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Unintended Pregnancy And Induced Abortion In the Philippines

CAUSES AND CONSEQUENCES

Unintended Pregnancy And Induced Abortion In the Philippines: Causes and Consequences

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Acknowledgments

Unintended Pregnancy and Induced Abortion in the Philippines: Causes and Consequences was written by Susheela Singh, Haley Ball, Rubina Hussain and Jennifer Nadeau, all of the Guttmacher Institute; Fatima Juarez, Centre for Demographic, Urban and Environmental Studies, El Colegio de México, and independent consultant; and Josefina Cabigon, University of the Philippines Population Institute. The report was edited by Susan London, independent consultant. Kathleen Randall, of the Guttmacher Institute, supervised production of the report.

The authors thank the following current and former Guttmacher Institute staff members for providing assistance at various stages of the report's preparation: Akinrinola Bankole, Erin Carbone, Melanie Croce-Galis, Patricia Donovan, Dore Hollander, Sandhya Ramashwar and Jennifer Swedish. The authors also acknowledge the contributions of the following colleagues at the University of the Philippines: Celia Abbago, Cleopatra V. Alvaro, Gloria Oracoy, Josephine Parinas, Florence Tolentino and the team of supervisors and interviewers, for coordination of fieldwork, data collection and processing, and research assistance on the National Survey of Women and the collection of hospital reports; and Francisco de los Reyes for sample design.

Members of the Project Advisory Panel provided valuable advice and direction: Roberto Ador, Philippine Legislators' Committee on Population and Development Foundation (PLCPD); Honorata L. Catibog, Family Planning Unit, Philippines Department of Health (DOH); Milagros Fernandez, Philippines DOH; Loreto B. Roquero, Family Planning Unit, Philippines DOH; Ramon D. San Pascual, PLCPD; and Carolyn I. Sobritchea, Center for Women's Studies, University of the Philippines. The Institutional Review Board of the Guttmacher Institute and the following members of the local ethical review committee reviewed survey protocols and design: Leonardo de Castro, Fogarty International Center Bioethics Program, University of the Philippines; Alfredo Tadiar (retired), College of Law and College of Medicine, University of the Philippines; and Cecille Tomas, College of Medicine, University of the Philippines.

The contributions of a stakeholders' forum were essential to determining the scope and direction of the report. The following participants offered their input and advice: Merlita Awit, Women's Health Care Foundation; Hope Basiao-Abella, WomenLead Foundation; Ellen Bautista, EngenderHealth; Kalayaan Pulido Constantino, PLCPD; Jonathan A. Flavier, Cooperative Movement for Encouraging NSV (CMEN); Gladys Malayang, Health and Development Institute; Alexandrina Marcelo, Reproductive Rights Resource Group (3RG); Junice Melgar, Linangan ng Kababaihan (Likhaan); Sharon Anne B. Pangilinan, Institute for Social Science and Action; Glenn Paraso, Philippine Rural Reconstruction Movement; Corazon M. Raymundo, University of the Philippines Population Institute; Rhodadora Roy-Raterta, Family Planning Organization of the Philippines; Carolina S. Ruiz-Austria, WomenLead Foundation; Joy Salgado, Likhaan; Jojo Sescon, Remedios AIDS Foundation; Joyce Valbuena, Health Action Information Network; and Georgina Villar, Thea Initiative.

Early drafts of the report benefited from input from John B. Casterline, Pennsylvania State University; Jonathan A. Flavier, CMEN; Alexandrina Marcelo, 3RG; Junice Melgar, Likhaan; and Carolina S. Ruiz-Austria, WomenLead Foundation. Cookee Belen and Alexandrina Marcelo of 3RG coordinated communications and outreach throughout this project. Kathy Toner, Michael Tan and Mai Taqueban, of The David and Lucile Packard Foundation, were especially supportive in organizing the stakeholders' forum and in providing comments on drafts of this report.

This report was made possible by funding from The David and Lucile Packard Foundation.

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Executive Summary

Each year in the Philippines, hundreds of thousands of women become pregnant without intending to, and many women with unintended pregnancies decide to end them by abortion. Because abortion is legal only to save a woman's life, most procedures are clandestine, and many are carried out in unsafe circumstances. Unsafe abortion can endanger women's reproductive health and lead to serious, often life-threatening complications. Furthermore, unsafe abortions impose a heavy burden on women, their families and society by virtue of the serious health consequences that often ensue: These health problems can keep women from work and school, and treatment can be costly and consume scarce medical resources at both public and private health institutions. Because abortion is highly stigmatized and largely prohibited, information on abortion is difficult to obtain. However, new research findings shed light on the causes, level and consequences of abortion in the Philippines.

Unintended pregnancy is common in the Philippines, and it often leads to abortion

- Six in 10 Filipino women say they have experienced an unintended pregnancy at some point in their lives. About 1.43 million pregnancies each year—nearly half of all pregnancies in the Philippines—are unintended.
- A higher proportion of pregnancies are unintended in Metro Manila than in any other major geographic region, and a higher proportion of unintended pregnancies in Metro Manila end in abortion than elsewhere.
- Some 54% of women who have ended an unintended pregnancy by abortion were not using any family planning method when they conceived. Of those who were practicing contraception, three-fourths were using a traditional method.
- The average Filipino woman wants 2.5 children. In order to achieve that goal, she must spend more than 19 years using effective contraceptive methods.
- However, nearly half of all married women of reproductive age have an unmet need for effective contraception—that is, they are sexually active, are able to have children, do not want a child soon or ever, but are not using any form of contraception or are using traditional methods, which have high failure rates.
- Among women who need but are not using contraceptives, 76% fear contraceptive side effects, almost half are ambivalent about becoming pregnant (48%) or exhibit poor planning about when to use contraceptives (41%), and 24% mention difficulties in accessing contraceptive services.

Induced abortion is widespread, and its practice takes many forms

- An estimated 473,000 abortions occur annually. One-third of women who experience an unintended pregnancy end it in abortion.
- Women from all segments of society experience abortion. Women who have had an abortion resemble average Filipino women: The majority are married, Catholic and poor. They have some high school education and have already had several children.
- When asked why they sought an abortion, 72% of women cite the economic cost of raising a child; 54% say they have enough children; and 57% report that the pregnancy occurred too soon after their last one.

- Most women do not make the decision to end a pregnancy alone. Forty-three percent consult their husband or partner, and 25% discuss the matter with a friend or relative.
- Thirty-three percent of women who eventually complete an abortion rely on a husband, partner, relative, friend or neighbor, or take steps to end the pregnancy themselves; 15% consult a pharmacist; and 15% consult either a traditional healer or a street vendor. Only 29% of women obtain an abortion from a doctor.
- Because the cost of relatively safe procedures performed by trained providers in hygienic settings (4,000–15,000 pesos, or US$73–273) is often many times higher than that of unsafe and less effective methods (costing as little as US$1), poor women tend to use unsafe methods.
- Only 30% of women who attempt an abortion succeed in having one, and many women try again and again to end a pregnancy. With each unsafe attempt at ending her pregnancy—successful or not—a woman increases the risk to her life and health.

Unsafe abortions often put women's life and health in jeopardy

- Eight in 10 women who succeed in ending their pregnancy have health complications, and more than half of these women report having severe complications.
- The severity of complications varies according to the abortion method women use: Some 70% of women who use massage or insertion of a catheter and 44% of those who use misoprostol suffer severe complications, compared with only 13% who undergo dilation and curettage or manual vacuum aspiration.
- Poor and rural women often lack access to safer methods and providers, and thus experience higher rates of severe complications than do their wealthier and urban counterparts.
- Because of the high cost of postabortion treatment and the condemnatory attitudes of some medical providers, some women who experience complications do not seek care.
- An estimated 79,000 women were hospitalized because of health complications of abortion in 2000. This translates into an annual rate of 4.5 abortions for every 1,000 women of reproductive age.
- An estimated 800 women per year die from complications of unsafe abortion.

Action on many fronts is needed to reduce levels of unintended pregnancy and unsafe abortion in the Philippines

- Increased use of effective contraceptives would help women achieve their desired family size, and thus prevent unintended pregnancies, which, in turn, would reduce the need for abortion and the grave health consequences and costs of unsafe abortion. This will require increasing knowledge about, access to and government funding for modern methods, especially among poor and rural women.
- Increased resources should be directed at improving the quality of postabortion care for women with complications by expanding services such as those offered under the PMAC (Prevention and Management of Abortion and its Complications) program.
- To ensure that all women receive the care they need, medical professionals should be trained to carry out the full range of reproductive health services—including legal abortions, postabortion care and contraceptive counseling—in a client-centered, compassionate manner.
- Young people, as well as adults, need complete and accurate information on reproductive health and contraception, the risks of unsafe abortion, and the health and societal benefits of family planning.
- Policymakers must clarify the legal and medical grounds on which abortion may be allowed and ensure that women are able to access safe, humane abortion services to the extent they are permitted.

Chapter 1

A Critical but Concealed Issue

Ideally, pregnancy is a wanted and happy event for women, their partners and their families. Unfortunately, this is not always so. Around the world, millions of women every year become pregnant unintentionally. In the Philippines, as in other countries, some of these women are faced with a difficult choice: to give birth to a child that they are not prepared or able to care for, or to obtain an illegal, and often unsafe, abortion.

In the Philippines, nearly half of pregnancies are unintended, and hundreds of thousands of such pregnancies end in induced abortion each year.[1] Almost all of these abortions are illegal because of a colonial-era law that criminalizes the procedure (see box, page 8). Women obtaining abortions risk prosecution and a prison sentence of up to six years, while anyone providing or assisting in the procedure faces a similar sentence, as well as the loss of any medical license.[2] Abortion may be obtained legally if it is necessary to save a woman's life, but in practice, this exception is of little use because many doctors are unwilling to risk performing the procedure, given the potential for severe penalties.[3] The fact that abortion persists despite this restrictive atmosphere suggests a dissonance between the realities of women's lives and the policies and public discourse that surround the issue of abortion.[4]

Unsafe abortion places a considerable burden on Filipino women and society. The first national study on this issue found that in 1994, the prevalence of induced abortion was moderately high by worldwide standards, despite the severity of the Philippine abortion law.[5] In-depth studies done in Metro Manila around that time found that induced abortion occurred in all population groups, especially among women who did not wish to become pregnant but were not practicing contraception.[6] Small-scale, hospital-based studies carried out in the late 1970s and 1980s demonstrated that abortion was common in rural areas as well, that women used a variety of safe and unsafe techniques to end a pregnancy, and that many women were being treated for complications of induced abortion, which often had severe consequences for their health.[7]

This report provides new in-depth information on the burdens of unwanted pregnancy and unsafe and clandestine abortion that so many Filipino women face. The report's aim is to stimulate informed public discussion of the issues in order to achieve workable solutions to the problem of unsafe abortion and its root cause, unintended pregnancy.

Unsafe abortion threatens women, families and society

One in every seven pregnancies is terminated by abortion each year in the Philippines.[8] Some of these procedures are performed by doctors, nurses and midwives working in private offices or clinics, but because many health professionals lack necessary training, skills and medical equipment, even procedures performed by health professionals can be risky. Abortions performed by practitioners with no formal training in abortion provision—pharmacists, traditional healers, street vendors or pregnant women themselves—are even less safe. Two in three Filipino women who terminate a pregnancy experience complications, such as severe pain, infection and even death.[9]

The State recognizes the sanctity of family life and shall protect and strengthen the family as a basic autonomous social institution. It shall equally protect the life of the mother and the life of the unborn from conception.

—Article 2, section 12, of the 1987 Constitution of the Republic of the Philippines

Because abortions are largely clandestine, the number of Filipino women who die due to unsafe abortion is difficult to obtain, but is estimated to be 800 per year.* The World Health Organization estimates that in Southeast Asia, unsafe abortion accounts for 19% of all maternal deaths in any given year.[10] Preventing risky procedures would certainly help the Philippines reduce maternal ill-health and mortality. Doing so would also contribute directly to meeting the Millennium Development Goals adopted in 2002 by all United Nations member states, including the Philippines, especially the goals of improving maternal health and promoting gender equality. Although the country's maternal mortality rate fell from 280 per 100,000 births in 1990 to 200 in 2000, it is still far short of the goal of 70 set for 2015.[11]

The decision to end a pregnancy through abortion can have grave consequences for women and their families, and can be costly for society as a whole. Women suffering from health complications following an unsafe abortion may be forced to take time away from work or school and may not be able to care for their families while they recuperate. Even worse, abortion-related complications may lead to long-term health consequences, such as infertility. In the most extreme cases, complications may result in death, leaving families impoverished and children motherless and at risk.[12]

Induced abortion and related complications also consume scarce monetary and human resources. Relative to average income levels in the Philippines, abortions performed by medically trained practitioners can be very costly. Women must either divert money from essential expenditures, such as food and housing costs, to pay for these procedures, or resort to a less expensive—but also less effective and more dangerous—type of abortion. Postabortion complications can add to this cost. Poor women, in particular, may have trouble obtaining treatment for complications and may not seek or delay seeking care for this reason. In addition, ill-health following unsafe abortions can have a marked impact on women's ability to work, causing further economic strain for them and their families.

At the national level, unsafe abortion creates a drain on the country's health care system. As one of the 10 most common reasons for hospitalization at many hospitals in the Philippines,[13] treatment for complications of abortion requires scarce medical resources (operating rooms, hospital beds, blood supplies, antibiotics) and personnel. Thus, these complications exert substantial pressure on an already overburdened national health system—pressure that could be largely eliminated by addressing the problem of unsafe abortion head-on.

Most abortions stem from unintended pregnancies

In most cases, women decide to seek abortions because they are faced with unintended pregnancies. The reasons pregnant Filipino women give for not wanting to be pregnant vary with their life circumstances: Most often, they or their families are too poor to provide for a child or for another child. Other women already have too many children; become pregnant too soon after the last birth; feel they are too young; would have to end or, at best, postpone their work or education; are single; or are in difficult

*This number was calculated by first multiplying the maternal mortality rate (source: see reference 11) by the number of births in 2003 (sources: National Statistics Office (NSO) and ORC Macro, *Philippines National Demographic and Health Survey, 2003*, Calverton, MD, USA: NSO and ORC Macro, 2004; and NSO, *2000 Census of Population*, CD-ROM, Manila, Philippines: NSO, 2004). This product was multiplied by 0.19, the proportion of maternal deaths due to abortion in Southeast Asia (source: see reference 10).

or unstable relationships.[14] When effective modern contraceptives (largely discouraged by the Catholic Church, which plays a prominent role in Philippine society) are not used or fail, and an unintended pregnancy results, women often have few options. Thus, the practice of induced abortion is largely a result of the difficulties women and couples face in preventing pregnancies they do not want.

