get pregnant again, then return..."

[29_M_SECONDARY_MARRIED_OPERATOR]

"Side effects? Seen before in book, err…some will be infertile! Still got… err… if want to get pregnant next time, maybe that chance to have a miscarriage will be more… got percentage, correct?"

[26_C_ SECONDARY _MARRIED_ECONOMIC RICE SELLER]

There was also a fear of the risk of uterine cancer and the possibility of giving birth to a child with a handicap or other abnormalities in the future.

"Tak tahu lah. Yang tu je lah yang tahu pun. Mungkin kanser kut. Kanser rahim ke"

> "Don't know lah. That one is the only one I know. Maybe cancer. Uterus cancer or what"
>
> **[29_M_SECONDARY_MARRIED_OPERATOR]**

> "After abortion, the doctor encourage us not to get pregnant for 2 years. They are afraid the child will be abnormal"
>
> **[22_M_SECONDARY_MARRIED_HOUSEWIFE]**

With surgical abortions, the respondents knew about the dizziness and cramps afterwards. With medical abortions, they understood that they may experience prolonged cramps and bleeding and the low failure rate that needs to be excluded at the follow-up visit.

> *"Ada, kalau kadang-kadang doktor berlaku pendarahan berpanjangan kan? Yang tu saja lah kalau dia habaq macam kalau ada makan ubat ataupun lepas buat tu kalau dalam masa dia nanti mai period balik… dalam masa dua minggu lah kan? Kalau kata berlaku pendarahan sampai sebulan ha… memang kena pi ataupun pendarahan yang banyak yang memang kena direct pi hospital lah yang tu kan? Mari sini kalau sini buka lah kalau tak buka kena direct hospital terus lah"*

> "Ah, sometimes if there is prolonged bleeding right? That's all they told, like if after taking the medication or after the surgery, when the period comes back…in two weeks time right. If let's say the bleeding is continuous until one month, bleeding is too much then have to go to the hospital directly"
>
> **[29_M_SECONDARY_MARRIED_OPERATOR]**

Some expressed surprise that they had experienced none of the side effects mentioned after their surgical or medical abortion.

> *"Ahh, dia pun kata ada sakit kepala, rasa pening-pening..ahh…sakit perut. Tapi bagi saya, saya tak ada apa. First time also same, second time also same"*

> "Ahh, they said will get headaches, feel dizziness…ah…stomach pain. But for me, I have nothing [absence of effects of abortion]. First time also same, second time also same"
>
> **[38_I_SECONDARY_MARRIED_HOUSEWIFE]**

> "Nothing, just people say after abortion, body will be weaker, but I abort twice still nothing. The body is still normal"
>
> **[43_C_SECONDARY_MARRIED_HOUSEWIFE]**

Sources of Information

The respondents generally indicated that they knew of many women who have had abortions and that these services are available. However, it was only when they needed an abortion themselves that they tried to get more specific information, like which clinic, the cost, etc.

"Many people talked about it, since quite some time ago. I didn't come, because it's very far. People all came here to do abortion. When you said 'wash stomach' [abortion], all the street people also know! Whole street Malays, Indians also tell you that here is good, here is good…come here"

[42_C_PRIMARY_MARRIED_CLERK]

"Hm, macam dekat Penang ni...I yang selalu doktor suggest tu sini lah...tapi ada jugak dengar kawan – kawan habaq klinik belah ada ada jugok lah dalam penang ni kan? Tapi kiranya famous, rasanya sini kut"

"Hm, like here in Penang, they always suggest the doctor here. But there are some who heard from friends that there are other clinics [for abortion services] in Penang. But the famous one is here I guess"

[29_M_SECONDARY_MARRIED_OPERATOR]

"Because I, previously I memang tau klinik ni. Because I work at a manufacturing last time, kita memang ada banyak foreigner. So, foreigner kita semua perempuan. So, ada banyak kes jugak. Then, daripada tu, I tahu klinik ni"

"Because I, previously I already know of this clinic. Because I work at a manufacturing [factory] last time, we have a lot of foreigners. So our foreigners are all female. So, there were quite a lot of cases also. Then from there, I know of this clinic here"

[38_M_TERTIARY_MARRIED_HR OFFICER]

Sources of information mainly came from friends or colleagues at work, especially for those in factory settings where many young women work. Otherwise, they received information from close female relatives (sister, mother, aunt, etc.). Doctors at private clinics or hospitals sometimes refused to even give a consultation if a request for a possible abortion is made and they rarely refer the client to a suitable provider; more often than not, it is the reception nurse who gives this information.

"Hmm I ada kawan bagi tahu...ahh dia pun pernah datang jugok kan. Ahh I bagi tahu dekat dia lah...kata masalah i pahtu dia kata klinik...klinik rakyat...ahh...planning family punya dia kata boleh untuk...nilah untuk...cegah kehamilan untuk pakai alat ke apa ka untuk semuo lah dia tuh pi tanya tengok...dia kata sebab tapi dia pun orang bagi tahu dekat dia..."

"Hmm, I have a friend who told me…she came here before. I told her my problem then she mentioned this clinic for family planning. She said for prevention of unwanted pregnancy, to wear instrument [contraception] or for all these things lah…she asked me to go and ask"

[29_M_SECONDARY_MARRIED_OPERATOR]

"Ha…rakan sekerja...pahtu dia kata bagi tahu kata klinik rakyat...family planning nilah dia kata...cumo pergi try tanya dia kata dengar dengar depa kata klinik ni boleh..."

"Ha…colleagues…after that she told me of Klinik XXX. Family planning clinic this one…she asked me go try because she heard from other people this clinic can [provide abortion services]..."

[29_M_SECONDARY_MARRIED_OPERATOR]

"Through my sister-in-law. She came here to put IUD [intrauterine device]. Then, she told me that this place does abortion"

[42_I_SECONDARY_SEPARATED_PRODUCTION OPERATOR]

"Tak...I pernah tengok I punya kakak sepupu seorang lah, dia pergi buat pengguguran. Bukan melalui ubat laa. Dia buat lagi satu jenis, apa...cuci la. Dia orang buat macam tu la. First time I tahu melalui dia la. Dia tak cerita laa, tapi I punya mak... mother cakap laa dia pernah buat laa. Ah, dia cakap macam buat pengguguran tu kena macam...kena tahu apa... badan semua akan jadi macam lemah sikit an. Macam orang kata bersalin la. I punya mother cakap lah"

"No, I have seen one of my cousin sisters, she went for abortion. Not medical abortion. She did the other one…washing [D&C]. They all do that. First time I knew, it was through her. She didn't tell but my mom said she did before. She said after abortion, the body will become weaker, just like people giving birth. My mother said so"

[22_M_SECONDARY_MARRIED_HOUSEWIFE]

"From my sister and my…from one of my colleagues. She never did abortion, but her…how to say, nanny, I mean her babysitter had abortion. So she's telling me all kinds of experience and all those stuff"

[29_I_TERTIARY_MARRIED_SUPPORT SPECIALIST]

Their comments on other sources of information, such as magazines and newspapers, were that the information was inadequate and often moralistic in tone, thus, not very useful. The Internet was hardly used; one client looked for abortion information in Chinese and got an address in Taiwan!

"Adalah i tengok macam...dekat dalam majalah dalam buku – buku macam tu kan..."

"Yes, I saw in magazines and books"

[29_M_SECONDARY_MARRIED_OPERATOR]

"I…mungkin ada baca dalam majalah lah. You know, sometimes majalah tu dia boleh share…info dengan you. Dia tak bagitahu in details tapi bagitau story saja. Kalau TV, radio…TV tu, dia lebih kepada cerita tentang em…buang anak kan? Pengguguran ni tak banyak tapi mungkin sesetengah cerita tu, dia cerita yang melalui kisah-kisah dia sahaja lah. Meaning macam background dia lah kan. Ah… mungkin dia… pernah buat pengguguran lah…"

"I read it in magazines. You know, sometimes magazines they share the information with you. The [magazines] don't tell in detail but just tell the story. If TV, radio...TV, is more on stories of dumping babies right? Abortion, not a lot but maybe in some of the stories, women who had [abortion] tell stories of their own, like her background [stories of personal experience]. Maybe she has had an abortion"

[38_M_TERTIARY_MARRIED_HR OFFICER]

"I got find on the internet before I got pregnant. So I go to web and search it, so yeah. I search got Taiwanese hospital there. Got abortion. Taiwan. Yeah. It's in Taiwan right?"

[29_C_SECONDARY_SINGLE_ADMIN CLERK]

"Ah, the Chinese newspaper. Hmm, actually, they also didn't tell a lot lah. And then they would tell abortion is very not good, and then…what else, what else like that lah. No. It's not enough. Also read in magazine. Not a complete one"

[25_C_SECONDARY_SINGLE_HAIRSTYLIST]

"Then after that, before I did abortion all that, I always go home and went back and Google and find all the stuff. Even, my husband also looked into the Internet and he found, how many weeks is that? Is it sin or not? He also called, concern of that. He was looking… the Google it said and I saw in the internet. How many months? How big is that? So, and all the stuff"

[29_I_TERTIARY_MARRIED_SUPPORT SPECIALIST]

Legal and religious status of abortion

There was a strong general impression that abortion is illegal in Malaysia based on their knowledge that government hospitals do not provide this service. When questioned closely, however, many said they were not sure.

"Tapi tak pastilah, macam, dia punya law macam mana kan? Tak pasti lah"

"But I am not sure what the law is. Not sure"

[31_M_TERTIARY_MARRIED_CLERK]

"This one I think not legal one. Ya, ya, ya. I think so it is like that one. The...no permission to do this one. I also… I also don't know"

[25_C_SECONDARY_SINGLE_HAIRSTYLIST]

"Saya rasa takde. Tak sah. Salah lah"

"I think don't have [not legal]. Not legitimate. It's wrong"

[38_I_SECONDARY_MARRIED_HOUSEWIFE]

"I rasa keguguran ini belum diterima kerana kalau dia diterima, diorang akan announce, siapa yang, err, sudah pregnant, belum berkahwin, diorang tak akan buang baby diorang merata-rata. Diorang akan melahirkan baby..."

> "I think abortion is not accepted yet because if it is already accepted, they will announce, who is pregnant, not married, they won't throw their baby everywhere. They will give birth to the baby"
>
> **[25_M_SECONDARY_MARRIED_CLERK]**

Some expressed the view that there may be circumstances where abortion is permissible but were not certain what they are. Others quoted the fact that since the clinic provides abortions so openly, it must 'surely' be 'licensed and legal'!

> "So far should be legal one, if not legal he won't, let doctor see one ma. If it is not legal, they will not explain and give you a letter, will call you to hospital, got doctor explain to you ma. I confirm, because we confirm with them ma, because normally as I know, a lot of people should be, if illegal, will not open a shop lo, right or not?"
>
> **[26_C_SECONDARY_MARRIED_SALESPERSON]**

> *"Tapi yang setahu I, klinik ni...ahh sebab depa kata dia memang ada lesen kan? Dia memang ada lesen, lepah tu, dia memang klinik planning tu memang, dia...dia, sah lah kut. Sebab, dah kalau kata dia...takdak lesen, takkan dia nak buka lama dah…I tahu klinik ni dah buka...camtu je lah...(laugh) I berani datang jugok lah sebab dah memang I tahu dia memang ada lesen untuk memang klinik untuk planning macam ni je lah..."*

> "But as far as I know, this clinic…because they said they have the license right. They really have the license…if don't have, they won't be here for so long. I know this clinic is here for long. I dare to come here because I knew they have the license for a family planning clinic"
>
> **[29_M_SECONDARY_MARRIED_OPERATOR]**

> *"Ya. Is legal or not. Tapi kalau ada klinik yang buat, dia mesti boleh. I think lah. Kalau tak, tentu akan ambush. Macam dadah lah... kalau legal kan... tentu orang tak tangkap orang. Betul tak?"*

> "Ya. It's legal or not. But if there is a clinic which does this [abortion], sure they can [provide abortion services]. If not, sure they [police] will be ambushed. Just like drugs, if it's legal…sure people won't apprehend them. Right?"
>
> **[38_M_TERTIARY_MARRIED_HR OFFICER]**

> "Actually in Malaysia, see what person lo. Because I think…if it's, err… can counted legal. Because…if someone is not able to bear a child, if born also no use la…because…correct, someone can take care, you can send to orphanage, if that person not willing to, I let the child run here and there, you are not a responsible mother lo. Then if forcefully give birth to a child, but cannot give him happiness, you let him face that...because we human mind are usually influenced by parents, because I see human really, not I want to say, I saw a lot of children…one person's temper, one person's living style, all is made by us adults… really it is, so if really cannot give the child happiness, you bring him

to this world, are you influencing his thinking? Right or not? Cause harm to, not harm us, but the child, and also other people la"

[26_C_SECONDARY_MARRIED_SALESPERSON]

Religious views on abortion were brought up only with Muslim respondents and almost all categorically said it was sinful. A few were less dogmatic stating that health risks and financial status were considered justifiable reasons if abortion is done in early pregnancy. Several mentioned that it is even more sinful for unmarried women to seek abortion but they themselves justified their decision to abort as a necessity.

"Dari segi Islam memang tak boleh lah...haram lah...(laugh). Sebab-sebab...Ahh masalah kesihatan macam tu je lah..."

"In Islam it is forbidden. (laugh). Reasons ah…health problems like that lah [allow in health grounds]"

[29_M_SECONDARY_MARRIED_OPERATOR]

"I rasa tak kot [not against the law] Tak. Sebab I dah kahwin, so ni I punya planning for next...er, next time kan. So I rasa tak lah. Lagipun, husband pun sokong, bagi support lagi. Macam ni, untuk, err…better lah untuk baby yang nombor tiga"

"I don't think it is illegal. No. Because I am already married, so I am planning for next time right. So I think no lah [illegal]. Furthermore, my husband supports, gives me support. Like that it's better, for, er…better lah for the third baby"

[25_M_SECONDARY_MARRIED_CLERK]

"I know it's wrong also [illegal]. This I know. But no choice"

[42_C_PRIMARY_MARRIED_CLERK]

Personal Abortion Experience

Personal Experiences

The majority of respondents related their medical abortion experiences. Although some have had previous surgical abortions or manual vacuum abortions, many had experienced medical abortion for the first time, and hence, this explains some of their graphic descriptions. Several tended to highlight the clear instructions that Clinic XXX had given them as they related how their own experiences of the medical abortion process went according to the outcomes described in the health providers' instructions.

"So, dia orang lah ajar I macam mana…lepas I balik (ke rumah)…suruh follow…ubat apa kena makan lah, ambil semua (macam itu)…I ikut lah,I ikut. Memang sebagai dia orang cakap…semua I yang dapat…semua tanda tanda tu I dapat…semua tanda itu orang cakap semua I ada…I rasa pening, I rasa nak macam muntah, I cirit – semua I ada"

"So, they taught me how [to take the abortion pills]. After I went home…asked me to follow…which pills to take lah, take all…I followed. What they said was true…I got [effects of the abortion pills]. All the symptoms I got. All the symptoms they mentioned I got. I felt dizzy, I vomitted, I have diarrhoea. All I got"

[22_M_SECONDARY_MARRIED_HOUSEWIFE]

"[Take medicine] one time only…got 4 tablets…have to eat, put here and here…inside [both cheeks] the mouth. Ya…didn't swallow…after half an hour, just swallowed with water. And after that, eat an antibiotic. Then after that I slept whole day until 4 o'clock, then my period came"

[29_C_SECONDARY_SINGLE_ADMIN CLERK]

One respondent, who has had three medical abortions, not surprisingly, described the process rather clearly. She also highlighted that often the medical abortion package would include a spare set of four pills, making it eight altogether plus relevant medications to cope with the ensuing pain, diarrhoea, and nausea. Moreover, the contact numbers of the clinic as well as the attending doctor were given in anticipation of any emergency during or after the medical abortion process.

"…ambil ubat tu lepas tu balik dia bagi jadual perancangan makan ubat tu. Start pukul berapa...pukul berapa you continue...memang you kena ikut…mula mula doktor bagi tahu after you take break-fast, you makan ubat ni empat biji…so dia kata letak dekat sini dua tepi gusi ada 4…lepas tu jangan telan apa apa just biar kat situ sebab dia akan hancur sendiri ubat tu ok. So, bila hancur ubat tu dalam masa 30 minit, dia suruh minum antibiotik...selepas... 15 minit pula, darah dah mula keluar…doktor memang dah bagi spare…bukan 4 saja, dia bagi 8 ok – doktor kata kalau darah pun tak keluar dalam masa 3 jam you continue ok…sebab doktor ada bagi nombor kalau ada apa apa emergency…dia bagi…contack personal tu dia punya number dengan klinik, saya pun call klinik tu pada 12 tengah hari, saya bagi tahu darah pun dah keluar. So, dia kata you tak payah continuelah ok. Kalau you rasa nak diarrhoea, you minum ubat diarrhoea, kalau you rasa sakit perut, you minum ubat sakit. Semua siap dalam paketlah. So, dia bagi tahu kalau darah still banyak keluar sampai lebih seminggu, dia bagi ada satu surat pergi dekat GH (general hospital)"

"…took the pills after that they gave us schedule to take the pills. At what time…what time you continue…you really have to follow. First, doctor told after you have breakfast, you take four pills. He said put two at the side of the mouth, four at the side gums. Then don't swallow anything. Just let it be there because the pills will dissolve by itself. So after the pills dissolved in 30 minutes, he asked to take antibiotics. After 15 minutes, the blood starts to come. Doctor gave spare…not just give four [pills]…but gave eight [pills]. Doctor said if the blood didn't come out in three hours you continue ok, because doctor gave number [contact number] if there is any emergency. He gave…personal contact and clinic's contact number. I called the clinic at 12 noon and told them my blood came. So he said no need to continue. If you feel like diarrhoea, you take the diarrhoea medicine. If you have stomach pain, you take the pain killer. All

ready in packets. So, he told if there is still a lot of blood after one week, he got to give a letter to go to GH (general hospital)"

[26_M_TERTIARY_MARRIED_CLERK]

During the medical abortion process, they all felt painful cramps followed by intense bleeding for about an hour after which the bleeding continued like their usual period or menstruation. The pain level varied between respondents but compared to their normal period/menstruation, several pointed out the stomach cramps were more intense, the bleeding slightly more, and the duration of bleeding was about two weeks, i.e., about twice as long as their normal period.

"At first a bit darker in colour [bleeding], and after that it was like the usual period, red in colour. When I was bathing, there were some solid little pieces, but there wasn't a lot…"

[29_C_SECONDARY_SINGLE_ADMIN CLERK]

"Sakit…tapi dia macam biasa…macam senggugut biasa tu…bila kita ni, kita akan rasa darah turun…bila kita nak pergi toilet kita nak cuci, dia akan turun CHUP! Dia akan jatuh terus"

"Pain…but it's like normal…like period pain. We can feel when it bleeds. When we go to toilet to wash, it will come down like CHUP! It will fall down directly"

[22_M_SECONDARY_MARRIED_HOUSEWIFE]

"Sangat sakit…berapa minit pun tak boleh tahan ooh…then hmm you sendiri you boleh rasa tau dia…tiba tiba dia jatuh…you boleh rasa dia sudah tak…tak hidup tau…"

"Very painful…after a few minutes I cannot bear it…then hmm…you can feel it [foetus] …suddenly it falls …you can feel it is no longer…not alive"

[M_23_TERTIARY_MARRIED_CLERK]

Interestingly, one respondent shared that she was ready to (and she did) bear however much the pain because she was determined to terminate her pregnancy.

"Ah…direct dia keluar banyak. Tapi saya boleh tahan lah. Cepat bagi keluar habislah. Tapi saya tak takutlah…saya boleh tahanlah…bukan menangis ke tak ada Kalau keluar…tak ada muntah, tak ada pening. Semua sudah stop sebab dia (kandungan rahim) stop, dia keluarkan… memang saya pregnant ah, saya muntah. Muntah ada, penat ada, tak boleh jalan…tidur saja. Anak kecil lagi ada, macam mana lagi pregnant? Aiyo!"

"Ah…the blood came out directly and a lot. But I can bear with it. Faster let it come out finish. But I am not scared. I can bear it…didn't cry nothing. If it came out…no vomitting, no dizziness. All stopped because it [foetus] stopped. It came out. When I was pregnant, I vomitted. Vomit, tired, cannot walk…only sleep. My children are still small and now I am pregnant again? Aiyo!"

[28_I_SECONDARY_MARRIED_PART TIME DRIVER]

For a couple of women, the medical abortion process did not proceed like clock work. One initially had a difficult start as she found it difficult to swallow the medication without vomitting but she succeeded at the second attempt, with some encouragement and support from her husband. Another said she returned to the clinic for a follow up scan two weeks after the medication but she was told the abortion was incomplete. However, all was cleared later after she consumed the spare set of medication provided by the clinic.

