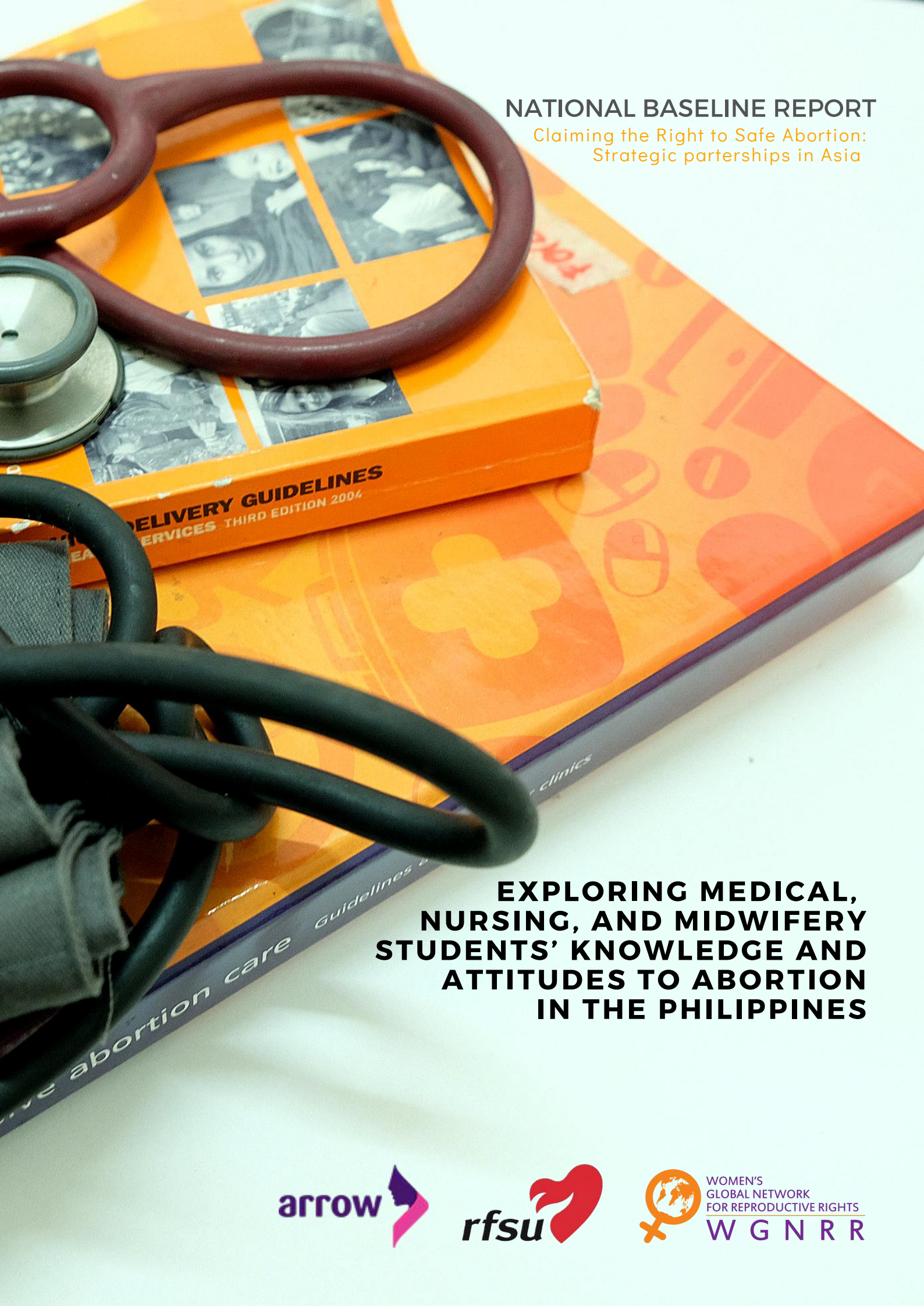


NATIONAL BASELINE REPORT

Claiming the Right to Safe Abortion:
Strategic parterships in Asia

# EXPLORING MEDICAL, NURSING, AND MIDWIFERY STUDENTS' KNOWLEDGE AND ATTITUDES TO ABORTION IN THE PHILIPPINES

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WOMEN'S GLOBAL NETWORK FOR REPRODUCTIVE RIGHTS
WGNRR

## ACKNOWLEDGMENTS

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Claiming the Right to Safe Abortion:
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# Exploring Medical, Nursing, and Midwifery Students' Knowledge and Attitudes to Abortion in the Philippines

## NATIONAL BASELINE REPORT

Women's Global Network for Reproductive Rights

# CONTENTS

# LIST OF ACRONYMS

AO- Administrative Order

DOH- Department of Health

FGD- Focus group discussion

PAC- postabortion care

SRHR- sexual and reproductive health and rights

SRH- sexual and reproductive health

WHO- World Health Organization

MCW- Magna Carta of Women

MMR- Maternal mortality ratio

MDG- Millennium Development Goals

WGNRR- Women's Global Network for Reproductive Rights

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# EXECUTIVE SUMMARY

The highly restricted legal environment and the stigma on abortion have historically driven the issue underground and marginalized abortion in the rights discourse in the Philippines. As a result, the healthcare system continues to fail in comprehensively addressing the sexual and reproductive health and rights (SRHR) of women. Healthcare providers are constrained within the legal ambiguity, stigma, healthcare system limitations, normative gender concepts, and personal belief systems that hinder them from adequately providing humane, non-judgmental, and compassionate sexual and reproductive health (SHR) services to women.

The Philippines is one of the remaining countries that criminalize abortion without clear exceptions on any grounds. The penal law however, can also be interpreted to allow abortion under the general provisions of "justification" and "necessity" when performed to save the life of a woman. But with such ambiguity, healthcare providers have remained afraid of criminal liability and women are forced to undergo unsafe abortions that lead to life-threatening complications and contribute to high maternal mortality. Since abortion is highly stigmatized, even women who had spontaneous abortion and need postabortion care experience abuse and discrimination.

Healthcare professionals are critical in this regard, since women need skilled and empathetic service providers to address their SRH needs. Even where protecting a woman's life is the only justifiable reason for abortion, it is essential that there are trained providers of abortion services and that humane, compassionate, non-judgmental postabortion care is widely available. Thus, building the knowledge and attitudes of health care professionals towards SRHR, including abortion and postabortion care, are key to women's access to quality care and consequently to their attainment of full range of human rights. They are also a key sector in contributing to an open and rational discourse on safe abortion rights.

The objective of this study was to explore what are the medical, nursing, and midwifery students' knowledge of abortion; views and attitudes toward abortion as a medical, social-political, and ethical issue; and what shaped these views and attitudes. Findings are hoped to provide initial insights to build future researches on and advocacy strategies to, at the very least, open conversations on abortion with academic healthcare institutions, healthcare students, and healthcare professionals.

This descriptive and cross-sectional study used quantitative and qualitative methods, conducted among final year medical, nursing, and midwifery students in three schools in Metro Manila; one school in Region 4A; and one school in Region 8. A total of 190 students were included in the survey (7 medical students, 142 nursing students, 41 midwifery students), and a total of 37 participants in five focus group discussions. Frequencies and percentages were used to summarize results of the survey. Qualitative data were transcribed and manually coded.

The results indicate that the participants were aware of the high prevalence of abortion, and many even personally knew women who had gone through an abortion. There was uncertainty on the legal status of abortion and whether healthcare providers are required to report women who had abortions. They had high awareness on the mistreatment and abuse of women seeking postabortion care in facilities.

They understood abortion mainly as pregnancy complication, as taught in their medical, nursing, and midwifery education. The students' discussions about abortion revealed how the interplay of religious, moral, socio-cultural, and ethical norms, influence their attitudes toward the issue. While they acknowledged abortion as a medical issue, much of their discourse was grounded on their religious and moral beliefs. They generally recognized abortion is a necessary medical procedure for obstetric emergencies and that medical and professional ethics require them to give priority to the patient's life. However, there was still stigma towards abortion due to religious beliefs; beliefs on the roles of healthcare providers; ideals of womanhood; and concepts of responsibility. This creates ambivalence towards abortion service provision and abortion law reforms.

The students held a strong opinion on women's choice and access to reproductive health service. They also supported women's reproductive autonomy, but their concept of autonomy was limited to what was perceived as acceptable based on religious and gender norms. Thus, abortion as a right had more support among study participants when it is medically needed, and less so when it is for other reasons. There were students, however, who had pro-choice attitudes and believed that a woman has the right to decide over her body and based on her given circumstances. They also strongly believed on women's right to humane, non-judgmental, compassionate postabortion care. These beliefs should be nurtured and reinforced in a supportive environment both in the healthcare education institutions, in health facilities where they train and will eventually work in, and in professional associations and organizations.

The findings point to the need to further examine how educational environment prepares medical, nursing, and midwifery students to navigate complex, contemporary SRHR issues such as abortion; to support formal education through partnerships with institutions or provide alternative learning spaces where future healthcare providers are supported to learn deeper on the contexts of women who have abortions, on legal policies on abortion and postabortion care, and to reflect on social and personal values and norms that negatively affect women's access to SRH services; advocate for clearer and more responsive professional guidelines for healthcare providers; and continue to deepen conversatins on safe abortion rights, and related issues such as gender equality, women's rights, and SRHR among healthcare providers, health advocacy groups, and women and human rights groups, among others.

# 1. INTRODUCTION

Abortion[1] is highly restricted and stigmatized in the Philippines. Because of this, women end up undergoing unsafe abortions,[2] which can cause health complications and have led to maternal deaths. Healthcare providers, on the other hand, are constrained in helping women who need abortion and postabortion care. It has been reported how healthcare professionals are challenged with navigating through personal beliefs, legal restrictions, and unsupportive healthcare system.[3]

Women's Global Network for Reproductive Rights (WGNRR) conducted a study on the knowledge and attitudes to abortion of future healthcare providers in order to recommend advocacy strategies that would open public conversations on abortion. It is important to know how future healthcare professionals – the medical, nursing and midwifery students –understand abortion and how their views are shaped.

WGNRR is a global network that builds and strengthens movements for sexual and reproductive health, rights, and justice. Our work is grounded in the realities of those who most lack economic, social and political power. Through critical analysis and strategic actions, we connect members, partners and allies, build knowledge, organize campaigns, and share resources. Our key objectives are to coordinate and strengthen national and regional networks of sexual and reproductive health and rights[4] (SRHR) organizations, initiating activities that ensure that all women and girls are able to exercise their right to make a free and informed decision regarding their sexual and reproductive health[5] (SRH).

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[1] May either be spontaneous or induced. In this report, the term is generally used to refer to induced abortion, as defined by World Health Organization International Classification of Diseases as: "intentional loss of an intrauterine pregnancy due to medical, or surgical means." World Health Organization, ICD -11 for Mortality and Morbidity Statistics, April, 2019, https://icd.who.int/browse11/l-m/en#/http%3a%2f%2fid.who.int%2ficd%2fentity%2f1517114528

[2]World Health Organization, Preventing Unsafe Abortion, February 19, 2018, https://www.who.int/en/news-room/fact-sheets/detail/preventing-unsafe-abortion WHO defined unsafe abortion as "procedure for terminating pregnancy, carried out either by persons lacking the necessary skills or in an environment that does not conform to minimal medical standards, or both." For more of how WHO's operational definition of unsafe abortion, see "Unsafe abortion: Global and Regional Estimates on the incidence of unsafe abortion and associated mortality in 2003," available at https://apps.who.int/iris/bitstream/handle/10665/43798/9789241596121_eng.pdf?sequence=1

[3] Center for Reproductive Rights. *Forsaken Lives, The Harmful Impact of the Philippine Criminal Abortion Ban*. New York: Center for Reproductive Rights, 2010.

[4] Combines the interrelated concepts of sexual health, sexual rights, reproductive health, and reproductive rights. The Guttmacher-Lancet Commission offers an integrated definition of the concept building on agreements, WHO publications, and on international human rights treaties and principles, recognising that achieving sexual and reproductive health relies on the realisation of sexual and reproductive rights, which are based on the human rights of all individuals. To see the full definition, see Starrs et al 2018, "Accelerate progress—sexual and reproductive health and rights for all: report of the Guttmacher–Lancet Commission" available at https://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(18)30293-9.pdf

[5] Anna Glasier et al., "Sexual and reproductive health: a matter of life and death," *The Lancet: Sexual and Reproductive Health 1,* October 2006, https://www.who.int/reproductivehealth/publications/general/lancet_1.pdf and World Health Organization, Sexual Health and its linkages to reproductive health: an operational approach, World Health Organization, https://apps.who.int/iris/bitstream/handle/10665/258738/9789241512886-eng.pdf?sequence=1

We focus our efforts on the most critical SRHR issues and have a strong focus on advancing access to safe abortion[6] from a rights-based approach. Together with members, partners, and allies, WGNRR defends existing progressive legislation, works to ensure the implementation of progressive laws, opposes restrictive laws and policies, challenges abortion-related stigma and discrimination, and advocates for the universal access to safe and legal abortion, regionally in Asia-Pacific and globally.

The issue of abortion in the Philippines is silenced and driven underground, making it more dangerous for women who need treatment and care, and closing further conversations on women's SRHR. Healthcare professionals are critical in this regard, since women need skilled and empathetic service providers to address their SRH needs. Their knowledge of and attitudes towards SRHR, including abortion, are crucial in women access to quality care, and attainment of overall SRHR. They are also a key sector in contributing to an open and rational discourse on abortion. It is thus important that SRHR issues, including abortion, are integrated comprehensively in medical and health education and training.

Similar studies on knowledge and attitudes of healthcare students and how abortion has been included in their education have been done in countries that have liberalized abortion, albeit in varying degrees. A similar study was also done in Argentina, where, although abortion is highly restricted, the law explicitly allows abortion in cases of rape or if the pregnancy poses a risk to the woman's health. The Philippine law, however, provides no explicit legal reason when abortion is permitted. At the onset, we recognize the difficulty of looking into the issue, particularly touching on how abortion is addressed in the healthcare education programs, within the existing legal context. This study, hence, was designed to be exploratory to provide initial insight to build future researches on and advocacy strategies to, at the very least, open conversations on abortion with academic healthcare institutions, healthcare students, and healthcare professionals.

**Research Objectives**

Medical, nursing, and midwifery students are the future healthcare professionals relevant for the provision of SRH services. The study will explore their knowledge of and attitudes to abortion, and how these knowledge and views were shaped. Data

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Building on the working definitions of World Health Organization, SRH refers to the state of physical, emotional, mental, and social wellbeing in relation to all aspects of sexuality and reproduction, not merely the absence of disease, dysfunction, or infirmity.

[6] World Health Organization,WHO launches new guideline to help health-care workers ensure safe medical abortion care, World Health Organization, January 8, 2019. https://www.who.int/reproductivehealth/guideline-medical-abortion-care/en/. According to WHO, abortion is considered safe when done with WHO-recommended method that is appropriate to the pregnancy duration, and if the person providing or supporting the abortion is trained. Such abortions can be done either as a simple outpatient procedure, using vacuum aspiration, or by using medical abortion, the use of pharmacological drugs to terminate pregnancy. For more details on what are the recommended methods, see "Safe abortion: technical and policy guidance for health systems," available at https://www.who.int/reproductivehealth/publications/unsafe_abortion/9789241548434/en/

from healthcare students regarding their knowledge and attitudes can provide insights to inform recommendations to enhance how healthcare education programs address critical SRHR issues such as abortion; point to opportunities for abortion stigma reduction; and organizing of SRHR advocates among healthcare students and professionals. Findings from the study can have implications on the approach of safe abortion rights advocacy in the restricted context of the Philippines.

Specifically, the objectives of the research are:

1. Determine what medical, nursing and midwifery students know about abortion.
2. Find out the views and attitudes of medical, nursing and midwifery students regarding abortion as a medical, socio-political and ethical issue.
3. Explore the influences that shape the knowledge, perceptions and views of medical, nursing and midwifery students on abortion.
4. Recommend advocacy strategies that will open conversations on abortion with academic healthcare institutions and healthcare providers on abortion towards achieving a more responsive, just, and women-sensitive healthcare system.

**Research Questions**

This research aims to answer the following questions:

1. What do medical, nursing and midwifery students know about abortion?
2. How do medical, nursing and midwifery students understand abortion as a medical, socio-political and ethical issue?
3. What influences the medical, nursing and midwifery students' knowledge and attitudes to abortion?
4. How do medical, nursing and midwifery students want abortion to be addressed in their education and in the healthcare system?

**Research Methodology**

This is an exploratory, descriptive, and cross-sectional study using quantitative and qualitative methods. The study design was deemed appropriate to explore a sensitive topic, particularly with a population that, to our knowledge, has not been studied in the Philippines in relation to their knowledge and attitudes to abortion.

*Sample*

A convenience selection of four academic institutions offering Doctor of Medicine, Bachelor of Nursing, and Bachelor of Midwifery was done in the study. Several institutions across the three major islands of Luzon, Visayas, and Mindanao were approached simultaneously to ensure higher success rate of approval. This decision

was cognizant of the general prevailing conservative attitude towards abortion, and the possibility of refusal to be involved on a study on a very polarizing issue, as evidenced by our previous engagements with various institutions in the course of our country advocacy to demystify and destigmatize abortion. It was initially planned to have equal number of public and private institutions, and the participating program of studies; i.e. two schools each for medical, nursing, and midwifery students. Final study sites, however, were the schools that gave us Ethics Committee approval in time for the conduct of the study. For schools that had no Ethics Committee in place, approval was secured from school administrators.

The study was conducted in three schools in Metro Manila (Luzon), one in Region 4A (Luzon), and one in Region 8 (Visayas). The type of institutions and the participating study programs in each school are described in Table 1:

**Table 1. Study sites, Type of institution, and Programs of study**

| School | Type of Institution | Participating Program of Study |
|---|---|---|
| School A (Metro Manila) | Public | Bachelor of Science in Nursing |
| School B (Metro Manila) | Private | Bachelor of Science in Nursing |
| School C (Metro Manila) | Public | Bachelor of Science in Midwifery |
| School D (Region 4A) | Private | Bachelor of Science in Nursing |
| School E (Region 8) | Private | Doctor of Medicine<br>Bachelor of Science in Nursing |

This research used survey and focus group discussions (FGD). We requested the participation of all fourth year students from the identified study programs to answer the survey questionnaire, and at least seven students from the same population to join the FGDs. Both the survey and FGD were conducted in the school premises. Since the entire population of final year students for each school is relatively small, the study aimed for a census sampling. However, final year students of Doctor of Medicine in School E (Region 8) were attending clinical clerkship in different facilities spread across areas. Hence, the school was only able to arrange the participation of seven students for both the survey and FGDs. Due to project timeline limitations only a survey was conducted with the nursing students in School B (Metro Manila).

Arrangements were made with school administrators and faculty to set the schedule of the surveys and FGDs. The purpose, nature, and organization of the research, as outlined by the Informed Consent Form, were explained to the students. The self-administered questionnaires were distributed after obtaining the informed consent of participants. Students who were absent during the survey were excluded from the sample. An FGD was conducted for each cohort of students.

The total sample size for the survey was 190. The FGD participants, who also answered the survey, reached a total of 37. Below is the summary of methods applied for each study site and sizes of respondents and participants:

**Table 2. Sampling size**

| School/Location | Degree Program of Participants | Method | Size |
|---|---|---|---|
| School A (Metro Manila) | Bachelor of Science in Nursing | Survey | 55 |
| | | FGD | 8 |
| School B (Metro Manila) | Bachelor of Science in Nursing | Survey | 30 |
| School C (Metro Manila) | Bachelor of Science in Midwifery | Survey | 41 |
| | | FGD | 7 |
| School D (Region 4) | Bachelor of Science in Nursing | Survey | 13 |
| | | FGD | 8 |
| School E (Region 8) | Doctor of Medicine | Survey | 7 |
| | | FGD | 7 |
| | Bachelor of Science in Nursing | Survey | 44 |
| | | FGD | 7 |

Bachelor of Science in Midwifery is a ladderized degree program. A student earns Diploma in Midwifery or Associate in Midwifery after successfully completing the two year course, and is eligible take the Midwife Licensure Examination conducted by the Professional Regulations Commission (PRC). We learned in the course of our data gathering that midwifery students taking the final year of the Bachelor of Science in Midwifery might already be currently service providers.

*Methods*

Survey

A structured questionnaire was developed based on the research questions and informed by previous similar studies. The tool covered: a) socio-demographic background and sexual and reproductive heath experiences of students; b) knowledge of abortion; c) sources of knowledge of abortion; and d) attitudes and opinions on abortion. For attitudinal questions, students were asked to respond to statements on a six point Likert scale (Strongly Disagree, Disagree, Somewhat Disagree, Somewhat Agree, Agree, Strongly Agree). To avoid response bias, we included both pro-choice and anti-choice statements. The questionnaire was developed in consultation with healthcare professionals.

The survey was originally planned to be online. The questionnaire was designed using the online tool Surveymonkey. However, due to the necessity of securing the participants' informed consent, as well as to ensure higher response rate, it had to be administered through pen-and-paper. The questionnaire was collected anonymously and responses were entered in Surveymonkey. Results were analysed using the online survey tool.