Unintended pregnancy itself reflects the interrelationships of broader changes that are taking place in Philippine society and in women's lives. Urbanization, increasing access to education, the spread of mass media and the growing likelihood that a woman will work outside the home or even overseas all create new alternatives and suggest new possibilities for women. To provide the best educational and employment opportunities for their children, parents may want to have small families so they can invest more in each child. Taking advantage of the same opportunities, women may also postpone getting married and starting a family. While delaying the start of planned childbearing, later marriage can also lead to an increase in unprotected sexual activity among unmarried men and women, heightening the risk of unintended pregnancies.

At the same time, weak government support for modern contraception and the insistence of the Catholic Church on natural family planning methods contribute to low levels of modern contraceptive use and persistent reliance on less effective methods. Many women use no family planning method at all. Often, this is because they lack adequate information about their risk of unintended pregnancy or they have not been counseled about all of their contraceptive options. Whatever the reasons, when couples want fewer children and fail to practice contraception consistently and correctly, a higher proportion of pregnancies will inevitably be unintended.

An informed public debate on the issue of unsafe abortion is urgently needed

Even though Filipino women have attained nearly universal literacy[15] and make up more than half of the country's vast and vital overseas workforce[16] and more than half of the voting population,[17] women from all segments of society jeopardize their health and risk legal sanctions to terminate unintended pregnancies. Yet the cultural and political environment that surrounds reproductive health issues in the Philippines prevents open discussion of unintended pregnancy. In this restrictive atmosphere, information on abortion incidence and practice is piecemeal at best.

The struggle for sexual and reproductive health and rights generates constant political conflict in the Philippines. Despite the very conservative position of the influential Catholic Church against modern contraceptives and abortion, the government has acknowledged and made some attempts to address the problems of unintended pregnancy and unsafe abortion. The Philippines Reproductive Health Program, created in 1998 in response to goals set at the 1994 International Conference on Population and Development, lists preventing and managing abortion and its complications as one of 10 reproductive health goals to be addressed.[18] The Prevention and Management of Abortion and Its Complications Policy, instituted in 2000, focuses on improving the quality of postabortion care and counseling.[19] The National Family Planning Policy of 2001 also mentions preventing abortion and its complications, and acknowledges that illegal abortion stems from unwanted and unplanned pregnancies.[20] Such policies indicate an awareness of the ill-health and death that result from unsafe abortion and an acknowledgment that the government and the public have a role to play in addressing these problems.

The legal status of abortion in the Philippines

Art. 256. Intentional abortion.—Any person who shall intentionally cause an abortion shall suffer:

1. *The penalty of* reclusion temporal*, if he shall use any violence upon the person of the pregnant woman.*
2. *The penalty of* prision mayor *if, without using violence, he shall act without the consent of the woman.*
3. *The penalty of* prision correccional *in its medium and maximum periods, if the woman shall have consented.*

Art. 257. Unintentional abortion.—The penalty of prision correccional *in its minimum and medium period shall be imposed upon any person who shall cause an abortion by violence, but unintentionally.*

Art. 258. Abortion practiced by the woman herself or by her parents.—The penalty of prision correccional *in its medium and maximum periods shall be imposed upon a woman who shall practice abortion upon herself or shall consent that any other person should do so.*

Any woman who shall commit this offense to conceal her dishonor shall suffer the penalty of prision correccional *in its minimum and medium periods.*

If this crime be committed by the parents of the pregnant woman or either of them, and they act with the consent of said woman for the purpose of concealing her dishonor, the offenders shall suffer the penalty of prision correccional *in its medium and maximum periods.*

Art. 259. Abortion practiced by a physician or midwife and dispensing of abortives.—The penalties provided in Article 256 shall be imposed in its maximum period, respectively, upon any physician or midwife who, taking advantage of their scientific knowledge or skill, shall cause an abortion or assist in causing the same.

Any pharmacist who, without the proper prescription from a physician, shall dispense any abortive shall suffer arresto mayor *and a fine not exceeding 1,000 pesos.*

—Revised Penal Code of the Philippines

The Philippine government, service providers, nongovernmental organizations, the media, international agencies and society in general, however, all need to have specific and up-to-date information to deal forthrightly with unsafe and illegal abortion. This report seeks to fill critical information gaps at the national and regional levels by documenting the scope, causes and consequences of unsafe abortion. It aims to use new evidence to build political and institutional commitment to addressing the issue of unsafe abortion and its impact on maternal health, by providing the evidence base for discussion and formulation of policies and programs to reduce unintended pregnancy and improve postabortion care.

A guide to this report

This report draws on research and analysis conducted between 2002 and 2005, as well as on data from the 1990s, to document the current situation and trends over the past decade (see box, page 10; and Appendix, page 31). Because illegal abortions generally go unreported, information from hospitals was examined to indirectly estimate the annual number of abortions in the Philippines. Women's accounts during a national survey provide additional detail to help paint the most complete picture to date of abortion in the country. Because of the decentralization of the health care system begun in the early 1990s, it is important to have local information that can be used to inform relevant policy and program change. Wherever possible, data are given for the 16 regions individually; elsewhere, data are given at the level of the four major regions.

Chapter 2 describes levels of unintended pregnancy and induced abortion in the country as a whole and in each region. Chapters 3 and 4 explore the characteristics, reasons and decision-making processes of women seeking to end a pregnancy, and the methods they resort to. Abortion-related health complications and their treatment are discussed in Chapter 5. In Chapter 6, abortion is placed in the context of a more detailed analysis of contraceptive use and unintended pregnancy. Finally, Chapter 7 links the research evidence to policy and program recommendations.

Data Sources

PRIMARY DATA SOURCES

The two primary sources of information for this report are a national compilation of the most recent available hospital reports and the 2004 National Survey of Women, conducted by the Guttmacher Institute and the University of the Philippines Population Institute.

- Hospital reports were used to estimate the incidence of induced abortion and related measures. As part of licensing regulations, all hospitals in the Philippines must submit to their regional department of health office an annual report that includes the number of patients treated for each of the top 10 causes of hospital admission. The central department of health authorized project staff to obtain these hospital reports and to analyze them for this project. Project staff collected available reports for all hospitals in the Philippines between 1996 and 2001; they started with the reports available at the central office, and then obtained nonforwarded reports directly from each of the 16 regional offices. Between May 2003 and February 2004, a total of 2,039 hospitals were identified, and usable reporting forms were obtained for 1,658 (81%) of them, representing 89% of all hospital beds. Estimates were made for hospitals for which reports were missing. An established methodology was used to estimate the total number of abortions in the country (see Appendix, page 31).
- The 2004 National Survey of Women, a survey of women of reproductive age, was designed to investigate the abortion-seeking process and the procedure's health consequences. It has national and regional representation. Some 4,094 women aged 15–49, both single and married, were interviewed. Using the 2000 Philippines census as the sampling frame, a stratified, multistage sample was designed. The sample design used a cluster approach with *barangays* (administrative units) as primary sampling units. Barangays were randomly selected; households in the selected barangays were chosen by systematic sampling, and an eligible respondent in each chosen household was interviewed. Although almost one in 10 Filipinos migrate temporarily to other countries as contract workers,[1] and more than half of these workers are women,[2] the sample design of the survey appropriately represents this group. The survey obtained information on several topics, including the respondent's demographic and socioeconomic characteristics; her history of fertility, pregnancy and fetal loss; her knowledge, attitudes and practices regarding contraception; her experience with unintended pregnancy and abortion; and detailed information on abortion-seeking behavior and the procedure's consequences.

Social and demographic information about which women have an abortion is based on the 15% of women who reported on the questionnaire that they had ever had an abortion, while specific information on methods, providers and decision making is based either on the 6% who said in the face-to-face interview that they had attempted an abortion or on the 2% who reported succeeding, depending on the topic.

ADDITIONAL DATA SOURCES

- The 1993 Demographic and Health Survey (DHS), the 1998 DHS and the 2003 DHS were used to obtain information on trends related to the context in which women experience unintended pregnancy and induced abortion. These surveys are part of an international research effort conducted by Macro International in cooperation with national governments. The samples are nationally representative and large enough to allow for regional estimates, although some change in the definition of regions occurred (14 regions in 1993 and 16 in 1998 and 2003). In the 1993 DHS, 15,029 women aged 15–49 years were interviewed; in the 1998 DHS, 13,983 women this age; and in the 2003 DHS, 13,633 women this age.
- The 1990 census and the 2000 census, carried out by the National Statistics Office, were used to obtain population statistics.
- A 1996 survey of knowledgeable health professionals, conducted by the Guttmacher Institute, was used to discern their perceptions of the conditions under which women obtain induced abortions.
- Qualitative studies among women who have had abortions, carried out by researchers and nongovernmental organizations, were drawn on for additional contextual information.

Chapter 2

The Scope of the Problem

Information on the current level of unintended pregnancy and abortion is essential for understanding the extent to which women face barriers in planning pregnancies and preventing unintended ones. Evidence on recent trends in these important indicators is also crucial in assessing whether changes in policies and programs are necessary.

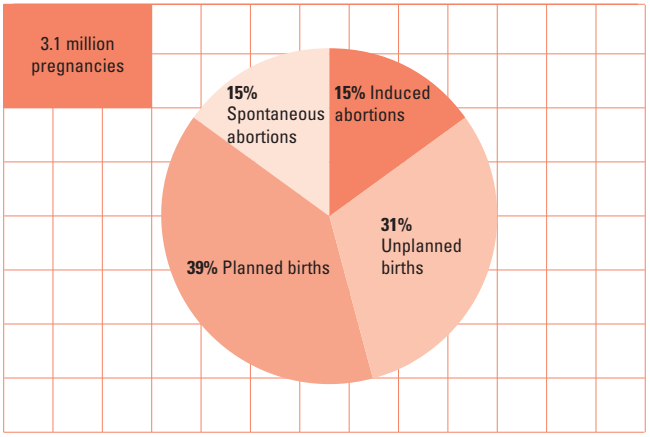
Because induced abortion is highly stigmatized and punishable by law in the Philippines, and because women and providers tend not to report the procedure, it is extremely difficult to directly measure the number of abortions occurring each year (see boxes, pages 12 and 13). However, analysis of hospital reports provides new estimates for 2000, applying a widely accepted methodology (see Appendix, page 31).[1] The same methodology was used in an earlier study to measure abortion incidence for 1994;[2] therefore, trends from the mid-1990s to 2000 can be assessed. These estimates of abortion are combined with information from national surveys on unplanned childbearing to calculate the level of unintended pregnancy.

Unintended pregnancy is the root cause of abortion

Some 3.1 million pregnancies occur each year in the Philippines. Of these, 15% result in induced abortions, 31% in unplanned births, 39% in planned births and 15% in spontaneous abortions (Figure 2.1).*[3] Thus, about 1.43

FIGURE 2.1

Nearly half of pregnancies each year end in an induced abortion or an unplanned birth.



Source Calculations based on data in reference 3.

*Calculation of pregnancy intentions, numbers and rates involved several steps. We estimated the annual number of births by applying age-specific fertility rates for each major region (calculated from 1993 and 2003 DHS data) to population estimates (census data from the National Statistics Office) for five-year age-groups of women for 1994 and 2000, respectively. Separately, we obtained the proportion of births that are unplanned—mistimed or unwanted at the time of conception—from national surveys for 1993 and 1998, and applied these to the estimates of the number of births. The number of unplanned births is combined with abortions to calculate the rate of unintended pregnancy for 1994 and 2000. Spontaneous abortions are estimated on the basis of biological patterns identified in clinical studies as 20% of live births plus 10% of induced abortions (source: Bongaarts J and Potter R, *Fertility, Biology and Behavior*, New York: Academic Press, 1983). Information on whether pregnancies ending in spontaneous abortions were wanted is lacking, but a certain proportion would have been unintended. Because this proportion is unknown, our estimates of unintended pregnancy do not include any spontaneous abortions and are therefore underestimates.

million pregnancies each year—nearly half of all pregnancies—are unintended. The annual rate of unintended pregnancy is 81 per 1,000 women of reproductive age, meaning that about 8% of Filipino women aged 15–44 conceive every year without intending to do so.

About one-third of these women end their pregnancies in abortion. In 2000, women in the Philippines had more than 473,000 induced abortions—compared with an estimated 400,000 in 1994. Because the population also grew during this period, the rate of induced abortion remained essentially constant—25 abortions per 1,000 women in 1994 and 27 per 1,000 in 2000 (Table 2.1).[4] In 2000, somewhere in the Philippines, a woman underwent an induced abortion nearly every minute of every day.

At the national level, little change occurred between 1994 and 2000 in the proportion of all pregnancies that were unintended or the rate of unintended pregnancy. However, both indicators increased substantially in Metro Manila. By 2000, more than half (56%) of pregnancies in this area were unintended, a substantial increase from 1994 (46%), and the unintended pregnancy rate was 97 per 1,000 women, up from 68 in 1998.[5] The situation differed in the other major areas of the country. In Rest of Luzon and in Mindanao, the proportion of pregnancies that were unintended changed little during this period, but the unintended pregnancy rate declined somewhat, from 85 to 78 per 1,000 women in Luzon and from 84 to 80 per 1,000 women in Mindanao, probably because the overall pregnancy rate fell in these regions. Visayas, the area with the highest unintended pregnancy rate in 1994, showed the most improvement, achieving an unintended pregnancy rate of 78 per 1,000 women by 2000 (down from 91 per 1,000 in 1994) and experiencing a small drop in the proportion of pregnancies that were unintended, from 48% to 44%.

Couples in all parts of the country have difficulty managing the number and spacing of their children

Six in 10 Filipino women aged 15–49 say they have experienced an unintended pregnancy.[6] Overall, in 2003, the average Filipino woman wanted 2.5 children but had 3.5.[7] This gap between desired and actual family size remained relatively stable between 1993 and 2003, although both measures declined.

The discrepancy between wanted and actual fertility varies by region; the largest gap between the two rates is experienced by women in Eastern Visayas and Bicol, who have an average of about 1.7 children more than they want.[8] In Metro Manila, the region with the highest proportions of women who are economically better off, unmarried, employed and educated, women want only two children and have 2.8, on average.[9]

The proportion who have had a recent unwanted birth is smaller among women who live in urban settings or who have at least a college education than among those who live in rural settings or who have an elementary or high school

TABLE 2.1

Estimated abortion rate, by survey year and region

Region	Estimated abortion rate*	
	1994	2000
TOTAL	**25**	**27**
METRO MANILA	**41**	**52**
REST OF LUZON	**30**	**27**
Bicol	20	25
Cagayan Valley	30	34
CAR	33	34
Central Luzon	39	27
Ilocos Region	27	38
Southern Tagalog	27	22
VISAYAS	**11**	**17**
Central Visayas	6	24
Eastern Visayas	16	17
Western Visayas	12	10
MINDANAO	**18**	**18**
ARMM	8	7
CARAGA	4	13
Central Mindanao	29	26
Northern Mindanao	11	25
Southern Mindanao	23	20
Western Mindanao	24	13

*Abortion rate is the number of abortions per 1,000 women aged 15–44 per year.