When relating their experiences, a number of women alluded to the convenience and ease associated with medical abortion. Being able to take the medication in one's own home was reassuring and seemed to be more within one's control, not to mention the benefits of comfort and privacy vis-à-vis having the procedure performed in a clinic or hospital. Several women even continued to go to work the next day after consuming the medication and waiting out the initial symptoms of painful cramps, diarrhoea, and nausea at home.

> *"Saya tak ambil cuti sebab saya still kena kerja jugalah…heehee… kena bawa banyak pad (sanitary pad)…tapi ok lah kerja tu tak berapa berat sangat. Just kita duduk, kerani kan so just tulis apa semua. Kita rasa ok lah"*
>
> "I didn't take leave (from work) because I still have to work…(laugh)…have to bring a lot of pad (sanitary pad)…but it's ok because it's not heavy work (job). Just have to sit down, clerical work, so just write things down. I feel ok"
>
> **[26_M_TERTIARY_MARRIED_CLERK]**

However, one respondent pointed out that medical abortion is convenient for those not working outside the home or who are housewives. She said that working women need at least three days leave due to the intense and intermittent bleeding.

> *"Bagi I, process tu…memang kalau kita suri rumah tu senanglah. macam kita bekerja ni, leceh sikitlah sebab sekejap lagi dia turun, sekejap lagi dia turun…kita tak tau…yang tu payahlah. Kalau kaedah ni, kalau orang kata kita cuci, hari ni kita cuci. Besok kita boleh kerjalah. Kalau macam process ni, kita kena ambil cuti lebih kurang dalam tiga hari sebab dia akan turun darah…"*
>
> "For me, the process…like we are housewife then it is easy. If we are working, it's a bit troublesome because when it [blood] comes down, we won't know. That's the problem. Like this method [medical abortion], people said when we washed, today we washed…tomorrow we can work. But if like this process, we have to take leave [from work]. Take leave for about 3 days because it bleeds"
>
> **[22_M_SECONDARY_MARRIED_HOUSEWIFE]**

Fears about Abortion and its Side Effects

The findings revealed two major fears with regards to medical abortion among the women in the study. The greatest fear was incomplete abortion followed by a very genuine worry that one could not conceive as easily as before. Other reported fears, such as safety, uncontrolled bleeding, and infertility are similar expressions of the two major fears mentioned above.

"Ya, ya…that one [whether abortion is complete] is the first [worry] and then the second is next time difficult to get pregnant. When I took this pill…I was also scared because can't clean it all up. I'm just scared of the difficulties in getting pregnant next time."

[25_C_SECONDARY_SINGLE_HAIRSTYLIST]

"Over bleeding then mungkin dia tak keluar semua lah…kalau tak keluar semua mesti dia mesti kena vakum lagi oh!"

"Over bleeding then maybe everything [foetus] won't come out. If everything didn't come out then must vacuum [go through MVA] again oh!"

[M_23_TERTIARY_MARRIED_CLERK]

It is pertinent to note that both married and single women were equally concerned about possible infertility or difficulty to conceive after an abortion, whether by surgical or medical abortion method.

"I'm scared next time I really want to get pregnant and then I can't!"

[25_C_SECONDARY_SINGLE_HAIRSTYLIST]

"So, tak berapa safe lah…vakum…sebab dia [doctor] cakap memang boleh jadi one percent mandul"

"So, it's not really safe, vacuum…because the doctor said there is 1% chance of infertility"

[M_23_TERTIARY_MARRIED_CLERK]

A couple expressed their initial fear that medical abortion would not be an effective method or it might not be appropriate for them as their body could be too strong to succumb to the medication. Although not as common, there was the fear that medical abortion could be harmful, like a poison, to the body, whereas surgical methods/MVA compared to medical abortion was feared to weaken the body.

"Kadang dia tak guna, dia tak turun kan…tak turun habis…kadang (bila guna) ubat tu kan…ubat kadang-kadang dia ada racun sikitkan?"

"Sometimes it won't be effective, it doesn't come down right…doesn't come out finish…sometimes [when consuming the abortion pills]…medicine sometimes they will have a bit of poison right?"

[35_M_SECONDARY_MARRIED_NASI LEMAK SELLER]

"Risau, sebab mak cakap badan weak semua kan…badan jadi lemah. Macam jadi…macam tak kuat lah kan"

"Worried, because my mom said the body becomes weak and not strong"

[22_M_SECONDARY_MARRIED_HOUSEWIFE]

With regards to side-effects, many of them said they did not experience any obvious direct side-effects so far. Indeed, they tended to report that they had none and that all was normal post-abortion, regardless of type of abortion method.

> "As usual…nothing, nothing at all [since previous surgical abortion]. No [side-effects for recent medical abortion either]…yes, as usual"
>
> **[38_C_PRIMARY_MARRIED_FACTORY QA]**

> *"Er…pernah ada (dengar tentang susah dapat anak selepas)…tak,tak, sekarang memang tak ada rasa apa…normal saja"*

> "Eh…have heard before [on infertility as consequence of abortion]. No, no, now I don't feel anything…just normal"
>
> **[M_23_TERTIARY_MARRIED_CLERK]**

However, despite experiencing no side-effects thus far, several said they were still concerned about potential side-effects, such as possible infertility, damaged uterus or reproductive cancer resulting from surgical methods.

> *"Bila masa akan datang…kiranya bimbang jugalah…macam rosak rahim takut jugalah, macam ada cancer ke… secara makan ubat ni, orang kata…bagi saya selamatlah...sebab diatak melibatkan apa-apa..."*

> "As for the future…it's quite worrying. Scared if the uterus is damaged, or if there is cancer... but [medical abortion], people said…I think it is safe because it doesn't involve anything"
>
> **[22_M_SECONDARY_MARRIED_HOUSEWIFE]**

One respondent revealed she was not so concerned about side-effects as she felt confident of the advanced technology in modern abortion methods and thus its safety.

> "I think now technology has improved. So, I am not scared of any side effects"
>
> **[25_C_SECONDARY_SINGLE_HAIRSTYLIST]**

Preferred Methods

The findings also revealed that the women preferred medical abortion to surgical methods, viz., dilation and curettage (D&C) and manual vacuum aspiration (MVA). Many of them also tended to cite similar reasons for their preference, such as, time-saving, relatively lower cost, easy/convenient procedure to be done at home, and comparatively little/no pain, that is, no more painful than their normal periods/menstrualtion.

> *"Baru rasa oh…I ingat ada satu kaedah saja, cuci saja. First time, I dengar ubat, I rasa seronok sikit. Senang kan ubat, tak sakit sangat. Hmm...I ingat telan saja...tapi dia orang bagi ubat hisap lah… I rasa ni lagi senang lah, pilih ubat"*

"I thought there is only one method, only wash [surgical abortion]. First time I heard of pills, I felt excited. Pills are easier, not so painful. Hmm.. I thought swallow only.. but they told me to suck. I think it's easier to choose pills [medical abortion]"

[22_M_SECONDARY_MARRIED_HOUSEWIFE]

"Should be medical abortion…we don't need to spend so many hours… medical abortion is more saving [cost] than surgical"

[38_C_PRIMARY_MARRIED_FACTORY QA]

"Makan ubat ni dia senang kan…dia cuma sakit sikit saja...sakit macam nak mai period saja kan...senang habislah"

"It's easier to take pills. It only hurts a little. It hurts like when having period. Easy to finish [going through the abortion process]"

[35_M_SECONDARY_MARRIED_NASI LEMAK SELLER]

At times, women were motivated to opt for medical abortion out of their fear of surgical methods in terms of the pain involved, feeling weak, and the requirement to stay-in for a brief period at the clinic for post-abortion monitoring.

"Because the operation, er, need to…how to say, need to ah…sleep lah for two hours. And then I heard my friends say…if er like how to say your whole body will like…no energy"

[25_C_SECONDARY_SINGLE_HAIRSTYLIST]

"Cuci…rasa takut sakit…kawan-kawan ada cakap sakit...dia bagi tidur kan…sakit itu saya tak berani lah kan"

"Wash [surgical abortion]. I'm scared of the pain. Friends did say it hurts…they will let us sleep [anaesthesia]…(because) of the pain, I don't dare"

[35_M_SECONDARY_MARRIED_NASI LEMAK SELLER]

Interestingly, one knowledgeable respondent pointed out that the choice of abortion method should depend on the gestation/pregnancy duration and not merely one's subjective preference. That is, according to her, medical abortion is the preferable method for pregnancy below 8 weeks while surgical methods would be best for those who were already pregnant for 12 weeks and more.

"Kalau saya…kalau macam kandungan kita masih awal… dalam dua bulan ke bawah tu, macam tu…paling cepat, saya pilih selesa makan ubat lah. Tapi kalau dah tiga bulan ke atas tu…sebaiknya cucilah. Lagi senang sebab kalau makan ubat pun, dia takkan turn dah sebab dia dah besardalam perut"

"If for me…if the pregnancy is still in the early stage…below two months, I am more comfortable taking the pills [medical abortion]. But if it is three months

and more, it's better to wash [surgical abortion]. It's easier because even if take the pills, it [foetus] won't come down because it is already big in the stomach"

[22_M_SECONDARY_MARRIED_HOUSEWIFE]

However, there were several women who said they preferred the MVA method to medical abortion. They explained that they would rather the entire procedure be handled by a doctor as that way the women need not have to see or deal with all the bleeding. One also said she would feel less anxious if the abortion procedure is handled by a doctor in a clinic compared to her having to administer the medical abortion procedure herself at home.

"…saya tak suka makan ubat lah. Kalau makan ubat…sakitlah. saya tak suka. Direct abortionlah"

"…I don't like to take medicine [medical abortion]. If take pills, it's painful. I don't like. So, direct abortion"

[28_I_SECONDARY_MARRIED_PART TIME DRIVER]

"…yang doktor sendiri buat tu memang OK sebab selepas dia dah cuci semua darah dekat dalam, so tinggal sisa yang sikit saja so kita tak akan mengalami rasa sakit perut. Just kita rasa badan letih sajalah OK…yes, lebih suka doktor yang buat. Yang tu kata orang lebih senang sikitlah sebab kita sendiri tak takut sebab kita tak nampak darah beku tu keluar sebab doktor dah clean dekat dalam siap-siap, so cuma darah yang bekas buat tu mungkin yang tu memang biasa. Tapi yang ubat ni kita memang rasa cemas sikit"

"The one that the doctor performed [surgical abortion] is OK because after he washed all the blood inside, so left only some so we won't feel the stomach pain. We just feel our body is tired. Yes preferred the one that the doctor does [surgical abortion]. That one people said is easier because we will not be scared as we don't see the clotted blood come out because the doctor cleaned everything inside. It's just some blood staining that is usual after the procedure. But the medicine makes us feel anxious a bit"

[26_M_TERTIARY_MARRIED_CLERK]

Barriers

The common barrier cited by almost all respondents appeared to be the basic lack of abortion services. Many specifically mentioned that abortion services are not provided in government hospitals which implies that such services are neither common nor universal, particularly for medical abortion. Although some private clinics/hospitals do provide abortion services, not many were aware of this since this is not public knowledge. Indeed, many women said they only found out through word of mouth, mainly from friends or colleagues.

"If you get pregnant, if you want to do an abortion, you cannot go [to] government clinic hospital – you can only come here [private clinic]"

[38_I_SECONDARY_MARRIED _HOUSEWIFE]

"Tak ada, farmasi semua tak ada. Baru ni, I mai minta ubat lewat period pun dia cakap tak ada.Semua farmasi tak ada… sekarang tak ada, mana-mana farmasi cakap tak boleh jual"

"No, all pharmacies don't have. Recently, I asked for pills for late period and they said don't have [not available]. All pharmacies don't have. Everywhere pharmacy said cannot sell"

[32_M_SECONDARY_MARRIED_FACTORY LINE LEADER]

Several women found the health provider's judgmental attitude to be a barrier in their search for abortion services.

Yet another barrier was the cost of abortion services. Some women felt that medical abortions tended to cost less than surgical or MVA procedures, and hence opted for the former. Several said they had no choice but to pay for the abortion services even though they found the cost to be high as they badly needed the services.

"Yeah, money is a problem because only my husband is working. And I'm a housewife…three children, some more have to support my father-in-law also…that's one problem lah. I take pills because first time I do wash [surgical abortion]…nearly five hundred ringgit"

[38_I_SECONDARY_MARRIED_HOUSEWIFE]

"Ada [problem with cost] juga lah. Tapi kita apa…terpaksa jugalahkan?"

"Got [problem with cost] also lah. But we are forced to right?"

[22_M_SECONDARY_MARRIED_HOUSEWIFE]

A number of women with diverse ethnic backgrounds did mention objections from family, mothers or mothers-in-law in particular, but somehow they said they managed to circumvent the objections and proceed with their own decision to abort.

"…kalau dapat halangan pun, dari sebelah mak mertua memang halangan lah…memang dia tak bagi. Kalau boleh dia suruh teruskanlah. Hah…dia seronok I dapat ni [her last pregnancy]. Tapi I kata tak mau. Dia kata tak baik. Berdosa. Lepas tu, I cuci juga. Lepas tu, dia tanya pasal apa Nampak perut tak besar pun ? I kata hmm…hari tu I tak sengaja terjatuh…Allah kesiannya tak ada rezeki…dia jatuh mak, kena cucilah. Tak apa lah dia kata lepas ni jaga jaga lah, janganni dah"

"…even if there is resistance, from mother-in-law there is resistance lah. She don't allow [abortion]. She asked me to continue [the pregnancy]. She is happy I got this [her last pregnancy]. But I said I didn't want it. She said it's not good [abortion is not good]. It's sinful. After that, I just went to abort it. After that, she asked how come she noticed that the stomach didn't grow bigger? I said 'hmm…that day I fell down accidentally'…'ala…what a pity that God's gift is lost'...'it fell [miscarriage]mom…so had to go for a wash [menstrual regulation]. 'Is okay' she said 'next time have to be careful, don't let it happen again'"

[22_M_SECONDARY_MARRIED_HOUSEWIFE]

Decision-Making, Support and Relationships

It was found that women tended to make their own decision to abort whether they were married or single. Subsequently, they would then discuss with their husbands or boyfriends. Boyfriends tended to accept their pregnant partner's decision but a few women said they had to persuade their husbands to agree with their decision to abort.

> *"(Keputusan) Sendiri…husband cakap kalau nak tak nak pun, sendiri punya suka lah kan."*
>
> "[Decision] Myself…husband said if want don't want (to continue the pregnancy), it's up to me"
>
> **[35_M_SECONDARY_MARRIED_NASI LEMAK SELLER]**
>
> "…and then I made my own decision. About my husband, he didn't have much comment…we discussed a little while and [we] said don't want [to carry the baby to term]"
>
> **[38_C_PRIMARY_MARRIED_FACTORY QA]**
>
> "…when I know this lah…I didn't think about that and then I just told my boyfriend…I want to do the abortion"
>
> **[25_C_SECONDARY_SINGLE_HAIRSTYLIST]**
>
> *"Aha, memang pertama kali dia tak setujulah, ok? Tapi oleh kerana saya dah cakap dengan dia, dia pun kena faham kan... OK lepas bila dah bincang elok-elok dengan dia, ok dia pun faham situasi"*
>
> "Aha, initially at first he didn't agree lah, ok? But because I speak to him, he has to understand right. Okay after discussing with him properly, okay he understood the situation"
>
> **[26_M_TERTIARY_MARRIED_CLERK]**

Interestingly, not all single women immediately decided to abort due to their unmarried status. For instance, one said she decided because her boyfriend at the time was not the man she wanted to marry. Conversely, a single woman might want to marry and keep her pregnancy to term but was forced to decide to abort because her partner convinced her he was not ready for marriage and could not earn enough to support her and their child.

> "First time [I aborted], I was so young and that guy, I didn't think he is the one. So the second time [when I was pregnant] I was thinking this man is the one [I would want to marry]. So I told him…but he was scared he couldn't afford, because he wants to take care of the two of us. Because he actually…he cannot say the words…I think…[you know] guys…so, I decided myself [to abort]"
>
> **[25_C_SECONDARY_SINGLE_HAIRSTYLIST]**

Although less common, it emerged that the husband made the decision and then the wife agreed.

> *"Err…first, dia…my husband lah then… I pun rasa tak berapa ready"*
>
> "Err...first, he, my husband lah [made the decision to abort] then…I also feel I am not quite ready [to have a baby]"
>
> **[M_23_TERTIARY_MARRIED_CLERK]**

Some women tended to report initially that it was a mutual or joint decision to abort by both husband and wife. Yet, subsequently they admitted it was she who first decided to abort and then persuaded her husband to agree.

> *"Er…keputusan saya dengan husband lah. Keputusan sama lah. Kalau ikutkan, husband memang dia tak bagi…tapi kita tak mampu…husband ikut saja…dia ikutlah (jika tidak) macam mana?"*
>
> "Er…my decision together with husband lah. Together decide lah. If follow husband, sure he don't let…but we can't afford…husband just follow only…he follow lah [if not] how?"
>
> **[22_M_SECONDARY_MARRIED_HOUSEWIFE]**

One woman felt strongly that such decisions should be made by both her and her husband rather than to discuss with or gather support from her mother, sibling or close friends which she thought would only confuse her.

> *"Tak tahulah…kalau orang lain cakap, ada setengah orang kata tak mau, setengah orang kata mau. Tu confuse lah saya…tak mau cakap dengan dia (her mother). Suami dengan saya rahsia lah…senang sikitlah. Kalau dekat jiran pun kata…setengah orang dia bagi positive, setengah orang negative. Itu saya tak mau dengar lah…saya bincang dengan suami, suami kata macam ni, ok, direct"*
>
> "Don't know. Some people said don't do [have abortion], some said do. I'm confused lah. Don't want people to tell her [her mother]. Keep it as secret with my husband lah. It's easier. Even my neighbour said...some they gave positive [opinion], some negative. Those I don't want to listen lah. I discussed with my husband. Husband said okay, direct [straight for abortion]"
>
> **[28_I_SECONDARY_MARRIED_PART TIME DRIVER]**

Role of Man as Husband/Partner in Motivating or Demotivating the Women in Making Decision on Abortion

The role of the male partner in decision-making with regards to seeking abortion was also investigated in the study. For those who were married or had a stable relationship, there was discussion about the abortion. Some of the respondents jointly made the decision to have the abortion. The support from their spouse or partner was seen in the form of moral and

physical support such as accompanying the woman for the services or visit to the clinics or searching information on abortion, or in the form of financial assistance.

> "So, my colleague informed me of this clinic. Heard that this clinic does abortion. So, I went back home and asked my husband. So, he said that we will go and ask"
>
> **[29_M_SECONDARY_MARRIED_OPERATOR]**

> "We both go to the clinic. We both talked about it. He doesn't want it [baby]. I vomit, I was tired, sleepy, he didn't want [baby]. He didn't want because we still got small children. I have housework to do, I cook. Again, I vomited, for about two months I vomited and had headache. So, we came here [to the clinic for abortion]"
>
> **[28_I_SECONDARY_MARRIED_PART TIME DRIVER]**

In this regard, the majority reported receiving support from their husband or boyfriend more often than from parents, siblings, or friends. They revealed that, often, such support was in terms of accompanying them to the clinic for the abortion and sharing the cost. One husband even did the initial reconnaissance visit to the area and located the clinic first before bringing his wife there for the abortion. Another husband accompanied his wife for all her three abortions at the clinic.

> "Cost…I paid half of it, and my husband paid another half"
>
> **[38_C_PRIMARY_MARRIED_FACTORY QA]**

> *"Saya suami, dia memang memandu lori. Dia sudah tahu (lokasi klinik ini)...pasti sini ada, dia bagi planning lah...saya pun masuk sinilah"*

> "My husband, he drives a lorry. He already knew [location of the clinic]...sure here [clinic] got, they give planning lah [family planning]. I come in here lah"
>
> **[28_I_SECONDARY_MARRIED_PART TIME DRIVER]**

> *"Yes, memang dia (husband) teman…yang kedua pun sama dan ketiga pun sama"*

> "Yes, he [husband] is the one who accompanied me...the second [abortion] same and third [abortion] one also same"
>
> **[26_M_TERTIARY_MARRIED_CLERK]**

Single women, however, tended to be supported by their boyfriends mainly in terms of sharing the abortion expenses but almost none said their boyfriend went to the clinic with them when they had it done. One boyfriend did call after the abortion to show his concern.

> "…share [the cost]…share only yeah. He did ask me is it okay already and called me to take all rest"
>
> **[29_C_SECONDARY_SINGLE_ADMIN CLERK]**

Some women received a lot of support from their own mother or good friend. One single/ unmarried woman explained that although her mother would have preferred her to get married and have the baby, she nevertheless indirectly agreed with her decision to abort by not reprimanding her and, instead, took good care of her during the post-abortion period. Getting support from a good friend who accompanied her to the clinic for the abortion and being her confidante to share her fears and emotions was also reported.