Focus Group Discussions

To delve deeper into the attitudes and opinions on abortion of students, a semi-structured FGD guide with open-ended questions were developed. Vignettes based on real-life experiences of women who had experienced abortion taken from published materials were also used to stimulate discussion. Participants of the FGDs were a combination of volunteers and those who were assigned by the school administrators and faculty.

**Data analysis**

Data from the survey were analysed in Surveymonkey and SPSS and described using simple descriptive statistics. Mean and percentages were used to summarize categorical data to describe knowledge and attitudes.

Interviews were digitally recorded, transcribed verbatim, and analyzed. Recordings were listened to by another person, who then edited the transcripts for inconsistencies. Emerging codes were identified by reviewing the transcripts. Codes were organized into categories and sub-categories. The coding and initial analysis was done by the first author. Initial analysis and results were then reviewed by the second author and a subsequent collaborative analysis was done.

**Limitations of the study**

This study has several limitations. First, respondents may have interpreted questions and answer options in the self-administered survey differently. For example, it was observed during the conduct of survey that some respondents were uncertain on how to describe themselves in the sexual orientation question. The answer options in the Likert-scale may also have different meanings to different respondents.

Second, social desirability bias may have influence the responses. It was observed that some students also started asking each other or peering over the paper of the persons seating beside them. Despite instructions to answer the survey based on their own personal knowledge and beliefs, there were instances of some respondents conferring among each other, and social desirability bias may have higher influence in their responses.

Third, due to the challenges and limitations in getting approval of institutions and getting respondents, sample sizes were highly unequal and prevent us from making generalizations for the entire population of the medical, nursing, and midwifery sudents of the five schools. Data is skewed highly towards nursing students who comprise a big majority of the entire sample. More so, our findings may not be generalizable to the entire population of medical, nursing and midwifery students in the Philippines. The knowledge and views of medical students may also markedly

differ from that of nursing and midwifery, having longer and specialized education. Many of the midwifery students who participate in the study were also experienced health service providers, thus their knowledge and views may be significantly different from the nursing and medical students.

# 2. COUNTRY PROFILE: SOCIO-ECONOMIC AND POLITICALCONTEXT

The Philippines has a projected population of 105, 765, 722 as of April 2018.[7] Of the total population, 52.8 million are women and 53.8 million are men.[8] The youth (15-29 years old) makes up about 27% of the population.[9]

One in every five Filipinos is poor, according to the latest estimate of poverty incidence in the Philippines.[10] In 2015, there were 22 million poor Filipinos. Among the basic sectors, farmers, fisherfolks, children, self-employed and unpaid family workers, and women, had higher poverty incidence.[11] Official estimate places the poverty threshold or the average monthly income for a person to meet basic food and non-food needs in the Philippines at Php 1,813 per month (roughly about USD 1 per day). Of the total number of poor Filipinos, there were 8.1 million who were not even able to meet their basic food needs.[12] However, the official methodology for measuring poverty has been criticized for using a very conservative threshold, and is said to result to underreporting the real magnitude of poverty in the country.[13]

The devolution of government services in 1991 paved the way for decentralization and local government units were granted autonomy and responsibility to deliver primary public health services with the technical aid of the Department of Health (DOH).[14] Provincial governments manage the secondary and tertiary hospitals, while national government manages a number of tertiary level facilities.[15] The structure created what the World Health Organization (WHO) describes as "fragmentation in the overall management of the system."[16] As a result, there is unequal quality and access to health services across the country, with concentration of health services in relatively affluent urban areas.[17] While human resources for healthcare is identified to be at the same rate with other upper-middle income countries and higher-income countries (at one per 10,000 Filipinos), there has been stagnation in the public sector

[7] The Projected Population as of April 18, 2018 is 105,765,722. This is based on the 2015 Census of Population with a Total Population of 100,979,303 and 2010-2015 Population Growth Rate of 1.72 and calculation using Geometric Equation. http://www.popcom.gov.ph.
[8] Philippine Statistics Authority. "Women and Men Factsheet 2018." Philippine Statistics Authority, accessed February 9, 2018. https://psa.gov.ph/gender-stat/wmf.
[9] Philippine Statistics Authority. "2015 Poverty in the Philippines." Philippine Statistics Authority, accessed on August 8, 2018. https://psa.gov.ph/sites/default/files/2015_povstat_FINAL.pdf.
[10] Philippine Statistics Authority, "2015 Poverty,"
[11] Philippine Statistics Authority, "2015 Poverty,"
[12] Philippine Statistics Authority, "2015 Poverty,"
[13] Ibon Foundation. "2015 Poverty Results No Reason for Complacency–IBON," IBON Foundation, October 27, 2016. http://ibon.org/2016/10/2015-poverty-results-no-reason-for-complacency-ibon/.
[14] Oscar Cetrángolo et al., "Healthcare in the Philippines: Challenges and Ways Forward," Friedrich Ebert Shiftung Website, 2013. https://www.fes.org.ph/wp-content/uploads/2014/03/1._FES_Healthcare_2013_Zeta_Final_LowRes3.pdf.
[15] Cetrangelo et al., "Healthcare,"
[16] Alberto G. Romualdez, Jr. et al., "The Philippines Health System Review," 1, no. 2 (2011) (*World Health Organization*, 2011). https://www.wpro.who.int/philippines/areas/health_systems/financing/philippines_health_system_review.pdf.
[17] Cetrángolo et al., "Healthcare," 7

in the recent years partly due to migration of trained health professionals overseas.[18]

The problem in healthcare system is characterized with the high out-of-pocket (OOP) expenditure for healthcare. The limited breadth and depth of coverage of social health insurance program, as well as the low coverage rate among the population resulted in high-levels of OOP payment especially among poorest households.[19] From 2014 to 2016, out-of-pocket health expenditure was 54.2%, while government schemes and compulsory contributory healthcare financing schemes are only at 34.2%.[20] Even patients confined in public facilities had to rely more on OOP.[21]

The existing decentralized health provision system has also been identified as a factor for women's difficulty in obtaining contraceptive information and services. Women's access to reproductive health care and services has been subjected to the whims of government leaders who made policies based on their personal religious beliefs. Local government leaders passed anti-modern contraceptive policies that prevented women, particularly low-income women, from accessing free modern contraceptives.[22]

It has been said that the magnitude of induced abortion occurring each year in the country has to be understood within the context of the social and political restrictions affecting women's access to reproductive health services--from the decentralization and its resulting gaps in health and family planning services; to gender norms and misconceptions on modern contraceptives; and to the strong anti-choice influence of the Catholic Church.[23] The Catholic Church hierarchy has a long history of playing a major role in Philippine politics, and their opposition to the use of contraceptives has been influential in the delay of the passage of Republic Act 10354 or the Responsible Parenthood and Reproductive Health Law of 2012 (also known as RPRH Law).[24]

The Philippines has the most vibrant and advance civil society in the world and has the largest number of civil society organizations (CSO) per capita in Asia, and many believe that if CSOs have contributed to the democratization anywhere, it should be

[18] Romualdez et al., "Philippines Health,"
[19] Romualdez et al., "Philippines Health,"
[20] Philippine Statistics Authority. Total Health Expenditures grew by 8.0 percent in 2017. October 18, 2018, https://psa.gov.ph/national-health-accounts-press-releases.
[21] The Philippine Health System At A Glance, Chapter 1, https://www.doh.gov.ph/sites/default/files/basic-page/chapter-one.pdf
[22] Romeo B. Lee, Lourdes P. Nacionales, and Luis Pedroso, "The influence of local policy on contraceptive provision and use in three locales in the Philippines," Reproductive Health Matters 17, no. 34 (2009): 99-107, https://doi.org/10.1016/S0968-8080(09)34472-9.
[23] Fatima Juárez et al., "The Incidence of Induced Abortion in the Philippines: Current Level and Recent Trends," International Family Planning Perspectives 31, no.3 (Sepember 2005): 140-149, https://doi.org/10.1363/3114005.
[24] Sonia Narang, "Catholic Leaders Battle against Free Birth Control in the Philippines," Public Radio International, January 22, 2015, https://www.pri.org/stories/2015-01-22/catholic-leaders-battle-against-free-birth-control-philippines.

in the Philippines.[25] Since post-Marcos dictatorship era, many CSOs were formed and took an active role in bringing about transformative social change for the benefit of poor, marginalized, and excluded groups, and in holding the government accountable. It is in this spirit that women's organizations, RH advocacy groups, grassroots community groups led an over a decade advocacy for the passage of the RPRH Law. When the Manila City government signed Executive Order 03 in 2000 that declared the city to take an "affirmative stand on pro-life issues" as an exercise of its power under the devolution of "people's health and safety" to the local government, a Task Force Convention on the Elimination of Discrimination against Women (CEDAW) Inquiry comprised of women's organizations and RH networks, challenged the EO at the CEDAW Committee level. As a result, the CEDAW Committee report in 2015 calls on the Filipino government to respect, protect, and fulfill women's reproductive rights and address the unmet need for contraception by ensuring universal and affordable access to the full range of sexual and reproductive health services, commodities and related information, including access to emergency contraception. The Committee has issued a robust set of recommendations, which includes urging the Philippines to revoke executive orders 003[26] and 030,[27] decriminalize abortion, and sensitize government representatives towards eliminating ideological barriers that limit women's rights.[28] The CEDAW recommendation formed as basis for advocacy for the decriminalization of abortion.

[25] Asian Development Bank. Civil Society Briefs Philippines. (Publication Stock:February 2013), https://www.adb.org/sites/default/files/publication/30174/csb-phi.pdf

[26] Executive order issued in 2002 by Mayor Lito Atienza in Manila City "Declaring Total Commitment and Support to the Responsible Parenthood Movement in the City of Manila and Enunciating Policy Declarations in Pursuit Thereof," which banned contraceptives in the city.

[27] Executive Order issued in 2011 by Mayor Alfredo Lim in Manila City entitled "Further Strengthening Family Planning Services," which imposed a funding ban on modern contraceptives

[28] Center for Reproductive Rights, Forsaken Lives.

# 3. COUNTRY SRHR PROFILE

The Philippines is a signatory to international treaties and agreements that seek to promote, protect, and fulfil SRHR of its people. These are the Beijing Declaration and Platform of Action, the Programme of Action of the International Conference on Population and Development (ICPD), the CEDAW, the Convention on the Rights of the Child (CRC), and the International Covenant on Economic, Social, and Cultural Rights, among others. While certain steps have been taken by the Philippine Government to implement the recommendations of these international bodies, such as the adoption of a national reproductive health law[29] and the Magna Carta of Women (MCW),[30] women and girls in the Philippines still persistently experience legal, policy, and practical barriers to access SRH information and services including, safe and legal abortion services.

The state of SRH in the Philippines has been described by the World Health Organization (WHO) as lagging behind other countries in Southeast Asia, with high incidence of untintended pregnancies, due in part to high unmet need for contraception, with many cases leading to maternal deaths and unsafe abortions. [31]

The maternal mortality ratio (MMR) has remained persistently high compared to the average for the Southeast Asia sub-region.[32] While maternal deaths went down from 152 per 100,000 live births in 1990 to 114 in 2015,[33] it is more than double than the Millennium Development Goals (MDG) target of 52 deaths per 100,000 live births[34]. The main causes of maternal deaths are pregnancy complications, including hypertension, during labor, delivery and perpeirum; postpartum hemorrhage; and abortion-related complications.[35]

While there has been a decline in the fertility trends due to increased use of modern contraceptives, the present contraceptive prevalence rate is still at 54%,[36] failing short of the MGD target of 100% by 2015.[37] According to WHO, the common reasons for not choosing modern contraception are unfounded fear of side effects,

[29] Office of Secretary, Department of Health. "Memoradum Circular 2013-0011." *Philippine Commission of Women.* March 21, 2013. http://pcw.gov.ph/sites/default/files/documents/laws/republic_act_10354_irr_0.pdf (accessed April 18, 2018).
[30] Memorandum Circular No. 2013-0011, PDF, Department of Health Office of the Secretary, March 21, 2013.
[31] CNN Philippines Staff. UN, WHO: Reproductive health in the Philippines lags behind ASEAN neighbors. March 5, 2016. http://cnnphilippines.com/news/2016/03/05/un-who-reproductive-health-philippines-lagging-asean.html
[32] MMR is 110 per 100,000 live births for the sub-region. Source WHO et al., Maternal mortality in 1990-2015, Philippines. https://www.who.int/gho/maternal_health/countries/phl.pdf
[33] WHO et al., Maternal mortality in 1990-2015, Philippines. https://www.who.int/gho/maternal_health/countries/phl.pdf
[34] Philippine Statistics Authority, Statistics at a glance of the Philippines' Progress based on the MDG indicators, Philippine Statistics Authority, November 2017.,http://www.psa.gov.ph/mdgs-main/mdg-watch
[35] Department of Health, "Maternal Deaths by Main Cause," Department of Health, December 9, 2013, https://www.doh.gov.ph/Statistics/Maternal-Deaths-By-Main-Cause.
[36] Philippine Statistics Authority. "2017 National Demographic and Health Survey." Philippine Statistics Authority Philippines, accessed on December 19, 2018. https://psa.gov.ph/sites/default/files/PHILIPPINE%20NATIONAL%20DEMOGRAPHIC%20AND%20HEALTH%20SURVEY%202017_new.pdf
[37] Philippine Statistics Authority, "2017,"

opposition from religious groups, lack of knowledge, and lightly taking the risk of pregnancy.[38]

About 17% of married women have unmet need for family planning.[39] The figure is much higher at 49% among sexually active unmarried women, despite the total demand for family planning among these women being higher than the demand among currently married women (81% versus 71%).[40] This means that these women do not want a child soon or want to stop childbearing altogether but are not using or cannot avail of contraception. Eleven percent (11%) of births in the country are not wanted at all, while 16% were mistimed (wanted at a later time).[41]

The misguided idea that poor families still choose to have more children despite not having the capacity to support them still persists. When, in fact, women from poor households in the lowest wealth quintile do favor family planning and actually have higher demand for it compared to women in richer households. The total demand for family planning[42] in the lowest and second lowest wealth quintile is 73% and 76%, respectively, while those in the highest wealth quintile is 65%.[43]

However, poor women and those in rural areas are more likely to face barriers in accessing contraceptives and other family planning services. Rural women will give birth to more children in their lifetime compared with urban women; women with lower education and income also have higher unmet need for family planning compared with women with higher education and income. Location and wealth and education level also determine a woman's access to proper medical attention and facilities. The proportion of getting antenatal, delivery care, and post natal check-up from a skilled provider, and delivering in a health facility, generally increases with wealth and education level, and from rural to urban.[44]

Teenage pregnancy has also become a major concern in the country. Teenage pregnancy in countries in the Asia-Pacific region declined in the last two decades except in the Philippines.[45] One in 10 girls aged 15-19 have already given birth or are pregnant with their first child.[46] The rise in adolescent fertility rate is found to be linked particularly to the growth in proportion of young people that are sexually active and the very low rate of modern contraceptives among young people especially adolescents.[47] Despite increasing levels of sexual activity, majority of young people expressed having inadequate knowledge about their sexual and

[38] CNN Philippines Staff, "UN, WHO: Reproductive Health in the Philippines Lags behind ASEAN Neighbors," CNN Philippines, March 5, 2015, accessed April 18, 2018, http://cnnphilippines.com/news/2016/03/05/un-who-reproductive-health-philippines-lagging-asean.html.
[39] Philippine Statistics Authority., "2017,"
[40] Philippine Statistics Authority, "2017,"
[41] Philippine Statistics Authority, "2017,"
[42] Total demand for family planning services is the sum of the met and unmeet need for family planning
[43] Philippine Statistics Authority, "2017," 21
[44] Philippine Statistics Authority, "2017," 21
[45] Fritzie Rodriguez, "Teen pregnancy down in Asia-Pacific, except PH – report," Rappler, (February 3, 2016), https://www.rappler.com/move-ph/121135-teenage-pregnancy-sexual-reproductive-health-unfpa.
[46] About 9% of young women aged 15-19 are either pregnant with their first child or have had live birth.
[47] Asian-Pacific Resource & Research Centre for Women. Sex & Rights: The Status of Young People's SRHR in Southeast Asia (Kuala Lumpur: Asian-Pacific Resource & Research Centre for Women).

reproductive health. The absence of comprehensive sexuality education and the lack of SRH services for young people is placing young people, particularly young women, at risk. Twenty eight percent (28%) of married adolescent women aged 15-19 and 18% of women aged 22-24 have unmet need for SRH services.[48] According to a 2013 report, 32% of births to women younger than 20 in the Philippines were unplanned, and 27% for women aged 20-24 years old.[49] While use of contraceptives has been encouraged through policies, they are given only to married individuals of reproductive age;[50] culturally, sex remains a taboo for young people.

The provision of SRH services, in particular universal access to modern family planning methods, is a continuing political and moral debate in the country. The Catholic Church hierarchy maintains its opposition to population control and modern contraception, and that the debate is inexorably tied to the Church's long-standing enmeshment in the politics of the country where 80% of the population is, at least nominally, Catholic.[51]

The difficult passage and implementation of the RPRH Law attests to the contested nature of SRHR issues in the Philippines. The Supreme Court (SC) suspended the law after objections from religious groups led by the Catholic Church that alleged that the rights to religion and free speech have been violated. In 2015, the SC further issued a temporary restraining order on the procurement, sale, promotion, and distribution of contraceptive implants after groups filed petitions describing these products as "abortifacient".[52] President Duterte signed an executive order in 2017 calling for universal access to modern family planning methods and the accelerated implementation of the RH Law.[53] But the Catholic Church immediately reiterated its position against "any law that promotes natural and artificial family planning methods".[54]

[48] Philippine Statistics Authority and ICF, Philippines National Demographic and Health Survey 2017: Key Indicators, report (Quezon City, Philippines, and Rockville, Maryland, USA: PSA and ICF, 2018).
[49] Guttmacher Institute. *Unintended Pregnancy and Unsafe Abortion in the Philippines: Context and Consequences.*Guttmacher Institute, no.3 (2013). https://www.guttmacher.org/sites/default/files/report_pdf/ib-unintended-pregnancy-philippines.pdf.
[50] Aya Tantiangco, "The crusade against contraceptives and reproductive rights" *GMA News Online.* December 18, 2017, https://www.gmanetwork.com/news/news/specialreports/636969/the-crusade-against-contraceptives-and reproductive-rights/story/.
[51] Gideon Lasco, "Inside the Philippines' long journey towards reproductive health," The Conversation, (May 9, 2017), www.theconversation.com/au.
[52] Tarra Quismundo, "High court stops DOH contraceptive implants," Inquirer.net, July 4, 2015, https://newsinfo.inquirer.net/702730/high-court-stops-doh-contraceptive-implants
[53] Trisha Macas, "Duterte signs EO on modern family planning," GMA News Online, January 11, 2017, http://www.gmanetwork.com/news/news/nation/595380/duterte-signs-eo-on-modern-family-planning-palace/story/.
[54] Lasco, "Inside"

# 4. ABORTION: COUNTRY SITUATION, CRITICAL ISSUES AND ATTEMPTS TO ENSURE THE RIGHT TO SAFE ABORTION

An estimated 1,000 maternal deaths each year—roughly three deaths a day—are caused by unsafe abortions.[55] Estimates of the number of abortions has increased from 560,000 in 2008 to 610,000 in 2012[56] with most being performed clandestinely and in unsafe conditions due to the legal restrictions and stigma on abortion. Using the national abortion rate in 2000, an estimated 100,000 women sought postabortion care in 2012; approximately two in three women who terminate a pregnancy experience a serious and often life-threatening complication.[57] Negative attitudes of healthcare providers and the high costs of treatment and medication prevent an estimated one in three women with complications from seeking postabortion care.