Notes CAR=Cordillera Administrative Region. ARMM=Autonomous Region of Muslim Mindanao. CARAGA=Cagayan Autonomous Region and Growth Area.

Sources **Major regions:** Reference 4. **Other regions:** Special tabulations of hospital record data from 1993–1995 and 1999–2001.

Women are often reluctant to talk about their abortions

In countries such as the Philippines, where abortion is illegal, underreporting of events in surveys can be a major constraint in carrying out research on abortion. For this reason, the 2004 National Survey of Women used a pair of data collection approaches intended to minimize underreporting and provide a means of assessing the representativeness of the data and quality of the reporting of abortion. First, in a face-to-face interview, women were asked detailed, direct questions about their experience of abortion and its circumstances. Second, women were asked to complete a brief, confidential questionnaire asking directly if they had had an abortion since 2000; they sealed the questionnaire in an envelope before returning it to the interviewer. Only 2% of women reported in the face-to-face interview that they had obtained an abortion. In contrast, 15% of women indicated in the confidential questionnaire that they had done so. This disparity highlights the importance of using research methods that overcome women's reluctance to disclose their experience of abortion.

education.[10] This is probably due in part to a higher level of use of effective contraceptive methods among the urban and better educated groups. Nationwide, however, 55% of all married women are at low or no risk of unintended pregnancy—they are infecund, want a child soon, are pregnant and want the pregnancy, or are able to become pregnant but do not want a child soon or ever and are using a modern method of contraception. This leaves 45% of married women with an unmet need for effective family planning—and at great risk for unintended pregnancy—because they do not want a child soon or ever, but are not using a contraceptive method or are using a traditional method.[11]

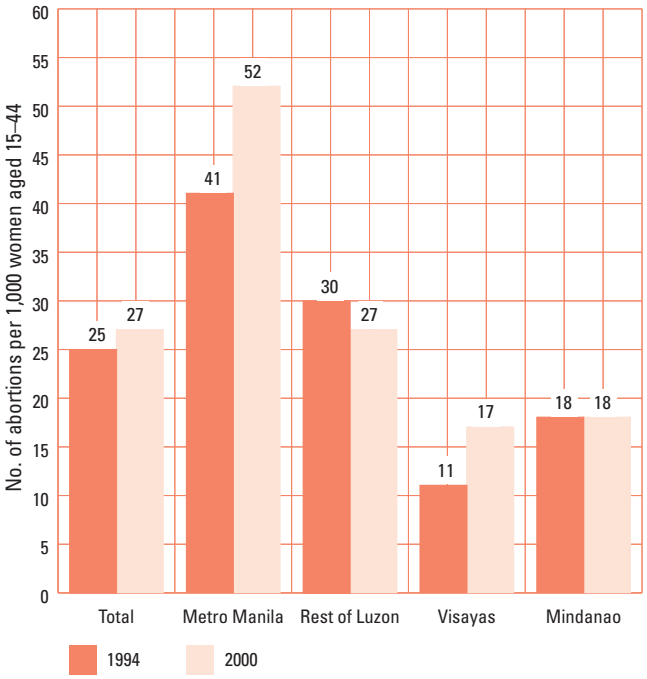
Women who become pregnant when they are not prepared to care for a child—whether they were not using a contraceptive, were using an ineffective method, were using a method incorrectly or inconsistently, or experienced method failure—may be highly motivated to prevent an unplanned birth. One-fourth of Filipino women who have ever had an unwanted pregnancy say they have had an abortion.[12]

Induced abortion rates vary greatly across regions

Large differences in the incidence of abortion exist across regions. Women in Metro Manila not only experience more unintended pregnancies than their counterparts in other regions, they also terminate such pregnancies more frequently. Three in 10 pregnancies in this region end in abortion—a proportion twice that in Rest of Luzon, and three times that in the other two major regions of the country, Visayas and Mindanao.[13] Women from nearby regions who come to Metro Manila seeking better, more accessible or more anonymous postabortion care may account for a small proportion of the abortions attributed to the capital region. In that case, the abortion rate for Metro Manila may be slightly overestimated, and the rate for neighboring regions somewhat underestimated. However, hospitals are fairly well distributed across the country, so it is unlikely that large numbers of women travel to the capital for postabortion care.

FIGURE 2.2

Between 1994 and 2000, abortion rates did not change much nationally, but they increased in Metro Manila and Visayas.



Source Reference 14.

Metro Manila saw an increase in its abortion rate over the period of 1994–2000, from 41 to 52 procedures per 1,000 women aged 15–44 (Figure 2.2).[14] This indicator also rose in Visayas, from the previously low rate of 11 abortions per 1,000 women in 1994 to a still relatively low rate of 17 in 2000. In contrast, abortion incidence did not increase in the other two major geographic areas.

Large differences are also apparent within these four major areas of the country (Table 2.1).[15] For instance, the abortion rate in Rest of Luzon in 2000 varied from 22 in Southern Tagalog to 38 in Ilocos Region; in Visayas, from 10 in Western Visayas to 24 in Central Visayas; and in Mindanao, from seven in the Autonomous Region of Muslim Mindanao (ARMM) to 26 in Central Mindanao.

Informed policy making requires better recordkeeping

To measure progress toward improving public health—such as reduced levels of unintended pregnancy and unsafe abortion among Filipino women—policymakers must have access to reliable information on the public's health needs and the services being provided. In the Philippines, complications following unsafe abortions (an indicator of levels of these procedures generally) are a leading cause of hospitalization, yet reports that would permit documentation of these cases (as well as the full range of the causes for hospitalization) are not compiled, processed or tabulated at the national level. In addition to retrieving official reports submitted to the national Department of Health, researchers collecting data for this study had to visit many regional department of health offices to obtain reports for the more than 2,000 hospitals in the country—a process that took several months.

Improving government data collection and analysis would enable decision makers to develop better-informed public policies, monitor the implementation of policies and programs, and evaluate progress. Such results are critical to efforts to meet the Millennium Development Goals and ensure a healthier society.

Rates of abortion in each region are expected to be related to the level of use of modern contraceptives, as well as the level of unmet need for contraception. Yet in some regions, such as Metro Manila, Ilocos Region and Central Visayas, even as modern contraceptive use rose between 1993 and 2003, abortion rates stagnated or increased slightly.[16] In countries such as the Philippines, where women and couples increasingly want small families, contraceptive use may not at first keep pace with this growing motivation to control fertility.[17] That is, for a transitional period of time, the proportion of couples who wish to space their births or end their childbearing but who are not using modern contraceptives may increase—and as a result, more couples may experience unintended pregnancies and seek abortions. Eventually, evidence from other countries shows, contraceptive use becomes more widespread and abortion rates decline.

Chapter 3

Why Women Have Abortions

Filipino women of all ages, in all parts of the country and from all educational, economic and social backgrounds have had an abortion at some point in their lives. What are their circumstances and motivations?

In most respects, Filipino women who have an abortion are, on average, just like any Filipino women of reproductive age (Figure 3.1, page 16).[1]

- Nine in 10 have ever been married or in a consensual union.
- More than half have at least three children.
- Roughly two-thirds are poor.*
- Nearly 90% are Catholic.
- Seven in 10 have at least some high school education.

The proportion of women younger than age 20 is lower among women who have abortions than among all Filipino women of reproductive age, which is expected, given that many adolescent women are not yet sexually active.

Women have many reasons for choosing abortion

Despite the common perception that abortion occurs primarily among women who wish to conceal the "dishonor" of a nonmarital pregnancy, women's reports of their multiple and overlapping reasons for having attempted to end an unintended pregnancy show that this is not the case.[2]

*In order to create a wealth index, we classified respondents into quartiles, based on their possession of certain amenities (electricity, radio, television, gas or electric stove, refrigerator, electric fan, air conditioner, washing machine, indoor toilet, tap drinking water inside household, cellular telephone, telephone, bicycle, car, household helper or maid). We define nonpoor women as those in the highest 25% of respondents; the remaining 75% of women are defined as poor.

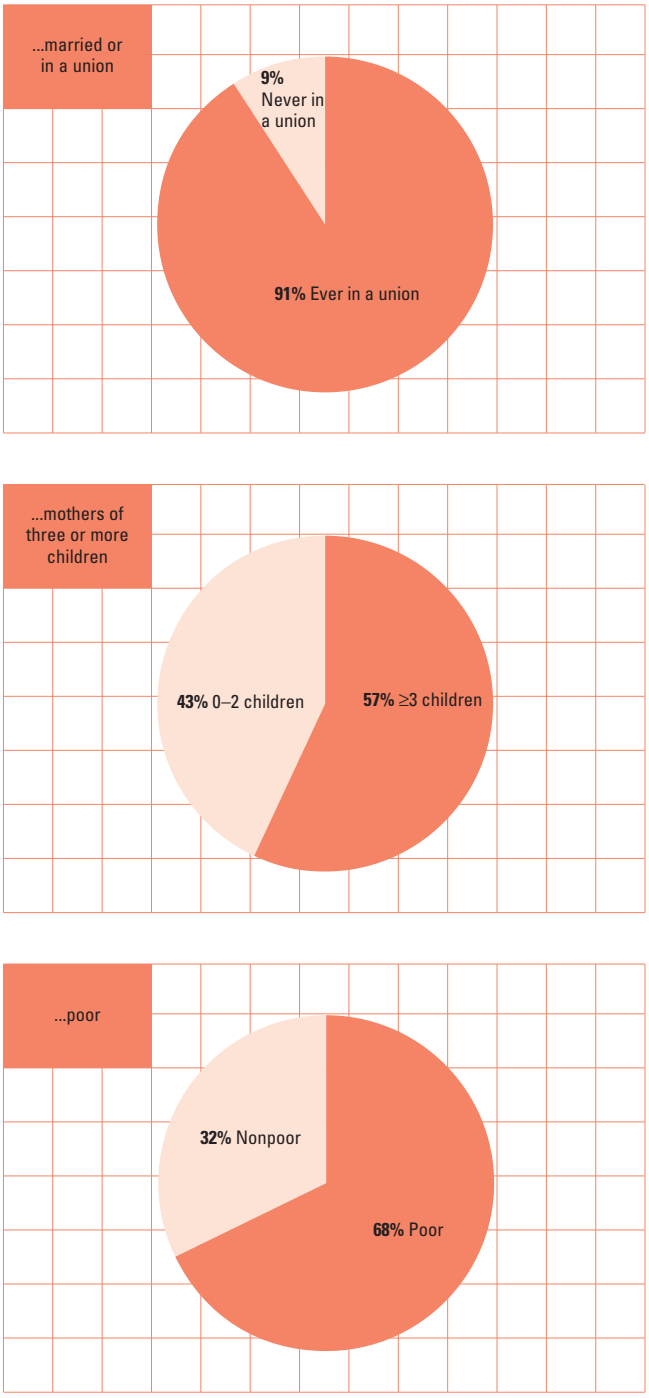
The most common reason is an inability to afford the economic cost of raising a child, a reason cited by 72% of Filipino women who have attempted to have an abortion. More than half of abortion seekers gave a reason relating directly to unmet need for family planning: Some 54% felt they had enough children, while 57% believed that the pregnancy occurred too soon after their last one. Thirty-one percent of women sought an abortion because they feared that a pregnancy would damage their health, and another 32% because they felt that their husband, partner or relatives did not want the pregnancy. One in four women tried to end a pregnancy because of problems with their partner; that is, their partner had abandoned them, was not their husband or was not deemed to be a good father. Some 13% of women who ever attempted an abortion reported having done so because their pregnancy resulted from forced sex.

One characteristic that is closely associated with a woman's reasons for attempting to end an unintended pregnancy is her age. Larger proportions of older women than of their younger counterparts cite the expense of raising a child, the desire to space the births of their children, concern about limiting family size or health worries as strong motivations for seeking an abortion. On the other hand, larger proportions of younger than of older women try to terminate their pregnancies because they want to avoid conflicts with school, have problems with their partner or the man who made them pregnant, or consider themselves too young to have a baby.[3]

Women's economic status is also an important factor in why they decide to have an abortion (Figure 3.2, page 17).[4] Although the financial cost of raising a child and the desire to space births or limit family size are among the leading reasons cited by both poor women and better-off

FIGURE 3.1

The majority of women having abortions are...



Source Reference 1.

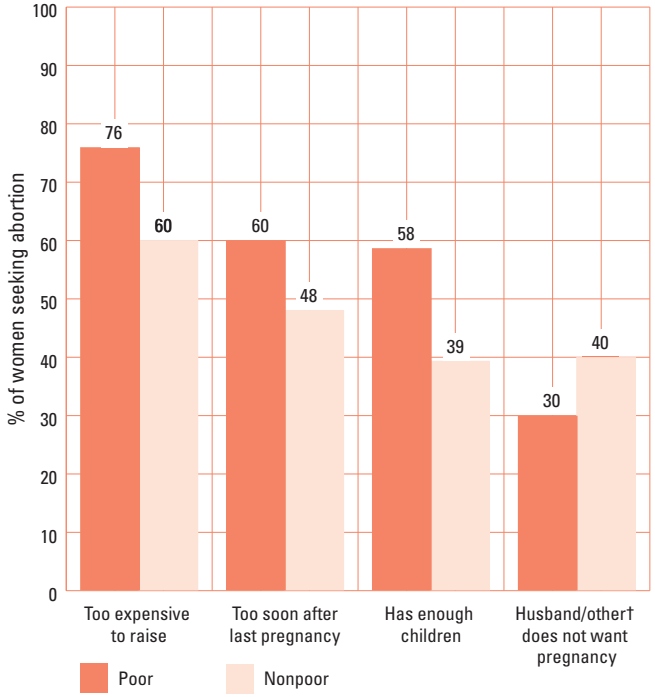
women who have sought to end a pregnancy, these reasons are given by larger proportions of poor than of wealthier women. By contrast, a larger proportion of better-off women say that opposition to the pregnancy by their husband, partner or relatives was a motivation.