> "My mum said because she is old already, she hopes I will marry. I have a baby already so she said if I can marry, no need to have an abortion so she can be a grandmother. But I said, I don't want means don't want. She didn't scold me. Ya…[she] got [take care and cook]…sesame oil chicken. She [her good friend] gave me support…ya, I keep talking and telling her my feelings then she just said abortion is a…she is an expert on this. She said abortion in the world… outside of the city and overseas – America, England – there abortion is a normal thing. Then she said don't worry. She said don't be too sad and get upset. So, now I feel much better"
>
> **[29_C_SECONDARY_SINGLE_ADMIN CLERK]**

Feelings/Emotions Post-Abortion

Women in the study revealed a range of emotions, from seemingly "no feelings" to not wanting to think about the abortion, to relief, and to "very sad"/feelings of loss.

> "I think I don't have any feelings. No, I didn't feel [the] loss or anything. I didn't think about this. I didn't think that thoroughly."
>
> **[38_C_PRIMARY_MARRIED_FACTORY QA]**

> *"Bagi saya, gugur itu adalah macam…rasa puas lah…rasa dia lega…"*

> "For me, the abortion was like…I felt satisfied. I felt relieved..."
>
> **[35_M_SECONDARY_MARRIED_NASI LEMAK SELLER]**

> *"Oooh...you tengok dia keluar, rasa sangat sedih oh! And you nampak…hmm, memang sedih…"*

> "Ooh…you see it come out [foetus], and feel very sad oh! And when you see…hmm, it's really sad.."
>
> **[M_23_TERTIARY_MARRIED_CLERK]**

> "…sometimes when I'm taking care of other people's children and carrying them, I imagine that if I didn't do the abortion, the baby would probably be as adorable. I'd have thoughts like these."
>
> **[29_C_SECONDARY_SINGLE_ADMIN CLERK]**

Mixed emotions of relief and regret post-abortion were also common. Much of the feeling of regret resulted from guilt over aborting the baby. Indeed, given the multicultural and religious background of the respondents, their feelings of regret and guilt were very much based on their religious beliefs. Women felt regret and guilt because they believed abortion was wrong

and this cuts across all three religions – Islam, Buddhism, and Hinduism. It is pertinent to note, in some detail, how they coped with this guilt emotion in the way/s they interpreted their respective religion.

"Memang satu…satu tension, satu sedih lah…kan I cakap dalam kita orang punya Islam kan, dosa kan. I takut yang tu juga...I sabar saja lah...bagi tahu lah dia (husband), share dengan dia juga...dia kata bukan nak buat apa, bukan sengaja kita nak nikan...dia terjadi"

"It's really a tension, sad right. Like I said in our [religion] Islam it is a sin. I feel scared too, so I just keep patient. Let him know [husband], share with him. He said it's not that we want to do it, not that [we] purposely wanted this [pregnancy] right...it just happened"

[22_M_SECONDARY_MARRIED_HOUSEWIFE]

"Ada, memang ada perasaan satu rasa kesal, rasa kecewa pun ada sebab...memandangkan ekonomi sekarang ini saya sendiri sanggup membuat pengguguran tanpa...kerelaan lah...perasaan kecewalah mengenai sikap saya sendirilah sebab OK memandang kita ni Islam, macam kita Islam memang tak digalakkan"

"Got, there is a feeling of regret, disappointment because…looking at the economy now I am willing to have abortion. Feeling disappointed towards my own attitude because okay since we are Muslim, like for Muslims it is not encouraged [to have abortion]"

[26_M_TERTIARY_MARRIED_CLERK]

"I am a Buddhist. Everything, every single thing also has a soul although it hasn't taken shape yet. It is also a life, so I blamed myself. Before the abortion, even a dot is also a life. I told the baby it's not that I don't want you but life forces people to do things. I have no choice but to abort you. Yes, I talked to it [foetus] first. If not later…like I've heard in my hometown there was a woman, after her abortion she said that she doesn't know why, but everywhere she goes, she feels that there are 'things' following her. I know this is not scientific but it's better to believe. Yes, I talked to it, because I'm the mother. Whether or not it can accept depends on the baby itself, not us. We've already decided don't want already"

[29_C_SECONDARY_SINGLE_ADMIN CLERK]

"No… I just… like you know for Chinese… the ghost month? I do a prayer for the baby. With my boyfriend that time in the Chinese temple. For the ghost month, we do a ceremony for the baby. I think until this year… I think six years already we do the ceremony. I think this year, it's coming soon so we are going to do for the second baby…the second abortion. So we need to do two ceremonies (giggles). Er…. my heart feels more comforted. Then I think that's good for my baby. For him like, for the baby to… get another mum…. To get another mummy. A better way. I feel guilty"

[C_25_TERTIARY_MARRIED_HOUSEWIFE]

Abortion Services

Accessibility

Generally, abortion services are neither widely known nor readily available. A couple of respondents lamented the uncertain situation whereby some doctors offer abortion services while some do not. Hence, they could never be sure who they could approach. One pointed out that this is rather unsettling versus the desired state of universal or widely available abortion services:

> *"Susah juga…bila kadang kadang depa nak bagi ke tidak macam itu lah…nak macam kadang kadang ada doctor yang bagi ada setengah yang tak bagi kan"*
>
> "It's hard...when sometimes they [doctors] want to give or not [the abortion service]. Sometimes, some doctors give, some doctors don't give"
>
> **[35_M_SECONDARY_MARRIED_NASI LEMAK SELLER]**

It is thus not surprising that in relating their experiences of abortion seeking, a number revealed a zigzag trail of trial and error that was time-consuming and involved extra costs. One respondent recalled she had to go and ask from clinic to clinic and still had no positive response after going to three clinics. She felt exasperated but then she remembered vaguely hearing about one clinic that provided abortion services. However, when she found the clinic she was told they had stopped doing abortions and referred her to Clinic XXX in Penang. Due to the perception of its clandestine nature, a woman seeking abortion services often had to carefully phrase her enquiry, which further added to the stress. For example, one respondent tried asking first about a pregnancy scan and then only enquired about an abortion:

> *"Saya er (tanya)…reception kan…saya scan tanya…saya mengandung ke tak mengandung? Satu klinik tu kata, sini tak ada scan…saya direct boleh jumpa doktor ke? Dia kata, sebab apa you pergi jumpa? Saya kata, saya nak gugur. Sekarang saya tak mau anak. Oh sini tak boleh gugur, dia kata"*
>
> "I er [asked]…reception right. I asked about the scan…if I am pregnant or not pregnant. One clinic said, 'here don't have scan'…'Can I see the doctor directly?' She said, 'why you want to see doctor?' I said, 'I want abortion. Now I don't want to have child'. 'Oh, here cannot abort' she said"
>
> **[28_I_SECONDARY_MARRIED_PART TIME DRIVER]**

Almost all respondents said they did not bother to enquire at government hospitals or clinics as they assumed abortion services were not provided there since abortion is illegal. This perception seemed to cut across ethnicity and marital status.

> "…if I go to the government hospital, I need to keep the baby already (nervous giggle)…cause government is, very strict and I hear from my friend that abortion is illegal"
>
> **[29_C_SECONDARY_SINGLE_ADMIN CLERK]**

Another married Indian respondent cited her bad experience at a government hospital. She related how the doctor became angry with her when she hesitated to make an antenatal care appointment after the doctor confirmed her pregnancy. When she explained it was because she wanted to discuss with her husband about a termination, the doctor reacted angrily and told her she could not abort as it was wrong.

> *"Saya sudah mengandung...saya kata, tunggu doktor, saya pi dengan suami saya. Anak lagi ada kecil-kecil, tunggu. Doktor marah. 'Tak boleh gugur. Salah'"*
>
> "I was already pregnant…I said 'Wait doctor'. I went with my husband. 'My children are still young, wait'. The doctor scolded, 'Cannot abort. It's wrong'"
>
> **[28_I_SECONDARY_MARRIED_PART TIME DRIVER]**

Given the difficulties in accessing abortion services as described by the respondents, it was revealed that sometimes women had to resort to taking traditional abortifacients. One Malay respondent explained that when it was difficult for her to obtain abortion services, she had to use Chinese medicine but she said it was not effective. It is pertinent to note that she had requested her friend to buy the Chinese medicine as he had bought it for his wife several times for the same purpose of abortion!

> *"Ah…I tak tahu [pergi mana cari klinik]…lepas tu, tanya kat seorang kawan tu – dia biasa…isteri dia dulu biasa...dia beli ubat cina ni...I suruh dia beli...tapi dia tak...tak berkesan. Dia tak boleh…dia tak mau turun juga"*
>
> "Ah…I don't know [where to find clinic for abortion]. After that, I asked one of my friends. He is used to it. His wife last time used to buy Chinese medicine. I asked him to buy but it didn't work. Not effective. It didn't want to come down [bleeding]"
>
> **[22_M_SECONDARY_MARRIED_HOUSEWIFE]**

Many respondents said they usually would hear or get to know about abortion services through word of mouth from friends or colleagues. A few sought information from the clinic receptionists although this was not the norm. When prompted if, by any chance, they had found out from formal sources, such as health information leaflets or the media, the majority responded negatively. Worthy of note, several had lamented that trying to seek information, even from friends, about abortion services could be a daunting experience because they felt 'shame', 'it's a sin', and feared 'people talk behind our backs'.

Moreover, they also revealed that they were often not satisfied with the information given as it was often inadequate or superficial. One recalled she was already emotionally quite distressed over her unplanned or unwanted pregnancy at the time as she was anxious to access abortion services as early as possible in her pregnancy. Under such circumstances, she explained she felt she could not look for information from various sources and sieve through all the information for a genuinely informed decision.

"Mmm…memang kita tak puas hati lah. Sebab cuma dengar macam ni sajalah kan...(bukan) secara detailnya...sepatutnya kita tengok maklumat dulu lah sebelum kita nak maini kan?Tapi kita dalam keadaan kecemasan...kita tak boleh nak fikir dah. Mana kita nak dapat maklumat kan?"

"Mmm, of course we are not satisfied. We only heard of it but [not] like in detail. We are supposed to look at the information before coming here right? But we are already in an emergency circumstance. We cannot think anymore. Where to get information right?"

[22_M_SECONDARY_MARRIED_HOUSEWIFE]

With regards to cost, it appears that this did not have a major impact on women's access to abortion services. The majority of respondents said the cost charged at the present clinic was reasonable and affordable. When probed, several of them revealed they paid between RM150 – RM260 for medical abortion services at this clinic. One discerning respondent felt that the cost was reasonable and appropriate for the standard of services she had received at this clinic. A couple of them, however, felt the cost to be high. A Malay housewife respondent felt that fees for medical abortions was reasonable but the cost of surgical abortion services (RM400 – RM700) was high and not affordable to low-income groups. She then proposed that the cost of abortion services be staggered according to one's level of income earnings. She hoped a discount could be offered to the poor or lower-income group. Another felt a woman would be forced to pay whatever the cost if she is desperate for the abortion services.

"Err…bagi saya kos dia OKlah sebab berbanding dengan dia punya harga dengan servis dia. Kira samalah (dengan) standard dia."

"Err…for me the cost is okay because compared to the price and the service given. The standard is the same"

[26_M_TERTIARY_MARRIED_CLERK]

"Ah…macam kaedah ubat tu, I rasa berpatutan lah sebab ubat dia kan…memang ubat tu kat tempat lain memang mahal lagi. Tapi macam kaedah cuci tu… rasa sini mahal lagi lah…kalau boleh macam kurangkan sikit lah...untuk macam kita golongan yang tak mampu...kalau boleh adakan diskaun ke?"

"Ah…like the medical abortion, I feel the price is reasonable because the pills…the pills sold at other place is much more expensive. But if like the wash [surgical abortion]…I feel here it's more expensive lah. If can, make it cheaper a bit…to help people who cannot afford…if can maybe have discount?"

[22_M_SECONDARY_MARRIED_HOUSEWIFE]

Health Providers

The majority of respondents said they were satisfied with the services at Clinic XXX. Many had highlighted two key features of Clinic XXX abortion services that stood out and impressed them. The first was the detailed and clear information on the two methods of abortion offered at the clinic, and in particular, the systematic information provided for the medical abortion

process. The second was the emphasis on post-abortion follow-up care. The respondents tended to compare these two features against their experiences in other clinics they had been to.

> "I feel I got all the information I can accept and they explained. The service [provider] is also very kind. I think when I came in the first time, the nurse, she explained to me. I feel this nurse is very kind, can help us to get more information about the abortion. And I feel I was able to find the way to decide my life already. Then she explained to me [what] you need or don't want, how to prevent…all she got explain to me. So, I feel very okay lah"
>
> **[29_C_SECONDARY_SINGLE_ADMIN CLERK]**

> "Hmm…they told me if you choose the medication – not 100% [effective for complete abortion], actually operation also…you know, the doctor also can't confirm 100%. So, they gave options, and then I choose the medication, and then they say, if you took the medication and then after that really not clear, then you must come back to do the operation"
>
> **[25_C_SECONDARY_SINGLE_HAIRSTYLIST]**

A number of the respondents were particularly happy with the reassuring post-abortion follow-up as, when they turned up at the clinic, the health providers took much effort to scan and confirm that the medical abortion they carried out at home was completely successful. A couple of them appreciated that there were no extra charges for such post-abortion care and pointed out that, instead, they were refunded for any surplus medications they returned!

> "After the abortion…come to check up…[explained how] to prevent [becoming] pregnant, you need to use condom or eat medicine [the pill]…"
>
> **[29_C_SECONDARY_SINGLE_ADMIN CLERK]**

> *"Follow up tu, dia scan, dia tengok dah bersih, so dia kata dah clear dah semua. Lepas tu, dia panggil I nak ambik untuk kirakehamilan lah sebab I cakap tak nak lah kan...lepas tu ada ubat dia panggil kita…ambil balik dia orang kasi duit balik lah…klinik lain tak pernah buat macam ni…okay…puas hati lah…"*

> "The follow-up, they scanned, they will see if it is clean [complete abortion], so they said everything is clear. After that, the medication. They called to ask to bring back to them and they will refund the money lah. Other clinic has never done like this…okay…satisfied"
>
> **[22_M_SECONDARY_MARRIED_HOUSEWIFE]**

It appears that several of the single unmarried respondents were particularly appreciative when health providers were not judgemental about them which was another positive feature at Clinic XXX. This was highlighted by a single woman who had experienced resistance in other clinics prior to going to Clinic XXX:

> "Then she sits down and asks you which hospital would you like your baby delivered ah? How old are you? Married? Haven't married oh? May I scan – I asked? Here, we don't offer abortion…doctor hasn't come yet. Why not you go to other clinic? Not so helpful, not so kind. So resistant…like as if you are single and unmarried, she like…refused that you come to consult her"
>
> **[29_C_SECONDARY_SINGLE_ADMIN CLERK]**

Several respondents emphasized they found health providers at Clinic XXX to possess good communication skills, such that they felt no tension when doctors informed them of the various options, or explained the abortion process in detail or when they were counselled about contraception during post-abortion follow-up.

> *"Ah…Dia semua sudah bagi tahu macam ni, macam ni, dia bagi standby ubat, surat…dia bagi semua…"*
>
> "Ah...they already told everything like this, like this, they gave standby medication, letter...they give everything"
>
> **[28_I_SECONDARY_MARRIED_PART TIME DRIVER]**
>
> *"…I rasa cukuplah (maklumat)…kita first time, kita tak biasa.. Ok kita makan ubat macam ni, macam ni…depa terangkan satu – satu…OK lah. Kita berpuas hatilah…cara macam mana kita nak makan? Lepas tu, kalau kita tengok darah terlampau sangat…depa bagi kita surat, kita akan transfer ke hospital sekali gus"*
>
> "...I think enough [information]. We first time…we are not used to it. Okay we take the pills like this, like this…they explained one by one. Okay lah. We are satisfied. How are we supposed to take the pills? After that, if we see that the blood comes out too much, they will give us a letter, and we are transferred to the hospital immediately"
>
> **[22_M_SECONDARY_MARRIED_HOUSEWIFE]**
>
> *"Er dia bagi tahu…masa sakit tu kena ada orang ya…suami kena ada di rumah lah…jangan tinggal seorang…kena hádala orang dalam rumah. Masa sakit mungkin dia akan pengsan ke…kalau ada turun darah banyak, doctor cakap pergi hospital besar lah kan untuk cucilah"*
>
> "Er they told…when in pain that time there must be people. Husband has to be at home lah, don't be alone. Have to have someone at home. When in pain maybe you will faint or what. If the blood comes out a lot, doctor said must go to big hospital to wash lah"
>
> **[35_M_SECONDARY_MARRIED_NASI LEMAK SELLER]**

They said they had time to think before they decided on the abortion and on the choice of abortion method. Furthermore, although they were counselled about post-abortion contraception, they were not pressured or forced to take contraceptives. A few also pointed out they were satisfied with health providers in Clinic XXX because they found them to be

kind and generally with positive attitudes compared to the 'clinical' attitude they had experienced in other clinics.

> *"Kira…dia explain dia macam tak bagi kita rasa, orang kata apa, takut apa kan. Dia bagi kita rasa tenang sikit kan…macam setengah doctor tu macam bagi kita rasa tension…kadang kadang tak pandai cakap kan dengan dia punya patient tu. Tapi OK lah doctor kat sini macam cakap dengan kita dengan carayang orang kata apa – bagi kita tenang, tak bagi kita tension…puas hatilah"*
>
> "They explained in a way like they don't make us feel scared or what. They make us feel calm, like some doctors they gave us tension. Sometimes they are not good in talking with their patient. But okay lah the doctors here, like when they talked to us, they calmed us down, didn't give us tension…satisfied lah"
>
> **[22_M_SECONDARY_MARRIED_HOUSEWIFE]**

> *"Hmm…saya memang berpuas hati dengan yang itulah…dekat sini staf pun saya sukalah sebab depa bagi kita suggestion, cadangan OK. Dia tak galakkan kita tapi dia bagi cadangan untuk selepas buat penguguran ni. Untuk ambil apa-apa plan yang sesuai untuk kita…dekat sini dia bukan kata orang, kira macam menggalakkan untuk kita membuat pengguguran. Tapi dia lebih menggalakkan kita untuk merancang supaya mengelakkan pengguguran itu berlaku"*
>
> "Hmm…I am satisfied with that lah. Over here, I like the staff because they gave us suggestions. They don't encourage us but gave suggestion on what to do after abortion. To take up what plan [contraception] that is suitable for us. Over here they don't like…encourage us to have abortion. But they are more about encouraging us to plan [contraception] to avoid abortion from happening [in the future]"
>
> **[26_M_TERTIARY_MARRIED_CLERK]**

> "Yeah, all the process – they are very kind I feel, and the services so good, yeah…they gave me time to think, yeah, want or don't want [my pregnancy] Because at the start she asked me, I also already said I want to take medical [abortion] already"
>
> **[29_C_SECONDARY_SINGLE_ADMIN CLERK]**

However, some respondents also revealed dissatisfaction with health providers at Clinic XXX. One respondent singled out one doctor whom she felt was condescending, arrogant, insensitive to her preferred choice, and generally just not respectful of her as a patient.

> *"Er…yang tu doctor… tak tahu nama…dia macam sombong sikitlah…dia macam dia anggap I macam low class…dia kutuk dia punya patient depan patient, dia marah dia punya nurse depan patient – oh, tak boleh tahan dia…I rasa tak perlu simpati lah, just you tak perlu…er…kasar sangat…I sudah tau nurse sudah cakap you tak boleh buat vakum sebab you lambat. Then, I just tanya dia sekali lagi…er…boleh vakum tak? And then dia cakap dengan nurse 'mereka mahu cuti lagi, boleh dapat MC (medical certificate) lagi', tapi I tak minta pun. Dia cakap depan I, tapi dia cakap Inggeris"*

> "Er…that doctor…don't know the name…he/she was a bit arrogant. He/she treated me as if I am low class. He/she insulted his/her patient infront of the patient. He/she scolded the nurse infront of the patient – oh, I cannot tolerate him/her. I feel like I don't need sympathy lah, it's just that you don't need to be so rough. I already know, nurse said you cannot do because you are already too late. Then I just asked her again…er…can vacuum or not?' and then she said to the nurse… "they want to take more leave [from work], can get more MC (medical certificate)', but I didn't ask also [for medical certificate]. He/she said in front of me, but he/she said in English"
>
> **[M_23_TERTIARY_MARRIED_CLERK]**

Interestingly, one respondent mentioned her dissatisfaction with the follow-up services at Clinic XXX, in contrast to the majority who were generally satisfied. She explained that she would like to have had another follow-up session three months after the abortion to check and monitor the state or health of her uterus. She felt the current practice of a two weeks' follow-up, that is more aimed at ensuring complete or successful abortion, is not adequate.