Abortion is legally restricted in the country. The Philippine Constitution, however, does not expressly prohibit abortion.[58] The 1987 Philippine Constitution declares in Article II Section 12 that the State shall "equally protect the life of the mother and the life of the unborn from conception"[59] and may be intrepreted to allow abortion when the life or mental health of the woman or girl is at risk.[60] Even the Philippine Commission of Women (PCW), despite stating that the Constitution has an "anti-abortion" policy, concedes that that the equal protection clause can be argued that therapeutic abortion[61] is allowed when the life of the mother is in danger.[62]

A Supreme Court decision in 1961, on the case of a doctor who performed an abortion on a woman was sued for damages by her husband, has ruled that a fetus is not endowed a civil personality under Article 40 of the Philippine Civil Code.[63] The Civil Code clearly states that legal personality begins only at birth, thus, the embryo or fetus is not on the same level as the life of the woman and is not accorded the same rights and protection as a legal person.[64] It also argued that prenatal

[55] Guttmacher Institute. *Unintended Pregnancy and Unsafe Abortion in the Philippines*. Fact Sheet Guttmacher Institute, July 2013. https://www.guttmacher.org/fact-sheet/unintended-pregnancy-and-unsafe-abortion-philippines.
[56] Guttmacher Institute. Unintended Pregnancy and Unsafe Abortion in the Philippines: Context and Consequences.Guttmacher Institute, no.3 (2013). https://www.guttmacher.org/sites/default/files/report_pdf/ib-unintended-pregnancy-philippines.pdf.
[57]Guttmacher Institute, *Unintended: Context.*
[58] Center for Reproductive Rights, Forsaken Lives.
[59] The Constitution of the Republic of the Philippines. Official Gazette. https://www.officialgazette.gov.ph/constitutions/1987-constitution/
[60] Center for Reproductive Rights, Realizing, 2
[61] Used to refer to abortion medically necessary to save the life, preserve the health, and/or prevent disability of the woman. How therapeutic abortion is defined in specific contexts may vary depending on laws.
[62] "Laws, Issuances and other Legislation on Women,"Philippine Commission on Women, accessed on April 30, 2019, https://pcw.gov.ph/laws?page=14.
[63] Claire Padilla, "Philippine Constitutional Guarantees, Comparative Law and International and Regional Human Rights Standards Support the Right to Safe and Legal Abortion." *EnGendeRights Fact Sheet 3*.
[64] Claire Padilla, "Philippine Constitutional,"

protection as provided by the Constitution cannot be taken in a way that abrogates women's rights, including rights to health, life, privacy, religion, equality, and equal protection of the law.[65]

However, the Philippine Revised Penal Code criminalizes abortion without for any exemptions, making it one the most restrictive laws on abortion in the world. The Code, though revised in 1930, is essentially the same law under the colonial Spanish rule in the country. It penalizes doctors and midwives "who take advantage of their scientific knowledge or skill"[66] to perform abortions with six-year imprisonment. So are pharmacists who give out "any abortive" without "proper prescription from a physician."[67] The woman who undergoes an abortion or consents to have an abortion, and even parents who act with the consent of the woman, can get imprisoned for up to six years.[68] Again, it may be interpreted that abortion to save the life of the pregnant woman can be carried out legally using the general criminal principles of necessity set forth in the Article 11 of the Code.[69] Even so, the legal interpretations have not been tested in a court in actual cases.[70] Thus with such ambiguity, healthcare providers have remained afraid of criminal liability.

The ambiguity of when the law permits abortion in the Philippines is evident in how the policy environment has been described in literature. It has been reported that "the law does not make an explicit exception to save a woman's life" which can be interpreted to allow life-saving abortions;[71] but also described as "abortion is illegal in the Philippines in all circumstances, even when continuing a pregnancy endangers the pregnant woman's life;"[72] and elsewhere it was described that "the only acceptable reason for an abortion is when the mother's life is in danger, in which case permission for the abortion must be obtained from a board of medical professionals."[73]

The RPRH Law of 2012, while it is landmark legislation for Filipino women's reproductive health rights, does not recognize abortion and access to abortifacients in its definition of reproductive health rights.[74] Despite its proscription of abortion, the legality of medical treatment for women with postabortion complications, however is clear:

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[65] Claire Padilla, "Philippine Constitutional,"
[66] Revised Penal Code, Act 3815, Articles 258-259 (1930).
[67] Revised Penal Code, Act 3815, Articles 259 (1930)
[68] Revised Penal Code, Act 3815, Articles 258 (1930)
[69] Asia Safe Abortion Partnership, "A Study of Knowledge, Attitudes and Understanding of Legal Professionals about Safe Abortion as a Women's Right," https://asap-asia.org/pdf/Philippines_Abortion_Booklet_Update.pdf
[70] Center for Reproductive Rights, Forsaken Lives, 29
[71] Center for Reproductive Rights. World's Abortion Laws. Center for Reproductive Rights, 2019. https://worldabortionlaws/map/.
[72] Guttmacher Institute, Sexual and Reproductive Health of Young Women in the Philippines: 2013 Data Update. Guttmacher Institute, https://www.guttmacher.org/fact-sheet/sexual-and-reproductive-health-young-women-philippines-2013-data-update#9.
[73] Pew Research Center, "Abortion laws around the world", September 30, 2008. https://www.pewforum.org/2008/09/30/abotion-laws-around-the-world/
[74] Responsible Parenthood and Reproductive Health Act of 2012 (2012).

> "While this Act recognizes that abortion is illegal and punishable by law, the government shall ensure that all women needing care for post-abortive complications and all other complications arising from pregnancy, labor and delivery and related issues shall be treated and counseled in a humane, nonjudgmental and compassionate manner in accordance with law and medical ethics."[75]

The right to postabortion care was also codified in Republic Act 9710 or MCW in 2009. While MCW calls for the prevention of abortion, it guarantees that women have the right to access services for management of pregnancy-related complications.[76]

The postabortion care policy of DOH was started through Administrative Order (AO) 45-B series of 2000. The order provided for medical services for "women who have had abortion, regardless of cause."[77] In 2016, the government had a new Prevention and Management of Abortion Complications (PMAC ) policy, AO No. 2016-0041, on the provision of postabortion care in private and public health facilities and the promotion of its integration with other reproductive health programs. Apart from recognizing the provision of the RH Law on humane, nonjudgmental and compassionate postabortion care, and adding a penalty clause to the provision, the policy also clearly stated, "no woman or girl shall be denied appropriate care and information on the ground that she is suspected to have induced an abortion."[78]

AO No. 2016-0041 bore positive features that would advance women's rights. It emphasized the treatment of women who have abortions not as criminals but as individuals with rights and dignity that must be respected. The policy also covered teenage girls, included a provision for an anonymous complaint mechanism where women who experience postabortion mistreatment and abuse could lodge complaints, and provided for the protection of the privacy and confidentiality of women seeking postabortion care. The policy recognized the duty to provide postabortion care as a matter of medical ethics and clarified that health service providers shall not be penalized for giving medical care to women who have abortions.[79]

But in 2018, DOH issued AO No. 2018-0003 entitled "National Policy on the Prevention of Illegal and Unsafe Abortion and Management of Postabortion

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[75] Responsible Parenthood and Reproductive Health Act, Act 10354, Section 2 (J) (2012).
[76] Magna Carta of Women, Act 9710, Section 17(7) (2009)
[77] Department of Health. *Prevention and Management of Abortion and its Complications (PMAC) policy.* Administrative Order No. 45-B. (Philippines: 2000), http://www.postabortioncare.org/sites/pac/files/MOHPhi_Administrative_Order_45B.pdf.
[78] Department of Health, Government of the Philippines. National policy on the Prevention and Management of Abortion Complications (PMAC). Administrative Order No. 2016-41. Published 2016. https://www.scribd.com/document/344526773/DOH-AO-2016-0041-Prevention-and-Management-of-Abortion-Complications.
[79] Melissa Upreti and Jihan Jacob, "The Philippines' new postabortion care policy," International Journal of Gynecology & Obstetrics 141, no.2 (January 2018): 268-275, https://doi.org/10.1002/ijgo.12452.

Complications."[80] The new policy rescinds AO No. 2016-0041 and thereby revokes all the positive features and women's rights-based principles of the previous PMAC policy.

The current postabortion care policy is criticized for moving away from "a holistic and ethical approach to women's reproductive health."[81] For one, the policy's language reinforces the stigma on abortion. It cites "absolute prohibition on abortion" as part of its commitment to uphold the right of every Filipino woman, thereby reiterating that abortion is not a woman's right and reinforces the typical view of women who have abortion as criminals. It fails to address the difficulties that women and healthcare providers face in the context of postabortion care such as:

- Lack of privacy and confidentiality of patients
- Practice of reporting women who have abortions to the authorities
- Involvement of conscience to refuse legally mandated care
- Absence of redress mechanism for women who are mistreated and abused[82]

The current policy is feared to prevent healthcare provides from providing ethical and medically appropriate postabortion care and reinforce negative attitudes towards women needing postabortion care. [83] Women suffering abortion complications often delay asking for medical intervention, at times until they are already in danger of dying, for fear of being arrested.[84] Women are also forced to leave the hospital or clinic without receiving emergency treatment when healthcare providers start humiliating or threatening them of arrest and prosecution.

Women who seek medical care for complications from abortion are more likely to be shamed and discriminated against by doctors than those seeking attention for other medical problems. Even the doctors and healthcare professionals who sympathize with the women who have had abortion feel stigmatized by their peers. Doctors interviewed attributed the stigma to the criminalization on abortion, personal religious views, and the Catholic Church's relentless campaign against modern contraception and abortion.[85]

[80] Department of Health. *National policy on the Prevention of illegal and unsafe abortion and management of postabortion complications.* Administrative Order No. 2018-0003. (Philippines: 2018), https://home2.doh.gov.ph/ais_public/aopdf/ao2018-0003.pdf
[81] Melissa Upreti and Jihan Jacob, "The Philippines rolls back advancements in the postabortion care policy. International Journal of Gynecology & Obstetrics 142 no.2 (June 2018). http://doi.org/10.1002/ijgo.12530.
[82] Upreti and Jacob, "Philippines rolls,"
[83] Upreti and Jacob, "Philippines rolls,"
[84] Padilla, "Right"
[85] Center for Reproductive Rights, Forsaken Lives

# 5. ABORTION: GAPS IN UNDERSTANDING AND ADDRESSING THE ISSUES

Because of the stigma and the legal restrictions, the extent of abortion in the Philippines is not fully determined. Both women and providers are not likely to report the procedure, which makes it difficult to directly estimate the exact number of abortions. There is no official system for tracking abortion-related deaths, and in cases where unsafe abortion is the real cause of death it may not be officially recorded as such.[86] Available study on abortion incidence in the Philippines uses indirect estimation techniques and hospital records.

Studies describe Filipino women's experience of abortion, including profiles of women who have abortion, reasons for abortion, methods of abortion, and consequences of unsafe abortion. Abortion was found to usually occur at the peak of the woman's reproductive period (i.e. 20-29 years old) for both spontaneous and induced abortions. Most of these women were Catholics and were married or in union. Women who had undergone abortion were found to be better educated than the general population of women, particularly those women who had undergone an induced abortion. But while these women seemed to have attained higher education, women who had undergone abortions were more likely to be unemployed or are in low-paying jobs. More abortions occur to space, rather than stop childbearing. [87]

However, poor women are more likely than non-poor women to use riskier methods. The most common reason women identified for inducing abortion was the inability to afford the cost of raising a child. Other reasons were to limit and space children; avoid danger to health; and lack of support from partners or family. Further, 13% of women who had undergone abortion got pregnant as a result of rape.[88]

The methods of abortion range from safe surgical and medical procedures, to dangerous methods such as insertion of foreign objects into the cervix, and physical labor. Among the modern methods are the use of mifepristone and misoprostol, manual vacuum aspiration, dilation and curettage, and dilation and evacuation or hysterectomy. Unsafe abortion methods commonly used are abdominal massage, insertion of rubber catheter or other objects into the vagina and cervix, and ingestions of concoctions such as bitter herbs. [89]

Unsafe abortion can lead to life-threatening consequences and maternal mortality. The complications experienced by women who had unsafe abortion range from medical, psychosocial, to physical discomfort that consequently affects their ability

[86] Center for Reproductive Rights, Forsaken Lives, 30.
[87] Corazon M. Raymundo et al., Unsafe Abortion in the Philippines: A Threat to Public Health (Quezon City: UP Office of the Vice-Chancellor for Research and Development, 2001)
[88] Susheela Singh, Unintended pregnancy and induced abortion in the Philippines: Causes and consequences (New York: Guttmacher Institute, 2006)
[89] Singh, *Unintended;* Center for Reproductive Rights, Forsaken Lives

to perform daily activities including going to work.[90] The criminalization of abortion in the Philippines has made abortion extremely unsafe; increased stigma on abortion; led to abuses, such as cruel and degrading treatment of women seeking postabortion care; and marginalized postabortion care services in the health system, all of which put women's lives at risk.[91]

It has been explained how abortion stigma leads to denial of safe abortion care even when the legal requirements for an abortion are met. The stigma results in two different unethical behaviours – one is the refusal to provide safe abortion services to women who meet the legal requirements for obtaining legal abortion, and the other is to discriminate against women with complications of induced abortion. Healthcare providers often claim conscientious objection, or to refuse based on religious, moral, or philosophical grounds.[92]

Abortion stigma has been defined as "a negative attribute ascribed to women who seek to terminate a pregnancy that marks them, internally or externally, as inferior to ideals of womanhood."[93] The distinguishing feature of abortion stigma from other types of reproductive stigmas is that women who seek to end a pregnancy are making an active decision to end a potential life. [94] This definition is interpreted that it is not only life that women can give but also death, which is deeply disturbing to social mores.[95] Abortion stigma is also defined "a shared understanding that abortion is morally wrong and/or socially unacceptable,"[96] and is found to play a role with abortion providers, systems of care, communities, laws and policies and the media.

Abortion is stigmatized because it violates the "feminine ideals" of womanhood, such as nurturing motherhood and sexual purity; by attributing personhood to the fetus; because of legal restrictions; because it is viewed as dirty or unhealthy; and because anti-abortion forces have found stigma as a powerful tool to put up barriers and change cultural values so that women will seek abortion less frequently even if it is legal.[97]

Applying the theory of stigma as social process with a four-component model,[98] abortion stigma is described to manifest in: 1) labeling women who have had

[90] Raymundo et al., *Unsafe Abortion, 86-93*
[91] Center for Reproductive Rights, Forsaken Lives
[92] Anibal Faúndes and Laura Miranda, "Ethics surrounding the provision of abortion care," *Best Practice & Research Clinical Obstetrics & Gynaecology* 43, no.50-57 (August 2017), https://doi.org/10.1016/j.bpobgyn.2016.12.005.
[93] Anuradha Kumar, Leila Hessini and Ellen M.H. Mitchell, "Conceptualising abortion stigma," Culture, Health & Sexuality 11, no.6 (July 2009), https://doi.org/10.1080/13691050902842741
[94] Kumar, Hessini and Mitchell, "Conceptualising,"
[95] Anuradha Kumar, "Everything Is Not Abortion Stigma," *Womens Health Issues* 23, no. 6 (November 2013), https://doi.org/10.1016/j.whi.2013.09.001.
[96] Cockrill, Kate and Adina Nack, "I'm Not That Type of Person": Managing the Stigma of Having an Abortion, Deviant Behavior 34, no. 12 (2013): 973-990, http://dx.doi.org/10.1080/01639625.2013.800423.
[97] Alison Norris et al., "Abortion Stigma: A Reconceptualization of Constituents, Causes, and Consequences," *Womens Health Issues* 21, no.3, http://doi.org/10.1016/j.whi.2011.02.010.
[98] Bruce G. Link and Jo C. Phelan, "Conceptualizing Stigma." *Annual Review of Sociology* 27, (August 2001): 363-385.

abortion and their service providers as deviant; 2) stereotyping women who have had abortion to negative traits such as promiscuity, carelessness, selfishness, and without compassion for human life. Service providers are stereotyped as cold, unfeeling, and motivated by greed; 3) separating women and service providers from the rest to shame those marked by stigma; and 4) discrimination or status loss for women who have had abortion and their service providers. [99]

But stigma is not linear. Abortion stigma is further explained to be a cause and can also be consequence of inequality. For instance, the limited access to abortion and trained providers and abortion laws being part of criminal laws could be causes of abortion stigma, or they could be consequences. It is not a binary concept, and the intensity of abortion stigma may vary depending on how legally restricted abortion is.[100]

Woman's right to have an abortion is also often refuted using what is called the Responsibility Objection. This concept "holds that a woman is responsible for the fetus growing inside her body as a result of her willing participation in sexual activity."[101] The four reiterations of Responsibiliy Objection are described as:

1) Harm Version or that an individual is causally responsible for producing a harmful situation and that situations was produced via voluntary acts which one either knew (or should have known) might result in the harmful situation
2) Care version or that you have an obligation to avoid for another's welfare, even at great cost to yourself
3) Tacit Consent version or that the pregnant woman had tacit consent to the consequence of pregnancy by engaging voluntarily in sexual intercourse
4) Negligence version or that the now pregnant woman failed to avoid the consequence of becoming pregnant.[102]

But a person may have both positive and negative attitudes towards abortion. Ambivalence in abortion resulting from the belief on the right of the fetus and the reproductive autonomy of a woman has been studied in relation to political attitudes in the United States.[103] It was found that voters have ambivalent attitudes about abortion rights, and the degree of ambivalence varies according to the circumstances under which an abortion is obtained.

[99] Kati LeTourneau, *Abortion Stigma Around the World: A Synthesis of the Qualitative Literature* (2016).
[100] Kristen M. Shellenberg et al., "Social stigma and disclosure about induced abortion: Results from an exploratory study," Global Public Health 6, Sup1 (July 2011), https://doi.org/10.1080/17441692.2011.594072.
[101] Ian McDaniel, "The Responsibility Objection to Abortion: Rejecting the notion that the responsibility objection successfully refutes a woman's right to choose," Bioethics 29 no. 4 (2015): 291–299. https://www.doi.org/10.1111/bioe.12097.
[102] McDaniel, "The Responsibility," 293
[103] Stephen C. Craig, James G. Kane, and Michael D. Martinez, "Sometimes You Feel Like a Nut, Sometimes You Don't: Citizens' Ambivalence About Abortion," Political Psychology 23, No. 2 (2002).

In the Philippines, just like many other contexts, abortion stigma manifests in the provision of therapeutic abortion[104] and the treatment of women with postabortion complications. Even when medical providers believe that therapeutic abortion is legally provided for by the law[105] resistance in policy reforms is ultimately rooted in the view that "termination of pregnancy is morally wrong at all times."[106] The dominant discourse on abortion is described as fundamentalist in nature, centered on the fetus rathered than on the woman who have the right to bodily integrity and autonomy. [107] While the fetus figures prominently in legal discourse, terms like "child" and "baby" are used far more often in popular discourse.[108] Anti-choice groups in the Philippines have used images of fetus that were given names to frame pro-choice as not only anti-life but also anti-baby and anti-child.[109] The term "unborn" also became popular since 2002 when then President Gloria Macapagal-Arroyo declared a "Day of the Unborn," coinciding with the Catholic feast of the Annunciation.[110]

But while the abortion rights discourse is skewed towards the rights of the fetus over that of the woman, studies point to the reality that women still choose to have an abortion for various reasons. While women who have abortion may feel guilt or remorse, but women also feel relieved for having avoided the pressing problems if they go through with the unintended pregnancy.[111] The experience of women who resorted to abortion primarily out of poverty has been described as "lifeboat ethics," where they resort to abortion because they try to rescue themselves and their families from poverty.[112] Women's decision regarding termination of pregnancy is influenced by the support or non-support of their partners, by the strength of their support system, and by religious beliefs. However there are also instances when the decision to end the pregnancy is a woman's sole decision, particularly for women who have more economic means, those empowered to take ownership of their body, or when their pregnancy was a result of abuse or rape.[113]

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[104] Therapeutic abortion is defined according to laws in specific context. abortion refers to an abortion recommended when the woman's health is at risk. Definition from https://www.health.harvard.edu/medical-tests-and-procedures/abortion-termination-of-pregnancy-a-to-z

[105] Asia Safe Abortion Partnership, "A Study," 07

[106] Aurora E. Perez, "Policy Issue Briefs:The Ambiguities and Ambivalence on Abortion Issues in the Philippines," Philippine Commission on Women. https://library.pcw.gov.ph/sites/default/files/Policy%20Issue%20Brief%20abortion_0166.pdf

[107] Lalaine P. Viado. "Unsafe Abortion and Fundamentalism in the Philippines: Locating absences, dredging trenches," ISIS International, http://www.isiswomen.org/index.php?option=com_content&view=article&id=1081%3Aunsafe-abortion-and-fundamentalism-in-the-philippines-locating-absences-dredging-trenches&catid=143

[108] Michael L. Tan, "Fetal Discourses and the Politics of the Womb," *Reproductive Health Matters* 12, sup24 (2004): 157-166. https://doi.org/10.1016/S0968-8080(04)24013-7.

[109] Tan, "Fetal,"

[110] Tan, "Fetal," 160

[111] Raymundo et al., *Unsafe Abortion, 95*

[112] In a master's thesis, "Aborted Stories: Maternal Health Crisis in Eden,", Efenita Taqueban, University of the Philippines, 2010.

[113] Consuelo Foundation, Unwanted Pregnancies: Understanding and Action in Behalf of the Poorest Women in Metro Manila, Makati City, 2011..

In Pew Research Center's 2013 Global Attitudes survey in 40 countries, abortion tops as the most morally unacceptable issue for Filipinos.[114] Ninety-percent (93%) of those surveyed found abortion morally unacceptable. Among the 40 countries included in the survey, Philippines was the most unaccepting of abortion. While in view of such poll, it can be held that Filipinos are generally against abortion, but earlier studies also point to the ambivalence that Filipinos have on abortion. The moral restriction and the public knowledge that abortion is illegal while also finding abortion also justifiable in certain cases, particularly when needed to save the health of the woman, rises to ambivalence towards abortion and abortion reforms in the Philippines.[115]

Objections on abortion in the country are very much entrenched in religious beliefs. A qualitative study on Filipino urban young adult's perceptions and practices of abortion revealed that despite the common occurrence of abortion in their communities, they see abortion as immoral and would lead to negative consequences.[116] The views on unintended pregnancy and abortion is laden with moral and religious beliefs and stigma pervasive in the negative language used to describe the woman who had abortion such as loose, criminal, and immoral. Abortion is seen to invoke "*gaba*" (punishment and bad karma) that may take in the form of negative health consequences. However, some of the participants find abortion more acceptable (in varying degrees) in situations such as dire health, economic concern, and partner abandonment. Gender differences in acceptance of abortion in different situations were also observed.