Abortion is often a shared decision

Most women do not make the decision to end a pregnancy alone. Nearly seven in 10 women who seek an abortion discuss their decision with at least one person: Forty-three percent consult their husband or partner, sometimes in addition to other people; 25% discuss the matter with a friend or relative, and not with their husband or partner (Figure 3.3).[5] In cases where the man responsible for the pregnancy is consulted, three-quarters approve of the woman's obtaining an abortion. Regardless of who is consulted, the woman typically initiates the discussion (83% of cases). Seven in 10 women report having had the final say in the decision to seek abortion.[6]

FIGURE 3.2

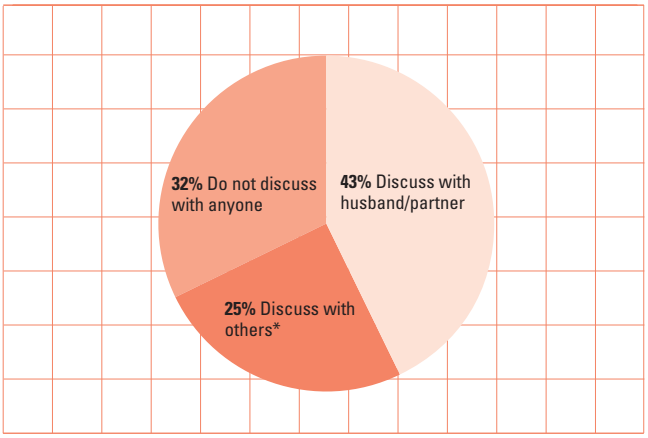
Both poor* and nonpoor women seeking abortion are concerned with the high cost of raising children.



*See footnote on page 15.
†Other includes partner or relatives.
Source Reference 4.

FIGURE 3.3

Two-thirds of women who attempt an abortion discuss the decision with someone.



*Friend or relative.
Source Reference 5.

Chapter 4

How and Where Women Obtain Abortions

The process of obtaining an abortion in the Philippines can be a long and arduous one, and there is no assurance of success. Fewer than one in three women who seek an abortion complete the process.[1] Many women endure multiple attempts—some with serious health consequences—before terminating their pregnancy or giving up on obtaining an abortion. Women are so concerned about the consequences of an unintended pregnancy that many are willing to risk their freedom, their health and even their lives to end it.

Induced abortion in the Philippines takes many forms

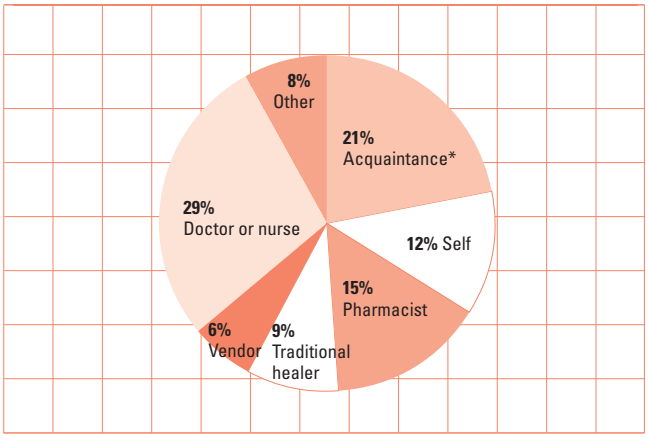
Abortion techniques used in the Philippines range from safe surgical procedures performed in hospitals to highly dangerous procedures, such as inserting foreign objects into the cervix or ingesting toxic substances. The type of abortion a woman obtains depends on many factors: her access to information on available methods; how early in pregnancy she decides on and obtains the procedure; her ability to pay for it; the method used by the provider she chooses, or that she herself uses; the training and skill of the practitioner; and the conditions under which the procedure takes place (hygienic or not). In places where modern, reliable methods are available, abortion-related complications are largely avoidable. But in the Philippines, the type of provider, the gestation at which pregnancy is terminated, the setting and the methods used vary greatly; these factors play a large role in determining the level of risk an abortion will entail.

Most Filipino women who successfully obtain an abortion do so within the first trimester of pregnancy.[2] However, nearly one-fourth of women who eventually end their pregnancy fail to have the procedure within this safest window of time and have a later—and riskier—one. The proportion delaying an abortion until the second trimester or later is higher among poor women than among their nonpoor counterparts (28% vs. 15%). Such a delay is also more prevalent among older women (30–49) than among those aged 15–29 (27% vs. 15%).

One-third of women who eventually complete an abortion rely on a husband, partner, relative, friend or neighbor, or take steps to end the pregnancy themselves (Figure 4.1).[3] Others consult a pharmacist (15%), traditional healer (9%) or street vendor (6%). Only about three in 10 women go to a general practice doctor, obstetrician-gynecologist or nurse to obtain the abortion.*

FIGURE 4.1

Most women who have an abortion do not obtain it from a doctor.



*Woman obtained an abortion method from her husband, partner, relative, friend or neighbor.

Source Reference 3.

*Estimates in this chapter refer to women's last attempt at obtaining an abortion, unless otherwise stated.

Filipino women employ a wide range of methods when attempting abortion[1]

- Surgery or "operation" (D&C or MVA)
- Misoprostol
- Hormonal pills
- Injectable hormonal contraceptive
- Insertion of a catheter into the cervix
- Insertion of other objects into the cervix
- Massage
- Aspirin or other medications
- Eating or drinking traditional medicine/herbs
- Drinking alcohol
- Fasting
- Climbing a tree
- Jumping
- Exercising

One-third of women report having the abortion in a hospital or health center.[4] About half of women undergo the procedure in their own or someone else's home, and the rest attempt an abortion or obtain methods at a pharmacy, from a sidewalk vendor or market, or outdoors (in mountains, forests, backyards or gardens).

One in four women who obtain an abortion have a surgical procedure, by either dilation and curettage (D&C) or manual vacuum aspiration (MVA). Another quarter ingest herbs or insert them into their vagina. Equal proportions of women report using misoprostol (Cytotec) or massage (15%), or insertion of a catheter (15%) to induce abortion. About 20% of women use nonabortifacient hormonal drugs (birth control pills or the injectable), aspirin (Cortal), other medications or drinks (see box). Some women know little about what they are ingesting or inserting, and the medication they use may actually include stronger drugs than they think, such as misoprostol. Given that some of these methods are not effective in inducing abortion, it is likely that some women who have an abortion also go to a clinic or hospital for treatment of complications, and that the procedure is completed there.[5]

Many abortion providers and methods are unreliable at best and dangerous at worst. But the high cost of a relatively safe surgical abortion in a clinic, 4,000–15,000 pesos (US$73–273), can prohibit women from accessing safer procedures.*[6] For comparison, an herbal drink obtained on the street or a procedure performed by a traditional healer can cost around US$1. More than eight in 10 women who make a single attempt to end a pregnancy spend less than 100 pesos (about US$2), making it clear that many women resort to methods that are affordable, but often risky and ineffective, rather than costlier, safer and more effective procedures.[7]

*The monthly minimum wage for nonagricultural work ranges from 7,958 pesos (US$155) in Western Visayas to 12,219 pesos (US$238) in Metro Manila (source: Department of Labor and Employment, National Wages and Productivity Commission, Current regional daily minimum wage rates, 2001, <http://www.nwpc.dole.gov.ph/rtw.html>, accessed Mar. 14, 2006).

Better-off women have safer abortions

The correlation between women's ability to pay for an abortion and the relative safety of the procedure is apparent in the different abortion experiences of poor and nonpoor women. Financially better-off women tend to have abortions performed by safer methods, such as D&C or MVA, whereas poor women often use massage, insertion of a catheter or other techniques, including ingestion or insertion of substances purchased on the black market or from street vendors (Figure 4.2, page 20).[8] Larger proportions of nonpoor women than of their poor counterparts are treated by general practice doctors and obstetrician-gynecologists (55% vs. 17%). By contrast, larger proportions of poor women obtain an abortion with the help of a friend, relative or partner, or induce the abortion themselves (44% vs. 30%). Furthermore, larger proportions of nonpoor women than of their poor counterparts seek an abortion in a relatively safe environment—in a clinic, hospital or health center (60% vs. 21%)—while a larger proportion of poor women than of nonpoor women attempt the abortion at their own or a friend's house (55% vs. 30%). Thus, poor women are presumably at a higher risk for experiencing postabortion complications than are their wealthier counterparts.

Mary made six attempts before ending her pregnancy successfully

Mary, a married woman in her early 30s, did not tell the man who made her pregnant about her desire to obtain an abortion and began the process when she was one month pregnant. In her first attempt to induce abortion, she took aspirin (costing 3 pesos*) but remained pregnant. She then tried ingesting local liquor (12 pesos), jumping, taking herbal remedies and getting a massage from a traditional healer (60 pesos). None of these methods worked. Mary could not afford a large sum to end the pregnancy but eventually found a way to pay 3,000 pesos for hospitalization and a surgical abortion. The six attempts at ending her pregnancy took Mary two weeks. She experienced severe bleeding and emotional stress after taking aspirin, but no immediate health problems from the liquor, jumping or herbs. The massage caused her moderate pain, severe bleeding and emotional stress. In the days after her surgery, Mary experienced moderate pain, which she attributed to the sum of her abortion efforts, but she had no long-term health problems. She did not get any advice from the doctor who performed the surgery on how to avoid or delay getting pregnant in the future.

2004 National Survey of Women

*Approximately 51 pesos equal US$1.

Cynthia made five attempts but remained pregnant

Cynthia, a single woman in her early 20s, informed her partner of her desire to end her pregnancy and had his approval. She was one month pregnant when she attempted to stop the pregnancy; however, she failed to induce abortion, despite five attempts. First, she had a massage by a traditional healer (costing 80 pesos*). Her successive attempts included drinking an herbal concoction, taking a medicinal syrup (100 pesos) and consuming another herbal drink (200 pesos). She finally ingested misoprostol (200 pesos) but remained pregnant. Throughout the process of seeking an abortion, she experienced various health complications: The massage caused severe pain and severe emotional stress, the herbal concoction gave her mild pain and severe emotional stress, the medicinal syrup caused moderate pain and severe emotional stress, and the misoprostol caused severe pain and severe emotional stress. However, she reported no long-term health consequences.

2004 National Survey of Women

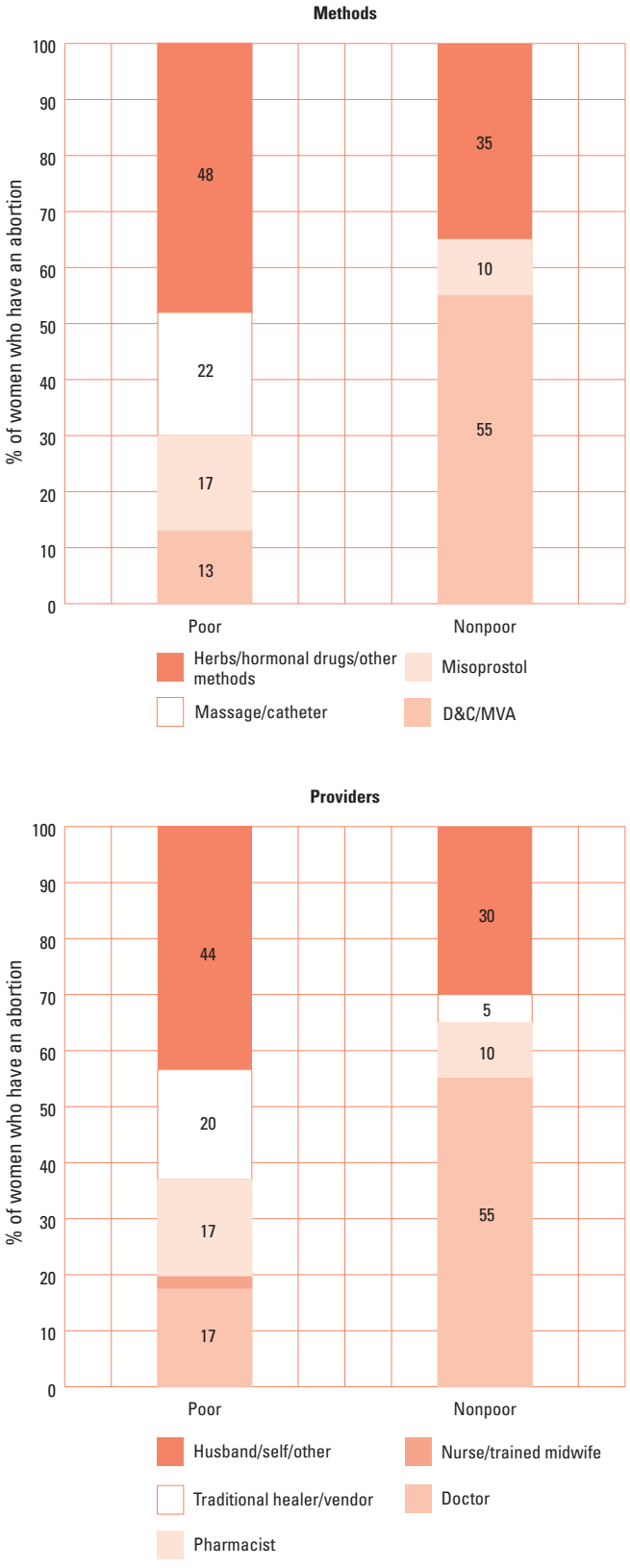
*Approximately 51 pesos equal US$1.

Many women do not succeed in terminating their pregnancy on the first try

Of the women who succeed in ending their pregnancy, many are able to do so only after multiple attempts (see box, page 19). Just one-fifth of women who attempt to have an abortion succeed on the first try. Two-thirds of women who are not able to end their pregnancy on the first attempt simply give up. Another 16% of women who try to have an abortion make two attempts to end their pregnancy, and about half succeed in doing so at this second attempt. About one in 10 make three or more attempts. A small minority of women report making four or more attempts (some make as many as six); of this group, three in 10 succeed, while the others give up and remain pregnant (see box).[9] With each unsafe attempt at ending her pregnancy—successful or not—a woman increases the risk to her life and health.

FIGURE 4.2

Poor women have riskier abortions than their nonpoor counterparts.



Source Reference 8.

Chapter 5

The Consequences Of Unsafe Abortion

Where abortion is legal and performed under hygienic conditions by a trained provider, it is extremely safe.[1] Clandestine abortion, however, often entails serious physical risk for the woman involved. Provider training is lacking, equipment is often unavailable and costs of safe procedures are high in settings where abortion is illegal. As a result, poor women in particular must resort to unsafe procedures, generally performed in unhygienic settings. Under these circumstances, many things can go wrong.

Complications following an unsafe abortion can include retained pregnancy tissue, infection, hemorrhage, septic shock, anemia, abdominal injury (including uterine perforation), cervical or bowel damage, and toxic reactions to chemicals or drugs used to induce the abortion. Over the long term, such complications may lead to chronic problems such as pelvic infection, which increases the risk of ectopic pregnancy and infertility.[2] In the most extreme cases, women can die from complications.