> *"Kalau ikutkan memang tak cukuplah sebab kita…[selepas] makan [ubat] dua minggu kita akan datang. Patutnya, macam kita buat paymentlah…tiga bulan lagi datang ke sebab kita nak tengok kesan dia macam mana kan…sama ada effect ke tak ada effect…follow-up tu kurang puas hatilah sebab depa cuma tengok…sudah bersih, tak ada apa…kalau boleh lah…dalam tiga bulan ke empat bulan ke kita mai balik, kita buat check uplagi sekali…nak tengok macam mana rahim ok ke ataupun dia ada effect"*

> "By right it's not enough because [after] we take [abortion pills] in two weeks we will come [back to the clinic]. By right, it's like how we make the payment, three months come back again because we want to see the effects [of abortion], how it will be. Whether there are any effects or not. The follow-up is less satisfying because they just see [scan] if it's clean already, nothing else. If can lah…in three or four months we go back again to do a check up once more. Want to see if the womb is ok or if there are any effects"
>
> **[22_M_SECONDARY_MARRIED_HOUSEWIFE]**

Comparatively, more respondents tended to be less satisfied with health providers in government hospitals/clinics with whom they had encountered when seeking abortion services. As previously mentioned, they experienced doctors who were judgemental and labelled abortion as 'wrong' or a 'sinful' act. Sometimes, women were denied their right to decide not to carry their pregnancy to term and were instructed not to abort because it would be against their religion, and to deliver and then give up their baby for adoption instead.

> *"…kalau boleh I tak mau dah lah…'Pasal apa you buang? You tahukan itu satu dosa', dia kata…tapi, pendapatnya memang betul lah kalau ikut dalam kita punya agama, kami memang tak boleh lah... tapi tak mampu, terpaksalah. Jadi, dia cakap pada saya, 'kenapa tak lahirkan juga…bagi dekat orang?' Boleh nak bagi? Dalam kandungan OK tak apa, kita setuju nak bagi, selepas dia lahir kita tengok*

dia…kita tak sampai hati nak bagi…daripada rasa serba salah baik kita buat kaedah ni tak apa…serba salah terus hilang! Dia kata tu bukan masalah…besar. Dia kata itu kita boleh mau…kita boleh settle"

"…if can I don't want already.'Why you want to throw [abort]? You know that is a sin right', doctor said. But doctor thinking is correct, if follow our religion, we cannot [abort]. But we cannot afford, so have to. So, doctor said to me, 'why don't want to give birth to it and give it to somebody else?' Can we give? In the womb it's okay no problem, we can agree to give, but after giving birth we look at it [the baby]…we will not have the heart to give away. Then rather than feel guilty it is better to do this way [abortion]. The guily will be gone immediately. Doctor said it's not a big problem. The doctor said if we want…we can settle"

[22_M_SECONDARY_MARRIED_HOUSEWIFE]

These respondents also mentioned that it was difficult to accept such attitudes which belittled them as the doctor likened them to irresponsible teenagers who would usually take the easy way out by aborting. They felt the doctor should be more sensitive to their specific needs, in particular, the real difficulties they faced in trying to prevent pregnancy and not assume they were wanton teenagers caught with an unwanted pregnancy.

"...bukan cara macam ni (pengguguran)...cara paling mudah sekarangni remaja sekarang, ambik kaedah mudah...cuci, cuci!'...tapi orang kata, cara dia cakap macam kita tak boleh terimalah. Macam memang kita tahu kita ada penyakit ni...tapi takkan sampai satu kaedah pun kita tak boleh nak guna? Kalau setiap tahun...setiap kali kita pregnant, macam mana? Kita mesti nak ni...OK kita boleh pakai kondom, kondom sampai bila? Husband kita mesti tak mau punya... depa kadang kadang penat juga, nak lepas...tapi kita tak pandai nak jaga waktu waktu dia"

"..not this way [abortion]. The easiest way now in teenagers, take the easy way out…wash, wash [abort]! But the way he/she talks we cannot accept it. Like of course we know that we are having a health problem…but don't tell me there is not even one way that I can use [contraception]? If every year…every time we get pregnant how? Of course we want to. Okay we wear a condom, but until when? Our husband sure wouldn't want. Sometimes they get tired too, to let out [ejaculate sperm]. But we are not good in controlling the time [to ejaculate]"

[22_M_SECONDARY_MARRIED_HOUSEWIFE]

Pre- and Post-Abortion Counseling

Both single and married respondents expressed their appreciation for the pre-abortion counseling at Clinic XXX as it was non-judgemental or impartial and, basically, focussed on providing information and choices.

"They did explain in detail to me…[they] let us decide whether we are taking this medicine[medical abortion]"

[38_C_PRIMARY_MARRIED_FACTORY QA]

"…the first time I came, before scanning the baby, also got explain to me already. They gave me time to think, yeah, want or don't want…"

[29_C_SECONDARY_SINGLE_ADMIN CLERK]

Although the majority of respondents could have already decided on abortion prior to going to the clinic, they felt that the counselling was essential.

"…mereka explain loh…mula mereka cakap 'betul mahu buatke?'…mereka ada tanya betul nak tak…'sure? simpanlah'…kalau mereka tanya macam ni OK jugalah boleh bagi fikir sekejap, tapi I rasa tiap tiap orang yang mai sini sudah confirm mahu buat punyalah. You tanya macam ni pun tak guna…hmm…I rasa perlu jugalah…someone tanya you 'you confirm you betul mahu"

"…they explained. First they will say 'are you sure you want to do [abortion]?'…they got ask if really want to abort…'sure? Keep lah'. If they asked like that okay, it allows us to think for awhile. But I feel every one who comes here is already certain that they want to do [abortion]. You ask like that also no use. I think it is necessary also lah someone to ask you 'You really confirm want [abortion]' "

[M_23_TERTIARY_MARRIED_CLERK]

Pre-abortion counseling also dispelled the women's pre-existing fears/doubts and clarified misinformation they might have had. Several respondents, however, commented that Clinic XXX's pre-abortion counseling lacked details about abortion.

"Hmm…because they (nurse) explained to me like it will come out like the period, so I don't think anymore [i.e. worrying about whether a whole baby will be expelled]….[laugh]"

[29_C_SECONDARY_SINGLE_ADMIN CLERK]

"Sekarang tu kira nak tau lagi detail lah…apa nanti jadi. Apa yang akan berlaku. Apa yang perlu kita jaga"

"Now want to know more details, what will happen later. What do we need to take care of"

[22_M_SECONDARY_MARRIED_HOUSEWIFE]

With regards to post-abortion counselling, several felt it could be improved to include even more detailed information about the effects of abortion and contraception (such as, contraceptive failures and side effects).

"*…bila kita akan mai balik, doctor akan scan…dia cakap OK, tak ada apa…er, betul ke doctor ni kata tak ada apa – macam I selalu fikir betul ke? Betul ke selamat?...ada effect ke apa…lepas kita cuci ni…pasal apa kita rasa lain ah? Rasa macam...kita selalu kalau kita lepas beranak kan...kenapa dia sini nampak macam lainah? Rasa kat sini buncit, pasal apa? Takkan lah ada kesan pasal ni kan? Patutnya, dia kena terangkan lah"*

"…when we come back here, doctor will scan…the doctor said OK, nothing…er, is it true when the doctor said there is nothing - like I always think is it true? Is it safe now? Are there effects or not…after we washed…why do we feel different? Feel like…always after we gave birth right…why is it that she looks different ah? Feel that it's bloated here, why? Not from the effects of this [abortion] right?

[22_M_SECONDARY_MARRIED_HOUSEWIFE]

"Kena, nak [tahu]…kalau tak mau hamil, nak try ke ubat, cucuk punya atau apa ni…ahh IUD ke?...[maklumat] tak cukup…nak cegah [kehamilan] nak tahu tu…pakai apa…IUD dia boleh mengandung tak atau tidak kan – semua orang kata boleh mengandung kalau guna yang itu kan…kalau inject pun sama juga, dia kata."

"Must, want [to know]…if don't want to get pregnant, want to try the pills [oral contraceptives], injections [injectables], or what. IUD [information] is not enough. Want to prevent [pregnancy], want to know that…wear what…IUD can get pregnant or not right – everyone said can get pregnant if use that one [IUD] right…if injection also same, they said"

[35_M_SECONDARY_MARRIED_NASI LEMAK SELLER]

Some pointed out that besides contraception, post-abortion counseling should also incorporate sharing of feelings and emotions. Yet others felt this was not necessary because it was too private to share.

"Er…I rasa selepas itu, patut ada [counseling] …hmm cerita loh kita punya experience sakit macam mana sebab…er cakap dengan husband macam tak faham apa apa (laughter)…so need someone untuk dengar kita, kita cakap apa loh…macam cakap macam ni lah [referring to the interview]"

"Er...I feel that after that [abortion], should have [counseling]...to tell our experience of how the pain was. Because talk to husband, he don't understand anything (laugh)…so need someone to listen to us, what we said...talk like this [referring to this ongoing interview]"

[M_23_TERTIARY_MARRIED_CLERK]

"Hmm…no [need counseling]. I think…because I think that this one is a private [matter]. Ah, so no need to…share. Maybe I no need lah I think…ya, maybe someone needs lah."

[25_C_SECONDARY_SINGLE_HAIRSTYLIST]

Another interesting finding was that some women expressed their appreciation for their husbands' or boyfriends' involvement in pre- and post-abortion counseling.

"Yes, bagi saya dengan suami, kami memang biasa berdua mai, jadi dia [clinic staff] memang akan melibatkan suami lah [dalam kaunseling] …dan dia bagi kita masa untuk berfikir…sama ada betul nak buat benda ni atau tak…selepas

tu dia kata…perancangan yang baik lah…mula mula pun dia [suami] takut juga kesihatan saya selepas ini…tapi bila dia sendiri menanyakan doktor tu, so doktor dah explain dekat dia, dia rasa puas hatilah. So, dia tak ragu ragu…"

"Yes, for me and my husband, usually we come together. So they [clinic staff] will involve husband lah [in the counseling]. They gave us time to think. Whether we really want to do this [abortion] or not. After that, they will say…good planning lah. At first he also [husband] fear of my health after this. But when he asked the doctor, the doctor explained to him he is satisfied lah. So, he don't have doubts."

[26_M_TERTIARY_MARRIED_CLERK]

Reproductive Health Knowledge

This study revealed that the women generally had superficial reproductive health knowledge. For example, one woman was aware of the fertile period but did not know specifically when.

"That's why they say sometime after period how many days ah, there is the… [fertile period].. Ah, ah that one ah very *subur* [fertile]. So I don't know."

[38_I_SECONDARY_MARRIED_HOUSEWIFE]

While some were knowledgeable about the signs and symptoms of pregnancy, there were others who were not aware. Missed period, fatigue, nausea, and unusual cravings were some of the pregnancy signs and symptoms cited. A home pregnancy test was done by some young women to confirm their suspicions of being pregnant.

"My period is usually on the 5th, and then I had my fever before 5th, and I'm not feeling well and sleepiness was also before the 5th. After that on the 5th, my period didn't come, and then on the 10th. After five days, I went to buy the test."

[29_C_SECONDARY_SINGLE_ADMIN CLERK]

"Ah... Apa letihlah, lepas tu, satu minggu dah saya semua letih dah saya tak boleh buat, pening ada, muntah ada tapi saya perasan saya mengandung kah? Habis tu, saya pergi check dengan klinik lah. Tapi dia kata mengandung. Saya terkejut!"

"Ah…like tired lah, after that…one week already I was tired and couldn't do [work], got dizziness, vomit got, then I realised could I be pregnant? Then, I went and checked in the clinic. Then he/she said I am pregnant. I was shocked!"

[28_I_SECONDARY_MARRIED_PART TIME DRIVER]

"Dia preg... saya beli pregnancy test kan. Ha, beli. Tengok-tengok, dua. Ha, terkejutnya."

"I bought the pregnancy test right. Ha, bought. See see, two (two lines indicated on pregnany test). Ha, (was) shocked"

[21_M_SECONDARY_SINGLE_PROMOTER]

Those who were not aware, they did not suspect they were pregnant until physical changes, such as weight gain, were noticed.

> *"Dia yang bangkitkan sebab dia yang menyedari perubahan tinggi. Saya makin, orang kata, makin gemuk. Dia kata, apa pasal gemuk ni. Lepas tu, dia suruh saya check"*
>
> "He is the one who brought it up because he realised some changes. I was becoming, people say, I became fatter. He said 'why are you fatter?', after that he asked me to check."
>
> **[21_M_SECONDARY_SINGLE_PROMOTER]**

> *"Then I, pasal I nampak perubahan kat perut I, makin lama, makin besar. Lepas tu, I pergi klinik swasta...dia scan. Dia kata ada objek dalam perut. Sebab I...makin lama, makin besar. Kita dah mai period macam biasa bulan-bulan. I takut ada...ada pertumbuhan ke apa ke...sebab sekarang ni kan macam-macam penyakit ada...I pergi try scan kan lah...Doktor scan, ada benda dok bergerak dalam perut. Hah? Lepas tu I kata, my period macam biasa lah... Sekarang ni I tengah period lah... Ok. Lepas tu, dia kata, you pernah try pregnant test tak? I tak trylah pregnant test. Sebab I dah bulan-bulan mai period. Dia kata, ok takpa... buat pregnant test lagi sekali. Buat-buat memang..."*
>
> "Because I saw changes in my stomach area…the longer [time], it gets bigger [tummy]. After that, I went to a private clinic…he/she scan. He/she said there is an object in the tummy. Because I…the longer it gets [time], it gets bigger [tummy]. I have period like usual, monthly. I was scared if I have any growth or what…because there are so many kind of disease nowadays. I went to scan lah. Doctor scanned, there was an object moving in the stomach. Ha? Then I said 'my period is normal (regular). Now I am having period'. Ok, after that, doctor said, 'Have you tried pregnancy test?' I didn't try because every month I have my period. Doctor said 'It's okay do the pregnancy test again'. I did then really…[pregnant]"
>
> **[22_M_SECONDARY_MARRIED_HOUSEWIFE]**

Knowledge of Contraception

Types of Contraception

Almost all the women interviewed knew of some modern contraceptive methods, the most common being the oral contraceptive pill and intrauterine contraceptive device (IUCD). However, this was usually followed by a list of undesirable side effects they had heard from friends or relatives.

> "Oral contraceptive pills, or put IUCD, sometimes it will cause some problem la. Or don't want that oral contraceptive pills, condom. No, it's after eating pills that will have side effects, confirm. Side effects means it will cause harm to our vagina, I heard that before. Hmm, heard before, but I did not try it before, so I

don't dare to say. So I heard that, because I had seen that person not just eat oral contraceptive pills, still eat weight-losing pills, also facing I don't know la, but will affect her body, when the effect comes, you will be fat, will very serious. Then the second thing is, now she has given birth, but is scared it will be harder to give birth in future, because you don't know that medicine, I don't ask her the medicine is more power or what la"

[26_C_SECONDARY_MARRIED_SALESPERSON]

"IUCD, I heard from some people, they said that one is dangerous. But I don't know, but they say…yeah, scared (to have IUCD insertion). They say that it can [have] side effects. Like, they say like, if long time means, some time we forgot you know, you don't know that the thing is inside. It becomes like karat (rusted)"

[38_I_SECONDARY_MARRIED_HOUSEWIFE]

"Sebab yang saya tau, pil perancang keluarga dia banyak risiko. Saya tak sure. Tapi yang saya tau. Saya pernah dengar. Sebab pil perancang boleh buat kanser payudara"

"Because from what I know, the family planning pills have a lot of risks. I am not sure. But from what I know, I have heard. Because the pill [oral contraceptive] can cause breast cancer"

[21_M_SECONDARY_SINGLE_PROMOTER]

Due to fears of the oral contraceptive pill's side effects, some women reported that they resorted to using the withdrawal method, while acknowledging their uncertainty of its effectiveness which, in turn, caused them much anxiety.

"I just plan myself. So, sometimes when we have sex or what, I tell my husband to take out [withdrawal] or put the water [sperm] outside or whatever it is. And then sometimes yes, sometimes no, sometimes accidentally happen. So, I cannot control myself"

[42_I_SECONDARY_SEPARATED_PRODUCTION OPERATOR]

"Bukan kata boleh, ber...tak berapa sure boleh pun kan (on withdrawal method). Tapi I rasa lebih senang. Sebab...banyak macam err..pil perancang dia banyak side-effect.Erm. Masalah dia tiap-tiap bulan you you takut ohh you mesti rasa ohh takut..sangat takut. Takut ada lagi. Sebab sebab dulu nurse ada cakap, 'You guna cara ni pun tak, tak berapa..one hundred percent[efektif]'"

"Not to say can, not really sure if really can right [on withdrawal method]. But I feel that it is easier. Because a lot…like…contraceptive pill also have a lot of side effects. The problem is every month you will feel scared, oh you will feel very scared. Scared to get [pregnant] again. Because last time the nurse did say, "You use this method also it's not really, not really 100% [effective]"

[M_23_TERTIARY_MARRIED_CLERK]

While some women knew that breastfeeding can prevent pregnancy from occurring (exclusive breastfeeding on demand for six months has a contraceptive effect, i.e., lactation amenorrhea method (LAM)), they were not clear on the criteria that must be followed for LAM to be effective. This, in the end, led to an unwanted pregnancy.

> *"Lepas tu, saya tanya dengan doktor, saya lagi breast feeding, mana boleh mengandung? Itulah sekarang takda satu bulan sampai satu dengan enam bulan...er...tak dapat anak. Lepas tu, you jaga sendiri kalau breastfeeding ke, tak breastfeeding ke tak kira. Mesti boleh dapat anak"*
>
> "After that, I asked the doctor, I am still breastfeeding, how could I get pregnant? That's why now no, one month to six months…er…cannot get child [pregnant]. After that, you have to watch yourself [contraception] whether you are breastfeeding or not breastfeeding it doesn't count. Sure can get child [pregnant]"
>
> **[28_I_SECONDARY_MARRIED_PART TIME DRIVER]**
>
> "Cause at that time I was still breast feeding. Then, from what I know…they say when you are breastfeeding you can't be pregnant"
>
> **[25_C_TERTIARY_MARRIED_HOUSEWIFE]**

Satisfaction of Contraception Knowledge Received

When asked specifically if the information on contraception was clear or complete, mostly answered in the negative.

> *"Buat masa ni, nak kata saya tahu banyak itu tak bolehlah. Sikit-sikit tu saya tahulah. Memang tak cukuplah [contraception information received]"*
>
> "At this time, can't say that I know a lot. Little bit I know lah. It's really not enough [contraception information received]"
>
> **[M_35_SECONDARY_MARRIED_CLERK]**
>
> *"Er...bagi I masa... cukuplah depa macam. Depa tapi tak secara terperinci lah... dia pun cuma ringkaskan lah... Cara kita faham sajalah"*
>
> "Er…for me enough lah like…but not in detail lah [contraception information] …they only simplified…in the way we will understand"
>
> **[22_M_SECONDARY_MARRIED_HOUSEWIFE]**
>
> *"Arrr…tapi I rasa mereka [health providers] tak cakap…banyak kaedah. Cuma cakap dua. Kira ada dua,dua kaedah saja loh. Tak berapa cukup [contraception information]. Hmm…"*
>
> "Arr…but I feel they [health providers] didn't say…there are many methods. Only say two [method]. So only two, two methods only lah. Not really sufficient [contraception information]. Hm."
>
> **[M_23_TERTIARY_MARRIED_CLERK]**

Some who had taken up a safe contraceptive method after the abortion felt they had been correctly advised.

> *"Tapi I kadang-kadang tanya lah...kalau macam kita nak mengelakkan, macam kita tak reti nak jaga...tak tahu tahap kesuburan macam mana, macam mana...so, depa akan terangkanlah. Ah hah...Waktu bila kita boleh...Ah...macam mana kita ni, macam mana kita tahu tahap kesuburan. Er...puas hati. Sebab kita tak biasa. Kita takda experience. Kita tak tahu. Selama ni kita tak tahu...bila depa (clinic) dah beritahu macam ni, oh kita dah tahu macam mana nak mengatasikan tu kan"*

> "But sometimes I ask…if we want to avoid [getting unwanted pregnancy], like we don't know how to prevent…don't know level of fertility like how, how…so, they will explain lah. Ah hah…when we can…how we, how we know levels of fertility. Er…satisfied because we are not used to it. We don't have experience. We don't know. All the time we don't know…when they [clinic staff] told us like that, oh we know how to overcome the problem"
>
> **[22_M_SECONDARY_MARRIED_HOUSEWIFE]**

Sources of Contraception Information

As above, most women mentioned multiple sources of contraception information, such as from female relatives, friends, family planning clinics, and reading materials. Contraception information from family and friends tended to lean towards the negative aspects, such as the side effects.