Not much is known on how health service providers' view abortion owing to the dearth of studies specifically looking into this population's attitudes and opinions on abortion in the Philippines. Previous studies have included service providers as respondents or participants along with women and young people, and focused more on their knowledge of the law and the consequences of the legal ambiguity on abortion.

In a survey with health service providers and young people on how the law influences young people's access to SRH services in the Philippines, respondents were asked on their knowledge of the legal grounds for abortion. [117] Health service providers were found to be aware of the strict legal prohibitions on abortion, where a majority thought that abortion is never permitted legally in any circumstances. Majority of the service providers (66%) indicated that in their own opinion, abortions should never be allowed. But there were service providers who believed that abortion is justified to save a woman's life.

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[114] Pew Research Center, Global Views on Morality, Pews Research Center, accessed March 29, 2019, https://www.pewglobal.org/2014/04/15/global-morality/table/abortion/

[115] Perez, "Policy,"

[116] Gipson, Jessica D., Alanna E. Hirz, and Josephine L. Avila. "Perceptions and Practices of Illegal Abortion among Urban Young Adults in the Philippines: A Qualitative Study." *Studies in Family Planning* 42, no. 4 (December 2011): 261-272. https://doi.org/10.1111/j.1728-4465.2011.00289.x

[117] International Planned Parenthood Federation. Overprotected and Underserved, The Influence of Law on Young People's Access to Sexual and Reproductive Health in the Philippines. International Planned Parenthood Federation 2017: 52-54.

The lack of consensus among health professionals has been observed on the circumstances under which abortion to save the life of a woman can be performed. In an interview with physicians, some point that the decision to perform abortion is "often based on the medical and ethical position of his or her institution or professional group."[118] The Philippine Obstetrical and Gynecological Society (POGS) guidelines on "Ethical Issues in Fetomaternal Care" permit medication or treatment only when the "intended effect is to treat another medical condition and not cause abortion itself," consistent with the Roman Catholic's "double effect" principle.[119] Based on the guidelines, only in cases of ectopic pregnancy are surgical methods acceptable. The guidelines proscribe use of certain forms of cancer treatment for pregnant women and abortion on the grounds of fetal impairment.

In 2011, a feature story was published describing what went in a case conference organized by the Department of Obstetrics and Gynecology of the Manila Doctors' Hospital. According to the writer who participated in the case conference, the ethical issue of termination of pregnancy to save a woman was discussed. The writer went on to describe the views of two Filipino physicians also present in the said conference:

> "Dr. Nora Silao, department chair, said the focus of treatment should have been in treating the mother for her severe pulmonary hypertension, giving her whatever treatment she required to improve her hemodynamic instability. If the baby is aborted in the process, then that was not directly induced by the physicians, and there can be no ethical question."
>
> "Lourdes Capito, head of the ethics committee of the Philippine Obstetrical and Gynecological Society (POGS), categorically said that in our country, such act is considered both unethical and illegal. Direct abortion for any cause is still abortion. "Even therapeutic abortion is not allowed in our country," she emphasized."[120]

The views of the two practitioners were slightly different in that the former recognized that saving the woman could have abortive outcomes, which would not be considered unethical; while the latter claimed that therapeutic abortion is unethical whatever the circumstances may be. Despite the difference in nuances, what can be gleaned from the anecdote above is that there is a highly conservative attitude towards abortion among Filipino physicians and what seems to be a tendency to distance themselves from the issue.

In many other societies, healthcare professionals generally have reservations about abortion. Religious convictions, beliefs about professional roles and ethics, and

[118] Center for Reproductive Rights, Forsaken Lives, 66
[119] Center for Reproductive Rights Legislative Brief, Realising a Healthy, Equal, and Thriving Philippines: The role of Abortion Law Reform in Achieving the Nation's Development Goals, Center for Reproductive Rights, 2018
[120] Rafael Castillo M.D. "Is it ethical to terminate pregnancy because of the mother?" Philippine Daily Inquirer. April 8, 2011. https://l.facebook.com/l.php?u=https%3A%2F%2Fbusiness.inquirer.net%2F718%2Fis-it-ethical-to-terminate-pregnancy-to-save-the-mother#ixzz5ldx8XCPk.

feelings of unpreparedness give rise to dilemmas among healthcare providers studied in sub-Saharan Africa and Southeast Asia where abortion is allowed in varying degrees.[121] This affects the relationship between them and the women are seeking abortion services.

In the United States where abortion is generally legal, it is the third most frequently performed surgery on women of reproductive age, but it has become highly marginalized within medicine such that very few physicians provide abortion services. While abortion stigma, violence, and political contention provide some explanation, willing physicians are further constrained by structural barriers that effectively institutionalize buck-passing of abortion patients to abortion clinics. [122]

Studies in other countries have also looked into health students' knowledge and attitudes toward abortion for its potential to provide recommendations for better contexts for women. However, there is a dearth of similar literature on the experiences of countries such as the Philippines where abortion remains highly restricted.

Even in countries where abortion laws are liberalized, medical training on abortion was still found insufficient. A survey done in medical schools in Canada and the United States showed that a third of these schools "do not include any discussion of therapeutic abortion, pregnancy options counselling, postabortion care, or abortion access, law, or policy."[123] There are limited learning opportunities on unintended pregnancy and abortion available for undergraduate medical students, resulting to a general lack of understanding about abortion. The undergraduate medical students still reported willingness to include some aspect of abortion care in their medical practice if given sufficient training about the procedure.

Medical students reported varying degrees of support to abortion and willingness to include abortion in their future practice. Studies found that greater acceptability and readiness to perform an abortion grew with the length of their medical education and clinical experience.[124] It has been suggested that age may influence opinion because "life experience gives medical students a broader understanding of the

[121] Ulrika Rehnström Loi et al., "Healthcare providers' perceptions of and attitudes towards induced abortions in sub-Saharan Africa and Southeast Asia: A systematic literature review of qualitative and quantitative data," BMC Public Health 15, no.1 (February 2015), https://doi.org/10.1186/s12889-015-1502-2.
[122] Lori Freedman, *Willing and unable: Doctors constraints in abortion care* (Nashville: Vanderbilt University Press, 2010)
[123] Cessford and Wendy V. Norman, "Making a Case for Abortion Curriculum Reform: A Knowledge-Assessment Survey of Undergraduate Medical Students," Journal of Obstetrics and Gynaecology Canada 33, no. 6 (June 2011): 580, https://doi.org/10.1016/s1701-2163(16)34905-2
[124] Roger A. Rosenblatt et al., "Medical Students' Attitudes Toward Abortion and Other Reproductive Health Services," Student Education 31, no.3 (April 1999): 195-199.; Shotorbani et al., "Attitudes and Intentions of Future Healthcare Providers Toward Abortion Provision," *Perspectives on Sexual and Reproductive Health* 36, no.2 (2004): 58-63, https://doi.org/10.1363/3605804.; Zoran Trninic et al., "Attitudes of Students of Medicine, University of Mostar According to Induced Abortion," *Psychiatria Danubina* 29, 4th ser (November 2017); Stephanie B. Wheeler et al., "Attitudes and Intentions Regarding Abortion Provision Among Medical School Students in South Africa," *International Perspectives on Sexual and Reproductive Health* 38, no.03 (September 2012): 154-163, https://doi.org/10.1363/3815412.;

vagaries of existence that make abortions at times unavoidable."[125] Women were also found to have more favorable attitudes toward the provision of wider reproductive health services including abortion.[126] Some studies however, did not find conclusive evidence that age, sex or study program influence attitude towards abortion.[127] Aside from age, it was also reported that students who are currently in a relationship, who have ever had sexual intercourse, and who know anyone who has terminated a pregnancy were more likely to be have liberal views towards a woman's right to an abortion.[128]

Beyond socio-demographic characteristics, correlations were seen with students' attitudes towards abortion with their opinion on the beginning of life;[129] and their willingness to take part in abortion provision on the extent of participation required, the circumstances of the pregnancy and the stage of pregnancy.[130] Students were most likely support that abortion is willing to perform therapeutic abortion or when women's life is at risk, if the fetus has congenital defect or malformation, and if the pregnancy was the result of rape or incest.

Knowledge of the law has also been cited to affect medical students' willingness to include abortion service in their future practice. Despite abortion being permitted on the grounds of saving the life of woman, preserving physical and mental health, and socioeconomic reasons in India,[131] medical students described a fear to provide abortion in their future practice.[132] The medical students lacked understanding of the law and confused the legal regulation of abortion with the law governing gender biased sex selection, and concluded that abortion is illegal. The interviewed medical students' attitudes were supported by their experiences and perceptions from the clinical setting as well as traditions and norms in society.

In Vietnam where abortion laws are fully liberalized, midwifery students saw their future tasks mainly related to childbearing and less to other reproductive health issues, such as abortion and prevention of sexually transmitted diseases and HIV.[133] Midwifery students revealed that the main reason for choosing midwifery as a profession was to care for women in labor and delivery, thus facing a dilemma when it comes to abortion provision.[134] To address the ethical dilemmas of future

[125] Rosenblatt et al., "Medical Students,"
[126] Rosenblatt et al., "Medical Students,"

[128] Sara D. Rominski et al., "Attitudes toward abortion among students at the University of Cape Coast, Ghana," Sexual & Reproductive Healthcare 11(October 2016): 53-59, https://doi.org/10.1016/j.srhc.2016.10.002.
[129] Maria Sol Rodriguez-Calvo et al., "University students' attitudes towards Voluntary Interruption of Pregnancy," *Legal Medicine* 14, no. 4 (July 2012): 209-213, https://doi.org/10.1016/j.legalmed.2012.02.002.
[130] Rodriguez-Calvo et al., "University,"; Trninic et al., "Attitudes of Students," ; Wheeler et al., "Attitudes,"
[131] Guttmacher
[132] Susanne Sjöström et al., "Medical students are afraid to include abortion in their future practices: In-depth interviews in Maharastra, India," BMC Medical Education 16, no. 1(January 2016), https://doi.org/10.1186/s12909-016-0532-5
[133]Klingberg-Allvin et al., "Ethics of justice and ethics of care Values and attitudes among midwifery students on adolescent sexuality and abortion in Vietnam and their implications for midwifery education: A survey by questionnaire and interview," International Journal of Nursing Studies 44, (February 2007):37-46, https://doi.org/10.1016/j.ijnurstu.2005.11.018.
[134] Loi et al., "Healthcare,"

healthcare providers, it is suggested that reflective pedagogy and moral reasoning should be included in the Vietnamese midwifery education and training programs, exposing students to different ethical perspectives can enrich midwifery students' understanding of the complexity of reproductive health issues.[135]

All studies emphasize the importance of education, amending the curriculum to increase levels of student's understanding of the laws, ethics and responsibilities, and including sexual and reproductive health services such as abortion and postabortion care in the curriculum. In Argentina, for instance, misconceptions were observed to be due to the fact that abortion is inadequately covered in the medical curricula.[136] A study in United States also found that medical students learn from a hidden curriculum that was found to distract from core content, incorporate social judgment of patients into medical practice, and promote normative gender concepts.[137]

The existing literature describe how the mutually reinforcing abortion stigma and criminalization of abortion creates general conservative, at times negative, attitudes toward abortion of healthcare providers and students, even in countries that have fully or partially liberalized abortion laws. The stigma and criminalization are born out of religious and moral beliefs, social norms, and expectations placed on women.

This leads to the question, then, on how advocates can sustain the conversation with the healthcare service sector on safe abortion rights in the highly restricted context of the Philippines. Though we are inclined to believe that Filipinos are unaccepting of abortion, advocates have noticed changing attitudes towards abortion.[138] It can be said that the creation of the Philippine Safe Abortion Advocacy Network (PINSAN) in 2015, the first network of human rights advocates that openly talked about the issue[139] and calling for the decriminalization of abortion in the Philippines, is an indication of that. For instance, for the first time in the history of POGS Annual Conferences, the right to postabortion care and safe abortion was tackled in 2018.[140] A Facebook post[141] of the event has gained a substantial traction given how polarizing the issue of abortion is in the country. The current study aims to gain insights that could point to advocacy strategies to widen the spaces and deepening the conversations there are on abortion by looking into the knowledge and attitudes of students who are the future healthcare providers.

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[135] Loi et al., "Healthcare,"

[136] Belén Provenzano-Castro, Silvia Oizerovich and Babill Stray- Pedersen, "Future healthcare professionals' knowledge about the Argentinean abortion law," International Journal of Medical Education 7 (March 2016): 95-101, https://doi.org/10.5116/ijme.56e0.74be.

[137] Elliot et al., "Without any indication": stigma and a hidden curriculum within medical students' discussion of elective abortion," Social Science and Medicine 214, (October 2018):26-34, https://doi.org/10.1016/j.socscimed.2018.07.014

[138] This was the observation shared by members of Philippine Safe Abortion Advocates during sharing of initial results finding in January 2019.

[139] https://pinsan.ph/wp-content/uploads/2018/10/anthology-colored.pdf

[140] Shared by Atty. Claire Padilla of EnGendeRights during sharing of initial baseline findngs in Janaury 2019

[141] Clara Rita A. Padilla, "While priests have their pulpits, I have the ever reliable mic... Gave my nth talk on women's right to access postabortion care and safe abortion last Wednesday," Facebook, January 18, 2019, https://www.facebook.com/engenderights/posts/10214169426578410.

# 6. BASELINE RESEARCH FINDINGS

## 1. FINDINGS FROM SURVEY

This section describes the findings from the survey. The survey was conducted in five schools in major and highly urbanized cities in Luzon and Visayas with final year students of Doctor of Medicine, Bachelor of Science in Nursing, and Bachelor of Science in Midwifery.

### 1.1 Profile of study areas

Participants were from three schools in Metro Manila; one school in Region 4A (Luzon); and one school in Region 8. Metro Manila or the National Capital Region (NCR) is the country's capital and is entirely urbanized (100% level of urbanization).[142] It is the most densely populated region in the country, with a population density 60 times higher than the national level.[143] The total population of the NCR accounted for 12.8% of the Philippine population in 2015. [144]When the national poverty incidence among families is placed at 16.7%, poverty incidence among families in NCR is estimated at 2.7%.[145] The participating institutions from NCR are two public schools (one with Bachelor of Science in Nursing program and the other with Bachelor of Science in Midwifery) and one private school (Bachelor of Science in Nursing program).

Region 4A (Luzon) has a 66.4% level of urbanization.[146] The total population in the region accounted for 14.3% percent of the Philippine population in 2015.[147] The poverty incidence in the region is at 6.8%.[148] The study was conducted with students from the Bachelor of Science in Nursing program in one private school in Region 4A.

Meanwhile, while Region 8 (Visayas) has only an 11.9% level of urbanization,[149] the study site was also in one of the highly urbanized cities in the region. The total population of Region 8 comprises 4.4% of the Philippine population in 2015. Poverty incidence among families in the region is 30.7%, which is almost twice of the

[142] Philippine Statistics Authority. "Urban Population in the Philippines," Philippine Statistics Authority, March 21, 2016. https://psa.gov.ph/population-and-housing/node/138311.
[143] Philippine Statistics Authority. "Philippine Population Density," Philippine Statistics Authority, September 1, 2016. https://psa.gov.ph/population-and-housing/node/62690.
[144] Philippine Statistics Authority. Population of the National Capital Region. May 31, 2016. Philippine Statistic Authority. https://psa.gov.ph/content/population-national-capital-region-based-2015-census-population
[145] Philippine Statisitics Authority. 2015 Full Year Official Poverty Statistics of the Philippines, Philippine Statistics Authority, 2015. https://psa.gov.ph/sites/default/files.
[146] Philippine Statistics Authority. "Urban Population,"
[147] Philippine Statistics Authority. Population of Region IV-A- CALABARZON. June 2, 2016. Philippine Statistics Authority. https://psa.gov.ph/content/population-region-iv-calabarzon-based-2015-census-population.
[148] Philippine Statisitics Authority. 2015 Full Year Official Poverty Statistics of the Philippines
[149] Philippine Statistics Authority. "Urban Population,"

national rate.[150] The study was conducted in one private school with students from Bachelor of Science in Nursing and Doctor of Medicine program.

### 1.2 Profile of survey respondents

A total of 190 students from four schools were included in the survey (7 medical students, 142 nursing students, 41 midwifery students). All of the medical students were enrolled in a private school, while all midwifery students were from a public school. Majority (61%) of nursing students were from private schools, while the rest (39%) were in public schools. (See Table 3)

The mean age was 23 years, with the minimum reported age was 18 years and the maximum was 49 years. The mode was 20 years. (Data not shown)

Of the total respondents, majority was female in all the study programs. Majority of the respondents were Catholic in all the three study programs, and reported to attending religious services "about once a week." Most of the students are single and with no children. In terms of family income, more of the nursing and midwifery students reported to belong in the two bottom income brackets. Of the participants who reported as single, majority were in a relationship. Adding the number of married participants and those in cohabitation (live-in), the total percentage of participants who reported to have had relationship experience was 80%. (See Table 4)

Table 5 and 6 describe sexual and reproductive health experiences of the respondents. [151] Majority described themselves as heterosexual. About 41% reported to have had sexual experience, while almost half (45%) of the respondents said they never have had any sexual experience. About 15% indicated unwillingness to answer this question. The most reported contraceptive choices were male condoms and pills. A significant percentage of the contraceptive users still relied on the natural methods of rhythm/calendar (19%), and withdrawal (38%). (See Table 4)

**Table 3. Types of institution**

| Type of university | Medicine (n=7) | Nursing n=142 | Midwifery n=41 |
|---|---|---|---|
| Private,<br>Non-Sectarian/Non-Religious | 100% (7) | 61% (87) | 0 (0%) |
| Public | 0 (0%) | 39% (55) | 100% (41) |

[150] Philippine Statisitics Authority. 2015 Full Year Official Poverty Statistics of the Philippines

[151] As part of research sensitivities, the data on sexual and reproductive health experiences will not be aggregated by study programs.

**Table 4. Profile of respondents**

| CHARACTERISTICS | Medicine | Nursing | Midwifery |
|---|---|---|---|
| | n=7 | n=142 | n=41 |
| **Gender** | | | |
| Female | 71% (5) | 65% (92) | 90% (37) |
| Male | 29% (2) | 30% (43) | 7% (3) |
| Identify as… | | 4% (6) | 3% (1) |
| **Religion** | | | |
| Catholic | 86% (6) | 78% (111) | 78% (32) |
| Protestant | | 4% (6) | |
| Muslim | | 1% (1) | 2% (1) |
| Buddhist | | 1% (1) | |
| No religion | | | |
| Others | 14% (1) | | 20% (8) |
| **Attendance to religious service** | | | |
| Everyday | | 2% (3) | 7% (3) |
| About once a week | 57% (4) | 51% (73) | 34% (14) |
| Once a month | 28% (2) | 10% (10) | 12% (5) |
| Occasional | 14% (1) | 32% (46) | 44% (18) |
| Not applicable | | 4% (6) | 2% (1) |
| **Civil status** | | | |
| Single | 100% (7) | 94% (134) | 61% (25) |
| Married | | 4% (5) | 32% (13) |
| Living-in | | 2% (3) | 7% (3) |
| *Relationship status among single:* | [n=7] | [n=134] | [n=25] |
| In a relationship | | 46%(61) | 68% (17) |
| No current relationship | 6 (86%) | 35% (47) | 24% (6) |
| Never been in arelationship | 1 (14%) | 19%(26) | 5% (2) |
| **Have child/children** | | | |
| Yes | 14%(1) | 9% (13) | 41% (17) |
| No | 86% (6) | 91% (129) | 59% (24) |
| **Average family monthly income** | | | |
| Php 19,000 and below | | 37% (53) | 17% (7) |
| Php 20,000-39,000 | | 20% (29) | 29% (12) |
| Php 40,000-59,000 | 14% (1) | 16% (23) | 27% (11) |
| Php 60,000-79,000 | 57% (4) | 10% (14) | 12% (5) |
| Php 80,000-99,000 | | 6% (8) | 5% (2) |
| Php100, 000 and above | 29% (2) | 8% (4) | |

**Table 5. Sexual orientation**

| How would you describe yourself? | Response rate (Frequency) |
|---|---|
| | n=190 |
| Heterosexual | 64% (121) |
| Homosexual | 11% (20) |
| Bisexual | 5% (9) |
| Other | 1% (2) |
| Prefer not to answer / No answer | 20% (38) |

**Table 6. Sexual experience and contraceptive use**

| Sexual experience | Response Rate (Frequency) n=190 |
|---|---|
| Have had sex | 41% (77) |
| Never had sex | 45% (85) |
| Unwilling to answer | 15% (28) |
| **Among those who have had sex** | |
| *Use of contraception* | |
| Yes | (48)* |
| No | (32)* |
| *Types of contraception used among contraceptive users* | **(n=48)** |
| Rhythm/Calendar | 19% (9) |
| Withdrawal | 38% (18) |
| Male condoms | 56% (27) |
| Oral contraceptives | 23% (11) |
| Implants | 4% (2) |
| Injectable | 10% (5) |

**Total response is more than the responses in "Have had Sex" suggesting a misreporting in the sexual experience question.*

## 1.3 Awareness and knowledge of abortion

### *1.3.1 Prevalence of abortion*

According to DOH data, "pregnancy with abortive outcomes" consistently ranks among the major causes of maternal deaths.[152] Without specifying what type of abortion (e.g. induced or spontaneous, safe or unsafe), respondents were asked whether they think abortion is among the top five causes of maternal mortality.