Tens of thousands of women are hospitalized for postabortion care every year

In the Philippines in 2000, almost 79,000 women were treated at health facilities for complications of induced abortion, according to hospital reports collected from all parts of the country (Table 5.1).[3] This means that in a typical year, 4.5 per 1,000 women of reproductive age—close to one in every 200 women aged 15–44—are hospitalized for abortion-related complications. The rate is down slightly from 5.0 per 1,000 in 1994. This decrease is most likely due to an increase in the use of safer abortion methods, rather than to a decline in the incidence of abortion.

Between 1994 and 2000, the rate of hospitalization for treatment after an abortion decreased in Mindanao and

TABLE 5.1

Hospitalization for unsafe abortion, by region

Region	No. hospitalized	Rate*	
	2000	1994	2000
TOTAL	**78,901**	**5.0**	**4.5**
METRO MANILA	**23,309**	**8.3**	**8.6**
REST OF LUZON	**34,018**	**5.9**	**4.5**
Bicol	3,957	4.0	4.2
Cagayan Valley	3,546	6.1	5.7
CAR	1,780	6.7	5.7
Central Luzon	8,667	7.8	4.5
Ilocos Region	6,063	5.3	6.4
Southern Tagalog	10,004	5.4	3.6
VISAYAS	**9,337**	**2.2**	**2.8**
Central Visayas	5,135	1.1	4.0
Eastern Visayas	1,984	3.3	2.8
Western Visayas	2,218	2.5	1.6
MINDANAO	**12,238**	**3.6**	**2.9**
ARMM	716	0.9	0.9
CARAGA	929	1.6	2.1
Central Mindanao	2,567	5.8	4.3
Northern Mindanao	2,558	2.2	4.1
Southern Mindanao	3,942	4.5	3.3
Western Mindanao	1,526	4.7	2.2

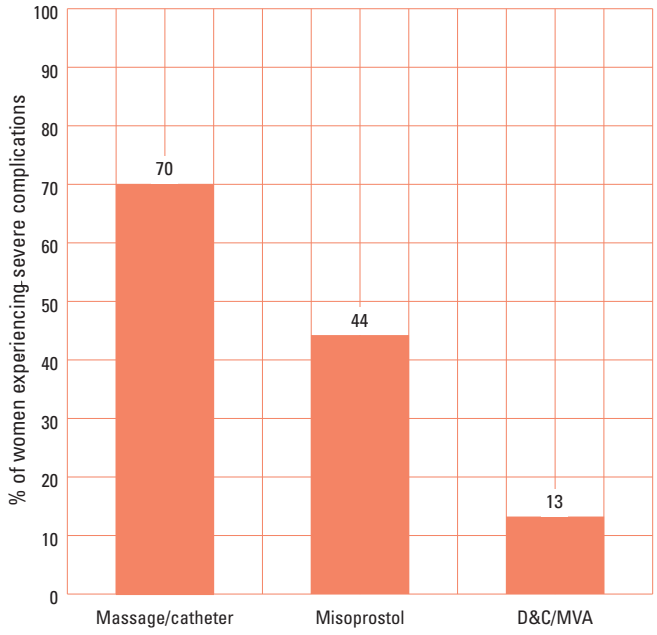
*Number of women hospitalized for complications of induced abortion per 1,000 women aged 15–44 (see Appendix).

Notes CAR=Cordillera Administrative Region. ARMM=Autonomous Region of Muslim Mindanao. CARAGA=Cagayan Autonomous Region and Growth Area.

Sources **Major regions:** Reference 3. **Specific regions:** Special tabulations of hospital record data from 1993–1995 and 1999–2001.

FIGURE 5.1

The risk of severe complications varies greatly with the method used.



Source Reference 6.

Rest of Luzon, but increased slightly in Metro Manila and Visayas.[4] Across regions, the largest increases in the rate occurred in Central Visayas (from 1.1 per 1,000 to 4.0 women aged 15–44) and in Northern Mindanao (from 2.2 to 4.1). Some of this increase may be the result of improved reporting on postabortion hospital care.

Women experience a range of complications

Women's own reports provide a deeper understanding of the consequences of clandestine abortion.[5] More than eight in 10 women who succeed in ending their pregnancy report a health complication due to their final abortion attempt*: Forty-six percent of women who succeed in having an abortion experience a severe complication (defined as severe bleeding, severe pain, moderate or severe fever, or any injury); 35% experience a lesser complication, including mild to moderate bleeding or pain, or mild fever. Morbidity due to unsafe abortion is not limited to those who succeed in having an abortion: Some four in 10 women whose abortion attempt fails also experience complications.

The prevalence of health complications varies by the method used to induce an abortion (Figure 5.1).[6] Severe complications occur in an estimated 70% of women who use massage or insertion of a catheter, and in 44% of those who take misoprostol. Only 13% of women experience severe complications from D&C or MVA.

Larger proportions of women who are poor or who live in rural areas than of other women resort to a high-risk method, an unqualified provider or both, and these groups are therefore more likely to develop complications. Four in 10 poor women who complete their abortion experience severe complications—twice the proportion among nonpoor women (Figure 5.2).[7] Some 92% of rural women experience health complications, and 38% have severe ones; in contrast, 69% of urban women experience health complications, and 33% have severe ones.

Physical complications are not the only negative consequences of an unsafe abortion. Women recovering from health complications may be unable to attend work or school, or to care for their children. Furthermore, many Filipino women report emotional stress following abortions, which is understandable, given the difficulty of making the decision and the clandestine and unsafe conditions under which they obtain the procedure. Some four in 10 women who report having had an abortion say they experienced emotional stress at the time.[8] Studies in other countries have found that women suffer from the social stigma of having obtained an abortion, as it is often difficult to keep the procedure a secret.[9] In the Philippines, given the strong influence of the Catholic Church, women are not simply the objects of social stigma—some also internalize it, becoming guilt-ridden and fixated on making penance for their "sin."[10]

Not all women who need postabortion care receive it

Women who develop health problems after an unsafe abortion may be reluctant to seek help. Sixty-five percent seek treatment at hospitals, private doctors' offices or clinics, or through other, informal providers. The remainder do without care and may well experience long-term consequences. Some women—an estimated 800 annually—die without receiving treatment or, in some cases, despite the efforts of medical providers to save their lives.[11]

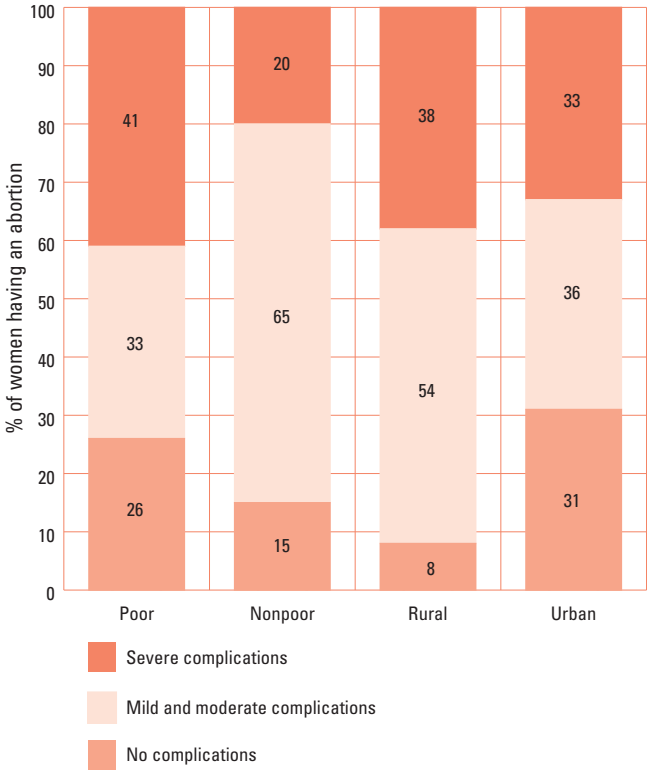
Cost is one significant barrier to treatment: According to informal conversations with hospital managers, women who seek postabortion care in government hospitals usually pay 1,000–4,000 pesos (US$20–80), while those who go to private hospitals pay 3,000–15,000 pesos (US$60–300).[12] In addition, seeking treatment is not always easy in an environment where abortion is not only legally banned, but also condemned by the Catholic Church.† In focus group discussions, some women report

*Unless otherwise indicated, data in this section are based on the 2% of women who reported that they had had an abortion in the face-to-face interview portion of the 2004 survey. Women were asked about four types of complications—bleeding, pain, fever and injury—for each action they took in attempting an abortion. On the basis of women's reports, researchers rated the severity of each complication as mild, moderate or severe.

†Islam, the second most common religion in the Philippines, takes a much more liberal view of abortion. The Qur'an allows abortion during the first four months of gestation and in instances in which the fetus is not viable or the pregnancy endangers the life of the mother or is the result of rape (source: Allian FPT, Sexual and reproductive health and rights: an Islamic perspective, *Rights Now*, 2003, 3(1&2):28–31).

FIGURE 5.2

Severe complications are more common among poor and rural women than among other women.



Source Reference 7.

avoiding postabortion care out of fear of being turned in to authorities or being treated disrespectfully by providers. Women who have sought and received services report that disapproving doctors and nurses have scolded them, handled them "roughly" and withheld pain relievers and anesthesia. Of women who have succeeded in obtaining care at hospitals, most have not received any counseling to address their concerns, their contraceptive needs or their informational needs regarding the risks of abortion and how to prevent unintended pregnancy.[13]

Doctors themselves confirm women's reports of bias against patients who have undergone abortion. Six in 10 of a small sample of providers interviewed in 1999 reported that although they believe women who have had abortions should receive medical attention, the women "are criminals and should be punished."[14] In a 1999–2000 study, Filipino health care providers reported having had difficulty providing proper treatment to women who concealed the fact that their medical emergency was the result of an illegal abortion. The same group of health professionals described their disapproval of induced abortion and their dismay at having to use scarce medical resources on women who have committed what many see as an immoral act.[15] Some hospitals go so far as to deny treatment to women with postabortion complications.[16]

Provider bias against abortion can also affect the kinds of treatment available to women who go to a hospital for care. A 1999 program to improve the quality of postabortion care in the Philippines found some facilities resistant to the safe and cost-effective MVA procedure on the grounds that related training and equipment could be used for clandestine abortion.[17]

Postabortion care is a substantial burden on the health care system

As one of the 10 most common causes of hospital admissions at many hospitals in the Philippines,[18] complications of abortion are not only a major concern for women seeking treatment, but also a major drain on health resources. Nearly two-thirds of postabortion care patients are treated in public hospitals, where poor women—the group with the highest risk of complications—are likely to obtain care. Although the total cost to the government of postabortion care is not available, a well-designed pilot intervention (see box) carried out in 2001 found that the per-patient cost of MVA was 735 pesos (US$14), while the cost of a D&C was 1,900 pesos (US$37).[19] Medical staff and other patients in both public and private hospitals also pay a price when time, skill, beds and supplies are required by patients with postabortion complications.

The Prevention and Management of Abortion and Its Complications Program

The Prevention and Management of Abortion and Its Complications (PMAC) program was established in 2000 by EngenderHealth, an international nongovernmental organization, and the Philippines Department of Health (DOH). PMAC aims to strengthen the capability of the country's health care system in the prevention and management of abortion and its complications, and to improve the accessibility of quality postabortion care services to all women of reproductive age in the country. PMAC initially covered eight project sites (four in Metro Manila and four in other regions) and had three components: preventing and treating abortion and its complications (which includes the introduction of MVA), counseling and linking PMAC services with other reproductive health services. In 2001, the program expanded to two additional sites (outside Metro Manila) and introduced a fourth component, focused on establishing a community-based support system for patients who have undergone abortion and their families. By 2003, using funds provided by the U.S. Agency for International Development, DOH and local governments, the program had been extended to 10 DOH-operated hospitals in Rest of Luzon, Visayas and Mindanao; the University of the Philippines–Philippine General Hospital; and six government provincial hospitals. In 2005, with United Nations Population Fund support, PMAC further expanded to 10 provincial hospitals and one city hospital, which were distributed across seven regions.[1]

Chapter 6

Need for Better Contraceptive Information And Access

In the majority of cases, women seek abortions because they are not able to care for a child, or for an additional child. High levels of unintended pregnancy are therefore at the very heart of why large numbers of Filipino women seek induced abortions each year. Major contributors to unintended pregnancy, in turn, include a lack of full and accurate information on family planning methods, and barriers to obtaining contraception, especially modern methods, which are highly effective for preventing pregnancy.

Filipino women spend many years at risk of an unintended pregnancy

On average, women in the Philippines become sexually active at 21 years of age—around the time that they marry.[1] However, some women are sexually active for one or more years before getting married. During this time, unless they use an effective contraceptive method, they are at high risk for unintended pregnancy, because most unmarried women do not want a child and there is strong social stigma against unwed mothers.

Perhaps even more importantly, although nearly all Filipino women want children, they spend many of their childbearing years trying to avoid pregnancy. The average Filipino woman wants 2.5 children. Therefore, of the 25 years between the ages of 20 and 45, she spends about 2.5 years trying to get pregnant, 1.9 years being pregnant and 1.2 years not at risk of becoming pregnant because she is breast-feeding exclusively or not having intercourse after delivery (Figure 6.1).*[2] That leaves 19.4 years during which she wants to postpone or completely avoid a birth. In other words, women must use effective contraception for the great majority of their childbearing years to avoid unwanted pregnancies. Some women's circumstances reduce their need for contraceptive protection; for example, some couples live apart for employment reasons, or the frequency of sexual intercourse may be low for other reasons, thus reducing the risk of pregnancy. Nevertheless, the average woman will need to use effective contraception for many years of her reproductive life if she is to prevent unintended pregnancy.

The poorest women, who want an average of 3.8 children, need to avoid pregnancy for slightly more than 16 years, while the wealthiest women must spend more than 21 years avoiding pregnancy in order to have only 1.7 children.†

Urban and college-educated women prefer to have an average of 2.2 children, and therefore spend a full 20 years trying to avoid pregnancy. By contrast, rural women and women who have had no education want more children (3.0 and 4.1, respectively). These women spend 16–18 years seeking to avoid pregnancy. These differences may partly explain why the level of abortion is higher among urban women and those with more schooling.