> *"Haa, tapi I punya…I berbincang semua ni dekat kat mak I punya aunty cakap tak payah la pergi. You punya husband jaga lah senang. Dia tak mau bagi I guna pil dia cakap, dia cakap hormon ke. Dia cakap hormon kita boleh ni la. Dia kata nanti tak bagus lah. Boleh dapat sakit lah, apa lah dia cakap hmm. Dia kata jadi gemuk lah. IUD tu I punya kakak sepupu yang cakap dia kata. Dia sampai teruklah keluar keputihan, period pun banyak, pastu tak normal. Takutlah"*

> "But as for me…I discussed with my mother, my aunt said no need to go [for IUD insertion]. [She said] you ask your husband to cooperate in preventing unwanted pregnancy. My aunty didn't want to let me take the pills [oral contraceptive], she said it's hormones. She said it's not good. Can get sick from it and all. She said can become fat. As for IUD, my cousin sister said she had a lot of white discharge and a lot of bleeding and then it was abnormal. I was scared"
>
> **[22_M_SECONDARY_MARRIED_HOUSEWIFE]**

> "Ya. And then I heard my friend said if you take it [oral contraceptive] too much, you…you will become fat. I don't know [is it true]. I'm so scared. Ya…she said to me they got side effects - can become fat. So they said, not to take it too regularly"
>
> **[25_C_TERTIARY_MARRIED_HOUSEWIFE]**

> "I thought about it before, but I did not put before [contraceptive patch]. I asked a lot of friends, they said after put this for a period of time, the hormone is like…did not come…period did not come. My friend, she said, she read that health care ah, saying that eating oral contraceptive pills is the most stupid (because) it's putting poison into her own stomach"
>
> **[36_C_SECONDARY_MARRIED_BEAUTICIAN]**

Personal Experience of Contraception

Contraception Practice

Most respondents have used one or two modern methods of contraception but stopped for various reasons.

> "It [IUCD] doesn't have any side effects, but when having sex it will cause bleeding. I usually bleed a lot during period. When doing it [having sex] I will bleed. I'll feel uneasy, the bleeding makes me feel uneasy. I took it out again. So all those things that related to placing or taking orally are not suitable for me. Sometimes we forget [to take the oral contraceptives]. 1 day, 2 days, then period comes, then lost count. Period gets messed up"
>
> **[42_C_PRIMARY_MARRIED_CLERK]**

> *"Saya tak larat nak makan kan [oral contraceptives]. Jemu dah kan… empat tahun. Berhenti sat la...saya tak makan tu. Cuma suruh husband pakai kondom jela… tak larat kan"*

> "I have no will to take already [oral contraceptive]. Bored with it already…four years. Stop for awhile. I didn't take that [oral contraceptive]. Just ask husband to wear condom only…no will right"
>
> **[35_M_SECONDARY_MARRIED_NASI LEMAK SELLER]**

Among them, the Pill seems to be singled out for causing weight gain but many kept forgetting to take them routinely due to work pressure or 'balik kampung' [return to hometown] on long weekends or public holidays.

> "Yea, before this I took the pill. I got a strip [of oral contraceptive pills]. However, I didn't manage to finish it all. It's just that when you took the pills for one week, then one day you will forget to take the pill, and you will get your period uncertain. Yes, it is. So, after that, I didn't take the pills anymore. I always forgot to take the pill"
>
> **[38_C_PRIMARY_MARRIED_FACTORY QA]**

> *"Er...saya pilih IUCD tu, I rasa IUCD tu ok untuk sayalah. Kalau saya pilih ubat, memang saya tak rajin makan ubat. Saya suka lupa. So, I rasa, ubat tak sesuai untuk sayalah"*

"Er…I chose the IUCD, I think IUCD is okay for me lah. If I chose medicine, I am not diligent to take the medicine [oral contraceptive]. I always forget. So I think medicine is not suitable for me lah"

[M_35_SECONDARY_MARRIED_CLERK]

Decision-making in Contraception Use

Difficulties in discussing contraception with husbands referred mostly to condom use and withdrawal. Muslim women seemed to have more difficulty discussing this with their husbands. When starting on the Pill or putting in the IUCD, the husband's 'permission' was often expressed as 'he doesn't seem to object; so he agrees'.

"I tak tau, bila pakai, kondom, husband cakap tak ok, tak. Jadi, kita, jadi macam susah jugak oh..hehe. Pasang? Dia takmau. Dia tak bagi, sebab dulu, I cakap takpelah, dulu I pasang sini, sekarang I mau cuba kerajaan kan. I mau cuba sana, tengok macam mana. Dia tengok I punya muka, dia cakap tak payahlah. I nak cakap macam mana. Dia kata, I cakap tak payah you jangan susah, you mau, you pakai sarung, I cakap. Sarung pun pakai, dia macam tak puas kan, susah. Sekarang I dok plan sekarang, mungkin I makan ubat kot, so dia cakap I makan ubatlah"

"I don't know. When using the condom, husband said not ok, no. So we, become difficult also...hehe. If insert [IUCD] he don't want. He don't let, because last time, I said nevermind lah. Last time I inserted here [at this clinic]. Now I want to try government [clinic]. I want to try there see how. He looked at me and said no need. I want to say then how. He said, no need. I said '(if) no need then you don't be difficult, you want [sex], you wear condom', I said. He wore a condom, but it's like he is not satisfied right, difficult. Now I am planning, maybe I should take medicine [oral contraceptives], so he said I take medicine lah"

[32_M_SECONDARY_MARRIED_FACTORY LINE LEADER]

"Ah ha...guna kondom sajalah. Tapi kondom, abang I tak mau. Dia tak selesa. Kadang-kadang, dia kata gatal"

"Ah ha…use condom only lah. But condom, my husband doesn't want. He is not comfortable. Sometimes, he said it feels itchy condom caused"

[22_M_SECONDARY_MARRIED_HOUSEWIFE]

"I...discuss jugok lah dengan dia, takut jugok, kadang – kadang kan...kalau macam, memanglah kalau macam selalu sangat dekat lepas dekat luar kan? Kadang kan, macam dia pun tak puas ka apa kan? I pernah tanya dia...pahtu dia kata, memang lah...kadang – kadang tu, tapi i...memang kadang – kadang tu kat dalam jugok...tapi, lepas tu, pandai – pandai lah pi toilet ke apa ka"

"I…also discussed with him, scared also. Sometimes right, like if, of course lah if like always ejaculate on the outside right, sometimes, he is also not satisfied right. I asked him before, then he said, of course lah…sometimes, but I

> sometimes inside [ejaculate into the vagina] also…but, after that, be smart lah go to toilet or what"
>
> **[29_M_SECONDARY_MARRIED_OPERATOR]**

Non-Muslim women were more assertive; mostly making the decision on their own. Regarding the IUCD or Pills, they remarked that 'this doesn't effect them in any way, so why tell them?'.

> "No need to discuss, I never discussed such matter (laugh). I never discussed because it's our body. Why we need to discuss with him, right? Yeah, it's my body so I know what's suitable for me. It's impossible that I discuss with him every time. Later he gave answers which are not good. I will get even more confused. It's my body only I know what's suitable for me, you understand?"
>
> **[42_C_PRIMARY_MARRIED_CLERK]**

> "Correct, just when eating medicine time [contraceptive pills], he is not free lo, I sure have to solve this thing myself one"
>
> **[26_C_SECONDARY_MARRIED_SALESPERSON]**

Needs and Suggestions

Many types of responses were yielded when asked on ways to improve the current abortion service or what can be done to help women cope with abortion. The types of needs and suggestions raised can be divided into five categories: abortion information; abortion services; channels of information delivery; sexual and reproductive health knowledge and abortion prevention.

Abortion Information

Types of information

Generally, many women agreed that abortion information should be disseminated to the public to increase public awareness and knowledge on this issue. The types of abortion information most desired were in the following order: consequences/side effects, availability of the service, various methods of abortion, abortion procedures and post abortion care. Other information needs that were cited by individual women were effectiveness, legality, safety, ways to take care when undergoing abortion and cost.

Information on consequences/side effects of abortion

Generally, the majority of the women were concerned about the side effects after undergoing abortion. They also had heard a lot of stories about the side effects but were not sure of the authenticity of the information given, hence, most women would like to receive clarification. Some examples of information needs with regards to the side effects were illustrated in the quotes below:

> *"Ada macam orang cakap susah nak mengandung, betul ka? Nak tahu lagi detail lah pasal itu kan."*

"Some people said it's difficult to get pregnant again, is that true? I would like to know more details about that"

[22_M_SECONDARY_MARRIED_HOUSEWIFE]

Information on availability and accessibility

The question of whether or not to inform the public on the availability and accessibility of abortion services garnered divided views. As abortion is not a widely discussed issue in Malaysia, many people do not know where to obtain such services; a problem faced by some women in the study. When relating to social problems such as baby dumping, some felt that abortion services should be made known to the public regardless of marital status to prevent baby dumping and also to avoid embarrassment to an unmarried single parent. Some viewed the sin or consequences of baby dumping are greater than having an abortion, as they put it below:

"Tapi tulah, macam sat lagi kalau macam orang bagi orang tak kahwin dia, orang tahu macam klinik ni boleh buat pengguguran nanti ahh takpe, mengandung takpe, boleh cuci, mengandung takpe boleh cuci kan? Tapi daripada segi pun bagus jugok lah daripada nak buang anak tu kan? Kira biar buang daripada awal takpe kan? Dosa memang dah memang dosa dah lah kan? Kalau buat pun dosa, buang lagi lah dosa kan. Tapi daripada nanti kalau anak tu nak malu ke kira kita pikir macam tu kan? Kalau buang pun takpelah...kalau boleh sebarkan pun takpe lah, sebarkan kan? Bagi…"

"That's why, like if we allow people who are not married, they will know that the clinic does [provide] abortion and later [they will think] it's okay, getting pregnant is okay because can wash right? But in another way it's good also because then to throw the baby away right [baby dumping]…if throw away [abort] earlier is okay right? [compared to baby dumping]. It is already a sin that is being committed. If abortion is a sin, throwing away a baby is more sinful right. But then the child has to suffer embarrassment which is better like that [to abort]. If abort also nevermind. If can it's okay to be disseminated [information on abortion availability]. Let..."

[29_M_SECONDARY_MARRIED_OPERATOR]

However, some felt that abortion information should only be given to couples who are married and when they are not able to support too many children. There were concerns that illegitimate couples will 'misuse' the service if such information is given to them, such as utilising abortion services as a form of contraception.

"I can. And then, if they really cannot afford this, maybe don't want to…err, how to say, harm their children. So, I can tell them the place that does abortion."

[25_C_SECONDARY_SINGLE_HAIRSTYLIST]

"Macam untuk berkahwin lah, macam dekat klinik ke...kalau macam open pun, susah jugok...nanti kalau macam yang...couple – couple ni...ahhh pandai pulak, tahu pulak kat mana kat mana kan? Macam yang ahhh macam kat klinik...macam

ibu –ibu ke apa kan? Ahhh...yang sudah berkahwin…mungkin, mungkin lah ahhh macam orang – orang yang susah ke...kan? Anak ramai ka...macam kita...dia pun tak mampu ka apa kan?"

"Like for those who are married, like in the clinic or what…if it is open it will become problem also. Later all these couples, they will be smart to know where to get [abortion service] right. Like those clinics…mother clinic or what…for those who are married…maybe they have difficulties right. Too many children and can't afford or what"

[29_M_SECONDARY_MARRIED_OPERATOR]

"Tapi tulah, macam sat lagi kalau macam orang bagi orang tak kahwin dia, orang tahu macam klinik ni boleh buat pengguguran nanti ahh mengandung takpe boleh cuci kan?"

"That's why, like if we allow people who are not married, they will know that the clinic does [provide] abortion and later [they will think] it's okay, getting pregnant is okay because can wash right?"

[29_M_SECONDARY_MARRIED_OPERATOR]

Needs on medical abortion information

Since medical abortion is a relatively new method of pregnancy termination in Malaysia, women's poor knowledge of this method was also raised. Generally, information on medical abortion that the women required were on the side effects, safety, process, availability, effectiveness, ease of consuming the pills, cost, post abortion care, reason for the side effects after consuming the pills and the possible advantages of medical abortion to other abortion methods.

One woman perceived medical abortion to be safer compared to surgical abortion as it doesn't involve the use of instruments (less invasive), however, she was not sure if the pills will have any effects on her womb as she asked:

"Keselamatan sama, tapi tak tak tahu lah. Tulah sebab I rasa sebab, sebab dia tak pakai alat bila dia buat tu, mungkin safety sikit kan. Tapi kita tak tahu lah sebab mungkin ada, ada kesan sampingan semua ke kat dalam, dalaman. Kita tak tahu jugak lah yang tu. Yang tu sebab dia tak habaq lah yang tu kan? Kalau macam kita buat ni, apa yang kesan – kesan dia tu kan? Ada kita punya perempuan lah dalaman kan? Macam rahim kita macam mana, ok ke tak ok ke?"

"The safety is the same [both surgical and medical abortion], but don't know. That's why I feel, because when they don't use the instrument, so maybe it is safer [medical abortion]. But we don't know because there might be side effects inside [in the womb]. We don't know about that. Because they never told us all this right? Like if we do this [abortion], how it effects our womb? Our uterus is okay or not okay"

[29_M_SECONDARY_MARRIED_OPERATOR]

Abortion Services

Availability and accessibility

In terms of abortion services, women in the study were found to have divided views on its availability and accessibility.

Due to the difficulty of locating abortion services, some women felt that the current availability of abortion services is inadequate. Thus, the need to increase service availability is warranted. Some women felt that the government should make abortion services available legally (in the eyes of law) to prevent the far greater negative consequences of baby dumping and unsafe abortions.

> *"I rasa, I setujulah, kalau kerajaan bagi benda ni macam ni, open. Secara terbuka, sebab kalau diorang buat macam ni, memang salah, tapi at least tak ada tentang pembuangan bayi lah. Takde kesan yang buruk dan besar lagi."*
>
> "I feel, I agree lah, if the government let things [abortion] like that to be open. Because when they do this [abortion] is wrong but at least there is no baby dumping. There are no worse and severe consequences"
>
> **[25_M_SECONDARY_MARRIED_CLERK]**
>
> "I think the government should allow legal abortion for Malaysian women. To make it less harmful for those … those women who want to get an abortion. But since they can't get the service legally, they will do it illegally."
>
> **[25_C_TERTIARY_MARRIED_HOUSEWIFE]**

In contrast, there were some who disagreed with increasing service accessiblity as many would take the 'easy way out' when faced with an unwanted pregnancy, thus, promoting abortion.

> *"I pun tak berani cakap sebab tak ada, kan sekarang banyak kes sekarang yang nak menggugur pun bukan yang dah marriage kan macam Malay pun banyak lah kan? Tu, tapi kalau ada tempat macam-macam ni juga macam satu, orang kata apa, macam, satu masalah juga kan? Macam orang Melayu buat diam-diam, apa semua kan?"*
>
> "I also don't dare to say because there is no, now there are a lot of cases whereby those who abort are not married and many Malays right? So, if there is a place like that [place for abortion], it will also be a problem right. Like all those Malay women they do it [have abortion] secretly or what"
>
> **[31_M_TERTIARY_MARRIED_CLERK]**
>
> *"Tapi in terms of kalau you kata perlu ada banyak-banyak, then lagi banyak kes pengguguran kan... Service I tak berapa agree lah. Because if you have more, then people akan ingat ah takpa lah... Senang pergi klinik tu, senang pergi klinik ni."*

> "But in terms, if you said there is a need for many [abortion services], then there will be more abortion cases right. I don't really agree with the service. Because if you have more, people will think it is okay. It is easy go to the clinic."
>
> **[38_M_TERTIARY_MARRIED_HR OFFICER]**

> "No. Not at all. It's not advisable. If you get it from the pharmacy [medical abortion], everyone will go for the pharmacy, you know"
>
> **[29_I_TERTIARY_MARRIED_SUPPORT SPECIALIST]**

In order to prevent abortion from being too easily accessible, one woman suggested that the government should assess the woman's reason and need for an abortion by examining the financial background or family background before abortion is approved. She further proposed that the government monitor each woman's history so that the number of permitted abortions per individual could be limited.

> "I mean not allowed for everybody, because if this happens, this is why everybody are really… brave. I mean they dare to do all this abortion. If you have particular details, that you really cannot afford it, okay, we will see and all the stuff. And we see your family background, whether your family… how your husband working? Whether you had been working or not? How many children do you have? From that family background history, and then, you can really analyse, you get approval, then you can do abortion. If not, you shouldn't be allowed to have abortion if really cannot support. Or government should have, okay, if people really don't have support, like for single mothers whose guys ran away, you know. So, all this stuff, I think they should have. Like get approval from government. Okay, for those who are, how about the background, family background, should they really have? I mean get the support from government. Or they really can depend on themselves. So if everybody…you know…they are allowed to have abortion, so everybody will do that easily. If I'm the government, I would have records; oh, this person already had aborted two times, that's it. No more. So, you know, so… I mean…that's…"
>
> **[29_I_TERTIARY_MARRIED_SUPPORT SPECIALIST]**

As highlighted earlier on the reasons women deemed acceptable for an abortion, some women hoped that a facility/department would be set up to help women with such reasons, i.e., having too many children or having financial problems, by providing abortion services to those who are really in need.

> *"Ah, tapi, tapi kalau boleh, macam I ni, macam terus, I rasa perlulah ada lebih lah. Lebih lah pusat perkhidmatan untuk wanita macam ni kan? Macam tak bagi, bukan lebih banyak perkhidmatan pengguguran tau, macam orang kata, tempat boleh membantu wanita-wanita macam I lah, macam orang kata, tak mampu kan, macam tiba-tiba lekat kan? Kita nak pergi cuci, kadang-kadang, I rasa orang kata, planning tu macam tak kena kan? Macam orang kata, macam, kata family dah ramai, macam tu kita nak buang kan, kalau you pergi hospital pun memang tak orang tak boleh buat kan? Hah, so, kalau klinik pun fikir pasal masalah kewangan*

juga kan? So, kalau ada tempat yang orang kata boleh, orang kata boleh bantulah, macam tu. Pusat perkhidmatan yang boleh membantu wanita-wanita yang kurang bermampuan. Bagi mereka yang perlukan sangatlah, kira kalau ada lebih tempat macam ni kira ok lah."

"Ah, but if can like, like me, I think more is needed [abortion services]. Increase service facilities for women like that [women who can't afford financially to have another child]. Like…ah, not say to increase abortion services, but like a place to help these women, like me, like people say, those who can't afford and accidentally got pregnant. We want to go for a wash [abort], sometimes, when the family planning is not right. Like how people say, when the family is big [many children], so we need to abort, if you go hospital they won't do it right? Then if lets say clinic, then there is the financial aspect to worry about also right? So if there is a place where they can help like that, service facilities which can help women who can't afford [financially]. For those who really need it [abortion], if there are more of such places then okay lah"

[31_M_TERTIARY_MARRIED_CLERK]

"I think the government should build a department to help the…those people that don't want to be [pregnant] like in some cases of being raped by unknown [person]. Situation like this…don't want the ba-…cannot have the baby in the moment. Can organize someone…maybe can search for some advice then can do abortion there. Get one department to help those people."

[25_C_TERTIARY_MARRIED_HOUSEWIFE]

Health providers

All of the women interviewed were satisfied with the healthcare providers, including doctors, who provided the abortion service except for one. She relayed her negative personal experience and claimed that having an arrogant doctor will add to the fear of facing abortion itself and wished for doctors who are gentle and friendly.

"Improve doctor loh. Haha. Hmm…errr…lembut sikitlah. Haa. Haa, lebih friendly sikit. Sebab you banyak tu takut, dia lagi sombong macam ni. Err..tak you lagi takut tau. Haa."

"Improve doctor loh. (laugh). Hmm…more gentle…(laugh) friendlier. Because you are already so scared, then he/she is arrogant like that. Er…then you will be more fearful you know. Haa."

[M_23_TERTIARY_MARRIED_CLERK]

Counselling

Most women agreed that counselling can be a means to help women cope with abortion. Some women suggested that counselling can be used as a channel to deliver much more detailed information with regards to abortion.

"Kalau saya, kalau ikutkan memang perlulah. Macam kita, Eh betul ke doktor ni, kata takda apa...macam I selalu fikir, eh betul ke? Betul ke selamat? Ada effect ke apa...kadang-kadang, eh pasal apa lepas kita cuci ni... pasal apa kita rasa lain ar? Rasa macam, macam kita selalu kalau kita lepas beranak kan...dia akan...eh bila, kenapa dia sini nampak macam lain ah? Rasa kat sini macam buncit... pasal apa? Takkanlah ada kesan pasal ni kan? Patutnya, dia kena terangkan lah..."

"If me, there is a need [for counselling]. Like us, is it true when the doctor said there is nothing – like I always think, is it true? Is it really safe? Are there effects …sometimes, after we [abort]…why do we feel different? Feel like…if we gave birth right…why is it that she looks different? Feel bloated here, why? Not from the effects of this [abortion] right? By right, he/she [doctor] should explain"

[22_M_SECONDARY_MARRIED_HOUSEWIFE]

"Er...kita bagi kaunseling ataupun ada ubat ke untuk macam depa nak tak mau mengalakkan kan... Ubat ke. Kita terangkan effect dia... macam effect selepas ni, macam mana...Pengguguran tu, effect dia selepas kita ni...macam mana dia punya effect. Kaedah apa yang lebih senang macam kita nak mencegah."