[152] Department of Health, "Maternal Deaths,"

Majority of the students believed that abortion is among the top major causes of maternal deaths in the country, with majority of the respondents in all three study programs (71% medical students; 67% nursing students; 73% midwifery students) agreeing to the statement "Abortion is among the Top 5 leading causes of maternal deaths in the Philippines." This implies that the sampled students have considerable awareness that abortion is common and a significant contributor to maternal mortality. (See Table 7)

**Table 7. Knowledge of abortion prevalence**

| *Abortion is among the top 5 leading causes of maternal deaths in the Philippines* | | | | |
|---|---|---|---|---|
| | True | False | I don't know | No answer |
| **Medicine** (n=7) | 71% (5) | | 29% (2) | |
| **Nursing** (n=142) | 67% (95) | 10% (14) | 20% (28) | 3% (5) |
| **Midwifery** (n=41) | 73% (30) | 5% (2) | 20% (8) | 2% (1) |

When asked on what they think was the percentage among reproductive health age women that has unmet need for contraceptives, there was a high percentage of respondents in all study programs (57% medical students, 56% nursing students, 49% midwifery students) who reported not knowing. (See Table 8)

**Table 8. Knowledge of unmet need for family planning**

| *According to the latest NDHS, what percentage of women age 15-49 has unmet need for family planning?* | | | | | | |
|---|---|---|---|---|---|---|
| | About 50% | **About 17% *** | About 10% | About 5% | I don't know | No answer |
| **Medicine** (n=7) | 43% (3) | | | | 57% (4) | |
| **Nursing** (n=142) | 28% (39) | 7% (10) | 3% (4) | 1 % (2) | 56% (80) | 5% (7) |
| **Midwifery** (n=41) | 32% (13) | 12% (5) | 2% (1) | 2% (1) | 49% (20) | 2 % (1) |

The common notion that most women who had abortion had pregnancy outside of marriage still persisted among the respondents. None of the medical students thought that most women who had abortion are married or in consensual union, and majority of of the nursing students (68%) and of the midwifery students (49%) had the same view. (See Table 9)

**Table 9. Knowledge of profile of women who have abortions**

| *Most Filipino women who have abortion are married or in a consensual union* | | | | |
|---|---|---|---|---|
| | True | False | I don't know | No answer |
| **Medicine** (n=7) | | 57% (4) | 29% (2) | 14% (1) |
| **Nursing** (n=142) | 13% (28) | 68% (99) | 15% (21) | 3% (4) |
| **Midwifery** (n=41) | 10% (4) | 49% (20) | 39% (16) | 2% (1) |

### *1.3.2 Self-assessment of theoretical knowledge*

Majority of the students in all study programs indicated the moderate point in the scale (Fair and Good) when assessing their theoretical knowledge of SRHR. Slightly more medical students rated their knowledge as "Fair" over "Good" (57% and 43% respectively). For nursing students, around half (53%) rated their knowledge as

"Good" and 32% rated "Fair". Meanwhile, more midwifery students reported having "Good" knowledge (63%) and 22% indicated "Fair". (See Table 10)

**Table 10: Assessment of theoretical knowledge of SRHR**

| *How would you assess your theoretical knowledge of sexual and reproductive health and rights?* | | | | |
|---|---|---|---|---|
| | Poor | Fair | Good | Very Good |
| **Medicine** (n=7) | | 57% (4) | 43% (3) | |
| **Nursing** (n=142) | 4% (6) | 32% (45) | 53% (75) | 11% (16) |
| **Midwifery** (n=41) | | 22% (9) | 63% (26) | 15% (6) |

When assessing their theoretical knowledge of abortion, most of respondents in all study programs rated themselves as either having "Fair" or "Good" knowledge (See Table 11). On their self-assement of postabortion care, majority of the responses were still mostly in the moderate points of "Fair" and "Good" in the scale (See table 12). It can be noticed, however, that there were more students who assessed their theoretical knowledge of postabortion care as "Poor" compared to number of students who reported having "Poor" knowledge of abortion.

**Table 11: Assessment of theoretical knowledge of abortion**

| *How would you assess your theoretical knowledge of sexual and reproductive health and rights?* | | | | |
|---|---|---|---|---|
| | Poor | Fair | Good | Very Good |
| **Medicine** (n=7) | | 71% (5) | 29% (2) | |
| **Nursing** (n=142) | 4% (6) | 42% (60) | 49% (70) | 4% (6) |
| **Midwifery** (n=41) | | 46% (29) | 46% (19) | 7.3 (3) |

**Table 12: Assessment of theoretical knowledge of postabortion care**

| *How would you assess your theoretical knowledge of sexual and reproductive health and rights?* | | | | |
|---|---|---|---|---|
| | Poor | Fair | Good | Very Good |
| **Medicine** (n=7) | 14% (1) | 71% (4) | | 14% (1) |
| **Nursing** (n=142) | 15% (21) | 48% (67) | 34% (48) | 4% (5) |
| **Midwifery** (n=41) | 2% (1) | 29% (12) | 59% (24) | 10% (4) |

### *1.3.3 Knowledge of abortion procedures*

When asked if they know how medical abortion is done, a majority both among the medical and nursing students answered "Yes" (86% medical students, 63% nursing students). On the other hand, a majority of the midwifery students (59%) reported not knowing how medical abortion is done. (See Table 13)

With the question "What is the recommended method for medical abortion?" none of the medical and midwifery students identified the correct answer "Mifepristone followed by Misoprostol." Meanwhile, only 8% of the nursing students identified the correct answer among the given choices in the questionnaire. (See Table 14)

**Table 13. Knowledge of medical abortion**

| *Do you know how medical abortion is done?* | | | |
|---|---|---|---|
| | Yes | No | I don't know |
| **Medicine** (n=7) | 86% (6) | 14% (1) | |
| **Nursing** (n=142) | 63% (90) | 33% (47) | 4% (5) |
| **Midwifery** (n=41) | 34% (14) | 59% (24) | 7% (3) |

**Table 14. Knowledge of medical abortion methods**

| *What is the recommended method for medical abortion?* | | | | | | |
|---|---|---|---|---|---|---|
| | Oxytocin followed by Misoprostol | Misoprostol alone | Misoprostol followed by Mifepristone | Mifepristone followed by Misoprostol | I don't know | No answer |
| **Medicine** (n=7) | 71% (5) | | | | 29% (2) | |
| **Nursing** (n=142) | 22% (31) | 2% (3) | 5% (7) | 8% (12) | 58% (83) | 4% (6) |
| **Midwifery** (n=41) | 7% (3) | 5% (2) | 12% (5) | | 73% (30) | 2% (1) |

All of the medical students reported knowing how surgical abortion is done, as well as a majority (59%) of the nursing students. Midwifery students had the lowest rate (27%) of those reporting having knowledge of surgical abortion. (See Table 15)

Correspondingly, majority of the respondents in medical and nursing programs correctly identified Manual Vacuum Aspiration (MVA) as a safe surgical method among the choices, while 61% of midwifery student reported not knowing the correct answer. While it is a relatively small percentage, it is important to note that there were still those who identified "Intake of Cytotec" as a safe surgical method for abortion, even among the medical student group despite all of them reporting to knowing how surgical abortion is done. (See Table 16)

**Table 15. Knowledge of surgical abortion**

| *Do you know how surgical abortion is done?* | | | |
|---|---|---|---|
| | Yes | No | I don't know |
| **Medicine** (n=7) | 100% (7) | | |
| **Nursing** (n=142) | 59% (84) | 37% (53) | 4% (5) |
| **Midwifery** (n=41) | 27% (11) | 66% (27) | 7% (3) |

**Table 16. Knowledge of safe surgical abortion methods**

| Which among these is a method for safe surgical abortion? | | | | | |
|---|---|---|---|---|---|
| | Intake of Cytotec | Abdominal Massage | Vacuum Aspiration | I don't know | No answer |
| **Medicine** (n=7) | 14% (1) | | 86% (6) | | |
| **Nursing** (n=142) | 12% (17) | 2% (3) | 58% (83) | 25% (35) | 3% (4) |
| **Midwifery** (n=41) | 7% (3) | | 27% (11) | 61% (25) | 5% (2) |

*1.3.4 Knowledge of laws*

On knowledge of laws, 43% of the medical students said abortion is totally prohibited; while 57% believed that it is legally available only on the grounds of saving a woman's life. For nursing students, 26% said it is totally prohibited; 4% said it is allowed depending on the circumstances; and 55% said it is only legally available on the grounds of saving a woman's life. Midwifery students were also uncertain on the law with regards to abortion: 20% said it is totally prohibited; 7% said that it is sometimes allowed depending on the circumstances; and 46% said it is only legally available on the grounds of saving a woman's life. (See Table 17)

**Table 17. Knowledge of law on abortion**

| *According to the law, when can a woman access an abortion in the Philippines?* | | | | | | |
|---|---|---|---|---|---|---|
| | Always, there are no restrictions | Never, abortion is totally prohibited | Sometimes, depending on the circumstances | ONLY when it is necessary to save a woman's life | I don't know | No answer |
| **Medicine** (n=7) | | 43% (3) | | 57% (4) | | |
| **Nursing** (n=142) | 2% (3) | 26% (37) | 4% (6) | 55% (78) | 9% (13) | 4% (5) |
| **Midwifery** (n=41) | 5% (2) | 20% (8) | 7% (3) | 46% (19) | 17% (7) | 5% (2) |

The responses were even more varied on whether healthcare providers are required by law to report women who sought postabortion care after an induced abortion. Among medical students, more respondents (57%) believed that women should not be reported. Among nursing and midwifery students, more respodents believed that women who had abortion should be reported. About 1 out of 3 nursing and midwifery reported not knowing what the law requires. (See Table 18)

**Table 18. Knowledge of reporting women who had abortion**

| *Are health professionals required by law to report to the police a woman who sought postabortion care after an induced abortion?* | | | | |
|---|---|---|---|---|
| | Yes | No | I don't know | Skipped |
| **Medicine** (n=7) | 29% (2) | 57% (4) | 14% (1) | |
| **Nursing** (n=142) | 39% (56) | 25% (35) | 32% (46) | 4% (5) |
| **Midwifery** (n=41) | 49% (20) | 17% (7) | 32% (13) | 2% (1) |

## 1.4 Sources of knowledge of abortion

The students learned about abortion in the course of their studies. Majority of the students across all the programs cited Studies/School as their main source of knowledge of abortion (100% medical students, 95% nursing students, 98% midwifery students). (See Table 19)

**Table 19. Sources of knowledge of abortion**

| **Where did you hear from or learn about abortion?** | **Medicine** (n=7) | **Nursing** (n=142) | **Midwifery** (n=41) |
|---|---|---|---|
| Studies/School | 100% (7) | 96% (136) | 98% (40) |
| Friends | 43% (3) | 42% (49) | 34% (14) |
| Family | 43% (3) | 39% (55) | 17% (7) |
| Traditional Media (TV, radio, newspaper) | 71% (5) | 71%) (101) | 49% (20) |
| Social media | 71% (5) | 73% (104) | 44% (18) |
| My own research | 43% (3) | 32% (46 | 32% (13) |
| Church | 29% (2) | 20% (29) | 10% (4) |
| Doctors and other health professionals | 100% (7) | 51% (73) | 66% (27) |
| Personal experience | 14% (1) | 4% (5) | 5% (2) |
| NGOs/Cause-oriented groups | 43% (3) | 9% (12) | 55 (2) |

Doctors and other health professionals were the next main sources of knowledge, particularly among medical and midwifery students. It is unclear, though, whether they referred to the doctors and health professionals they met in the course of their studies. Traditional and social media were the other major sources of their knowledge of the issue. Church ranked lower than friends, family, and own research as a source of knowledge. Only a few of the respondents heard or learned about abortion from non-government/cause-oriented groups. Majority of the respondents from all programs have not participated in any activities discussing abortion outside their studies (data not shown). There were also a few who said having learned about abortion through their own personal experience. The survey did not determine, however, the nature of this experience (e.g as personal experience of unintended pregnancy or experience of friends and loved ones).

There were a high percentage of students (29% medical students, 37% nursing students, 61% midwifery students) who reported personally knowing someone who had an abortion. Among the respondents, midwifery students had the highest percentage of those who reported to have personal knowledge of someone who went through an abortion. This may be due in part that many of the respondents are already working in reproductive health service provision. (See Table 20)

**Table 20. Personal knowledge of women who had abortion**

| *Do you personally know someone who had an abortion?* | | | | |
|---|---|---|---|---|
| | Yes | No | Unsure | Skipped |
| **Medicine** (n=7) | 29% (2) | 71% (5) | | |
| **Nursing** (n=142) | 37% (53) | 56% (79) | 6% (9) | 1% (1) |
| **Midwifery** (n=41) | 61% (25) | 37% (15) | 2% (1) | |

There were students who reported having assisted in a case of abortion procedure during their clinical training (14% medical students, 16% nursing students, 20% midwifery students) (See Table 21). Only nursing and midwifery students (20% and 49%, respectively) reported having assisted postabortion care (See Table 22). The survey, however, did not determine the nature and level of service provision they had assisted in.

**Table 21. Experience of assisting abortion procedure during clinical training**

| In the course of your trainng, did you have the opportunity of assisting in a case of abortion procedure? | | | |
|---|---|---|---|
| | Yes | No | Unsure |
| **Medicine** (n=7) | 14% (1) | 86% (6) | |
| **Nursing** (n=142) | 16% (23) | 77% (109) | 7% (10) |
| **Midwifery** (n=41) | 20% (8) | 78% (32) | 2% (1) |

**Table 22. Experience of assisting in postabortion care during clinical training**

| **In the course of your training, did you have any opportunity of assisting in a case of postabortion care?** | | | |
|---|---|---|---|
| | Yes | No | Unsure |
| **Medicine** (n=7) | | 100% (7) | |
| **Nursing** (n=142) | 20% (29) | 68% (97) | 10% (14) |
| **Midwifery** (n=41) | 49% (20) | 39% (16) | 10% (4) |

When asked how they would describe the extent that SRH has been covered in their respective program of studies, majority of respondents (71% medical students, 59% nursing students, 61% midwifery students) believed it was "Adequately" covered. (See Table 23)

**Table 23. Perception on the extent of how SRH is covered in education**

| *How would you say has sexual and reproductive health been covered in your program of study?* | | | | |
|---|---|---|---|---|
| | Not at all | Somewhat | Adequately | Can't say |
| **Medicine** (n=7) | | 14% (1) | 71% (5) | 14% (1) |
| **Nursing** (n=142) | 7% (10) | 28% (40) | 59% (84) | 6% (8) |
| **Midwifery** (n=41) | 15% (6) | 20% (8) | 61% (25) | 5% (2) |

### 1.4 Attitudes toward abortion

Presented in Table 24 are the responses to the attitudinal statements. The statements aimed to determined where the medical, nursing, and midwifery students stand on reproductive autonomy and abortion as rights; on the view that abortion is a moral wrong; and their support to abortion procedure training as part of their education.

Most of the students agreed to the statement "Women should be able to make and execute independent decisions on their reproductive health, such as pregnancy." The response rates in the agree side on the scale for each program is: 100% medical students; 86% nursing students; and 85% midwifery students.

**Table 24. Attitudes toward abortion**

| | Disagree* | Agree** |
|---|---|---|
| **Women should be able to make and execute independent decisions on her reproductive health, such as pregnancy.** | | |
| **Medicine** (n=7) | | 100% (7) |
| **Nursing** (n=142) | 14% (20) | 86% (122) |
| **Midwifery** (n=41) | 15% (6) | 85% (35) |
| **Abortion is an appropriate topic in my program of study.** | | |
| **Medicine** (n=7) | | 100% (7) |
| **Nursing** (n=142) | 7% (9) | 93% (133) |
| **Midwifery** (n=41) | 5% (2) | 95% (39) |
| **Abortion is morally wrong.** | | |
| **Medicine** (n=7) | 14% (1) | 86% (6) |
| **Nursing** (n=142) | 14% (20) | 86% (122) |
| **Midwifery** (n=41) | 15% (6) | 85% (35) |
| **A woman should always have the right to an abortion to an unintended pregnancy.** | | |
| **Medicine** (n=7) | 100% (7) | |
| **Nursing** (n=142) | 81% (115) | 19% (27) |
| **Midwifery** (n=41) | 78% (32) | 22% (9) |
| **My education program should include training on abortion procedures.** | | |
| **Medicine** (n=7) | 43% (3) | 57% (4) |
| **Nursing** (n=142) | 38% (54) | 62% (88) |
| **Midwifery** (n=41) | 35% (14) | 65% (27) |
| **Students with moral objections should be excused from any trainings and discussions on abortion.** | | |
| **Medicine** (n=7) | | 100% (7) |
| **Nursing** (n=142) | 59% (83) | 41% (59) |
| **Midwifery** (n=41) | 29% (12) | 71% (29) |

** Combined responses of Strongly Disagree, Disagree, Somewhat Disagree*

*** Combined responses of Strongly Agree, Agree, Somewhat Agree*

While they tended to support women's right to reproductive autonomy, most of the respondents (86% medical students; 86% nursing students; and 85% midwifery students) agreed that abortion is morally wrong. Majority of the students in all the programs (100% medical students, 81% nursing students, 78% midwifery students) also disagreed that it is a woman's right to have an abortion in the case of an unintended pregnancy. However, there were 19% of nursing students and 22% midwifery students who considered abortion as right for women who had an unintended pregnancy.

Students' beliefs on the appropriateness of including abortion procedures in their education were varied. While they generally expressed disapproval of abortion, majority in each program tended to agree that they should be trained on abortion procedures (57% medical students; 62% nursing students; 65% midwifery students). However, all medical students agreed that students with moral objections should be excused from such training. About 71% of midwifery students also agreed.

Meanwhile, a slightly larger percentage (59%) of nursing students disagreed that students should be excused from such training on the basis of moral beliefs.

Students' support for the legalization of abortion can be described as generally divided between two views: absolutely anti-legalization and legalization for certain circumstances of pregnancy. Among the medical students, majority (71%) supported abortion to be legally available for certain circumstances, while 29% absolutely do not support abortion for any grounds. Among nursing students, 46% did not support abortion to be legally available for any grounds, while 39% supported legalization for certain circumstances. Similarly, 51% of midwifery students did not support abortion to be legally available, with 42% supported for certain circumstances. (See Table 25)

**Table 25. Opinion on legalization of abortion**

| *Should abortion be legally available in our country?* | | | | | |
|---|---|---|---|---|---|
| | Yes, Absolutely, in all circumstances | No, absolutely. | Yes, Under certain circumstances | Unsure | No answer |
| **Medicine** (n=7) | | 29% (2) | 71% (5) | | |
| **Nursing** (n=142) | 3% (4) | 46% (65) | 39% (56) | 8% (12) | 4% (5) |
| **Midwifery** (n=41) | 2% (1) | 51% (21) | 42% (17) | | 5% (2) |

Majority of students who agreed with the legal availability of abortion under certain circumstances supported the first two circumstances of pregnancy (when it is necessary to save the woman's life and when the fetus has severe impairment and unlikely to survive). This is true for students in all programs who indicated support for legalization of abortion under certain circumstances. None of the medical students supported abortion beyond medical reasons. Nursing and midwifery students supported more grounds for legal abortion. Following health reasons, midwifery and nursing students who agreed with legalizing abortion for certain circumstances supported abortion for rape, followed by economc reasons, and mental health reasons. (See Table 26)

**Table 26. Opinion on the grounds for legal abortion**

| *If yes, under certain circumstances, what circumstances? (Multiple answers)* | | | | | | |
|---|---|---|---|---|---|---|
| | When it is necessary to save the woman's life. | When the fetus has severe impairment and unlikely to survive. | When the pregnancy is the result of rape. | When the pregnancy is the result of incest. | When the woman is in psychosocial distress about the pregnancy (Mental health) | When the woman is living in extreme poverty and her child will also live in extreme pervert (economic) |
| **Medicine** (n=5) | 100% (5) | 20% (1) | | | | |
| **Nursing** (n=56) | 91% (51) | 61% (34) | 13% (7) | 2% (1) | 11% (6) | 13% (7) |
| **Midwifery** (n=17) | 94% (16) | 53% (9) | 18% (3) | 6% (1) | 6% (1) | 6% (1) |

When asked on their willingness to perform or assist abortion services in their future practice if abortion were made legally available in the country, the response rate significantly lowered. However, this may be due in part to a limitation in the survey tool. A mistake in the numbering of the questions inadvertently made some of the respondents skipped this question. Of those who answered the item, 71% of the medical students answered that they would absolutely not perform abortion, while 29% said they will in certain circumstances. Of those who answered among nursing students, there were more students willing to assist in certain circumstances than those who will absolutely not (28% versus 23%). Among midwifery students, majority (51%) will absolutely not assist in abortion. Those who indicated willingness to assist in all circumstances were from nursing and midwifery programs. (See Table 27)

**Table 27. Willingness to perform or assist if abortion were made legal**

| *If abortion were made legally available in the Philippines would you be willing to perform and/or assist in abortion service?* | | | | | |
|---|---|---|---|---|---|
| | Yes, absolutely in all circumstances | Absolutely not | Yes, only under certain circumstances | Unsure | No answer |
| **Medicine** (n=7) | | 71% (5) | 29% (2) | | |
| **Nursing** (n=142) | 4% (5) | 23% (32) | 28% (40) | 14% (20) | 32% (45) |
| **Midwifery** (n=41) | 5% (2) | 51% (21) | 22% (9) | 12% (5) | 10% (4) |

When asked on their willingness to assist in abortion when it is necessary to save a woman's life in the present legal situation, a higher percentage (43%)of medical students indicated that they are unwilling, while 29% indicated willingness, and 29% were unsure. More nursing students (51%) indicated willingness. For midwifery students, only 20% indicated willingness, while the same percentage (37%) were either not willing or unsure. (See Table 28)

**Table 28. Willingness to assist in abortion at present to save a woman's life**

| In the present legal situation where abortion is generally restricted, are you wiling to assist in abortion procedure to save a woman's life? | | | | |
|---|---|---|---|---|
| | Yes | No | Unsure | No answer |
| **Medicine** (N=7) | 29% (2) | 43% (3) | 29% (2) | |
| **Nursing** (N=142) | 51% (72) | 19% (27) | 25% (35) | 6% (8) |
| **Midwifery** (N=41) | 20% (8) | 37% (15) | 37% (15) | 7% (3) |

In the course of analysis of the study results, it was pointed that the inclusion of the phrase "where abortion is generally restricted" may have skewed the responses as it connoted a more restrictive policy environment.