Young adults are at particularly high risk

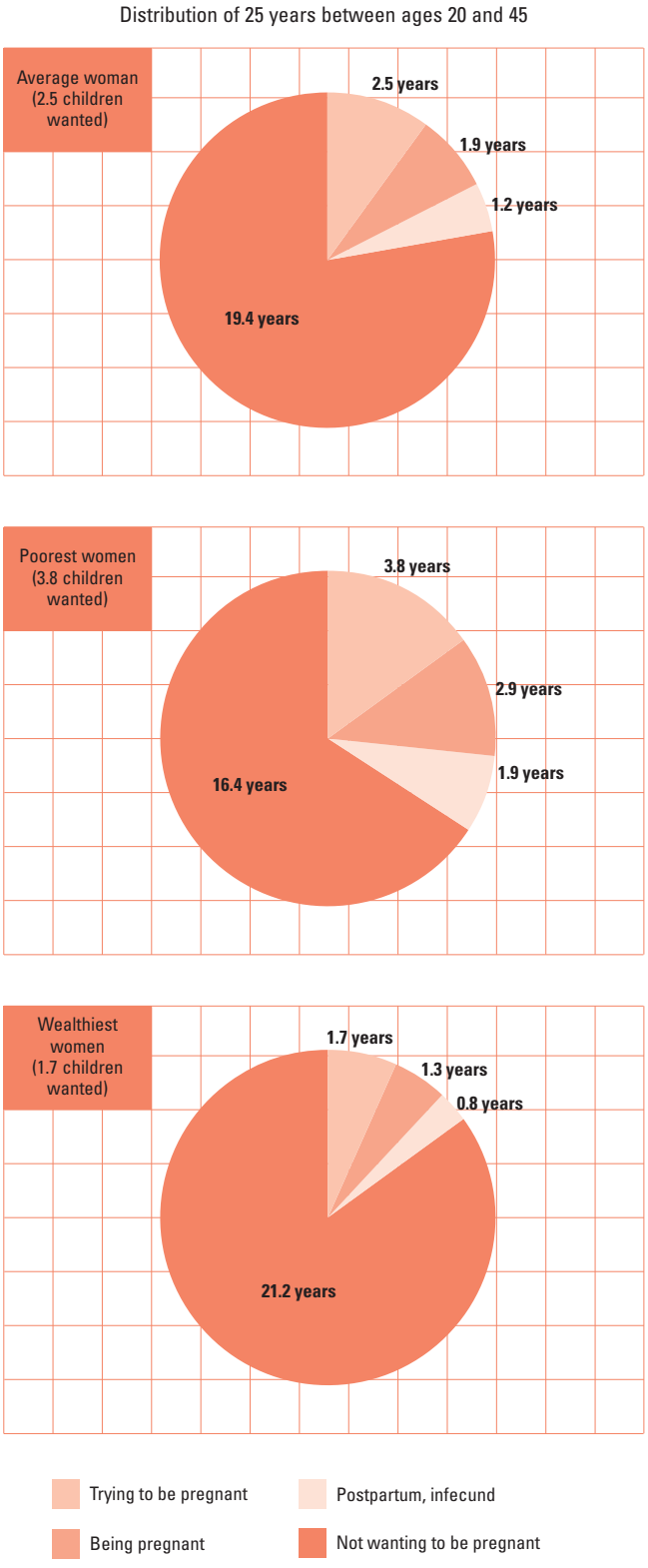
The 2004 National Survey of Women found that 46% of abortion attempts occur among young women: some 30% among women aged 20–24, and 16% among teenagers.[3]

*These are hypothetical estimates, based on the assumption that it takes a woman one year to become pregnant (source: Bongaarts J and Potter RG, *Fertility, Biology and Behavior*, New York: Academic Press, 1983), that each pregnancy lasts nine months and that, with the typical length of breast-feeding and postpartum abstinence, a woman is unable to conceive for six months following each birth.

†Women were categorized into quintiles on the basis of their ranking on the wealth index of the 2003 Demographic and Health Survey. The lowest and highest groups are compared here.

FIGURE 6.1

Women spend most of their reproductive lives avoiding pregnancy.



Note Poorest women and wealthiest women include those who are calculated to be in the lowest and highest wealth quintiles, respectively, according to the 2003 Demographic and Health Survey.

Source Reference 2.

Changing norms of sexual behavior—due, among other things, to growing access to global media and a job market focused increasingly on overseas employment—put adolescents and young adults at particular risk for unintended pregnancy and unsafe abortion. According to a study of sexual behaviors among youth, 16% of unmarried Filipino women aged 15–24 reported ever having had sex in 2002, up from 10% in 1994.[4] While the reported increase is only moderate, the study notes that many young people may be reluctant to admit they are having intercourse, so the actual level of sexual activity in both years is likely to be higher.

Sexually active young people may fail to seek out needed sexual and reproductive health counseling and services. Alternately, they may be denied such services, as providers tend to offer this care only to married people. Either way, women younger than 24 are underrepresented at family planning clinics, relative to their proportion of the population of sexually active women.[5]

Of the young unmarried women who reported having been sexually active in 2002, only 15% used a contraceptive the first time they had sex.[6] Although use increased somewhat over time—more than one-fifth of these women had practiced family planning the most recent time they had sex—it was still very low in a context where premarital pregnancy is so highly stigmatized. This low level of contraceptive use is not surprising, however, given persistent misconceptions about contraception among adolescents and young adults. According to in-depth interviews and focus group discussions held in 2003, men and women aged 15–34 use ineffective contraceptive methods (i.e., douching with vinegar before sex or jumping after sex) and hold a range of mistaken beliefs about modern methods, including beliefs that IUDs can be lost inside a woman's body, that condoms are appropriate only for casual sex and that vasectomy entails removing a man's penis.[7] Some of these misconceptions are echoed in women's fears about contraceptive side effects and in their incorrect understanding of pregnancy risks and fecundity.

The lack of information about sexual and reproductive health is not limited to contraceptive methods; the 2002 Young Adult Fertility and Sexuality Study found that although nearly all 15–24-year-olds have heard of HIV/AIDS, three in 10 believe that there is a cure, and nearly three-quarters believe that they have no chance of being infected.[8] Because sex education in Philippine secondary schools typically covers little more than anatomy,[9] many Filipino teenagers rely on their family members, peers and the media for information on contraceptives. Adults, both single and married, also tend to get family planning information from informal sources—neighbors, friends, relatives and the media—as well as from medically trained health care workers.[10]

Unmet need for effective contraception

Women who are married or in a consensual union are considered to be in need of effective contraception if they meet three criteria:

- They are fecund (i.e., they report that they are not menopausal, and neither they nor their spouse is infertile).
- They want to have no more children or want to postpone childbearing by at least two years.
- They are not using a modern method (the pill, IUD, implant, injectable, the condom, other barrier methods, and male and female sterilization). Women who are not using any method or who are using traditional methods (withdrawal, periodic abstinence or folk methods) are considered to be in need of effective contraception.

This definition differs from the standard definition used by the Demographic and Health Survey (DHS) in three important ways:

- Women who have recently given birth are classified as all other married women are, on the basis of the same criteria above. In contrast, the DHS measure classifies amenorrheic women according to the wantedness of their recent birth, rather than according to their preferences for future childbearing.
- Fecundity is measured on the basis of respondents' own reports. In contrast, for the DHS definition, the principal criteria used to classify a woman as infecund are that she is married, did not use contraceptives and did not give birth in the past five years. A limitation of these criteria is that this group of women may have had one or more abortions during the past five years to prevent giving birth.
- The DHS definition classifies traditional method users as having met their need for contraception.

Close to half of all Filipino women of reproductive age have an unmet need for effective family planning

Many Filipino women who do not want to become pregnant do not use a modern contraceptive method and have an unmet need for effective contraception (see box). More than four in 10 married women (45%) had an unmet need for effective contraception in 2003.[11] That is, they did not want a child in the next two years or did not want any more children and were able to become pregnant, but either were using no contraceptive method at all or were using traditional methods.* Such women are at high risk for unintended pregnancy and abortion. In addition, women who are using modern reversible methods are at some, though much lower, risk of experiencing contraceptive failure and unintended pregnancy.

Some progress has occurred since the 1990s: The proportion of married women who have an unmet need for effective contraception has decreased slowly but steadily from 54% in 1993 to 45% in 2003, as use of modern methods has increased from 25% in 1993 to 33% in 2003.[12] Nevertheless, the level of need for improved contraception remains very high among married women in the Philippines, despite nearly universal awareness of contraceptive methods among both sexes.[13]

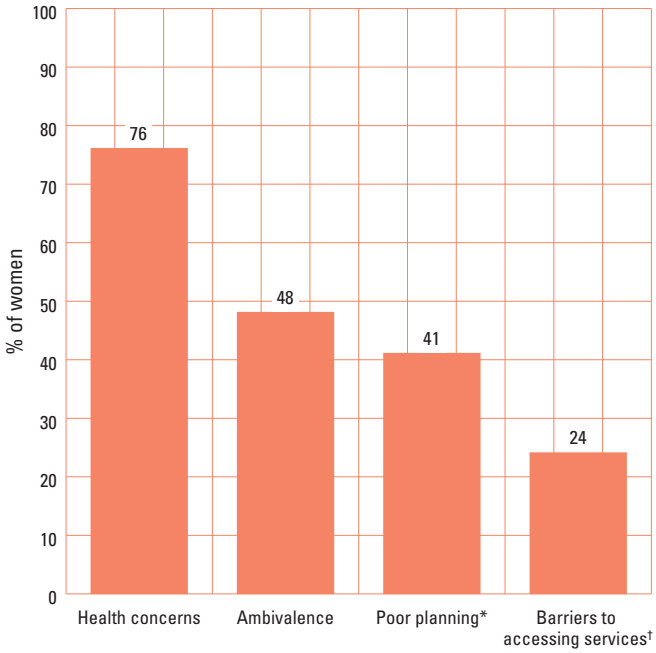
Among married women who do not want a child in the next two years but are not practicing family planning, about three-fourths have health concerns or fear that contraceptives will have side effects (Figure 6.2).[14] Almost half of women mention a number of reasons that reflect ambivalence about pregnancy or poor planning about when to use contraceptives. About one in four mention difficulties in accessing contraceptive services. Such responses highlight the need for better education and counseling on contraceptives, including their effects on a woman's body and where to obtain them, as well as basic education on pregnancy and reproductive health for both men and women.

Nearly half (46%) of women seeking abortions were practicing some form of family planning when they became pregnant.[15] Of these women, one-quarter were using a modern method; the rest were using a traditional method. Although neither contraceptives nor the people using them are perfect, failure rates for modern methods are very low.

*Traditional methods are withdrawal and all types of periodic abstinence, including natural family planning methods, such as the symptothermal method.

FIGURE 6.2

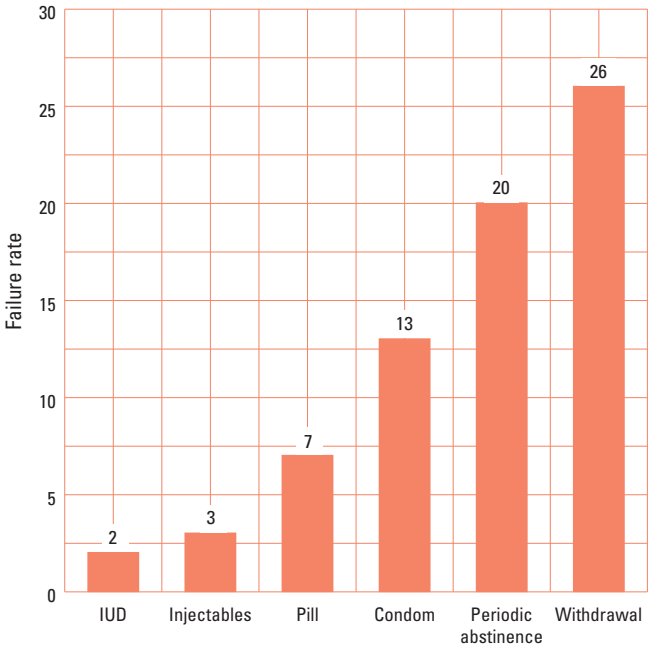
Married women who do not want a child soon give a variety of reasons for not using contraceptives.



*Reasons include "you don't think you will get pregnant now," "you don't expect to have sex" and "you don't think about it."
†Reasons include "you don't know where to get family planning services," "family planning services are too far away" and "you cannot afford the price."
Source Reference 14.

FIGURE 6.3

Women using modern methods experience lower failure rates than those using traditional methods.



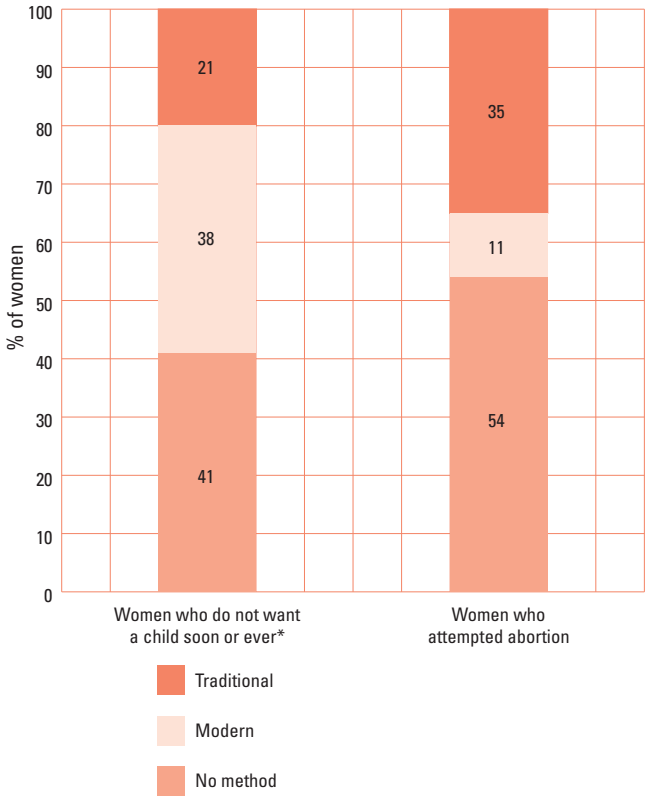
Note Failure rate is the number of women becoming pregnant per 100 women using the method for one year. Failure rates for all methods are underestimated because calculations do not include contraceptive failure that resulted in abortion.
Source Reference 16.

In typical, real-world use, no more than seven in 100 women in the Philippines become pregnant in their first year of using the pill, the IUD or injectables (Figure 6.3).[16] Traditional methods, by contrast, have much higher failure rates; for example, 20–26 in 100 women relying on any type of periodic abstinence or withdrawal get pregnant in a year.

Compared with women using modern methods of contraception, women using traditional methods account for a disproportionately large share of women seeking an abortion (Figure 6.4).[17] In 2003–2004, 35% of all women who reported seeking an abortion had been using traditional methods at the time they conceived, compared with 21% of all married women who did not want another child soon or ever. In contrast, only 11% of women seeking an abortion had been using modern methods when they became pregnant, compared with 38% of married women who did not want another child soon or ever.

FIGURE 6.4

Traditional method users make up a disproportionate share of women attempting abortions after contraceptive failure.



*Includes women aged 15–49 who are married or in a union.
Source Reference 17.