"Er…like give counselling or medicines [contraceptives] to them, don't want to encourage [abortion]. Pills [oral contraception] or what. We explain about the side effects…like effects after this [abortion], how is it. The abortion, the effect after we…what are the effects. What ways are easier for us to prevent [unwanted pregnancies]"

[22_M_SECONDARY_MARRIED_HOUSEWIFE]

Besides that, some women also would like the counselling to include discussions about feelings and emotions so that women can relieve their anxiety before or after the abortion. Some women claimed that they had no one with whom they can share their feelings and wished for somebody to talk to about what they had just gone through.

"Urmm. Urmm. Cerita loh. Kita punya experience sakit macam mana sebab…you cerita, err cakap dengan husband macam tak faham apa-apa (laugh). So need someone untuk dengar kita, kita kita cakap apa loh. Macam…errr…you rasa sakit macam mana..macam tadi I cakap sakit.. sakit".

"Urmm…to tell our experience of the pain…because talking with your husband is like...they don't understand anything (laugh)…so need someone to listen to us, to what we said. Like er…'how is the pain'…like just now I said pain, pain"

[M_23_TERTIARY_MARRIED_CLERK]

"We should call people like the parents or the husband. Tell them exactly the reason [for] abortion and what. Okay, let say the girl is like me. I really need someone...like I want to have the baby…but the people surrounding me don't want to support. So why not [do] counseling they said. If you want…really want the baby. When I came here, I really want to talk. But the thing is they don't have any detail counseling. Because I want to put all my…ya. I want to get a

consultation. I really do. Because here it's more to medical. So in terms of before that, where can I go to talk? Should I go for…I don't have…I cannot turn to my friend…even she…I feel like I want to tell to…even my parents are not even too, you know, like sit and they didn't even counsel me. They just say go for abortion. But they don't really ask me, how you feel? You want to do or not? You really like this baby or not? They don't really ask all this stuff but, for me, in future I want to encourage. Before they get abortion, look at the person and ask if they really want to have this baby or not?"

[29_I_TERTIARY_MARRIED_SUPPORT SPECIALIST]

"To decrease the guilty feeling…"

[25_C_TERTIARY_MARRIED_HOUSEWIFE]

There were suggestions to use counselling as a way to assist women in making the decision whether or not to have an abortion.

"Kaunselling...macam kat orang yang nak buat pengguguran lah, kena terang macam kesan – kesan dia, apa yang akan terjadikan nanti kan...apa ni, suruh pikir dulu ke, betui ke, confirm ke nak buat pengguguran ni an?"

"Counseling…for those who have abortion, have to explain about the effects, what will happen later right. Ask them to think about it. First, are they sure, and confirm that they want to have abortion"

[29_M_SECONDARY_MARRIED_OPERATOR]

"Because counseling can…how to say…can advise…"

[25_C_SECONDARY_SINGLE_HAIRSTYLIST]

"So, they should ask you, why…what's the main reason you want to abort...all this stuff. So, if you aren't able to support, you can't, you know, to get support for this baby, why you should go to this…to abort. So this kind of, you know, they should…I feel like…they should be more…encouraging. Encourage to give birth to the baby, compare to the…if they really…they said that…like…let's say the patient said that they don't have anybody supportive, so they should call anybody, you know, to come here…or someone…ask them to bring their family. Explain to them, why? What are the causes or the effects if you abort or if you give birth? Why? What's the reason you are unable to give birth, you know? We should call the people like parents or the husband. Tell them exactly the reason. But, for me, in the future I want to encourage. Before they get abortion, look at the person and find out if they really want to have this baby or not. It should be first go for counseling. Why you need abortion. What's the details? What's the need [for] the abortion that you are in this situation. Then you need to consult the doctors…and find out how is the process? How is your situation if you, you know, abort the baby, and what kind of things that you need to choose"

[29_I_TERTIARY_MARRIED_SUPPORT SPECIALIST]

In contrast, one woman had mixed views about counselling. She noted that the need for counselling on contraception will be more useful compared to giving counselling for abortion when one has already made a firm decision to have an abortion.

> *"Kaunseling tu, I rasa ok juga, ah, salah satu hah. Salah satu cara untuk bantu mereka hadapi pengguguran lah. Mm, sebelum nak menggugur pun kita kena explain kat dia orang kan? Apa dia side effect apa semua kan? Bagi maklumat lah hah. Takut nanti apa-apa pun kita yang nak kena tanggungkan? Hah, kaunseling tu, I rasa, nak efektif tak efektif pun tak tau lah sebab benda tu dah, benda memang, kalau gugur tu memang dah perlukan kira kena gugurkan jugalah. Tapi kalau, I, I rasa kaunseling tu dari segi pencegahan tu ok lah. Kalau dari segi pengguguran tu, nak kaunseling pun, no use ar. Use ar, use ar [laugh]"*
>
> "The counselling I feel is okay also, one of the ways to help them [women] to cope with abortion. Mm, before abortion we need to explain to them right? What are the side effects and all that right? Give information lah. Scared if anything then we have to be responsible for it right. Hah, the counseling, I feel, whether it is effective or not I am not sure also because for this kind of thing [abortion], if there is a need for abortion, then they must do it. But I feel if counseling in terms of contraception ok lah. If in terms of abortion, it's no use. Use, use [will it be useful] (laugh)"
>
> **[31_M_TERTIARY_MARRIED_CLERK]**

Follow-up

Some women brought up the need for follow-up to ensure that the body would be free from any effects from the abortion. One of them even hoped for several follow-up sessions to examine any possible long term side effects on the health status of the women following the abortion procedure.

> *"Follow up tu, kurang puas hatilah...sebab depa cuma tengok oh ok, sekarang sudah bersih takda apa. Kalau boleh lah, macam selepas kita cuba...dalam tiga bulan ke empat bulan kita mai balik...kita buat check up lagi sekali ke...nak tengok kesihatan macam mana...rahim ok ke ataupun dia ada affect. Macam selepas kita mesti nak tahu kan effect dia selepas tiga bulan ke empat bulan effect dia macam mana. Macam...er...tengok tahap kesihatan kita macam mana...lepas tu, effect dia. Takut effect akan datangkan...kalau macam tu, follow up macam tu kan...kita akan tanya, ok doktor, dalam masa tiga bulan ni, selepas kita cuba ni, kita nampak perubahan...kenapa? Ah mungkin, daripada situ, doktor akan jelaskan dia mungkin tak seimbang disebabkan apa...apa... apa..."*
>
> "The follow-up, I was quite dissatisfied with it, because just see that it's clean so there's nothing wrong. If possible, maybe we can try to come back after three to four months to do another check-up, to see how our health status, if our womb is affected. Of course we would want to know... how our health... the effects. Scared the effect will come. If that happens, we can ask the doctor, in the three months after the abortion, we see a change... why?
>
> **[22_M_SECONDARY_MARRIED_HOUSEWIFE]**

Monetary assistance

Another suggestion that was given to help women cope with abortion was providing monetary assistance. Many agreed that the cost of abortion should be reduced to help those who are financially incapable to pay for the service.

In fact, some women felt that the government should provide abortion services at a lower cost to help women who are financially incapable.

> "Because government should be, the fee should not be that expensive, should be like this, government hospital does not provide abortion service? Ah ah, not everyone can go [afford], the government should have this kind of surgery. Must have the economical aspect [capability]."
>
> **[43_C_SECONDARY_MARRIED_HOUSEWIFE]**

> "Em, I think government, if [they] have this kind of service, it will be more convenient. Those who cannot afford can go there."
>
> **C_26_Secondary_Married_Economic rice seller**

One woman even suggested that a loan can be given to help women pay for abortion.

> *"Kalau macam ...doklah macam...kalau kata dia nak mengugurkan kalau dia tak mampu ka ...kalau kata kita boleh tolong dia ...tengok jugak lah sebab dia macam mana macam mana kita bagi lah dia pinjam ke apa ka...[laugh]"*

> "If like...if she wants to abort but she can't afford [financially] maybe if we can help her...see how lah...depends on how we give...lend her [money] or what ...[laugh]"
>
> **[29_M_SECONDARY_MARRIED_OPERATOR]**

Although many suggested that lowering the cost would be useful, however, there were some who had other views. Some women felt that lowering the cost would promote abortion despite agreeing that it would help those facing difficult financial circumstances.

> *"But at least, ok lah...at that time bila you terpaksa buat, you takda lah terlalu em...pressure sangat. Because you tahu kan dia punya kos macam ini ok. So at that time you takda pilihan. Tak membebankan you sangat kalau tidak you kena fikir mana you nak cari lagi duit. Contohlah, tiga ratus apa kan...same time you fikir you punya problem you lagi...So, it's very pressure kan?"*

> "But at least, okay...at that time when you need to do it [abortion], you won't be too pressured. Because you know what the cost is, it's like that, okay. So at that time you don't have a choice. It won't burden you so much, if not you would need to think of where to find the money [for abortion service]. For example, 300 or something right...same time you have to think about your problem [the need for an abortion]. So, it's very pressuring right?"
>
> **[38_M_TERTIARY_MARRIED_HR OFFICER]**

Another woman agreed to reducing the cost of abortion in view of the issue of baby dumping.

> "I feel it's okay [to reduce abortion cost], but if you have, you are not ready also. Let's say people think that it will be expensive. I think you have read up a lot of articles in the papers…magazines…that have come out. A lot of places…that the…Indonesian foreigners; they are pregnant… but they just throw in the toilet. Flush out in toilet. Throw in the dustbin, and all those stuff."
>
> **[29_I_TERTIARY_MARRIED_SUPPORT SPECIALIST]**

In contrast, some didn't really favour the idea of cheaper abortion services. According to one woman, no matter how costly the procedure is, if a woman wanted it done, she would find ways to pay for it. As such, she further reasoned that reducing its cost would encourage abortion.

> *"Kalau boleh, kos tu kalau boleh untuk ni...kita memang tak mengalakkanlah. Orang kata, mahal macam mana pun, kalau ni depa nak juga. Kalau kita kurangkan, kita lagi mengalakkan orang untuk buat pengguguran. Macam harga tu, I rasa sekarang pun mahal pun, depa usaha juga. Kalau harga lagi kurang, lagi kerap...I rasa."*
>
> "If can, the cost for this [abortion]...we don't encourage lah. People said, no matter how expensive it is, if they really want it [abortion], if we reduce it [the cost], we will encourage people to go for abortion. Like the price, I feel now eventhough it's expensive, they will still find ways [to get the money] for abortion. If the cost is reduces, it will be more often [abortion]...I feel"
>
> **[22_M_SECONDARY_MARRIED_HOUSEWIFE]**

Interestingly, one woman expressed that she would not be confident of cheap abortion services for fear that the quality of service or abortion pills would be jeopardised.

> "Because you want to do all the process, like that, so the price I think… quite reasonable lah. If the price is 100 something, maybe I can get scared also. Don't know...don't know that one is really can or not [effective or not]"
>
> **[25_C_SECONDARY_SINGLE_HAIRSTYLIST]**

Need to Reduce Pain of Procedure

One woman also felt that measures to reduce the pain of the procedure would help women cope better with abortion.

> "*Then macam sakit...boleh kurang"*
>
> "The pain can be reduced"
>
> **[M_23_TERTIARY_MARRIED_CLERK]**

Suggestions on Channels of Delivery of Abortion Information

When asked about strategies to deliver abortion information to the public, some women felt that coverage of abortion information in the mass media is lacking. The women generally favoured this form of information delivery so that women wouldn't have to go through the trouble of looking for this service.

> "Services…they did not publish in the magazine or newspaper…none. Sometimes people do not know. Hmm, a lot people do not know. Magazine is also okay. Because more women will read magazines. For example those what…those mummy baby...those magazines. Surfing the internet also can"
>
> **[36_C_SECONDARY_MARRIED_BEAUTICIAN]**

> "Internet also can…yea. Websites like that ah…we Malaysia…don't have really… haha… I can't see"
>
> **[29_C_SECONDARY_SINGLE_ADMIN CLERK]**

A few also noted that abortion information through the media could be given by healthcare providers and doctors with more detailed information.

> *"Tapi, tengok pada yang pandai lah, yang yang pakar lah, yang nak bagi kaunselling macam…cuma kita macam, macam sendiri – sendiri ni cakap macam tu je lah kan? Kita tak, tak tahu lebih detail, macam mana isu – isu pengguguran ni"*
>
> "But, see those who are experts, those who give counseling like…like us. If among us, we talk among ourselves just like that right? We don't know, don't know in detail, what are the issues of abortion"
>
> **[29_M_SECONDARY_MARRIED_OPERATOR]**
>
> *"Macam mana. Senang la kalau doktor explain lagi senang la kot"*
>
> "Like how? It's easier if the doctor explains. It's easier"
>
> **[22_M_SECONDARY_MARRIED_HOUSEWIFE]**
>
> *"Ha. TV pun boleh la jugak melalui siapa doktor ka duduk buat temu bual kah macam tu boleh jugak"*
>
> "Ha. Through TV also can, say through interviewing a doctor like that also can [for abortion information]"
>
> **[22_M_SECONDARY_MARRIED_HOUSEWIFE]**

There were also suggestions that educational outreach can be conducted by hospitals/clinic staff and doctors through talks or seminars in clinics and hospitals on abortion service availability, and also to target rural communities as well as foreigners to create awareness and educate them on this issue.

"Ok bagi pendapat saya, satu melalui ah...mmmm macam apa ni...advertisement lah ok. Macam tajaan tapi bukan tajaan yang kata orang open lah. Ok macam contohnya maksud saya macam ada buat satu macam taklimat macam contoh dekat klinik klinik lain terutama klinik macam ibu dan anak. Ok macam dekat hospital kerajaan. Buat satu macam taklimat dan sambil membuat taklimat tu kata orang sampaikan benda yang ini tapi bukan yang untuk menggalakkan tapi untuk mencegahlah kan kata oranglah sebab apa yang berlaku zaman sekarang ni kebanyakannya yang macam buang bayi apa semua kan so masud saya. Ini cadangan saya lah. Ok macam contoh lah um...staf klinik ke atau doktor klinik ke pergi dekat klinik-klinik kerajaan yang lain macam GH kah untuk buat taklimat ok buat satu cadangan. Macam ah ...apa ni, bagi tahulah yang klinik ni buat benda-benda macam ni tapi untuk kebaikan aaa macam tu lah. Kira macam penyampaian..."

"Okay, in my opinion, one is through...like what...advertisement okay. Like an endorsement, but not endorsement that is open. Okay, like for example, what I mean is, do a lot of talks like for example in clinics, other clinics especially mother and child clinic. Okay like in government hospitals, do a talk and through the talk, give information on things [abortion information] like that, not to say encourage but to prevent [baby dumping]. Because right now, there are many people dumping their babies and all that I mean. This is my suggestion. Okay for example, clinic staff or doctor go to other government clinics like GH [general hospitals] to conduct talks. Like inform that the clinic do all these things like that but it's for the betterment...like that. Like dissemination...dissemination [of abortion information]"

[26_M_TERTIARY_MARRIED_CLERK]

"Okay, what we can do as a research or marketing, go for or bring a few staff. Government should hire a few staffs for public communication. Send them to all the factories…small factories. Specially, they need to go…concern all the estate…estate…which is really into the, you know, not in the cities. Outside of the city. Because a lot of things happen outside of cities and foreigners as well, you know…go to all the foreigner agencies. Call all the foreigner ladies, go to all the estates, out of the city factories, schools, all the staff. We need to go and tell all the info, share with them information on abortion because most of the people who did like that are uneducated people, and also they are out of the…emm…info, you know. Out of the knowledge of this abortion things, that's why they have the reasons to do all the stuff. So to avoid all the stuff, we need to share more info."

[29_I_TERTIARY_MARRIED_SUPPORT SPECIALIST]

One woman suggested that a special organisation be set up so that women can gather to share their problems or any health issues including issues with regards to abortion.

"Bagi saya kita boleh kata orang boleh membuat satu macam pertubuhan lah macam khas untuk wanita-wanita macam untuk apa kata orang untuk boleh kata orang berkongsilah masalah dari segi er...terutama dari segi macam ni tak

semestinya kita menggalakkan untuk pengguguran, tapi mungkin mengenai kesihatan. Ok mengenai yang tu lah"

"For me, we can, [get] people to set up an organisation especially for women. Like for them to share their problems in the aspects of…especially from the aspect of, not necessarily we encourage abortion, but maybe about health"

[26_M_TERTIARY_MARRIED_CLERK]

The content of the media information provided was also raised by one woman who felt that the current emphasis was mainly on advising women against baby dumping but not on solutions to unwanted pregnancies. She felt that women should be told of their options, such as safe legal abortion.

"Advertisement like that just say out regarding the abortion thing. I think it's very good but if you [do not] say just say don't… dumpthe baby? Don't give birth to the baby…must care [for] it and then say… don't want… after the baby is born and put in the rubbish like that. I think it's not the way and just say you are already pregnant. And put on the television, say if you don't want the baby just know that earlier…just do abortion. Don't throw it away after you give birth. Yeah. They...the television now just comes out and says… after the baby is born don't throw it like that only. They didn't say how to prevent it. So know early when you are pregnant then I feel just tell the woman if you know you are already pregnant, if you don't want just… get it to make abortion like that… good way for women"

[29_C_SECONDARY_SINGLE_ADMIN CLERK]

Contraception Needs and Suggestions

While all the women have had one or more abortions, the majority did not condone it. When asked for suggestions on ways to help women cope with an abortion, interestingly, they mostly emphasized the need for contraception information. They were clearly aware of the importance of contraceptive usage to prevent abortions.

Generally, they felt the need for more comprehensive information on contraception. Collectively, they wanted details on various methods of contraception, side effects, and the procedures. One woman expressed her lack of confidence with information given by friends and hoped for wider dissemination of contraception information.

"Err. Dia punya…errr...I rasa sebelum sebelum pregnant pun...errr...pen, pencegahan pil…perlu lebih. Just…tanya kawan-kawan I tak rasa betul-betul."

"Err...I feel before pregnant also... the prevention pill [information on contraception] has to be more [increase]. Just asking friends [on contraception information] I don't think is correct"

[M_23_TERTIARY_MARRIED_CLERK]

Many women viewed that information on contraception can be imparted through counselling where detailed information can be provided.

> "Yeah. Yeah. Counseling is a good idea. Ahh, they talk to them. So how, like how do they control their self or what, how do they prevent getting pregnant? You know after the period, how many days is it that they say husband and wife cannot (have sex)"
>
> **[38_I_SECONDARY_MARRIED_HOUSEWIFE]**

> *"Macam ni kena kaunseling lah kut. Mm, cara-cara pencegahan ke… sebab, nak abortion pun, kita orang kata, tak digalakkan lah kan dari segi kesihatan apa semua kan? Hah, so kalau boleh tu kaunseling pasal atau pun bagi you kata apa, ah macam bantuan kita, macam bantuan untuk dapatkan perancang pence, perancang pencegahan daripada orang kata daripada mengandun kan hah. Macam dia orang bagi, apa kata, macam bagi, orang kata, bagi bantuan lah, macam apa kata, macam, ada setengah pihak kesihatan bagi kita kondom kan? Dia orang bagi dekat kita kan? Kita perlukan benda tu kan hah? Macam orang kata tolong daripada, mencegahlah daripada ni kan? Hah, daripada mengandung ke apa, kan? Sebab kalau kita nak pasang alat pun, kos juga tu, hah, sebab setengah orang tak mampu. Setengah orang tu mampu, ok lah kan?"*

> "Like that needs counselling I guess. Mm, contraception methods or...because abortion is not encouraged in terms of health or what right? So if counselling on contraception or give assistance, assistance on how to use contraception against…from getting pregnant right. Like what people say, give help, like some health carers they give condoms? They give it to us right. We need all these things. Like what people said, it can help us to prevent from getting [unwanted pregnancy] like that. Because even if we want to use the instrument [to get IUD insertion], the cost...some people cannot afford. Some people who can afford, it's okay"
>
> **[31_M_TERTIARY_MARRIED_CLERK]**

> *"Er...kita bagi kaunseling ataupun ada ubat ke untuk macam depa nak tak mau mengalakkan kan...ubat ke. Kita terangkan effect dia...macam effect selepas ni, macam mana...Pengguguran tu, effect dia selepas kita ni...macam mana dia punya effect. Kaedah apa yang lebih senang macam kita nak mencegah."*

> "Er...we give counselling or any medication [contraceptives] for them so they won't be encouraging [abortion]. Medicine or we explain the effects, like the effects after this, how...the abortion, the effects after we...how are the effects like. What methods are easier for us to prevent [unwanted pregnancy]"
>
> **[22_M_SECONDARY_MARRIED_HOUSEWIFE]**

> *"I rasa kaunseling tu dari segi pencegahan tu ok lah. Kalau dari segi pengguguran tu, nak kaunseling pun, no use ar [laugh]"*

> "I feel if counselling in terms of prevention (of unwanted pregnancy) then it's okay. If in terms of abortion, then it's no use (laugh)"
>
> **[31_M_TERTIARY_MARRIED_CLERK]**

Interestingly, one woman preferred talks on contraception rather than on abortion, which she considered 'too late' since prevention is needed.