Socio-demographic characteristics of the respondents were crosstabulated with their attitudes and opinions on abortion. The following sub-sections discuss how respodents' responses vary based on family income, type of university, gender, and sexual and contraceptive experience. Due to the homogeneity of respondents' religion, it will not be included in the discussion.

*Family income*

There were no observable trends in attitudinal responses of students and opinion on the legalization depending on their reported average monthly income. For example, those who tended to agree with women's reproductive autonomy were students with family income of Php60,000-79,000 (middle tier), followed by those with income of lower than Php 19,000 (lowest tier). The percentage of those in Below Php19,000 income bracket that do not agree that abortion is morally wrong was also the same percentage with those in Php80,000-99,000 (highest tier). (See Table 29)

Also, both the highest and lowest percentage of support for legalization of abortion for all grounds were students from the highest tier (80,000-99,000 and Php Over 100,000 income brackets, respectively). (See Table 30)

**Table 29. Average family income and attitudinal responses**

| | | **Average family monthly income** | | | | | |
|---|---|---|---|---|---|---|---|
| | | **Php 19,000 and below** | **20,000-39,000** | **40,000-59,000** | **60,000-79,000** | **80,000-99,000** | **Php Over 100,000** |
| **Total responses** | | **60** | **41** | **35** | **23** | **10** | **17** |
| **Women shouLd be able to make and execute independent decisions on her reproductive health such as pregnancy** | *Disagree* | 12% (7) | 17% (7) | 20% (7) | 0% (0) | 20% (2) | 18% (3) |
| | *Agree* | 88% (53) | 83% (34) | 80% (28) | 100% (23) | 80% (8) | 82% (14) |
| **Abortion is morally wrong.** | *Disagree* | 10% (6) | 15% (6) | 14% (5) | 13% (3) | 10% (1) | 29% (5) |
| | *Agree* | 90% (54) | 85% (35) | 86% (30) | 87% (20) | 90% (9) | 71% (12) |
| **Abortion should always have the right to abortion in cases of unintended pregnancy** | *Disagree* | 77% (46) | 73% (30) | 83% (29) | 91% (21) | 100% (10) | 88% (15) |
| | *Agree* | 23% (14) | 27% (11) | 17% (6) | 9% (2) | 0% (0) | 12% (2) |

**Table 30. Average family monthly income and opinion on legalization**

| | | Average family monthly income | | | | | |
|---|---|---|---|---|---|---|---|
| | | **Php 19,000 below** | **20,000-39,000** | **40,000-59,000** | **60,000-79,000** | **80,000-99,000** | **Over Php 100,000** |
| **Total responses** | | **57** | **38** | **35** | **23** | **9** | **17** |
| **Should abortion be legally available in our country?** | *Yes, absolutely, in all circumstances* | 4% (2) | 0% (0) | 6% (2) | 0% (0) | 11% (1) | 0% (0) |
| | *No, absolutely* | 53% (30) | 47% (18) | 51% (18) | 48% (11) | 44% (4) | 35% (6) |
| | *Yes, under certain circumstances* | 37% (21) | 45% (17) | 37% (13) | 52% (12) | 33% (3) | 59% (10) |
| | *Unsure* | 7% (4) | 8% (3) | 6% (2) | 0% (0) | 11% (1) | 6% (1) |
| | | | | | | | |

*Type of institution*

When attitudinal responses were tabulated with the type of school that the respondents were enrolled in, there were slight differences in responses. Slightly more respondents from private institutions tended to support women's reproductive autonomy than those in public schools (88% versus 84%). However, the belief that abortion is morally wrong was slightly higher among private school students than public school students (87% versus 84%). More private school students also did not support abortion as a woman's right compared with public school students (84% versus 78%). (See Table 31)

**Table 31. Type of institution and attitudinal responses**

| | | Type of university | |
|---|---|---|---|
| | | **Public** | **Private (Non-sectarian/ non-religious)** |
| **Total responses** | | **96** | **94** |
| **Women should be able to make and execute independent decisions on her reproductive health such as pregnancy** | *Disagree* | 16% (15) | 12% (11) |
| | *Agree* | 84% (81) | 88% (83) |
| **Abortion is morally wrong** | *Disagree* | 16% (15) | 13% (12) |
| | *Agree* | 84% (81) | 87% (82) |
| **A woman should always have the right to an abortion in cases of unintended pregnancy** | *Disagree* | 78% (75) | 84% (79) |
| | *Agree* | 22% (21) | 16% (15) |

On their opinion on the legal availability of abortion, an equal percentage (48%) of private and public school students absolutely did not support legalization for any grounds. There were slightly more private school students who supported legal abortion for all grounds than public school students (4% versus 1%). There was also the same difference of 3% with the support for legal abortion for certain circumstances, only this time there was more support from public school students than private school students. (See Table 32)

Thus, in general, there were no discernable trends in the pro or anti-choice attitudes between students from public or private schools. It could be due in part to the fact that the sampling for each study programs is highly unequal (i.e. all medical students were from a private institution while all midwifery students were all from a public institution).

**Table 32. Type of university and opinion on legalization**

| | | **Type of university** | |
|---|---|---|---|
| **Total responses** | | **Public** | **Private (Non-sectarian/Non-religious)** |
| | | **91** | **92** |
| **Should abortion be legally available in our country?** | *Yes, absolutely, in all circumstances* | 1% (1) | 4% (4) |
| | *No, absolutely* | 48% (44) | 48% (44) |
| | *Yes, under certain circumstances* | 44% (40) | 41% (38) |
| | *Unsure* | 7% (6) | 7% (6) |

*Gender*

While in general respondents tended to agree with women's reproductive health autonomy, a higher percentage of male students agreed compared with females and those who identified as neither female nor male (In the table refered to as 'Others') (94% male, 85% female, 71% others). In the same way, a higher percentage among male (29%) agreed with women's right to abortion (29% male, 6% female, 14% others). There was also a lesser percentage of male (77%) who agreed that abortion is morally wrong compared with other genders (77% male, 90% female, 86% others). (See Table 33)

| Table 33. Gender and attitudinal responses | | | | |
|---|---|---|---|---|
| | | Gender of respondent | | |
| | | Female | Male | Others |
| **Total responses** | | **134** | **48** | **7** |
| **Women shoukd be able to make and execute independent decisions on her reproductive health such as pregnancy** | *Disagree* | 15% (20) | 6% (3) | 29% (2) |
| | *Agree* | 85% (114) | 94% (45) | 71% (3) |
| **Abortion is morally wrong** | *Disagree* | 23% (14) | 23% (11) | 14% (1) |
| | *Agree* | 90% (120) | 77% (37) | 86% (6) |
| **A woman should always have the right to an abortion in cases of unintended pregnancy** | *Disagree* | 84% (113) | 71% (34) | 86% |
| | *Agree* | 6% (21) | 29% (140 | 14% (1) |

A higher percentage among male students also supported legal abortion provision for all circumstances (7% male, 2% female, 0% others) and for certain circumstances (33% male, 46% female, 43% others). (See Table 34)

**Table 34. Gender and opinion on legalization**

| | | Gender of respondent | | |
|---|---|---|---|---|
| **Total responses** | | **Female** | **Male** | **Others** |
| | | **129** | **46** | **7** |
| **Should abortion be legally available in our country?** | *Yes, absolutely, in all circumstances* | 2% (2) | 7% (3) | 0% (0) |
| | *No, absolutely* | 50% (64) | 43% (20) | 57% (4) |
| | *Yes, under certain circumstances* | 46% (59) | 33% (15) | 43% (3) |
| | *Unsure* | 3% (4) | 17% (8) | 0% (0) |

*Sexual experience*

Those who were unwilling to disclose their sexual experience and those who never had sex were more supportive of women's reproductive autonomy than those who reported to have had sex. However, the belief that abortion is morally wrong was highest among those who never had sex. The percentage of those who agreed with women's right to an abortion was also higher amongst those who had sexual experience and those who were unwilling to disclose compared with those who never had sex. (See Table 35)

The support for availability of legal abortion for all grounds and for certain circumstances was also higher among those who have had sex and unwilling to disclose compared to those who never had sex. (See Table 36)

**Table 35. Sexual experience and attitudinal responses**

| | | Sexual experience | | |
|---|---|---|---|---|
| | | **Have had sex** | **Never had sex** | **Unwilling to answer** |
| **Total responses** | | **77** | **85** | **28** |
| **Women should be able to make and execute independent decisions on her reproductive health such as pregnancy** | *Disagree* | 17% (13) | 13% (11) | 7% (2) |
| | *Agree* | 83% (64) | 87% (74) | 93% (26) |
| **Abortion is morally wrong** | *Disagree* | 23% (18) | 2% (2) | 25% (7) |
| | *Agree* | 77% (59) | 98% (83) | 75% (21) |
| **A woman should always have the right to an abortion in cases of unintended pregnancy** | *Disagree* | 79% (61) | 84% (71) | 79% (22) |
| | *Agree* | 21% (16) | 16% (14) | 21% (16) |

**Table 36. Sexual experience and opinion on legalization**

| | | Sexual experience | | |
|---|---|---|---|---|
| **Total responses** | | **Have had sex** | **Never had sex** | **Unwilling to answer** |
| | | 73 | 82 | 28 |
| **Should abortion be legally available in our country?** | *Yes, absolutely, in all circumstances* | 6% (4) | 0% (0) | 4% (1) |
| | *No, absolutely* | 42% (31) | 59% (48) | 32% (9) |
| | *Yes, under certain circumstances* | 52% (38) | 41% (34) | 64% (18) |

## 2. FINDINGS FROM QUALITATIVE DATA

Five FGDs were conducted: one with medical students, three with nursing students, and one with midwifery students. A total of 37 students participated, with 24 female and 13 male participants. The following section presents findings from the discussions.

### 2.1 Awareness and knowledge

*2.1.1 SRHR as choice and access*

Students described SRHR as choice, "right to decide," freedom from violence, and access to information and services to meet a person's, particularly a woman's, sexual and reproductive health needs. According to them, SRHR means having the choice to practice safe sex and use contraceptives. For them, a woman have the right to decide when to have children and how many by using family planning or contraceptive methods.

The SRH needs that were identified by students were largely concerned with family planning, and contraceptives (prevention of pregnancy, limiting and spacing children); prevention of sexually transmitted infections (STI) or having safe sex; and prevention of reproductive cancers. In this regard, the services identified needed were contraceptives and family planning (including commodities and counselling) and testing for STI and cancer.

Sexual orientation was mentioned once, associating it still with the choice of using contraceptives. While demonstrating limited knowledge of the concept of SRHR, even some students admitting that they "don't have clear idea" of what SRHR is, the concept of choice was recurring theme in their answers: choice to use contraceptives, to have sex, to practice safe sex, and to have children and number of children.

They focused on women's right to choose and access services, recognising that women bear the consequences of unplanned pregnancies. There were also a few mentions of male involvement and couple's shared decision-making. In particular women's right to "informed consent," that the woman can accept or to decline the use of contraceptives based on the correct information. The role then of healthcare providers is providing the right information:

> *Kailangan i-ano mo yung consent niya. Meron silang karapatan na maghindi at meron din silang karapatan na mag-oo. Kung sakaling mag-oo meron din silang karapatan na malaman yung mga bagay na napapaloob doon sa kanila napili na. I'm referring sa family planning so pagnapili nila yung bagay na yon nararapat lang na malaman nila kung ano yung mga bagay na mangyayari sa kanila so i-explain mo din yung bawat segundo.*

– Female, midwifery student, Metro Manila

*2.1.2. Abortion as pregnancy complication*

The medical, nursing, and midwifery students discussed abortion as a complication of pregnancy and can happen spontaneously or induced by surgical and medical methods. In this context, abortion was discussed by participants a medical procedure to "save the mother," in "life and death situation," or "life-threatening situation."

These situations are grounds for therapeutic abortion. However, because of the legal uncertainty surrounding abortion in the Philippines, even the legality of therapeutic abortion is still often questioned or denied.[153] Hence, we asked the students of their familiarity with the term, and if they would consider termination of pregnancy in the medical indicators they mentioned as meeting the criteria of therapeutic abortion. Only participants of three out of the five FGD groups reported familiarity with the term therapeutic abortion and affirmed that such cases mentioned fall within it.

Participants' discussion of abortion as a medical issue revolved around the pregnancy-related complications that could have abortive outcomes. Among the medical indications for abortion mentioned by the participants were increased endural risk, eclampsia, ectopic pregnancy, molar pregnancy, cardiovascular disorder, bleeding disorder, and neural tube defects. There was also emphasis on proper assessment, including determining fetal viability, as medical indicators for surgically terminating a pregnancy. There were also mentions of complications resulting from unsafe abortion.

Among midwifery and nursing students, there were discussions of types and methods of abortion. The level of familiarity differed from group to group, and from student to student. Often mentioned procedure is dilation and curettage. There was less familiarity with how medical abortion is done, only mentions of "Cytotec."

Medical students were more articulate of the clinical procedures. It was clarified, however, that they were trained to "induce labor" and "not abortion":

> *Yung tinuro sa amin is not the abortion per se, but how to induce labor, since kung ininduce, nilalabas man yung baby so you can have surgical and medical action for that one. You can use oxytocin for contraction or your progesterone din for smooth muscle contractions, then pwede ka madilation and curettage. May ininsert na medicine. Depende lang po. There are a lot of ways actually... Alam naming kung paano pero yung pagtuturo sa amin is hindi para mag abort kundi paano mag induce ng labor like that.*
>
> – Female, medical student, Region 8

[153] Claire Padilla, "Right to Safe and Legal Abortion, Divorce, Marriage Equality and Women's Affirmative Action Missing in PDu30 SONA," July 23, 2018, https://abortion-news.info/tag/clara-rita-padilla/.

*2.1.3 Reasons for abortion*

Abortion was broadly categorized by students as "unintentional" and "intentional"—the former referring to spontaneous abortion and for medically necessary abortions, and the latter for other nonmedical and/or social reasons. (See Table 37)

**Table 37. Reasons for abortion**

| "Unintentional" | "Intentional" / Induced |
|---|---|
| • Spontaneous/miscarriage<br>• Increased endural risk<br>• Eclampsia<br>• Ectopic pregnancy<br>• Molar pregnancy<br>• Cardiovascular disorder<br>• Bleeding disorder<br>• Neural tube defects | • Rape<br>• Economic reasons<br>• Mental and psychological<br>• Avoid disruption of studies<br>• Stigma on teenage pregnancy<br>• Left by their husbands/partners<br>• To work<br>• To work overseas<br>• Unwanted pregnancies due to:<br>  ○ Risky sexual behaviour<br>  ○ Lack of knowledge<br>  ○ Curiosity to sex among young people<br>  ○ Not using or discontinued use of contraceptives/family planning methods<br>  ○ Extramarital affairs |

"Unintentional" abortion was also sometimes referred to as "valid" or "acceptable" reasons, conveying a bias towards abortion when it is a medical necessity and when the woman wanted to continue the pregnancy but could not because of life-threatening risks.

Unwanted pregnancies were often seen as resulting from risky sexual behaviour, particularly among young women. However, some students also linked the problem to lack of knowledge and further to lack of sexuality education among young people.

Midwifery students, in particular, were able to articulate more nuanced reasons why women have unintended pregnancies. Taking from their experiences working in health facilities, they described the situations why women fail to use contraceptives. For one, women do not use contraceptives due to fear of side effects and other misconceptions on contraceptives because they "prefer to believe other people" rather than health providers. A participant also narrated how one client who was physically abused by the husband to prevent her from using contraceptives. Some women also fail to return on their schedule to get contraceptives such as pills and injectable. When probed what reasons they were aware of why women do not return to their facilities, there was a consensus among the group that it was usually because of "laziness."

*2.1.4 Uncertainty on the law*

Consistent with the results of the survey, participants had differing knowledge of when law permits abortion. They were aware that abortion is legally restricted, many believing that it is allowed only for "valid" reason, which is to save the life of the woman:

> *Dito sa Pilipinas, parang legal ang abortion kapag, yun nga, nanganganib yung buhay ng ina…*
>
> - Male, nursing student, Region 4A

While others, despite acknowledging that therapeutic abortion can be done, maintain that abortion is still totally prohibited:

> *So, in abortion, in medicine they also practice that pero here in the Philippines somehow abortion is not really parang allowed in a sense…that it's not really allowed. It's not really allowed talaga.*
>
> – Male, Nursing student, Region 8

There was more uncertainty whether healthcare providers are legally required to report to authorities women who sought postabortion care following an abortion. Many of the students opined that women who are treated in the hospitals have the right to confidentiality and privacy, thus, should not be reported. Others maintained that since inducing abortion is a criminal offense, then these women should be reported to the police or to the local government. Meanwhile, other students believed that the women should be referred only to the women's desk, if a facility has one. Similarly, there were suggestions that the women should be referred to the Department of Social Work and Development (DSWD) or to its facility-based counterpart or officer. It was also argued that when the pregnancy was a result of violence, then the case should be reported to the police. Others who were uncertain said it should be based on the official policy of the hospital on such cases. In particular, many students believed that cases of repeat abortion should be reported to authorities.

Meanwhile, students reported not being aware of the DOH policy on postabortion care. It was also perceived, though, that a policy is not necessary since doctors have the ethical obligation to treat emergency cases.

*2.1.5 Mistreatment and abuse of women seeking postabortion care*

Students described how women receive abuse from healthcare providers when seeking reproductive health services in facilities. Students narrated how they witnessed the verbal abuse and threats women experience in hospitals. The abuse is not limited only to women who had abortions, but even those who access prenatal services and during childbirth.

Students recounted how nurses and doctors treated women negatively, particularly teenagers. According to them, the words were “painful” and “humiliating”. The young women are often blamed for their situation. Students expressed concern that such degrading treatments would only hinder women from seeking health services in the future.

One incident retold by a student illustrates the degrading treatment received by a 14-year-old who was in labor:

> *It was the nurses, maraming sinasabing di maganda. magsasabi na ‘Ano masarap diba, ngayon manganganak ka na.’ Yung mga ganun. Parang hindi naman maganda siguro kasi yung patient nagsusuffer na in the first place. Their words are very painful. Makikita mo talaga sa mukha ng mother na nahihirapan na sya tapos sasabihan mo pa ng masasamang salita, like okay, parang winawasak nya ang tao. Ano nalang mangyayari sa tao nayun dadating na baby nya tapos parang yung stigma sa kanya is dapat di mo pa yun ginagawa.”*
>
> - Male, medical student, Region 8

Women who come in the hospital with vaginal bleeding and suspected of abortion are said to be constantly pushed to admitting they induced abortion. According to the accounts of the students, the women were reprimanded and even warned that they will be refused treatment if they will return to the hospital for inducing abortion again. The maltreatments were said to happen while other patients and hospital staff is around, making the situation more humiliating for the patient.

A student recounted her own experience of being admitted in the emergency room at the same time with a woman who came in for postabortion treatment:

> *Kasi noong time na buntis kasi ako, kasabay ko siya sa ER. Ngayon eh di nagbebleed. ‘O anong ginagawa mo diyan?’ Ganun yung mga doktor. ‘Eh kailan mo yan pinalaglag?’ Nang-seseduced sila ng ano para umamin.”*
>
> - Female, midwifery student, Metro Manila

A very alarming incident was also shared by a midwifery student of how a woman she accompanied to the hospital was denied treatment and even brought to the police and subsequently charged. The incident also illustrates how criminalization of abortion may influence willingness of healthcare providers to refer patients even for postabotion care:

> *Ah may isa akong pasyenteng sinamahan sa ospital then na deny siya kasi… actually na report pa siya. Buti hindi ako kasama doon kahit sinamahan ko lang siya kasi professionally tinanong din naman ako bakit mo sinamahan kasi accessory to the crime ako if ever e so ako inano ko lang siya na sinamahan ko lang siya dun kasi nag-bleed siya kaya nandun ako pero dun sa ginawa niyang yun hindi ako kasali. So ang ginawa nagpatawag ng barangay kasi sa Las Pinas kasi automatic yun once na may ganoong case,*

*nagrereklamo sila agad-agad. So ano kasi yun e, intentional talaga na pinalaglag so nung dinugo siya ayun pati ayun nakasuhan din siya"*

– Female, midwifery student, Metro Manila

## 2.2 Sources of knowledge

*1.2.1. Limitations in education*

School or education is the main source of students' knowledge of SRH, including abortion. As a medical issue, they learned about abortion as pregnancy complication. It is touched on in many subjects, particularly in maternal and child health/care. It was often discussed in relation to family planning and contraceptives failure, maternal mortality, birth rate, and complications resulting from abortion.