Chapter 7

Addressing Abortion as A Public Health Concern And Social Problem

In 2000, more than 473,000 Filipino women underwent induced abortions, one in every seven pregnancies was terminated and 27 in every 1,000 women aged 15–44 had an abortion.[1] These figures expose the reality that a substantial proportion of women in the Philippines rely on abortion to control their fertility—despite laws that prohibit it, social mores that stigmatize it and health risks that make abortion complications a significant cause of morbidity and mortality for women. Women often have to go to great lengths to end their pregnancies, many suffer extensive physical harm and some die. The Philippine government and society have not effectively addressed these problems.

The abortion rate in 2000 was no less than that in 1994,[2] indicating that the factors motivating Filipino women and couples to choose abortion—including a lack of access to and knowledge of modern contraceptives—remain highly pertinent. Indeed, abortion is common in the Philippines because unintended pregnancy is common. Each year, more than 1.4 million Filipino women conceive when they do not want to.[3] One-third of them end their unintended pregnancy by abortion. Consistent and correct use of a modern contraceptive method could help many of these women prevent an unintended pregnancy and avoid having to make the difficult decision of whether or not to terminate a pregnancy.

A host of barriers keep women from preventing unintended pregnancy and induced abortion

Despite national policy that mandates the provision of both traditional and modern contraceptive methods,[4] several factors can make it difficult for women to obtain modern methods. The U.S. Agency for International Development is phasing out donations of modern contraceptives for distribution through the Philippine government and will completely end donations by 2008.[5] In addition, Philippine President Gloria Macapagal-Arroyo has vowed that her administration will support only natural family planning methods, and opposes the proposed Responsible Parenting and Population Management Act of 2005, which would encourage smaller families and ensure "access to a full range of legal, medically safe and effective family planning methods."[6]

Local and national policies also stand in the way of women and providers who wish to exercise reproductive rights. Local administrative orders—such as Mayor Lito Atienza's order to ban modern contraceptives in Manila—can pose a serious threat to family planning services, making it difficult for women to practice contraception if they cannot afford to travel to another city to obtain needed supplies and services.[7] Such an order within the capital city affects the whole country, sending the message to other local government units that they may likewise violate human rights conventions and family planning policies with impunity. Nationally, the emergency contraceptive Postinor (levonorgestrel), which could help some women avoid abortion, was banned in 2001, and neither this nor any other emergency contraceptive has been registered since.* [8]

In this environment, it is unsurprising that many men and women are misinformed about contraceptives, lack general reproductive knowledge, experience social pressure against using contraceptives and have difficulty obtaining their method of choice. Many women have not

*Emergency contraception is a concentrated dose of the same hormones found in ordinary birth control pills. It can prevent pregnancy if taken within the first few days following unprotected sexual intercourse. If a woman is already pregnant, emergency contraception will not induce an abortion.

even considered using a modern contraceptive to prevent unintended pregnancies; others decide not to adopt a method because they worry about side effects, their partner objects or they do not believe they will conceive. Without effective contraceptive use, it is inevitable that some women will become pregnant when they do not want to, and that some of these women will decide to seek abortions.

Abortion is a reality for women from all walks of life

Abortions are sought by women rich and poor, old and young, educated and uneducated, rural and urban, and from all parts of the country. Abortion is most common in urban areas, such as Metro Manila, probably because women in such areas are the most highly motivated to have small families and thus to avoid unintended births.[9] Women choose abortions for many reasons, but primarily because they believe they would not be able to provide for a child at this point in their lives as a result of their family's financial situation; existing obligations to work, school or other children; or relationship problems.

Women who decide to terminate their pregnancies often have a difficult time obtaining abortions. Many need to make multiple attempts before successfully ending a pregnancy, and many more give up before succeeding. Some women end their pregnancies themselves, while others seek help from friends, spouses, traditional healers and pharmacists, as well as qualified doctors, midwives and nurses. Although some abortions are safe, many more are performed by unskilled providers or under unhygienic conditions, resulting in serious medical problems. Complications are common among women who use unsafe methods and untrained providers, whether or not they actually end the pregnancy.

The time spent in seeking an abortion and in recovering from injuries and ill-health keeps women from fulfilling other responsibilities, such as making a living, attending school and caring for their families. The cost of this lost time, added to the health care costs of treating complications, means that unsafe abortion takes a great toll on society as a whole, as well as on individual women and their families. Furthermore, access to abortion, the type of procedure obtained and the quality of postabortion care often correspond with how much a woman is able to pay. Thus, poor women and their families, who cannot afford safer options, bear much of the burden of unsafe abortion.

Although abortion is legally permitted in the Philippines only to save a woman's life, it is probably not accessible even for this reason. The law prohibits importing anything intended to be used for inducing abortion—including "any printed matter which advertises or describes or gives directly or indirectly information where, how or by whom unlawful abortion is produced."[10] Furthermore, abortion techniques and the social and personal implications of abortion often are not addressed in medical training.[11]

Such circumstances make it hard for providers to perform these procedures even to save a woman's life and to counsel women on the appropriate actions when a pregnancy could be life-threatening; in addition, they make it difficult for women to locate a provider even when they meet the criteria for legal abortion.[12]

When health care providers are unclear about abortion laws and unwilling or unable to provide legal abortions, it is no surprise that they are sometimes also unqualified and unwilling to provide care to women who are suffering the effects of unsafe abortion. Women whose health and lives may depend on competent, caring treatment are often viewed as criminals by health care providers. Their chances of obtaining the care they need hinge on their personal resources and the policies, staff and equipment of their local hospital.

Recommendations

Evidence from countries around the world suggests that the main effect of outlawing and criminalizing abortion is not to make abortions less common, but to make them more dangerous. Abortion is at least twice as common in the Philippines as it is in western European countries where the procedure is legal and accessible.[13] In countries that have liberalized their abortion laws, overall levels of maternal death and illness have fallen dramatically.[14] In the Philippines, women's willingness to seek abortions from untrained providers and in unhygienic places, using techniques such as painful massages and ingestion of bitter herbs, and to try again and again when a method fails, makes it clear that legal barriers are not preventing abortions from taking place.

What will reduce abortion is helping women and couples get better information about sexuality, reproductive health and contraception, and better access to modern contraceptives, so they can prevent unintended pregnancies.

For national, regional and local policymakers, and government agencies at all levels, this means taking the following steps:

- Ensure adequate funding for the full range of family planning methods at all government-run clinics and hospitals at the national, regional and local levels.
- Allocate an appropriate share of funds earmarked for nongovernmental reproductive health organizations to those organizations that support and provide modern contraceptive methods.
- Improve the availability of affordable, high-quality family planning services to those who need them most, particularly poor women and rural women.
- Ensure that medical education for primary care providers, obstetrician-gynecologists, nurses and midwives includes training in modern, client-centered family planning counseling and services.

- Register and encourage the use of emergency contraceptive pills, which enable women to prevent unwanted pregnancy up to three days after having unprotected sex.
- Increase the provision of accurate and comprehensive information on contraception, including through public campaigns and sex education in schools.

For program managers, providers, advocates, media and other stakeholders, implementing these recommendations means taking the following steps:

- Provide complete, medically accurate, client-centered information on contraceptive methods, failure rates and side effects.
- Improve the competence and attitudes of public- and private-sector family planning providers.
- Offer counseling and services to young women and men, who are increasingly sexually active and need to know how to protect themselves.
- Educate men on the risks of unsafe abortion and the benefits of contraception.
- Encourage partner communication about sexuality, reproductive health and family planning.
- Work with Catholic Church leaders to find a common ground in preserving the life and promoting the health of Filipino women.
- Help develop a strong social movement in support of family planning and other reproductive health services by collaborating with a broad cross section of organizations that focus on women's rights, health, medicine and economic development.

Even with improved contraceptive access and use, some women will need to resort to abortion. Providing them with safe abortion services would largely prevent negative abortion-related health outcomes, and would be the most effective way to avert the heavy toll inflicted by unsafe abortion. For women who have undergone clandestine, unsafe abortions, health care providers should be better prepared to treat complications to reduce the high rates of abortion-related ill-health that Filipino women experience.

For national, regional and local policymakers, and government agencies at all levels, this means taking the following steps:

- Monitor the impact of unsafe abortion by improving the collection and analysis of data on women who experience postabortion complications and those who are hospitalized.
- Clarify the legal and medical grounds on which abortion may be allowed.
- Ensure that public facilities and health care professionals provide timely, humane treatment to women who seek abortions within permitted legal and medical criteria, and to all women who seek postabortion care.
- Ensure that medical education for all physicians includes training in abortion provision, emergency obstetric care, postabortion care (including surgical and medical procedures), postabortion contraceptive services and patients' rights.
- Encourage the use of manual vacuum aspiration for treatment of postabortion complications, as provided for under the existing Prevention and Management of Abortion and Its Complications program.

For providers, program managers, advocates, media and other stakeholders, this means taking the following steps:

- Educate the public about the causes and consequences of unintended pregnancy and unsafe abortion.
- Help women to understand the risks of unsafe abortions and to avoid these procedures.
- Advocate for safe abortion service provision.
- Educate doctors and nurses about their medical and ethical obligation to provide compassionate care to women with postabortion complications.
- Train hospital staff to provide better postabortion contraceptive counseling.
- Educate men about their role in and what they can do to prevent unintended pregnancy and unsafe abortion.

It is time to view abortion in terms of public health and women's well-being and dignity. During a decade of denial and condemnation, abortion rates in the Philippines have not declined. Rather, they have remained at a moderately high level by comparison with worldwide standards, and because these abortions have been illegal and unsafe, hundreds of thousands of women have suffered ill-health, economic loss and social stigma. To succeed in reducing this serious threat to women, families and society, all stakeholders in the Philippines—including policymakers, health care providers and advocates—must acknowledge the problem, confront its causes and address more compassionately and effectively its consequences.

Appendix

Estimates of Abortion: Data and Methods

Data availability and collection

In the Philippines, all hospitals, private and public, must submit an annual report to their regional department of health (DOH) detailing their facility's services for the year, including the top 10 causes of admissions. Regional offices are asked to submit these reports to the national DOH in Manila, although some do not. In the recent study, with data collection taking place in 2003–2004, researchers had to obtain a higher proportion of hospital records directly from regional DOH offices than they had in 1994.[1]

The format of the report is not standardized across hospitals, and the time period covered by the reports varies. However, comparable information needed for this study could be extracted.

Data collection involved three steps. First, we compiled a list of all hospitals, public and private, in the country. We used the national DOH's list of hospitals for 2002, lists generated by other institutions and the list compiled for the 1994 study to compare hospital names and locations, and to verify their status (existing, closed, new). A total of 2,039 hospitals were identified from all sources.

Next, with authorization from the national secretary of health, photocopies of all available hospital reports from the national DOH office in Manila were obtained. Reports not clear enough to photocopy were copied by hand. To obtain as complete a set of reports as possible, researchers visited all 16 regional offices.

Finally, a data file containing the basic descriptive characteristics of all hospitals was created from the master list generated for this study, supplemented with information from the hospital reports. This file included the name and location of each hospital, its level of care (primary, secondary or tertiary), its type (regional, district, provincial, city, municipal, community, general, medical center, university, research, specialized obstetric or other specialized) and its size (in number of beds). We extracted selected key data from each hospital's reporting form, including the number of women treated for abortion complications in hospitals in which abortion was among the top 10 causes of admission; the number of patients treated for the 10th cause in hospitals in which abortion was not among the top 10 causes for admission; the number of deliveries; the number of obstetric and gynecologic patients admitted; and the number of months covered by the report. These data were extracted for each year from 1996 through 2001.

Methodology

The indirect technique used for estimating the number of induced abortions in the country was the same as that used for the 1994 study.[2]

Calculating the total number of women hospitalized for the treatment of abortion complications

We estimated the number of women hospitalized for treatment of complications from any type of abortion (spontaneous or induced) in three ways. For hospitals in which abortion was one of the 10 leading causes of admission, the number of women hospitalized for abortion complications was estimated directly from the hospital's information. For hospitals that had a report but in which abortion did not rank among the top 10 causes, the number of patients admitted for abortion complications was estimated by assuming that this number was half that for the 10th-ranking cause of admission.* For all other hospitals (those for which reports were available but lacked information on the top 10 causes of discharge and those with missing reports), the estimate was derived by regression analysis, predicting the value from hospitals with information, on the basis of hospital characteristics.

Of the 2,039 hospitals identified, usable reports were obtained for 1,658. Although we obtained information for six years, this study uses data for the three most recent years, 1999–2001, because data for these years are the most complete and most current. All estimates presented here are based on averaged data for these three years.

Two basic adjustments were made to the data. If reports were available for the three-year period studied, the average annual number of women hospitalized for abortion complications was used. If a report covered only part of a year, the annual number of patients was estimated to be proportional to the number of months covered by the report, and the yearly values were averaged. For the 478 reporting hospitals in which abortion complications ranked among the top

*The following factors underlie this assumption: Health professionals report that abortion complications are widespread and treated in almost all hospitals; in hospital reports, abortion complications may be documented under several diagnostic codes, and often no single code ranks within the top 10 causes of admission, although the total number of women treated for abortion complications is likely substantial; and assuming half of the number of cases in the lowest of the top 10 causes reflects that the number of abortion cases will range from zero to just below the number in the 10th ranking cause.

10 causes of admission, a direct count of women hospitalized for this reason was available, and no further adjustment was made: The annual number of women treated for abortion complications in these hospitals was 71,837.[3]

For each of the remaining 1,180 reporting hospitals, a conservative assumption was made that the number of women admitted for abortion complications was half the number of patients admitted for the 10th leading cause of admission. Admissions for abortion complications in these hospitals totaled 26,845.[4]

Finally, indirect estimates were made for the 381 hospitals whose basic characteristics were known, but for which there were no data on cause of discharge or no report was available. The likely number of abortion complications treated annually in these hospitals was estimated using regression analysis. The analysis considered the number of abortion patients as a dependent variable, calculated on the basis of the hospital characteristics deemed to be important determinants of intake of abortion-related cases.* One interaction—that between ownership and number of beds—was significant and was included in the final regression equation. The equation was based on information from the hospitals with reports. The number of cases estimated for the 381 hospitals without reports was 6,311.[5] Thus, an estimated 104,993 women were hospitalized for abortion complications annually during the period of 1999–2001. The central year of the 1999–2001 period covered by the study is 2000, and the estimates therefore represent the situation in that year.[6]

Calculating the number of patients with complications of induced abortion

In settings in which induced abortion is highly legally restricted, hospital records typically do not distinguish between spontaneous and induced abortions because of the possible legal consequences for the hospital, the medical staff and the women themselves. Such is the case with hospital records in the Philippines. An essential step, therefore, was to estimate the number of women treated for complications of spontaneous abortion, to thereby obtain the number treated for complications of induced abortion.