> *"I prefer kalau pencegahan buat talk about pencegahan daripada you nak buat talk about…kalau berlaku apa you perlu buat. You know…so, better to mencegah lah. I mean better to prevent is better than to cure kan. So, lebih baik you buat talk about mencegah benda-benda ni daripada you nak buat talk. Kalau berlaku you patut buat benda-benda ni. So, you know...ada chance orang boleh buat la. Better kita talk, jangan buat..."*
>
> "I prefer if prevention, do talks on prevention [on unwanted pregnancy] rather than talks on [abortion]…if it happens [unwanted pregnancy] then what you should do you know? So, better to prevent lah. I mean better to prevent is better than to cure right. So, it's better if you do talk about all these things [prevention on unwanted pregnancy] than you do talks on [abortion]. If it happens [unwanted pregnancy) then you should do this. So you know…if there is a chance then people who do [have abortion]…better we try to prevent them not to do…[abortion]"
>
> **[38_M_TERTIARY_MARRIED_HR OFFICER]**

Although the government has helped in terms of contraception by providing cheap or free contraceptive pills and condoms, there were some who still felt that certain contraception methods were too expensive (e.g., contraceptive patch). One noted the need for the government to provide some expensive contraceptive methods at a lower cost as the cheaper contraceptive methods might not be suitable for some women.

> "Doctor…you mean government? Government…I don't know. Now everything so expensive. Needless to say about these patches, [hospital for] saving life one government hospital should charge cheaper. It may be suitable for some people, then some people don't need to take medicine anymore, and it may be more convenient for some people. So maybe they can do a promotion for awhile."
>
> **[42_C_PRIMARY_MARRIED_CLERK]**
>
> "Like, the monthly pills they are taking also, some people said they are expensive. That one can be cost effective. Sometimes suitable, sometimes not. Like put the IUD is safer. For me, I didn't put the IUD. I plan to but I don't know why I never…"
>
> **[42_I_SECONDARY_SEPARATED_PRODUCTION OPERATOR]**

Sexual and Reproductive Health (SRH) Education Needs and Suggestions

On the issue of SRH, some women related that poor awareness leads to unwanted pregnancies, abortion and baby dumping and felt that dissemination of knowledge on sexual and reproductive health is warranted.

> *"Ha, diorang kekurangan pengetahuan lah, biasanya ni. Diorang ingat benda macam ni, maybe, err, benda yang tak…tak perlu ambil beratlah. Diorang fikir benda ni senang saja. Kalau pregnant boleh buang, ha, macam tu lah. So, boleh jadi macam tu lah."*

> "Ha, they have lack of knowledge usually. They think that things [unwanted pregnancy] like that, maybe, things that they don't have to be concerned about. They think all these things [unwanted pregnancy]are easy only. If pregnant then can throw [abort], ha, like that. So that's why it's become like that."
>
> **[25_M_SECONDARY_MARRIED_CLERK]**

> "I think you have to read up on a lot of articles in the papers, magazines that come out. A lot of places…that the…foreigners; they are pregnant but they just throw in the toilet. Flush out in the toilet. Throw in the dustbin, and all those stuff. To avoid that, we should have these people…ask them why they throw their baby? Rather than you throw the baby at least you should you know…go for the urine test. If you know more we should share a lot of info to the person…people who don't know anything about the pregnancy. Because I read up a lot of things like [the] rubbish bin…they just wait until 8 months. They didn't even go and abort, they totally like…things come out and they just throw away rather than to go step by step. Okay, if you know your period doesn't come on this time, you go for urine test. Okay, that's a very early stage to go for this…"
>
> **[29_I_TERTIARY_MARRIED_SUPPORT SPECIALIST]**

Some women acknowledged that they had received some form of SRH knowledge but felt that the information was not enough. Many agreed that sexual and reproductive health knowledge should be disseminated in school and should include detailed information such as risks of premarital sex and preventing unwanted pregnancies.

> "Hmm, let them know, also can. Because some children don't know. Because [they] mix with other people, that people will control him. Let him see, then he [will] learn it like this, don't know, don't know the consequences. Once you have some knowledge, at least when he wants to do [sex], he will think, better than [if] he learnt from other people."
>
> **[26_C_SECONDARY_MARRIED_SALESPERSON]**

> *"Ok, err…kerajaan perlu beri macam, er, nasihat…yang macam mana…er, mungkin macam sekolah juga. Sekolah ada ajarkan, dalam sains, pendidikan macam ni. Tapi semua sedikit saja lah. Sebab I dulu masa sekolah pun, I tak faham, erm, cara…cara pendidikan tu. Cuma sedikit saja diorang…dia asas saja. Selebihnya kita tak tau. Jadi kerajaan boleh tolong untuk secara mendalam*

mengenai dengan pendidikan seks …masa sekolah. Er, tak masa sekolah saja. Selepas habis sekolah pun diorang kena, erm, lebih… ajar lebih mendalam lah, terangkan lebih mendalam. Akibatnya…ya. Tentang akibat dia. Kenapa buat macam ni. Erm, cara untuk mencegah dia."

"Ok, the government needs to give like, advice…that are like... maybe like in school. In school, in Science [subject], [through] education like that. But all these are [taught] little only. Because last time when I was in school also, I don't understand, erm, ways…the knowledge [being given]. Just abit only they…just the basic things [are being taught]. More than that we don't know. So the government can help through sex education in school, not just in schools only. After school [those who have finished their schooling] also they have to educate, erm, more…teach more in depth. Explain more in depth. The consequences…ya. About the consequences. Why do like this. Erm, ways to prevent it [abortion]"

[25_M_SECONDARY_MARRIED_CLERK]

"Kadang-kadang macam, macam Melayu, macam seks ni, macam malu sikitlah mau bincang kan. Macam pergaulan tu, macam perempuan dengan lelaki, dari sekolah kena tetapkan, bagi dia orang faham, kalau bercampur dengan lelaki ni, boleh, nanti boleh mengandung ke, kadang-kadang setengah, mungkin tak tau, kan, muda-muda kan, tak tau. Dari sekolah, biar ajar dia orang, bagi bila bergaul ni, apa risiko? Bila you bersama dengan lelaki ni, memanglah lelaki pandai kan? Bila bersama dengan lelaki, apa risiko you nanti? Jadi, jangan macam cepat terpengaruhlah dengan lelaki. Sebab, banyak tengok benda ni jadi, banyaknya tak kahwinlah. Sebab tak kahwin, salah satu dia sebab tak kahwin. Bila dah mengandung, taktau nak buat apa, lepas tu simpan, lepas tu beranak, buang. Dia orang ingat, mungkin tak ada jalan kot. I ingat, kadang-kadang duduk dengan family pun, family boleh tak tau pregnant, I pun hairan jugak"

"Sometimes like Malay, like about sex [aspect], it is embarassing to talk about it. Like communication, like between girls and boys, they have to set it in school, let them understand, if mix [have sexual intercourse] with boys, then they can get pregnant. Sometimes some, maybe they don't know right, the young ones, don't know. From school, teach them, give [educate] them, when being with boys, what are the risks, what are your risks later. So, don't be influenced by men. Because, having seen so many things happenned, many who are not married, one of the reasons is they are not married. So when they are pregnant, they don't know what to do, then continue to keep it [unwanted pregnancy]. After that when they give birth, they they throw. They think that, maybe there are no other ways. I think, sometimes, when they stay with their family also, their family don't know that they are pregnant. I am puzzled by this also"

[32_M_SECONDARY_MARRIED_FACTORY LINE LEADER]

"I feel that…can have some courses for women. In school, in college. I think college is better, and then in the secondary school for the teenagers then give them more [knowledge] of how the baby is conceived and how to abort like that. Because now teenagers also have baby already, even like our age"

[29_C_SECONDARY_SINGLE_ADMIN CLERK]

"Mm...ok lah. Baik juga dia. Baik sebab dia bagitau....laki pun ada. Perempuan pun sekali juga duduk. Diorang bagitahu macam direct ah. Memang budak perempuan malukan. Kalau masa tu juga kita orang tahu. Kalau lepas habis... sekolah habis kita orang tak tahu juga"

"Mm…okay. It's good also. Good because let her know [SRH education]…boys also. Girls and boys, let them sit together. They can explain [SRH education] to them directly. Girls will be shy. At that time then we will know also. After school finishes…after school finishes we won't know"

[28_I_SECONDARY_MARRIED_PART TIME DRIVER]

"Anjurkan program k dan bukan setakat pada klinik hospital tapi ke macam sekolah k. Ok yalah maksud saya macam tu menganjurkan program dan menyampaikannya dengan jelas lah"

"Organise programmes [SRH programmes] and not just in the clinics, hospitals, but in schools okay. Okay, ya, I mean organise programmes and disseminate it [SRH education] clearly lah"

[26_M_TERTIARY_MARRIED_CLERK]

Counselling was also suggested as a tool to deliver detailed information about SRH.

"Maybe, kalau ada…macam kaunseling untuk yang bermasalah. Penting jugalah, sebab kaunseling tu, setengah kaunseling dapat menerangkan kepada kita secara terperincilah, lebih..."

"If, there is...like counselling for those who are problematic. It's important also, because the counselling, some counselling can explain to us in [SRH information] detail, more to things like that"

[25_M_SECONDARY_MARRIED_CLERK]

One woman also felt that information on SRH knowledge should be given at home by parents or guardians so that children are well informed.

"Haa jadi macam pergaulan bebas, terlampau, kadang-kadang kita nasihat tak mau dengar. Susah nak bentuk yang tengah dok naik sekarang. Macam, kita larang, bila tengah seronok punya masa, semua tak dengar. Tapi, bila dah jadi susah, barulah. Masalah lelaki memang tak ada masalah. Lepas tangan, perempuan yang jadi masalah. Itulah, kadang-kadang didikan dari rumah, kena bagi dia orang tau, tau"

"Ha…it has to be like a free discussion, sometimes when we advise they don't want to listen. It's hard to mould these who are growing up now. Like, when we forbid, when they're having fun that time, all don't listen. But, when they have problems, then only [they listen]. Men don't have problems. Just let go, girls are the ones who have problems. That's why, sometimes teach them from home, have to let them know [SRH education]"

[32_M_SECONDARY_MARRIED_FACTORY LINE LEADER]

Suggestions on Preventing Abortions

Interestingly, although all the women interviewed had undergone abortions themselves, they did not encourage abortions generally and even suggested restricting abortions in the community. Among the suggestions were:

1. One reason that women have abortions is the limited financial means to support the child. Thus, they expressed hope that financial assistance can be provided by the government to help larger families or to promote couples to give birth to more children.

   "You can tell the government, if how many babies, how many babies and above, can help them. Uhm, his milk powder, anything ah…maybe, some people will think if they are giving birth more, okay, government will help more a bit"

   [36_C_SECONDARY_MARRIED_BEAUTICIAN]

2. Setting up of enquiry counters in clinics so that women can obtain information on alternative ways to avoid an abortion, such as information on shelter facilities and adoption programmes.

   "Perlu...macam mana kita nak mengelakkan. Kita tak mahu berlaku kan apa-apa. Selalunya, memang perlulah. Macam kebanyakan klinik tu apa...ada satu apa kata...kaunter khas lah untuk macam kita nak tanya pendapat ke. Macam mana kita nak mencegah ataupun nak ni kan. Nak mencegah ataupun kita macam... cara macam mana lebih bagus kita nak kalau boleh tak mau... mengelakkan pengggurankan. Macam ada tak tempat yang selamat macam...kita nak melahirkan juga...kita tak mau melalui proses..."

   "Need…how we want to avoid. We don't want anything to happen, right. Usually this is needed. Like many clinics…there is one…a special counter for us to ask for opinions. How we want to prevent or what right? To prevent or like…what ways are better if we don't want to…prevent abortion right. Like if there is a safe place like…if we want to give birth also…we don't want to go through the process [abortion]…"

   [22_M_SECONDARY_MARRIED_HOUSEWIFE]

3. Setting up a form of mutual agreement between pregnant women and prospective adopters.

   "Ada tak macam... apa kata... kita boleh pregnant, tapi dia ada satu macam lepas bersalin tu, anak tu kita boleh bagi ke siapa...daripada kita nak gugur. Dia satu orang kata...tubuh satu...macam...setengah tempat, rumah anak yatim nak ambik anak pun payah kan? Ok macam ok kawan ni, dia nak gugur, tapi kalau boleh ambil satu keluarga kah untuk bantu. Ok, lepas ni, dia mungkin rasa...selalunya, kalau jadi kes ni, sebab salah satu sebab kewangan ataupun...kadang-kadang husband buat hal ke apa...kita tanya pendapat. Kalau dia setuju nak melahirkan juga, er... dia setuju nak bagi anak ini kepada famili ni, buat satu perjanjian lah."

> "Are there like…we can be pregnant, but after giving birth, there would be a place, to give our child to anyone, who…[rather] than for us to abort, to set up an organisation. Like…some places…orphanage homes also find it hard to accept children right. Okay, like this friend, she wants to abort, if she can get a family to help. Okay, after this, maybe she will feel...usually, when such case happens, one of the reasons is financial [problem] or…sometimes the husband creates problems. We [can] ask for opinions. If she agrees to give birth to the child…she agrees to give this child to the family, like make an agreement"
>
> **[22_M_SECONDARY_MARRIED_HOUSEWIFE]**

DISCUSSION

Advances in medical technology have made abortion procedures simpler, safer and cheaper. Unfortunately, this has not made abortion more accessible for all women especially for the poor and other marginalised groups. This is due to extraneous factors such as culture and religion imposing the dogma of sexual morality on women and the society in general.

While women in Malaysia have been empowered in many ways including having access to education and managerial positions, their access to reproductive health care has been restricted by the factors above. It is therefore important that we understand the knowledge, attitudes and practices of women, especially those who have undergone abortions themselves, to enable us to take remedial measures towards improving the use and access to modern contraception and timely access to safe abortions.

Abortion as a Sin and Religiously Unacceptable Act

The respondents in this study perceived termination of pregnancy as a sin or an act discouraged or even forbidden by their religious beliefs. This element of guilt is universal irrespective of religion and culture. Having an unwanted pregnancy and seeking termination can be an emotionally challenging experience, emphasising the importance of pre-abortion counseling and the need for support and involvement of the husband/partner.

Fortunately, many respondents acknowledged that their husbands/partners provide financial, emotional and social support during or prior to seeking termination. Greater emphasis towards recognising the emotional and psychological implications of abortion are issues that should be addressed appropriately. This important holistic approach is perhaps lacking in many existing clinical settings indicating that all healthcare staff who are involved in managing such patients should have greater awareness and be given adequate training.

Termination of Pregnancy is a Common Event

The respondents thought that pregnancy termination is a common event and perceived that many women do it. Some also justified their actions by mentioning that it is better to abort than to abandon a baby. However, the women's perception that induced abortion is a common event in women's lives is not corroborated by official data. This has implications for evidence-based public health policies. The de-stigmatisation of abortion and its inclusion into all SRH services is a stated objective of the ICPD Plan of Action and in the Millennium Development

Goal (MDG) objective 5b. It is also endorsed by WHO, Population Council and IPPF. Having a pregnancy termination in Malaysia is often not officially recorded.The majority of abortions remain unreported and its true extent remains unknown. However, estimates have shown the abortion ratio to be 17 abortions per hundred live births (Tey, 2011). The fundamental problems of unplanned pregnancy are the lack of sex education, contraceptive knowledge and services; issues which need to be highlighted to policy makers.

To achieve the Millennium Development Goals (MDGs), weaknesses in the existing programmes for promoting contraception need to be reviewed. This will reduce the incidence of unplanned or unwanted pregnancies and the need for terminations.

Complications of Abortion are Not Known

There were also some misconceptions regarding termination of pregnancy, especially in terms of complications. Although a few were aware of complications such as infections and sub-fertility in future pregnancies, unfortunately, many have unfounded fears regarding the frequency of more serious complications that rarely arise. This clearly indicates the lack of awareness and understanding of abortions among the population. Although these findings might not be representative of the level of awareness among the general population, the lack of sexuality education and its implications is indeed a great concern. Various efforts have been made to incorporate it as part of secondary school education, but its full implementation has been hampered by its taboo status. More aggressive measures with the involvement of policy makers and the co-operation of teachers and parents will definitely be needed.

Financial Constraints and Large Family Size Lead to Abortions

The common reasons for women to seek termination in this study were financial constraints and the inability to support a large family. However, many seemed unaware that, in terms of health care cost and financial burden of caring for a child, it is cheaper to seek contraception than to terminate a pregnancy. Worthy of note, many are married, a fact which remains overshadowed by the tendency to sensationalise the issues of young single women undergoing abortions, a reflection of the patriarchal values prevalent in society.

Education and prevention remain the priorities which are still lacking in our own setting. Perhaps more aggressive measures to educate the clients, opportunistic counselling during contact with healthcare providers and increasing uptake of long acting reversible contraceptive (LARC) methods are positive measures to overcome unplanned pregnancies. Improving awareness among healthcare staff and increasing the availability of LARC in all major hospitals in Malaysia are essential remedial steps to improve the quality of care.

Termination is Illegal

Most respondents said that termination is illegal although some of them were not quite sure of its legal status. Some knew that it could be done for foetal abnormalities while others thought that certain public clinics were specially licensed for this purpose. These vast differences in perception only prove the general lack of awareness and understanding of issues related to termination. Other surveys (Dalvie S, Barua A, Azmat K, et al., 2011; Dalvie S, Barua

A, Choong, S, et al., 2011; Dalvie S, Barua A, Dhungel, D et al., 2011; Dalvie S, Barua A, and Apte H., 2011; Dalvie S, Barua A, and De Silva, 2011; Dalvie S, Barua A, Widyantoro N, et al., 2011; Dalvie S, Barua A, Luczon C, et al., 2011) have observed that many healthcare providers were not able to confidently explain the legal status of abortion. Knowing one's rights to abortion under the law in Malaysia is important for women but it is critically important that healthcare providers be aware of the law. This vital information should be disseminated to all healthcare staff dealing with abortion-seeking clients. This will not only protect them but also enable them to provide quality care within the law.

Poor Access to Knowledge and Service Provision

The barriers identified by the respondents were financial constraints, lack of information on where they could obtain safe and affordable pregnancy terminations as well as the fear of discrimination from healthcare staff. Information was usually obtained from friends and relatives. Accessibility and difficulty in obtaining medications over-the-counter from pharmacies were also identified as difficulties. Many felt that this should be improved and that information on abortion services should be easily available and financially affordable.

Termination of pregnancy is legal in Malaysia within the fairly permissive provisions of the law. Further liberalization of pregnancy termination will not solve all the barriers mentioned above given the stigma attached to abortion. These obstacles to safe abortion can only be removed when there are clear official guidelines and directives to service providers on incorporating abortion as part of reproductive health services for women. Termination of pregnancies by unskilled providers (unsafe abortions) is probably quite low as suggested by the very low mortality rate from abortion complications in Malaysia. The Confidential Enquiries into Maternal Deaths lists 3 deaths due to abortion related conditions in 2000 and 6 deaths in 2005 being 1.8% and 4.8% of the maternal deaths in those years (Ministry of Health Malaysia, 2008). Morbidity arising from abortions by unskilled practitioners is unknown.

The proposal on setting up official Ministry of Health (MoH) guidelines on providing safe terminations by public hospitals with the aim of preventing illegal terminations and reducing morbidities still remains undecided. Unfortunately, this has resulted in the discrimination of this category of vulnerable patients by government healthcare staff. These are serious issues that should be urgently addressed. The resulting scenario where government healthcare staff withhold abortion services based on their own 'moral' position rather than on an understanding of the law is a serious ethical issue. The principle of conscientious objection should be applied by health professionals in such situations but it is often not done due to ignorance. An ethics and human rights-based module on patient management in healthcare should be implemented in in-service training courses for health care staff (Dickens, 2009).

Among respondents who have experienced both types of abortions, many pointed out that medical abortion is cheaper but is a longer and more painful procedure while surgical abortion is quicker, less painful but more expensive. Fortunately, many perceived traditional methods and herbal remedies as unsafe and unreliable compared to medical termination. Be that as it may, many would try them before seeking professional help because of difficulty in accessing providers. In most instances, the respondents claimed that the decision to seek termination was voluntarily made by them and not forced by their partners or families.

Recognition of Early Signs of Pregnancy

Unfortunately, many were unaware of signs of pregnancy and waited for more obvious signs of later pregnancy before seeking advice on confirmation. Early confirmation and intervention would reduce the cost and possible complications from the abortion. This again reflects on the poor reproductive health education provided in the education system.

Inadequate Contraception Information and Related Poor Compliance

Respondents generally did not have adequate and detailed information about contraception. Many were aware of combined oral contraceptive pills and intrauterine device but perceived these methods to have side-effects, especially in terms of weight gain. This perception was based on advice from friends and relatives often culled from anecdotal narrations.