Beyond obstetric emergencies cases, abortion is said to be usually touched on or taken as an example when discussing ethics or bioethics and laws related to medical practice. According to the participants, abortion is usually used as debate topics in ethics discussion.

A participant mentioned that abortion for reasons besides saving the life of the woman is discussed *"bigla-bigla"* (suddenly). That when the topic is sex relating to unwanted pregnancies, particularly teenage pregnancies, discussion would suddenly cut into the issue of abortion:

*Kasi nga, ayun po…sa mga unwanted… sa mga teenagers, mga unwanted pregnancies po, napapagusapan na namin na sa ospital ganito may nagpalaglag kasi hindi ready, kaya po nasisingit yung mga ganun.*

– Male, nursing student, Region 4A

Their education on abortion was was described by one nursing students as limited only to what is in the textbook:

*Parang book-based kami, mas nagfofocus kami kung ano lang nasa books. Di kami nagdedelve further…we base on everything on the book itself. If we say about the percentage of abortion in the Philippines, that depends on the updated version of the book itself."*

– Male, nursing student, Region 8

There were nursing students who perceived that their knowledge of contraceptives was "still not enough." In particular, they expressed not having enough knowledge of medicines and side effects of contraceptives. They were also more familiar with pills and condoms, and less on "invasive methods." While nursing students reported to having adequate theoretical knowledge of contraceptives and family planning, their confidence in sharing that information in future practice or to other people at present is mainly influenced by their own practical experience:

*In professional dapat may matutunan pa, mag dig in pa kami dapat, pero sa kagaya ko mother ako feeling ko enough na yung kaalaman ko kasi may mga experience na siguro…Pero sa kanila, sa mga bata parang hindi ko alam kung anong level na kanilang ano.*

– Female, nursing student, Region 4A

*Kulang pa yung aking kaalaman para magpayo doon sa isang tao, tapos, uhm, personal experience…hindi kasi ako gumagamit ng any contraceptives.*

– Female, nursing, Metro Manila

The midwifery students, who were already practicing as service providers, were already experienced in providing family planning information to clients. Medical students also gained experience in family planning counselling during their clinical clerkship and health teaching in their course on community health.

*2.2.2. Influences of personal experiences*

For many female students, their knowledge of abortion were also based on their personal experiences of disclosure from other female friends. Consequently, those students have more nuanced knowledge of the circumstances of women going through abortion, and affected how they see abortion.

A student shared that a friend terminated her pregnancy when they were still in high school, and described her friend's experience as a "painful" process:

*As for me, she is a very close friend. She was very shattered when she did it. Until now, I know for a fact that she is suffering, psychologically suffering, morally separated, very painful. For me, ang torment sa kanya, sa one time na ginawa niya, she will bring it for the rest of her life until she dies. Kaya hesitant akong magdiscuss.*

– Female, medical student, Region 8

Meanwhile, a student also shared how she came to accept the termination of pregnancy when it was needed to save her friend's life:

*I have a friend na nag undergo sa ganyang cases bali ilang times na rin siyang nagkaroon ng… na abort yung baby ayan nagkaroon siya ng miscarriage kaya lang nitong huli kailangan niya ng mamili between her life or yung baby…so nagdecide na siya kasi hindi na rin naman mabubuo yung baby sa loob so magkakaroon na rin ng problema kung matutuloy yung pregnancy niya kasi yung sakanya may problema siya sa heart…sa akin kasi nung time na yun nung una bago nangyari yun hindi ako, ayoko talaga sa abortion kahit doon sa mga napapanood ko ayoko pero nung time na dumating sa amin yung problema na yun kahit ako hindi ako makapili between doon sa baby tsaka doon sa friend ko pero sa akin yung friend ko kasi…so 100% para sakin yung wag na lang, wag na lang ituloy.*

– Female, midwifery student, Metro Manila

Two other midwifery students' have similar experiences of friends who had repeat abortions. According to one of the students, she felt an unwitting "accessory to the crime" for not knowing that her friend was pregnant when drinking the liquid concoction that she later found out was to induce abortion. The experience opened her mind on how abortion is commonly done by women. At the same time, the shock of knowing what her friend was doing without her knowledge, and even witnessing her friend disposing the expelled product of conception, left a strong impression and reinforced her opinion that abortion should not been done unless needed to save the woman's life. A male student also reported receiving disclosures from friends who were considering abortion. In such cases, he advised them to go through the pregnancy.

### 2.3 Views and attitudes toward abortion

The participants' attitudes toward abortion and abortion as a right range from absolutely against it, conditional support, to absolute support. This section details how they understand abortion and how it influences their attitudes toward the issue.

#### 2.3.1 Stigma on abortion

Participants described abortion as "*masama*" (bad or wrong), "mortal sin," "unethical" and "immoral." Negative attitudes toward abortion stem from religious beliefs, beliefs on the role of healthcare providers, ideals of motherhood, and other cultural norms.

##### 2.3.1a Religious belief

Students' views were influenced by their religious beliefs. When stating their opinion on whether abortion should be allowed or not, or when they think abortion is warranted, those who expressed stronger opposition argued based on "bible teaching," "ten commandments," "Catholic belief," and "faith."

As expressed by participant, despite the risk of pregnancy, a woman should hold on to her faith:

> *Kung nanganganib ang isang buhay ng babae at kung kailangan abortion… hindi pa rin ako sang-ayon sa abortion kasi depende yun sa faith mo sa God tapos kasi ang nasa isip ko lang minsan may mga sitwasyon na talagang kung matindi ang pagtitiwala mo sa Diyos naniniwala ako dun sa sinasabi nilang himala pero yung ay depende parin sa pananalig nila."*
>
> –Female, nursing student, Region 4

Induced abortion was seen as "taking away life," and "killing." Take into account this statement by one participant who maintained that life starts at the moment of fertilization, and therefore abortion is "taking away life":

*If the union of the sperm happened and it was taught to us na kasi that once it's united and once the fetus is formed, no one can decide whether to terminate it later because sabi naman, ewan, sa Bible verse 'because before, when we were in our wombs, God weave us, so, He is the only one who can decide whether one is to live or not'."*

- Male, nursing student, Region 8

The fetus, and all its previous embryonic development, was assigned the status of personhood. The term fetus, however, was rarely mentioned. Throughout the discussion in all the FGD groups, the fetus was referred to as "baby," "human," or generally described as "life." Hence, abortion was considered "unethical" since it takes away the "right to live" of a "human."

What was unethical or not was then negotiated based on the circumstances of pregnancy, or what circumstances were deemed as acceptable or not. Spontaneous and what they refer to as "unintentional" abortion in order to preserve the life and health of the woman was considered ethical.

*It would depend on what type of abortion po. For me, definitely for my personal stand, yung only abortion na acceptable ay yung unintentional abortion. Medically speaking, for example, may increase endural risk for the mother's health, let's say may instance na pipili kayo between the mother and the babies, especially on the early pregnancy.*

- Female, medical student, Region 8

*If a person would suffer a heart attack, or like may tumor or something, possibly it may be allowed because you're saving a life. I guess the baby also would not live if the mother is not there so parang dalawa tuloy sila na namatay. So maybe, ethically they have to consider yung way na ano…*

- Female, medical student, Region 8

Despite recognizing the necessity of abortion to preserve the woman's life, it was apparent in some of the participants' opinion that "termination of pregnancy is morally wrong at all times" as described in previous literature.

*Masama talaga kasi [ang abortion] kahit anong sitwasyon, nakalagay sa bibliya parang pumatay ka na rin ng tao di ba.*

- Female, nursing student, Region 4

However, there was also recognition that what is acceptable is not absolute. Students were aware that abortion laws are liberalized in other countries. And what is acceptable depends on the cultural context:

*Depende po kasi sa iba't-ibang bansa kung anu ung tradisyon nila tungkol sa mindset nila sa abortion. Dito sa Pilipinas, parang legal ang abortion kapag yun*

*nga nanganganib yung buhay ng ina. Tapos ung hindi naman maganda sa mga kabataan kapag aksidente lang nabubuntis.*

- Nursing student, Region 8

2.3.1b Beliefs on the role of healthcare providers

Because of the belief that abortion is "taking away life," students perceived that abortion goes against their profession. Even with the recognition that abortion is a necessary medical care for life-threatening pregnancies, there was still apparent dilemma in seeing abortion as a right. The dilemma stems from the belief that healthcare professionals "save lives' and are "pro-life," therefore abortion goes against their oath:

*Siguro doon sa kwento niya may right talaga ang isang babae or isang tao sa abortion pero as our profession parang hindi, hindi talaga kasi syempre as midwife or nasa medical ka syempre you save life so ang laking sapul sa profession namin pagnag-abort kami kasi wala yun sa scope of our studies or function naming so sa akin fifty-fifty siya akin.*

- Female, midwifery student, Metro Manila

Medical students also believed that even if the law will allow for the legal provision of abortion, doctors would still hesitate to provide as they are trained as "pro-life":

*Yes pro-life, let us take for example mapasa yung law kahit induced abortion madami pa ring mag-hehesitate kasi I don't know insult siya sa religion, no nga hindi talaga preserve life at all cost parang ganoon. Baka sa iba.*

- Female, medical student, Region 8

Midwifery students, meanwhile, perceived their role is mainly to ensure successful childbirth, and abortion care not within their tasks.

*As a midwife, makita mo lang na buhay ang bata, masaya ka na.*

- Female, midwifery student, Metro Manila

2.3.1c Ideals of motherhood

Expectations of how a mother should feel and act also shaped the views of those who are strongly against abortion. The students hold an essentialist view of woman as natural lifebearer, mother, and caregiver.

One expectation was that a woman would naturally develop the instinct to love her child and therefore should continue with the pregnancy despite the circumstances.

*Sakin naman po, no po ako doon sa abortion kasi ano diba as a mother sabi yung ibang bata nga po kaya mong mahalin yung sarili mo pang anak na*

*unintended hindi mo kayang mahalin syempre kahit papaano madedevelop po yung mother's heart sarili mo.*

– Female, nursing student, Metro Manila

Moreover, a "good mother" was also perceived as someone who would choose the life of the unborn over her own:

*Meron din kasi ibang mother na pinipili pa rin nila yung buhay ng baby so siya hindi siya ganoon so ok parin kasi meron pa rin naman like a good mother.*

- Female, nursing student, Metro Manila

2.3.1d Concepts of responsibility

While there was awareness on the varied reasons why women end up with abortion, unintended pregnancies were usually simplified to an outcome of woman's irresponsible sexual behaviour. Since "sex was a choice" and the woman had "pleasure" then women should live with the consequences of her actions, similar to the Tacit Consent version of the Responsibity Objection to abortion.

*For me it depends on the circumstances eh kasi pag sinabi kasing abortion pwedeng surgical abortion, like may ectopic pregnancy something like that. Pero yung will nung babae na gusto niyang ipalaglag just because hindi pa siya ready it is not. Binuo mo, ginawa mo, tumihaya ka, tumagilid ka whatever yung ginawa niyong position, ginawa mo, ginusto mo bakit nabuo na tsaka mo hihindian, ano masarap lang ganun."*

- Female, nursing student, Metro Manila

The blame is placed on the woman for putting herself in situation that led to a pregnancy, or the Harm Version of the Responsibility Objection.

*Yun talaga yung kasalanan yun kasi sinadya mo yon eh buhay yun aalisin mo kung ano man yung situation na sinasuffer mo kailangan mag-isip ka muna bago mo pasukin yung pagbubuntis halimbawa sa barkada oh di inuman ganyan isipin mo na ano ba yung mangyayari kapag naginuman kayong babae at lalake kaya kailangan ano pa rin aware*.

- Female, midwifery student, Metro Manila

Also related to ideals of motherhood, being a woman was also seen as having a "responsibility to give birth" to the child, also similar to the Care version of the Responsibility Objection:

*Sakin hindi talaga ako sang ayon dun sa abortion na yun pero sa field naming pwede talaga yung abortion kasi ng minsan di ba yung mga ectopic pregnancy kinakailangan talagang tanggalin yung baby sa nanay niya. Pero yung will nga ng nanay niya na i-abort yung bata, hindi kasi buhay na yan eh diba nakasaad naman siya sa sampung utos natin na wag kang papatay, bakit mo papatayin yung isang buhay na pwede mo naman buhayin pa yung isang buhay di ba?*

*Pinili mo yan eh dapat i-continue mo yan, may big responsibility ka as a mother di ba?*

- Male, nursing student, Metro Manila

Most women who had abortion in the country cite the inability to afford the cost of raising a child or an additional child as the reason for abortion. But for students who were strongly against abortion for economic grounds maintained that abortion is "not a solution to poverty."

Students holding this opinion cited that there are women living in extreme poverty who are still able to able to survive despite having more children than they can afford, hence proving that abortion is not necessary. The blame was also on the woman for not taking necessary measures to prevent pregnancy despite fully knowing she could not afford another child. This brings to mind what was described as Negligence Version of the Responsibility Objection.

*Ayun nga diba bakit ka pa mag-aanak ng marami kung pwede mo namang pigilan yung pagkakaroon ng anak, agapan mo ng maaga bago magsisi ka sa huli kasi hindi naman sagot ang abortion eh sa kahirapan.*

- Female, nursing student, Metro Manila

*2.3.2 Increased stigma towards repeat abortions*

There was a more pronounced negative attitude among the students towards women who had repeat abortions. Women who had repeat abortions were perceived as promiscuous and irresponsible.

*Siguro kung kinasanayan niya na magpaabort, pero pag once lang at di niya sinasadyan or dahil lang sa kulang yung kaalaman niya siguro mapagbibigyan pa rin. Pero pag pangalawa na, kalandian niya lang yun eh.*

- Nursing student, Region 4A

Women who had repeat abortions were deemed as less forgivable than those who had abortion once. Therefore, more students believed that women who had returned for postabortion care treatment after second or more abortions should be reported to the police. Linked with the idea that 'abortion is killing,' repeat abortion therefore is seen as 'killing repeatedly.'

*"So kung pitong beses siyang lumapit sayo for postabortion, what if di ba…Parang seven times na siyang pumatay ng tao."*

- Female, medical student, Region 8

*2.3.3 Abortion as a right when needed to save a woman's life*

Students' support of abortion as part of SRHR also depends on the circumstances of pregnancy. When the pregnancy is a risk to a woman's life, and abortion is not a choice but rather a medical necessity, then it was considered by participants as a right.

> *If the mother is suffering from something, hindi niya kaya to deliver the baby, I think we should terminate the baby for her safety.*
>
> - Female, nursing student, Region 8

Fetal viability was also a precondition whether an abortion can be deemed a right or not. They tended to be more supportive of giving the woman the choice to terminate the pregnancy when the fetus is unlikely to survive.

> *I also agree in that na pwede ring bigyan natin ng option yung mother na magkaroon sya ng abortion especially if kung yung anak nya is parang unlikely to survive or instance na hindi mabubuhay once ilabas nya or we should give the option to the mother that she can let the baby survive.*
>
> - Male, medical student, Region 8

Thus, when abortion is a woman's decision for reasons beyond medical, there was less support for abortion as a right.

> *Meron naman talagang instances na life and death matter sa mother and baby. Yung rape tapos nabuntis tapos dapat ipa-abort yung bata, never. Kasi hindi mo nga kasalanan pero hindi rin kasalan ng bata.*
>
> - Female, nursing student, Metro Manila

*2.3.4 Abortion as a woman's right to decide based on her circumstances*

Those who hold more liberal views on abortion exhibited more sympathetic attitude towards women who had to go through an unintended pregnancy. Those students who expressed support for abortion on more grounds cited rape, psychological or health, and economic reasons as among the warranted reasons for abortion.

They believed that rape survivors should not have to go through more trauma and psychological distress of carrying to term a pregnancy resulting from violence inflicted on them. They also argued that a woman must have the choice not to continue the pregnancy and be forced to raise a child in abject poverty.

> *I'm for abortion, yung iba naman kasi gawa ng rape di naman nila ginusto yung bata bakit nila bubuhayin, di ba may mother na na-dedepressed, di ba may mga patient sa center na di ba… mga side ng patient na rape diba kung nakikita nila yung bata lalo silang parang na-dedepressed kasi naaalala nila yung pagkakarape sa kanila…tsaka yung isa pa yung kahirapan kung gutom,*

*kung wala namang makain diba anong gagawin mo i-paabort mo na lang kesa naman gutomin mo yung bata mamatay pa sa gutom, yun yung point ko.*

Those who expressed support for mental health grounds stated that women should be allowed to have abortion if going through the pregnancy would cause her psychological problems.

*Kung sa akin mangyayari na halimbawa mabubuntis ako na unwanted, hindi ko ipaabort. Pero kung siya at magiging reason na magkakarion ako ng problema, halimabwa, psychologically, kasi hindi ko talaga siya gusto, bakit hindi ko siya ipapaabort.*

- Female, nursing student, Region 4A

While only very few, there were students who supported abortion on demand. While majority of the students negotiated the acceptability of abortion depending on the circumstances of pregnancy, the most pro-choice students reasoned that there are complexities with why women choose to have abortion, among them was avoiding having to raise children in abject poverty.

*Tsaka yung isa pa, yung kahirapan kung gutom. Kung wala na man makain di ba? Anong gagawin mo? Ipa-abort mo na lang kesa naman gutumin mo yung bata. Mamatay pa sa gutom, yun yung point ko*.

- Male, nursing student, Metro Manila

*2.3.5 Abortion as a woman's right to decide over her body and life*

Regardless of their moral views on abortion and support of abortion in different circumstances of pregnancies, students generally agree that it is ultimately a woman's decision over her body and her life. The decision lies on the woman carrying the pregnancy and healthcare providers should not judge a woman over her decision, as expressed below:

*For me morally, wrong talaga ang abortion, pero para sa mga babaeng nagpa abort na, I don't have the right to judge them parang iniisip ko nalang na it's their right, it's their body. Hindi ko naman yan katawan it's not my right to tell them pero as a person in the medical field I would suggest nalang na magpa counsel, para sa akin wrong talaga ang abortion.*

-Female, medical student, Region 8

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However, as one participant stated, while, unavoidably, one forms judgment over another person's action it does not change a woman's right to make her own decision on what she believes is necessary given her circumstances:

*Naniniwala ako na ano right ng babae na magdesisyon para sa sarili niya, kung gusto niyang magbuntis or magpalaglag.. parang desisyon niya yun, wala*

*tayong magagawa dun tayo ay tagahusga lang...So ano pag sinabi mo "Bakit niya pinalaglag?, Eh kung sabihin sayo, 'kung itutuloy ko to aampunin mo ba'?"*

- Female, nursing student, Region 4A

Even those who perceived abortion was wrong still believed that should not strip a woman her rights as a human:

*Kailangan pa rin natin respetuhin dahil tao din sila may mga nagawa silang kamalian pero pwede pa nilang itama yon parang hindi natin sila dapat i-judge dahil sa isang pagkakamali nila.*

- Male, nursing student, Metro Manila

As stated by one participant, the woman has the sole right to decide if her reason to have an abortion is enough or not:

*Sa akin naman po, tao pa rin naman po sila. Kasi option pa rin naman nila yun kung bakit nila ginawa yun. May dahilan pa rin naman po kila. Kung hindi enough sa inyo yun, eh kung sa kanila enough na yun?*

- Male, nursing student, Metro Manila

*2.3.9 Postabortion care is a woman's right*

Despite the conservative attitudes toward abortion, the students were in agreement that all women have the right to humane, non-judgmental, and compassionate postabortion care. For them, regardless of the reasons for abortion, healthcare providers should not refuse any women seeking postabortion. Denial of care was said to cause more harm.

*Bawal tanggihan ang patient; tapos tatanggihan mo pa parang pinatay mo na rin siya di ba?"*

- Female, nursing student, Region 4A

According to participants, healthcare providers should not discriminate and should treat all women with dignity. It is their role to provide comfort and moral support. That one's personal belief should not affect one's professionalism:

*Itrato mo siyang tao kahit ano man ang ginawa niya matanda ba siya bata, mayaman, mahirap itrato mo parin siyang pasyente nangangailangan ng care. Hindi ng pagpapagalit mo. So nga nila sinasabi diba ihiwalay natin yung personal, yung iniisip natin problems natin sa buhay. Be professional. "*

- Female, nursing student, Metro Manila

Despite own moral convictions on abortion, the students believe that a healthcare provider should not pass judgment on the woman. As expressed by a nursing student, a healthcare provider might not necessarily agree with the woman's reason but it is not within their right to judge another person's decision.