An indirect method of estimating the number of women hospitalized for spontaneous abortions—based on the known biological pattern of pregnancy loss by age of gestation—was used because it is comparable across regions and populations. Of all pregnancies that are observed at about five weeks' gestation, the proportion that survive to any given gestation and the proportion that end in live births are fairly constant across populations where induced abortion is not a factor.[7] In clinic studies, estimates of pregnancy loss by gestational age are based on all pregnancies recognized at an early point in gestation (e.g., at five weeks). An assumption was made that late spontaneous abortions (those occurring at 13–22 weeks) are likely to be accompanied by complications that require hospital care.† In the absence of induced abortion, these miscarriages account for 2.89% of all recognized pregnancies, and the ratio of late spontaneous pregnancy losses to live births (which represent 84.8% of all observed pregnancies) is 3.41 per 100 (2.89/84.8). This standard ratio may then be applied to the actual number of live births in a region or country to obtain an estimate of the number of women having late miscarriages. Because the number of live births is known, the ratio can be used to estimate the number of late spontaneous abortions in this study.[8]

The number of births for the year 2000, nationally and for the four major regions, was estimated by multiplying the age-specific fertility rates from the Philippines 2003 Demographic and Health Survey by the female population aged 15–44, which was divided into five-year age-groups (from the 2000 census).[9] These age-specific fertility rates refer to the three-year period before the interview and therefore approximate the reference year for the abortion estimates presented here. The ratio of miscarriages per 100 live births (3.41) was then applied to the number of annual births in the Philippines to obtain the number of late spontaneous abortions.

A further adjustment was needed to estimate the number of women hospitalized because of a late spontaneous abortion. Not all women who need hospital care for the treatment of these abortions have access to a hospital or use hospital services; an assumption was made that the proportion of women having a late spontaneous abortion who are likely to be hospitalized is the same as the proportion of women who deliver in a hospital among all who gave birth. Data from the 1998 Demographic and Health Survey show that nationally, 37% of women delivered at a health facility; the proportion varied by region: It was 73% for Metro Manila, 36% for Rest of Luzon, 29% for Visayas and 23% for Mindanao.[10] These data were used to estimate the numbers of women experiencing a late spontaneous abortion who would require and would obtain hospital care, by region.

Nationally, it was estimated that the annual number of women hospitalized because of spontaneous abortion is 26,092,[11] which corresponds to 25% of all women hospitalized each year for all abortions. The remaining women hospitalized for abortion complications, some 78,901,[12] were assumed to have undergone induced abortion.

*The characteristics used were ownership (public vs. private), hospital level (primary, secondary or tertiary), hospital size (number of beds) and region (according to the 16-region classification).
†Although some women who experience spontaneous abortion at gestations of 12 or fewer weeks may seek medical care, many are likely to do so on an outpatient basis, and relatively few will be hospitalized. Pregnancy losses after 22 weeks are not considered because they are usually classified not as abortions, but as fetal deaths.

Estimating the total number of induced abortions

The number of women treated in the hospital for complications of induced abortion is only a fraction of all women undergoing the procedure. Some women who end their pregnancy either do not need or do not receive hospital treatment. Therefore, the proportion of all women obtaining abortions who are likely to be hospitalized for complications was estimated. The inverse of this proportion provides a multiplier, or inflation factor, that, when applied to the number of women hospitalized for induced abortion, yields an estimate of the total number of women having induced abortions.

In general, the safer clandestine abortion services are, the higher the multiplier must be: For every woman hospitalized, many are likely to undergo safe abortions that do not result in complications or hospitalizations. Concomitantly, the riskier the available abortion services are in a given setting, the lower the multiplier will be: A higher proportion of women using such services are likely to have serious complications that require treatment. Safety is not the only consideration. The multiplier is also a function of the general availability of hospital services in a given setting. Where such services are easily accessible, the proportion of women with complications who receive hospital treatment will be higher. In poor regions or underdeveloped rural areas, on the other hand, hospitals are few and far between, and even women with serious complications may not get the treatment they need.

Ideally, a large-scale, community-based survey of women would provide a reasonable estimate of the proportion of women having induced abortions who are hospitalized. Because no such estimate existed, we sought other relevant information. Two sources were used: the multiplier used for the 1994 estimate of abortion, based on the body of evidence available as of 1997;* [13] and, because no large-scale quantitative data are available on this issue for the late 1990s, anecdotal evidence of changes in the provision of abortion services since the mid-1990s. The 1997 study concluded that a range of 4–6 (with a medium multiplier of five) was appropriate for the Philippines in the mid-1990s; in other words, one in five women having an induced abortion were hospitalized for complications.[14]

However, it is important to consider evidence of increasingly safe abortion services in the 1990s in estimating the multiplier for the year 2000. Anecdotal evidence suggests that the number of clinics offering safe surgical procedures has increased.[15] In these clinics, obstetrician-gynecologists train and supervise nurses and midwives in performing abortions.[16] In addition, the 1990s trend of increased use of misoprostol and other drugs to induce abortion is apparently continuing.[17] Misoprostol is highly effective[18] and has been available inexpensively on the Philippine black market for some years now.[19] Preliminary results from a small-scale 2004 qualitative study in Manila and its suburbs show that use of misoprostol was indeed very common: Close to one-third of attempts involved this method.[20]

Despite the cost constraints faced by poor women, the limited information available on recent trends and current conditions of abortion service provision suggests that the safety of abortion has likely improved over the last decade. As a result, the proportion of women obtaining an abortion who need hospitalization has probably declined, thus increasing the multiplier used to estimate the total number of abortions from the number of women hospitalized for complications of such procedures. It was therefore estimated that for 2000, the multiplier likely ranged from five to seven (i.e., between one in five and one in seven women having an induced abortion were hospitalized for complications).

The estimates of hospitalizations for complications of induced abortion for 2000 are based on three multipliers—five, six and seven.[21] To assess trends over the period 1994–2000, estimates for 2000 are based on the recommended medium estimate, calculated using a multiplier of six, and compared with the medium estimate for 1994, which is based on a multiplier of five.

*Two Philippine community surveys provided relevant information. One, conducted in 1978 in Cavite Province, found that 12% of women who reported having had one or more abortions had been hospitalized for complications. The other, conducted in 1994, found that among 170 women in Manila who reported ever having had an abortion, 36% had been hospitalized for complications. A third source of information is a 1996 survey of health professionals suggesting that one in four women who have an induced abortion are expected to be hospitalized as a result of complications (sources: see reference 13).

APPENDIX TABLE 1

Selected indicators describing the context in which women live and unintended pregnancy occurs, by region, and residence, Philippines, 2003

Region and residence	% of women 15–49			% of women 15–49, by religion				Among women 25–29, median age at first:		
	Living in urban areas	With ≥7 years education	With daily exposure to media	Catholic	Protestant/ Other Christian	Muslim	Other/none	Sex	Union	Birth
TOTAL	**58**	**76**	**80**	**82**	**12**	**4**	**2**	**22.1**	**22.2**	**23.4**
METRO MANILA	**100**	**88**	**92**	**89**	**8**	**1**	**2**	**23.0**	**23.3**	**24.8**
REST OF LUZON	**57**	**78**	**86**	**84**	**13**	**1**	**3**	**21.9**	**22.2**	**23.3**
Bicol	32	72	79	94	6	0	0	22.3	22.7	24.0
Cagayan Valley	23	71	74	78	19	0	3	21.2	20.9	22.2
CAR	40	81	75	66	24	0	10	21.2	21.6	22.8
Central Luzon	70	78	89	85	13	0	3	22.5	21.6	22.6
Ilocos Region	50	82	85	80	19	0	1	22.7	22.6	23.8
Southern Tagalog	67	79	81	83	12	1	3	22.3	22.9	23.8
VISAYAS	**42**	**68**	**76**	**90**	**9**	**0**	**1**	**21.2**	**22.2**	**23.1**
Central Visayas	58	69	79	90	9	0	0	21.9	22.8	23.4
Eastern Visayas	22	62	65	90	9	0	1	21.7	21.7	23.1
Western Visayas	35	71	78	90	9	0	1	21.2	21.9	22.8
MINDANAO	**39**	**67**	**68**	**65**	**15**	**10**	**3**	**20.9**	**21.2**	**22.5**
ARMM	31	52	37	16	2	80	3	20.3	20.1	21.5
CARAGA	46	73	77	73	25	0	2	20.7	21.2	22.8
Central Mindanao	38	71	74	63	22	12	3	21.0	21.0	21.8
Northern Mindanao	36	73	76	78	17	4	1	22.5	22.5	23.5
Southern Mindanao	55	72	81	79	15	3	3	21.3	21.7	23.2
Western Mindanao	27	63	63	74	12	8	6	21.3	21.0	22.4
RESIDENCE										
Urban	na	84	87	84	11	3	2	22.9	23.0	24.2
Rural	na	64	70	79	9	6	2	21.1	21.1	22.2

Notes na=not applicable.
CAR=Cordillera Administrative Region.
ARMM=Autonomous Region of Muslim Mindanao.
CARAGA=Cagayan Autonomous Region and Growth Area. Western Mindanao, Southern Mindanao and Central Mindanao refer to newly named regions Zamboanga Peninsula, Davao and SOCCSKSARGEN, respectively. Southern Tagalog comprises newly named regions CALABARZON and MIMAROPA, which were condensed for comparison purposes to match the designations in 1993 and 1998 Demographic and Health Surveys (DHS).

Source Special tabulations of the 2003 DHS.

Fertility and preferences among women 15–49				Childbearing		
% who want child later	% who do not want a child/another child	Wanted fertility rate	Total fertility rate	% of women 15–19 who have a child	% of births preceded by some care	% of births with nurse/doctor attending
42	**44**	**2.5**	**3.5**	**6**	**93**	**60**
44	**41**	**2.0**	**2.8**	**5**	**94**	**88**
40	**43**	**2.6**	**3.5**	**6**	**93**	**67**
45	45	2.6	4.3	6	95	48
36	48	2.6	3.4	11	92	54
46	39	2.7	3.8	7	88	61
34	45	2.4	3.1	3	95	87
46	41	3.0	3.8	7	91	74
42	42	2.5	3.2	5	92	64
43	**48**	**2.7**	**3.8**	**4**	**95**	**52**
41	48	2.6	3.6	6	96	70
47	45	2.9	4.6	4	96	35
41	51	2.7	4.0	3	93	45
44	**44**	**2.8**	**3.9**	**10**	**93**	**36**
56	23	3.7	4.2	11	94	22
45	45	2.8	4.1	9	96	41
44	46	3.0	4.2	1	94	38
45	44	2.8	3.8	7	92	41
40	48	2.2	3.1	9	96	46
35	54	2.6	4.2	14	88	31
45	41	2.2	3.0	5	94	79
39	48	3.0	4.3	8	93	40

APPENDIX TABLE 2

Estimated abortion rate; percentage of women using contraceptives, by method type; and percentage of married women with unmet need for modern contraceptives—all by year, according to region

Region	Estimated abortion rate		% of married women 15–49 using contraceptives									% of married women with unmet need for modern contraceptives		
			Any method			Modern method*			Traditional method†					
	1994	2000	1993	1998	2003	1993	1998	2003	1993	1998	2003	1993	1998	2003
TOTAL	**25**	**27**	**40**	**48**	**49**	**25**	**28**	**33**	**15**	**20**	**16**	**54**	**50**	**45**
METRO MANILA	**41**	**52**	**42**	**50**	**49**	**27**	**28**	**32**	**15**	**22**	**17**	**48**	**49**	**43**
REST OF LUZON	**30**	**27**	**39**	**48**	**50**	**25**	**29**	**35**	**14**	**18**	**15**	**53**	**49**	**44**
Bicol	20	25	36	40	48	16	19	24	20	22	24	64	60	57
Cagayan Valley	30	34	41	48	52	32	39	48	9	10	4	46	42	31
CAR	33	34	39	42	46	23	30	31	16	12	15	53	44	44
Central Luzon	39	27	44	56	55	31	35	40	13	20	15	46	42	41
Ilocos Region	27	38	39	44	51	22	29	35	17	15	16	56	51	42
Southern Tagalog	27	22	35	47	47	23	26	32	13	20	16	53	51	44
VISAYAS	**11**	**17**	**41**	**47**	**48**	**24**	**24**	**31**	**17**	**23**	**17**	**57**	**56**	**48**
Central Visayas	6	24	46	51	52	29	28	35	17	23	17	53	53	46
Eastern Visayas	16	17	36	43	44	18	16	27	18	26	18	62	65	50
Western Visayas	12	10	40	46	46	24	25	30	16	21	16	57	54	49
MINDANAO	**18**	**18**	**40**	**47**	**47**	**24**	**29**	**33**	**16**	**18**	**15**	**57**	**49**	**45**
ARMM	8	7	na	19	19	na	9	12	na	10	7	na	46	47
CARAGA	4	13	na	50	55	na	28	34	na	21	21	na	52	53
Central Mindanao	29	26	33	46	51	21	29	38	12	18	13	57	51	43
Northern Mindanao	11	25	49	55	55	31	34	34	18	21	21	53	51	48
Southern Mindanao	23	20	46	55	59	27	36	41	19	20	19	54	48	42
Western Mindanao	24	13	28	45	43	17	30	32	12	16	12	64	47	41

*The pill, IUD, implants, injectables, spermicide, condom and other barrier methods, and male and female sterilization. †Withdrawal and all natural family planning methods.

Notes: Abortion rate is the number of abortions per 1,000 women aged 15–44. na=not applicable. CAR=Cordillera Administrative Region. ARMM=Autonomous Region of Muslim Mindanao. CARAGA=Cagayan Autonomous Region and Growth Area.
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APPENDIX TABLE 3

Estimated number of women hospitalized for the treatment of abortion complications, by ranking of abortion complications in hospital service reports and by type of abortion, according to major region, 2000

Major region	Total	Hospital report* obtained		Hospital report* not obtained	Type of abortion	
		Abortion among top 10 causes of admission	Abortion not among top 10 causes of admission		Spontaneous	Induced
TOTAL	**104,993**	**71,837**	**26,845**	**6,311**	**26,092**	**78,901**
Metro Manila	29,881	22,566	5,989	1,326	6,572	23,309
Rest of Luzon	45,147	32,075	9,950	3,122	11,129	34,018
Visayas	13,642	8,839	4,095	708	4,305	9,337
Mindanao	16,323	8,357	6,811	1,155	4,085	12,238

*A total of 2,039 hospitals were included, of which 478 showed abortion as one of the 10 leading causes of admission in annual service data, and 1,180 did not; 381 hospitals did not submit annual reports. For the last group, numbers were estimated by regression analysis.

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ISBN: 0-939253-84-4

Suggested citation: Singh S et al., *Unintended Pregnancy and Induced Abortion in the Philippines: Causes and Consequences,* New York: Guttmacher Institute, 2006.

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