Compliance was also a major concern. Many were not satisfied with the information given by health care staff. This proves the importance of effective communication and counselling skills by health care staff. Improving the training of healthcare providers on birth spacing and contraception with greater emphasis on effective communication skills are essential steps.

Effectiveness of Contraceptive Promotion

Frequent audits of patients' compliance are needed to monitor the effectiveness of communication. Ensuring the availability of the full range of contraceptive methods, starting from emergency contraception and long acting reversible and non-reversible methods of contraception, should be made available in all the clinics and hospitals in Malaysia. Contraception clinics should also target and not omit adolescents and unmarried clients in recognition of the changing patterns of sexual behaviour.

However, there is further room for improvement. Adequate counselling of patients on pre- and post-termination care, improving accessibility, providing adequate knowledge and empowering women are vital measures. Proper clinical assessment, screening for sexual transmitted diseases and blood grouping, prophylactic treatment of common sexually transmitted diseases, providing emergency or long term contraception and effective follow up measures with proper referral pathways are lacking in our own clinical setting. It is an important health management concern and formulating national guidelines on this issue would be an important positive measure in conjunction with educating staff and disseminating information on the legal implications using evidence and ethics based guidelines.

STUDY LIMITATIONS

This study is not without its limitations. First, as in any qualitative studies, the findings cannot be generalised to all women who have had abortions. Further, the respondents recruited were from one urban clinic. Future studies in this area could venture into other clinics or settings that openly allow research to be done. The fact that abortion is still a very controversial issue in this society, access to clinics or other healthcare centres (for the purpose of research) is rather limited. As respondents relied on recollection of past experiences of abortion, recall bias could be another limitation. However, this potential limitation was addressed by reducing the length of recall period to within one year prior to data collection, viz., the inclusion critierion of having had the last abortion less than one year prior to date of interview.

POLICY CONSIDERATONS

Research on healthcare issues are only meaningful if lessons can be learnt leading to appropriate policy changes.

1. Policy changes are needed to address weaknesses in our school sex education programme and provision and promotion of comprehensive contraceptive services.

> Interviews with abortion respondents in this study revealed their awareness of the need for reliable contraception to avoid 'accidental' pregnancies but they lack sufficient knowledge and confidence to adopt a suitable and reliable method themselves.This study revealed that the abortion respondents were not only aware but had used contraception. However, many reported they were frustrated with contraceptive failures that either they themselves had experienced or had heard about from friends. Policy implications arising from this finding would require post-abortion counselling to address such frustrations as well as contraception promotion that is gender-sensitive and customized to individual needs.

2. Women and healthcare providers should be educated on the current status of the laws with regards to abortion in Malaysia.

> The respondents had little knowledge of the procedures or of the laws governing abortions here even though they knew it was commonly practised from hearsay.
>
> Their own experience of rejections and negative attitudes by doctors and nurses to their abortion requests both from the public and private sector suggests to them that abortions are probably illegal.
>
> That is also a reflection on the poor attitudes and lack of knowledge of healthcare providers.

3. There should be a review of the Ethical Codes of the regulatory professional bodies and national medical associations with regards to abortions so that current international frameworks on human rights and medical ethics can be incorporated in the guidance provided to registered medical practitioners in this country. Ethical considerations will have to take into account the boundaries set by religious bodies of various faiths while at the same time reflect the need to provide for individual patient's requirements after informed consent.

> Apart from their poor knowledge and understanding the abortion laws, healthcare providers should also be made aware of the code of professional ethics especially in relation to consciencious objections to artificial contraception and abortions.

On account of the lack of reliable data on abortions in Malaysia, policy makers still have the perception that abortions are not a significant problem and, thus, ignore the issue of unintended pregnancies ending in abortions. This is clearly refuted by estimates based on indirect data made by experts, e.g., WHO.

Clearly, from the reasons given for seeking abortion, the respondents were strongly motivated to limit family size or control the timeliness of childbearing, even after an unintended pregnancy.

4. There is a need for political will on the part of the government to implement a comprehensive reproductive health policy to build on previous advances in this area which have currently stagnated.

However, any change of legal status will not bring changes without a political commitment and clear directives to include abortions as an essential component of reproductive health services. This will help to destigmatise the issue to enable universal access to safe abortions for all women a reality.

CONCLUSIONS

Our findings showed that there is a conflict between the law and health providers' perception of the 'rightness' of abortion requested by their respondents. The health carer's obligation to respect the respondents' views within the law must be clearly established.

In a controversial area such as termination of pregnancy where clear battle lines have been drawn between pro-choice and pro-life, it is the voices of women that must be heeded. This research clearly shows that health professionals must ensure that they are guided by fundamental medical, ethical as well as rights principles in the management of pregnancy termination.

The ethical principles (British Medical Association, 2004) to be used are:

- **Autonomy** – The patient decides what is best for her. The consent of the patient is essential. Ethically, you do not need the husband's consent.
- **Non-maleficience** – Do not do harm. Advocate evidence based treatment based on the clinical situation. Personal prejudices should not cloud the clinician's decision.
- **Beneficience** – Do good. Do what is best for the patient.
- **Justice** – Practice within the boundaries of resource allocation. Management is not expensive and would not deny other patients any life saving treatment.
- **Honesty** – Explain all risks and choices. Do not force your personal viewpoints.
- **Power of covenant** – Provide a patient centered service. Do not impose more conditions than are required.

There must be national guidance that ensures personal prejudices and beliefs do not hinder the appropriate management of pregnancy termination. Recently, the Ministry of Health developed the first national guideline for termination of pregnancy to increase awareness among healthcare professionals of the existing provisions for abortion *(Guideline on Termination of Pregnancy in Government Hospitals, 2013)*. This guideline entails the clinical care for women undergoing procedures and precautions as well as information on the penal code, various religious standpoints on abortion and the Code of Professional Conduct. It is pertinent that the guideline be effectively implemented in public hospitals in Malaysia and healthcare professionals should accept and put the guideline into practice. Women must be able to access contraceptive advice and services throughout their reproductive life, no matter what their social, religious, and marital status.

REFERENCES

Allen-Meures P & Lane B. Social work practice: Integrating qualitative and quantitative data collection techniques. Social Work. 1990; 35(5): 452–58.

British Medical Association. Medical ethics today: the BMA's handbook of ethics and law. [2nd ed] London: BMJ Publishing Group, 2004: 153–4.

Dalvie S, Barua A, Azmat K & Mustafa H. A study of knowledge, attitudes and understanding of legal professionals about safe abortion as a women's right in Pakistan. Asia Safe Abortion Partnership. 2011: 1–13.

Dalvie S, Barua A, Choong S & Ramasami S. A study of knowledge, attitudes and understanding of legal professionals about safe abortion as a women's right in Malaysia. Asia Safe Abortion Partnership. 2011: 1–6.

Dalvie S, Barua A, Dhungel D & Shrestha P. A study of knowledge, attitudes and understanding of legal professionals about safe abortion as a women's right in Nepal. Asia Safe Abortion Partnership. 2011: 1–8.

Dalvie S, Barua A & Apte H. A study of knowledge, attitudes and understanding of legal professionals about safe abortion as a women's right in India. Asia Safe Abortion Partnership. 2011: 1–12.

Dalvie S, Barua A & De Silva. A study of knowledge, attitudes and understanding of legal professionals about safe sbortion as a women's right in Sri Lanka. Asia Safe Abortion Partnership. 2011: 1–10.

Dalvie S, Barua A, Widyantoro N & Silviane I. A study of knowledge, attitudes and understanding of legal professionals about safe abortion as a women's right in Indonesia. Asia Safe Abortion Partnership. 2011: 1–10.

Dalvie S, Barua A, Luczon C & Tadiar F. A study of knowledge, attitudes and understanding of legal professionals about safe abortion as a women's right in Philippines. Asia Safe Abortion Partnership. 2011: 1–12

Dickens BM. The Ethical Responsibilities of Conscience. IPPF Medical Bulletin. 2009; 43(4): 1–4.

Dickerson K. How important is publication bias? A synthesis of available data. AIDS Education Prevention: official publication of the International Society for AIDS Education. Feb 1997; 9: 15–21.

Division of Family Health Development, Ministry of Health Malaysia. Report of the Confidential Enquiries into Maternal Deaths in Malaysia, 2008.

Grossman D (2004). Medical methods for first trimester abortion: RHL commentary. The WHO Reproductive Health Library, No 9, Update Software Ltd, Oxford, 2006. www.rhlibrary.com

IPPF ESEAOR. Lifelink ESEAOR. From a choice, a world of possibilities. Legal status of abortion across the region. International Planned Parenthood Federation. IPPF, East & South East Asia and Oceania Region. Kuala Lumpur, Malaysia, 2011: 3.

Sackett DL & Wennberg JE. Choosing the best research design for each question. British Medical Journal. December 1997; 315(7123): 1636.

Singh S, Wulf D, Hussain R, Bankole A & Sedgh G. Abortion Worldwide: A Decade of Uneven Progress. New York: Guttmacher Institute, 2009.

Tey NP, Ng ST & Yew SY. Proximate determinants of fertility in peninsular Malaysia. Asia-Pacific Journal of Public Health. 2012a; 24(3): 489–99.

Ulin PR, Robinson ET, Tolley EE. Qualitative Methods. A Field Guide for Applied Research in Sexual and Reproductive Health. North Carolina: Family Health International, 2002. ISBN: 0-939704-74-9.

APPENDICES

Appendix A – Interview Guide

Topics to be discussed in the IDIs are as follows:

- What do women know about abortion, including medical abortion, where women can obtain abortion services, and what are their sources of information? (probe for awareness of types of abortion, its availability and accessibility, Abortion laws, etc)

- What are women's perceptions on abortion, on women who opt for abortion, the various methods of abortion and its consequences, for example, on future fertility, side effects, cost? (probe for both positive and negative aspects, from the social-cultural, religious, medical and legal perspectives) (probe about their experiences with abortion)

- What resources or abortion services have they utilized, or know of, and what do they feel about them in terms of, where appropriate:
    - Information, education on different methods
    - Information and education on contraception to avoid unplanned pregnancies
    - Medical care, safety of procedure
    - Post-abortion medical care
    - Supportive care, such as pre- and post-abortion counselling
    - Cost of procedure and follow-up care

- Among women who have had an abortion, did they have support, and from whom, in their decision to abort and in their choice, if any, of the method? What factors (or who) have helped and/or hindered in coping with their abortion

- What motivated women to seek medical abortion? (marriage, too many children, career, studies etc.)

- What are the barriers that prevent women from seeking or obtaining medical abortion? (probe financial, not knowing where to go, low knowledge, fear of side effects, safety issue)

- What information do women want on medical abortion? (probe for safety, efficiency, accessibility, availability, cost, etc.)

- Prior to seeking abortion in this clinic, what experiences did they encountered in getting help elsewhere and their opinions of the doctors that they have seen

- What can be done to help women cope with abortion? (Probe counseling, government medical subsidization, economic)

- Have you ever use contraception / family planning?

If yes,

- Which methods did you use? Where did you obtain the contraception? What were the reasons for using the contraception?
- Which method is most frequently used by you and why?
- Did you face any barriers in obtaining contraception? If yes, what were the barriers? How did you manage to overcome the barriers?
- Who decides whether to use or not to use the contraception, you or your partner?
- How do you feel about talking to your partner on using contraception? (by both parties)

If no / stop using,

- What were the reasons for not using contraception?
- Who makes the decision to not use / stop using contraception?
- How do they feel about talking to their partner on using contraception?

Appendix B – Consent form

Reproductive Rights and Choice: Insights from Women on Pregnancy Termination

Respondent Information Sheet

Introduction/Rationale

You are invited to take part in this research study, Reproductive Rights and Choice: Insights from Women on Pregnancy Termination funded by World Health Organisation. This one year research study is implemented by Professor Dr. Low Wah Yun, Assoc Prof Wong Yut Lin, Ms Tong Wen Ting at the Faculty of Medicine, University of Malaya, Kuala Lumpur, Dr Choong Sim Poey from Klinik Rakyat Family Planning Services, Gelugor, Penang, and Dato Dr Ravindran Jegasothy from Department of Obstetrics & Gynaecology, Hospital Kuala Lumpur, Malaysia.

In Malaysia, social and development policies have vastly improved women's access to education and employment opportunities. However, for a critical aspect of their lives, many women do not have control over childbearing mainly due to a lack of knowledge of, or confidence in, contraceptive methods or lack of control over family planning and contraceptive decisions. In the interests of reproductive health and rights, women are entitled to safe abortion. Although surgical abortion is widely available in Malaysia, medical abortion, a safer alternative, is still unknown to many. It cannot be denied that abortion is recourse for various personal reasons, such as, contraceptive failure, violence and exploitation of young girls. There are also legal provisions for it in this country. However, abortion information and services are still not accessible or acceptable to all women who need it. Although surgical abortion is widely available in Malaysia, medical abortion, a safer alternative, is still unknown to many.

It is thus appropriate and timely that a study on the availability and practice of medical abortion be undertaken. This research aims to determine the knowledge, perceptions and practices related to abortion among women and healthcare providers towards formulating policies and programmes to promote safe methods, namely, medical abortion.

The Purpose of the Research

The specific objectives of this study are:

1. To determine the extent of knowledge of and perceptions on abortion among women and their experiences with healthcare providers, namely the medical practitioners;
2. To identify the gaps in knowledge and understanding, particularly on medical abortion;
3. To assess the experiences of women who have had abortion, in terms of the type and quality of related services received (e.g. pre- and post-abortion counselling, and quality of care, etc); and,
4. To assess the scope and practices of abortion services provided by healthcare physicians in relation to the use of medical abortion methods.

The Procedure

We recognize the sensitivity of the topic/issues and hence we aim to listen fully and respectfully using face-to-face in-depth interviews with participant. This will be audio-taped and will generally take 60 to 90 minutes.

Participant's Cooperation/Responsibilities

You can choose a time that is convenient and comfortable to you. Please contact any of the the researchers if you wish to have more information about the study or if you like to participate in this study some other time.

Benefits

What will the benefits of the study be:

(a) To you as the participant?

Your participation in this study will contribute towards a better understanding of the knowledge, perceptions and practices related to abortion among women and healthcare providers that would culminate in realization of women's reproductive rights and choice.

(b) To the researcher?

We hope that this study will contribute towards formulating policies and programmes to promote safe methods, namely, medical abortion that in turn would lead to women's empowerment through reproductive rights and choice.

Risk

Participation in this study generally involves **NO** potential risks. However, should you feel any stress or emotional pain while sharing your experiences during the interview, please feel free to pause and continue later, or ultimately withdraw from the study if you decide you cannot continue. In addition, if there is a need for further support we will provide or refer you to the relevant organizations.

Confidentiality

Your identity and personal particulars in this study will be kept strictly confidential and accessible only to the researchers in this study. Data may be reported in scientific journals and will not include any information that identifies you. The voice recording will be destroyed after transcription and once the research report is completed.

Token of Appreciation

Participant's time and effort spent in the study will be greatly appreciated.

Voluntary Participation

Participation in this research is absolutely voluntary. You can stop participation at any time and we respect your decision/choice. There will be no adverse consequences. For e.g. your refusal to participate in this study will not result in any penalty or loss of any benefits; and you will not lose any of your rights for proper medical treatment.

Inform Consent

If you wish to participate in this study, please give your written (signed) OR verbal consent on the attached Consent Form. You will be given a copy of the Informed Consent Form.

Please do not hesitate to discuss any questions you may have with the researchers. You can also call us during working hours as below:

Lead researcher	: Prof Dr Low Wah Yun	Tel: 03-7967 5729 / 5748 Email: lowwy@ummc.edu.my
Co-researcher	: Assoc Prof Dr Wong Yut Lin	Tel: 03-79675737 Email: wongyl@ummc.edu.my
Co-researcher	: Dr. Choong Sim Poey	Tel: 04-658 1433 / 0433 Email: choong.sp@gmail.com
Co-researcher	: Dato Dr Ravindran Jegasothy	Tel: 03-26155555 / 5450 Email: jravi@hkl.moh.gov.my
Co-researcher	: Ms Tong Wen Ting	Tel: 03-7967 7502 Email: tongwenting@um.edu.my

Should you need any other information, please feel free to contact the researchers/members or the Ethics Committee Secretariat, University of Malaya Medical Centre at 7949 3209.

Reproductive Rights and Choice: Insights from Women on Pregnancy Termination

Informed Consent

Dear Respondent,

You are invited to take part in this research study, Reproductive Rights and Choice: Insights from Women on Pregnancy Termination funded by World Health Organisation. This one year project aims to determine the knowledge, perceptions and practices related to abortion among women and healthcare providers towards formulating policies and programmes to promote safe methods, namely, medical abortion.

This study is implemented by the Medical Education & Research Development Unit (MeRDU), Faculty of Medicine, University of Malaya. Kindly spend some time to go through the in-depth interview session with us. The information gathered will be kept strictly confidential. Your participation in this study is voluntary and involves **NO** potential risks.

To participate in this study, you must give your written (signed) / verbal consent in the Informed Consent Form provided. Your time and effort spent in this study are very much appreciated.

If there are any further queries regarding this study, please do not hesitate to contact us:

Lead researcher :	Prof Dr Low Wah Yun	Tel: 03-7967 5729 / 5748 Email: lowwy@ummc.edu.my
Co-researcher :	Assoc Prof Dr Wong Yut Lin	Tel: 03-79675737 Email: wongyl@ummc.edu.my
Co-researcher :	Dr. Choong Sim Poey	Tel: 04-658 1433 / 0433 Email: choong.sp@gmail.com
Co-researcher :	Dato Dr Ravindran Jegasothy	Tel: 03-26155555 / 5450 Email: jravi@hkl.moh.gov.my
Co-researcher :	Ms Tong Wen Ting	Tel: 03-7967 7502 Email: tongwenting@um.edu.my

We thank you for your cooperation and support.

Informed Consent Form

I hereby confirm the following:

1. I have read all the information in this Respondent Information Sheet and Informed Consent Form including any information regarding the risk in this study and I have had time to think about it.

2. I voluntarily agree to participate in this research study, to follow the study procedures and to provide necessary information to the researchers, as requested.

3. I may freely choose to stop participating in this study at anytime.

4. I give my consent (written/verbally) in contributing to this interview.

Participant

Name : _____

I.C No. : _____ Age : _____

Signature : _____ Contact No. : _____

Researcher/Witness

Name : _____

I.C No. : _____

Signature : _____ Date : _____

Appendix C – Ethics Approval

UNIVERSITY OF MALAYA
KUALA LUMPUR
UM MEDICAL CENTRE

MEDICAL ETHICS COMMITTEE
UNIVERSITY MALAYA MEDICAL CENTRE
ADDRESS: LEMBAH PANTAI, 59100 KUALA LUMPUR, MALAYSIA
TELEPHONE: 03-79493209 FAXIMILE: 03-79494638

NAME OF ETHICS COMMITTEE/IRB: Medical Ethics Committee, University Malaya Medical Centre ADDRESS: LEMBAH PANTAI 59100 KUALA LUMPUR	ETHICS COMMITTEE/IRB REFERENCE NUMBER: 830.25
PROTOCOL NO: TITLE: Reproductive rights and choice: Insights from women on pregnancy termination	
PRINCIPAL INVESTIGATOR: Prof. Low Wah Yun TELEPHONE: KOMTEL:	SPONSOR: World Health Organisation

The following item [✓] have been received and reviewed in connection with the above study to be conducted by the above investigator.

[✓] Borang Permohonan Penyelidikan	Ver date: 03 Jan 11
[✓] Study Protocol	Ver date:
[ ] Investigator's Brochure	Ver date:
[✓] Patient Information Sheet	Ver date:
[✓] Consent Form	Ver date:
[ ] Questionnaire	
[✓] Investigator(s) CV's (Prof. Low Wah Yun)	

and have been [✓]

[✓] Approved
[ ] Conditionally approved (identify item and specify modification below or in accompanying letter)
[ ] Rejected (identify item and specify reasons below or in accompanying letter)

Comments:

Investigator are required to:

1) *follow instructions, guidelines and requirements of the Medical Ethics Committee.*
2) *report any protocol deviations/violations to Medical Ethics Committee.*
3) *provide annual and closure report to the Medical Ethics Committee.*
4) *comply with International Conference on Harmonization – Guidelines for Good Clinical Practice (ICH-GCP) and Declaration of Helsinki.*
5) *note that Medical Ethics Committee may audit the approved study.*

Date of approval: 26th JANUARY 2011

c.c Head
Medical Education & Research Development Unit
(MERDU)

Deputy Dean (Research)
Faculty of Medicine

Secretary
Medical Ethics Committee
University Malaya Medical Centre

.....
PROF. KULENTHRAN ARUMUGAM
Deputy Chairman

For any enquiries regarding the information presented in this study,
please contact the principal investigator:

Prof. Dr. Low Wah Yun
Faculty of Medicine
University of Malaya
50603 Kuala Lumpur
Malaysia
Tel: 603 7967 5729 Fax: 603 7967 5769
Email: lowwy@um.edu.my

UNFPA MALAYSIA

ISBN 978-967-11589-4-4