However, dealing with such cases wherein one is emotionally invested could also be emotionally toiling for the service providers. As one student mentioned, they would also need to debrief and find psychosocial support after:

> *"Sa akin ha yung sasabihin ko yung feelings ko about doon na wrongly yung ginawa niya sasarilihin ko na lang yun kasi pwedeng maging problema ulit sa kanya pwedeng maka-apekto ulit sa kanya after kaya… parang ikaw parang nabigatan ka doon sa sitwasyon kailangan mo magsabi doon ka na sa ka nurse mo na alam mo ba na ganito naiistress ako kasi o hindi kaya hindi ka naman kasi pwedeng makipagtsismisan sa workplace uuwi ka ng bahay makikipag counsell ka ngayon sa pamilya mo sa jowa mo o sinong pwedeng malapit sayo na para mabawasan lang yung galit na narinig mo doon sa kwento ng pasyente na talagang hindi mo nagustohan."*
>
> - *Female, nursing student, Metro Manila*

*2.3.8 Resolving ambivalence*

In many instances, students expressed the dilemma between their religious beliefs and their expected professional conduct. For some, while they still saw abortion as intrinsically wrong, they were also aware that some pregnancies are a risk to a woman's health. Therefore, while they are still personally against abortion, they would perform or assist when it is needed to save a woman's life.

> *Ako po against po talaga ako sa abortion. Pero as my profession po, depende lang po yun sa case, yun nga pong life-threatening.*
>
> - Female, nursing student, Region 4A

For one participant, regardless of the woman's choice, fetal viability is the major condition for her professional decision:

> *I am Catholic, so actually may thin line talaga to differentiate yung therapeutic abortion and yung abortion na illegal. So kung yung abortion na spontaneous, na nagdecide ang mother, [pero] pwede naman siyang maging viable, I would not really assists on those procedures. Pero kapag threatened abortion, parang hindi talaga viable yung pregnancy, mag rerecommend ako.*
>
> - Female, medical student, Region 8

There were still a few, however, perceived that is still within a healthcare's provider right to refuse to assist even in the case of therapeutic abortion:

> *Pero halimbawa po duty ako that time tapos may ganoong case, halimabawa sa OR tapos ayoko talag ng ano ganoong procedure parang pwede akong magdecline kasi right din yun ng isang nurse na magdecline ka sa mga procedure na yon.*
>
> - Female, nursing student, Region 4A

When placed in the situation of the woman, some of the female students expressed that they would decide based on their personal beliefs. According to one participant, while her profession requires them to put the woman's life as a priority over the unborn, she would, personally, risk her own life if she was the woman with the life-threatening pregnancy:

> *Masama talaga kasi kahit anong sitwasyon, nakalagay sa bibliya parang pumatay ka na rin ng tao diba… Pero kung sa profession naman namin… halimbawa, delikado ang pagbubuntis ng ina, ano yung pipiliin, yung ina. Kung sa akin din sa sitwasyon kung asawa ko yun mangyayari as pipiliin ko yung ina, kaya kung sa sarii kong pananampalataya.paniniwala kung ako yung nagbubuntis ok lang sa akin mamatay ako kaysa patayin ko yung sarili kong anak.*
>
> - Female, nursing student, Region 4A

Those who had very strong religious convictions against abortion found it difficult to separate personal beliefs over professional ethics. A female student, working already as healthcare provider, recalled how she acted on her own volition when upon learning that a friend had already taken some steps to terminate a pregnancy. She gave her friend "*pampakapit*," (dydogesterone) without the knowledge of the woman on what the medicine was for. The same student, who is already working in a health facility, also shared that in the course of her practice she repeatedly encounters women who are considering abortion reduce their dissonance by treating the embryo as merely "blood." In such cases, the midwifery student said, she would insist to the patient that the embryo is already a "human."

### 2.4 Attitudes toward abortion education

There were two diverging opinion on whether abortion procedures should be include in the training of midwifery and nursing students. On the one hand is the fear that knowledge could lead to practice, and on the other hand is the recognition that it is necessary for them to effectively provide care for women.

#### *2.4.1 Knowledge could lead to practice*

Despite saying that abortion is acceptable and even necessary in certain circumstances, some midwifery and nursing students expressed a major concern over the inclusion of abortion procedures in their training. They believe that training on the procedures is best left only to specialists (obstetricians). These students worry that when they have full knowledge of abortion, they could practice and even profit from it.

> *As a nurse, may means and ways kami na halimbawa kung marunong kaming mag abort parang.. easy access na sa mga ganoong bagay. So parang hindi siya dapat dinidiscuss sa klase or yung procedure, kumbaga para kasing*

*magkakaroon kami ng idea na.. kasi diba pwede naming pagkakitaan mga ganon ganon."*

- Female, nursing student, Region 4A

Some were particularly concerned over female students knowing the procedures, which they feared could lead to inducing abortions themselves.

*On my part, as a girl, if I already know how to abort the baby pwede kong gawin yon in the future lalo na kapag emotionally unstable ka.*

- Female, nursing student, Metro Manila

As illustrated by the statement below of one participant, the reason is the same with the prevailing argument against sex education:

*Para po kasing binibigyan ng idea ang isang tao na pumatay po kasi nga po dati nagkaissue dun sa ano.. na bakit dun sa elementary student yun pong pag oopen ng about sex education..parang ganon yung sa abortion din.. bakit niyo po imumulat yung mata ng tao sa abortion yung po siguro sa tingin ko."*

- Male, nursing student, Region 4A

*2.4.2 Training needed to effectively provide care*

Those who supported the inclusion of abortion procedures in their training believed that it is necessary for them to assist doctors effectively during cases of therapeutic abortion and provide counselling to women.

*Kunwari nurse, ma-expose tayo doon sa ganoong scenario. Tapos syempre mag-assist ka. Eh di dapat alam natin yung yung ginagawa kasi magmumukha tayong tanga sa harap ng doctor kapag hindi natin alam yung gagawin natin.*

- Female, nursing student, Metro Manila

**2.6 Recommendations from students**

Students were asked how they think the abortion should be addressed in their education and in society, in general. Those who strongly opposed abortion called for stricter laws on abortion. For many, however, they felt that the ambiguity of the law should be addressed by providing clearly on when abortion is allowed:

*A clear line, kasi very vague. Madami kasi ang mga medical conditions that could warrant for some for recommending therapeutic abortion, but there are only few that is allowed legally and ethically for the abortion for example cp vs ectopic preganancy. Pero I've heard ha iba nga countries kapag , it is legal actually to abort.*

- Female, medical student, Region 8

It was also suggested that students should be informed of revisions in laws and on new policies that affect their profession. Accordingly, their knowledge of laws governing medical practices is limited only to what's on legal medicine books and they are unaware of new relevant policies.

Students also expressed interest in participating in seminars and forums discussing abortions. Meanwhile, they also called for "sex education" to address the issue of abortion at large.

## 3. DISCUSSION

Participants were aware that abortion is a common experience for many Filipino women. A significant percentage of participants even personally know women who had or considered having abortion. They perceived that abortion is a significant contributor to maternal deaths. The study, however, was not able to determine whether the students referred to only unsafe abortion as a leading cause of maternal mortality, nor on the extent of their awareness of safe abortion provision in the country.

However, while it is still argued by some practitioners that abortion even to save the life of a woman is unethical and illegal, the students recognized that there are circumstances when it is necessary to end the pregnancy to preserve the woman's health.

Majority of the participants assessed their theoretical knowledge of abortion and postabortion care as either "Fair" or "Good." However, particulary among medical and nursing students, there appears to have more limitations in knowledge of postabortion care than abortion, despite the fact that postabortion care is clearly guaranteed for by the law.

Students mainly get their knowledge about abortion as a medical issue through their formal education. Abortion is addressed in their studies as a pregnancy complication. Hence, their understanding of abortion as a medical issue was limited largely to the clinical procedure to preserve the life of a pregnant woman. This could help explain why they have more knowledge of the method for surgical abortion than medical abortion. Aside from medical and fetal indicators, the participants' discussion of abortion did not offer much in terms of how they see it as a medical issue. This could be due in part to the lack of probing questions for this aspect in the study instrument. Their lack of experience in assisting in abortion and postabortion cases during clinical training could also help explain the finding. Further, while abortion is discussed in classes, the topic seems to be glossed over, as suggested by participants' observations that abortion discussion is only "textbook-based" and taken on *"bigla-bigla"* (suddenly).

In this context, they understand abortion as pregnancy complication, and less so as a woman's choice. The lack of awareness on the wider social context of women who

have abortion was apparent in their belief that most women who have abortions are umarried or not in consensual union. In this regard, participants still perceived that most women who choose to have an abortion had pregnancies as a result of irresponsible sexual behaviors. This was despite the fact that they were also aware of the varied reasons why women seek an abortion, including rape, extreme poverty, stigma on teenage pregnancies, employment, and failure to use contraceptive or family planning methods.

While majority of midwifery and nursing students in the survey tended to agree that abortion procedures should be included in their training, participants in the FGD expressed reservations out of fear that knowledge could lead to practice—that female students could decide to have an abortion when faced with an unintended pregnancy; or that as nurses and midwives, they could end up assisting women in abortion.

Both results of the survey and discussions on their knowledge of the law with regards to abortion point to the impact of the law's ambiguity. Some were of the opinion that abortion is totally prohibited and others believe that it is allowed when it is necessary to save a woman's life. During the discussions, however, it was more apparent that students were aware that abortion is a necessary and practiced medical procedure for obstetrics emergency. There was more ambiguity on what is legally required for healthcare providers in terms of reporting women who had abortion.

The students' discussions about abortion revealed how the interplay of religious, moral, socio-cultural, and ethical norms, influence their attitudes toward the issue. While they acknowledged abortion as a medical issue, much of their discourse was grounded on their religious and moral systems. This, despite reporting that they get most of their knowledge of abortion from formal medical, nursing, and midwifery education, and that the church was not among the top sources. This shows that views on abortion are deeply rooted and integrated in the wider sociological environment and interactions of the participants of the study. As described in previous studies, healthcare students also learn from hidden curriculum that enables and creation and perpetuation of abortion stigma.[154]

Their views and opinions on abortion, particularly as a woman's right, could be rooted in how they understand and view other issues related to it. Their awareness of SRHR was limited to reproductive health, largely focused on family planning, and contraceptives in particular. Medical students had better articulation of these reproductive health services perhaps due to their longer and more specialized education and training. The midwifery students, on the other hand, were already practicing service providers. Among nursing students, those who have no personal experience in using any methods expressed having more limitations in knowledge.

[154] Elliot et al., "Without,"

While their knowledge of SRHR was limited mostly to reproductive health, students showed awareness and support to women's right to choose and make decisions, including the right to choose to have children or not and the number of children. In the survey, majority of the students in all programs agreed that it is a woman's right to make and execute independent decisions on her reproductive health, such as pregnancy.

In this sense, the participants appeared to strongly support women's bodily and reproductive autonomy. The extent to what choices women can make, however, were limited to what was believed was right and ethical based on religious convictions, and ideals of womanhood and/or motherhood. For instance, certain groups of study respondents (i.e private school students, students who never had sexual experience) tended to agree more with women's reproductive autonomy but at the same time, they were also the groups that tended to agree more that abortion is morally wrong and abortion should not be considered as a woman's right. This points to the need to examine how future and practicing healthcare providers conceptualize autononomy and how it affects delivery of reproductive health services for women.

Findings reveal that abortion stigma exists among the medical, nursing, and midwifery students who participated in the study. As shown in the survey responses, majority of students in all the programs agreed with "Abortion is morally wrong" and did not support women's right to an abortion in the case of unintended pregnancy. The fetus was assigned personhood and generally referred to as "life," and therefore abortion was perceived as "killing" or "taking away life." In relation, abortion was perceived as conflicting with healthcare providers role to preserve or "save life" at all costs.

While students supported women's right to choose and decide over her body, but students' support for abortion grew less with more control a woman have over the decision to terminate a pregnancy. Therefore, when the abortion is "unintentional" such as when the pregnancy is at a risk to woman's health, then the greater acceptability students had over the abortion and willingness to assist in service provision. In the same sense, when the fetus has less chance to survive, then the greater acceptability there was of abortion.

It also appears that the degree of control women had over the circumstances of pregnancy influences students' support of abortion. Students had stronger opposition to abortion when a woman was described to have deliberately had sex, and more so "enjoyed" the sex. Carrying the pregnancy to term, then, was a consequence and responsibility that that the woman had to bear. This view against abortion was described in literature as the Responsibility Objection.

The views of those who strongly opposed abortion were also influenced by their expectations of the "essential nature" of women as life-bearers and caregivers. It was believed that a woman would naturally learn to love a child even born as a result of unwanted pregnancy. Even an ideal mother was described as choosing the

life of the unborn over her own. Unwanted pregnancies were often linked to irresponsible sexual behaviour, and women labelled as "promiscuous." Induced abortion was also referred to as an act of "stupidity" and "selfishness." Unwittingly, since induced abortion was generally considered as a crime, women were still viewed as criminals. This was evident in the negative language use to describe women who had abortion such as "having killed someone." There was more pronounced stigma against repeat abortions and women who had more than one abortion is described as "killing repeatedly." Hence, they were deemed less forgivable and more deserving to be reported to the authorities. Studies on attitudes towards abortion found that negative language is usually associated with the discourse of repeat abortion. The negative language associated by the students with women who had abortion is the social process of stereotyping in abortion stigma wherein women are linked with negative traits.[155]

Despite the observable stigma towards abortion, participants' attitude towards safe abortion provision is best described as ambivalent. In the survey, the number of respondents who absolutely did not agree for legal abortion on any grounds was significantly less than those who said that abortion is morally wrong. Which means, a significant number of those who found abortion morally wrong still supported that abortion should be available for certain circumstances.

In the discussions, ambivalence was lessened when the abortion was for life-threatening pregnancies as participants' acknowledge medical ethics dictate priority of the life of the patient. However, there were still some students who felt that abortion is inherently against their religion, despite any circumstances. This finding is similar to what has been described as pro-choice healthcare provider's tendency to have "clinical" response and view abortion "part of the job" whereas those opposed to abortion "found it difficult to separate their personal feelings from professional conduct."[156] The few students who had the most liberal views of abortion, however, moved away from "clinical" reasoning on abortion. Their support to abortion went beyond the need to preserve the health and life of women, instead, they believed that there are complexities in women's circumstances for wanting and needing an abortion, including psychological and economic. Hence, they believed that women had to decide based on what is necessary given their circumstances.

However, the students believed that whatever the circumstances of abortion, every woman suffering from abortion-related complications deserve immediate, humane, non-judgmental, and compassionate postabortion care. They have very high awareness of mistreatment and abuse that women receive in facilities, particularly when seeking postabortion care. This points to the potentials of healthcare students as allies and even advocates for improved postabortion care policies and services in the country.

[155] Kumar, Hessini and Mitchell, "Conceptualising," 2.
[156] Jane Harries, Kathryn Stinson, and Phyllis J Orner, "Healthcare providers' attitudes towards termination of pregnancy: A qualitative study in South Africa" BMC Public Health (2009), https://doi.org/10.1186/1471-2458-9-296.

# 7. CONCLUSIONS

Abortion is prevalent in the Philippines, and the stigma and highly restrictive legal context pushes women to unsafe abortions, leading to maternal morbidity and mortaliy. As found in official inquiries, many women needing postabortion care are prevented from seeking the life saving treatment for fear of humilition, abuse, and possible persecution. The law does not clearly provide grounds for exemptions from criminal liability, and the ambiguity makes it harder even for healthcare providers to provide the needed medical care for women. Even in landmark legislations for reproductive health, abortion is excluded in the discourse of rights. The stigma on abortion also contributes to negative attitudes of healtcare providers on women seeking postabortin care. Knowing how future healthcare providers understand abortion is important to point directions on how to open conversations on abortion and advance the discourse on the right to safe abortion.

Perhaps owing to the difference in length, focus, and specialization of education of medical, nursing, and midwifery students, levels of knowledge of SRH and abortion differed. The highly unequal sample sizes of the survey also precluded the study from making generalizations to the whole population. It can be observed, however, from responses and in the qualitative data, that there were still limitations in awareness and knowledge of SRH, including abortion and postabortion care.

Their understanding of knowledge of abortion was largely limited to abortion as pregnancy complication. They recognize abortion as a necessary medical procedure for obstetric emergencies and that medical and professional ethics require them to give priority to the patient's life. Postabortion care is also a right of every women. They know that abortion is legally restricted, but have differing perception on the extent: others think it is totally prohibited while others believe it is legally warranted on certain grounds, and that ground believed by most as only when necessary to save a woman's life.

Ambivalence on abortion and legal abortion provision exists among the participants. While they acknowledge the need for life-saving procedure when therapeutic abortion is needed to save the life of the woman, there is ambivalence due to abortion stigma. What makes abortion morally and ethically wrong or unaceptable is is based on personhood of the fetus, religious and moral beliefs, beliefs of the role of healthcare providers, ideals of womanhood, and concepts of responsibility. Stigma is evident in the stereotyping of women who had abortion and labelling certain types of abortion as more "acceptable" than the others. Students tended to support abortion more as a woman's right when it is necessary to save a woman's life and less so when it is for other social reasons. However, students who had pro-choice attitudes toward abortion believed that abortion is a right for women to decide on her body and based on her given circumstances.

Prevailing attitudes toward abortion among the participants appeared to be largely influenced by factors beyond their education. Hence, it is necessary to continue

examining how educational environment of future healthcare providers either promote or challenge existing gender and cultural norms.

Stigma reduction workshops could help resolve ambivalence by exposing students to the complex realities of women who choose to have abortion; clarifying what the law says on abortion and postabortion care; expounding on abortion as a necessary healthcare for women and what professional guidelines for medical, nursing, and midwifery practitioners on abortion service provision are in other countries; and encouraging values reflection around gender norms and ethics and how they affect access and provision of SRH services to women.

While still very much confined within gender and cultural norms, there is already perceivable positive opinion and belief on women's bodily and reproductive autonomy among the participants. As observed during the discussions, the belief that only the woman has the right to decide over her body helped sway opinion towards safe abortion provision. Abortion stigma reduction workshops should leverage on this and support healthcare students and providers expand their concept of autonomy in the framework of SRHR and women's rights, in general.

The participants also strongly believed in women's right to humane, non-judgmental, compassionate postabortion care. These attitude should be nurtured and reinforced through suppportive policies and training environment. The supportive environment should be available for them in healthcare education institutions; in health facilities where they train and will eventually work in; and in professional associations and organizations.

# 8. RECOMMENDATIONS

Based on findings of the study, the following are recommended:

1. Inclusion of PAC education in the medical and nursing schools as first step towards making humane, non-judgmental, quality postabortion care accessible for women.

2. Medical schools, POGS, WHO, DOH, public health NGOs and safe abortion advocacy groups to equip medical and nursing students with skills and knowledge of new methods of PAC such as the use of MVA and misoprostol.

3. To integrate PAC into other medical discipline or specialty such as Emergency Medicine.

4. SRHR and safe abortion discussions to be incorporated into existing courses along with family planning and reproductive health modules. Integration of safe abortion discussion/education in medical, nursing and midwifery courses/curriculum would result in improved quality of reproductive health services and information for women.

5. To ensure the implementation of a rights-based PAC Policy, medical associations, women and SRHR groups, and public health NGOs should be part of the formulation of the policy.

6. Discussions, trainings and workshops on gender equality, women's rights and SRHR to be implemented in medical, nursing , and midwifery schools. Focus on second year midwifery students rather than fourth year students. Second year students are already legible for licensure and practice service provision after.

7. Safe abortion advocacy groups to conduct special courses on abortion stigma reduction with medical and nursing students, faculty members and schools heads.

8. Examine how medical, nursing, and midwifery curriculum address contemporary issues of sexual and reproductive health and how educational environment influence prevailing gender norms and stigma on abortion.

9. Further studies on knowledge and attitudes with medical, nursing and midwifery students. Because of the difference in curriculum and length of study, it is recommended that each program studied separately.

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# ANNEXES

## ANNEX 1. INFORMED CONSENT FORM

## EXPLORING MEDICAL, NURSING, AND MIDWIFERY STUDENTS' VIEWS AND ATTITUDES TO ABORTION IN THE PHILIPPINES

We are inviting you to participate in a study that explores the medical, nursing and midwifery students views and attitudes on abortion in the Philippines. The main objective of this study is to determine the knowledge, views and attitudes of medical, nursing and midwifery students on abortion in order to gain preliminary data to support further research and design of appropriate advocacy strategies in healthcare educational settings to open conversations on abortion in the context of sexual and reproductive health and rights (SRHR).

Specifically, the objectives are the following:

1) To determine what medical, nursing and midwifery students know about abortion.
2) To find out the views and attitudes of medical, nursing and midwifery students regarding abortion as a medical, socio-political and ethical issue.
3) To explore the influences that shapes the knowledge, perceptions and views of medical, nursing and midwifery students on abortion.
4) To recommend advocacy strategies that will open conversations with medical and health education institution on abortion within the context of SRHR.

Information about this study and its proponents are as follows:

| | |
|---|---|
| **Title of Study:** | Exploring medical, nursing and midwifery students' views and attitudes on abortion in the Philippines |
| **Study Team:** | Christelyn Sibugon, Primary Investigator<br>(Women's Global Network for Reproductive Rights)<br>Contact: 09177060971 email: teta@wgnrr.org<br>Marevic Parcon, Co-investigator<br>Romeo Marcaida, RN, Co-investigator<br>Ma. Dulce Natividas, Consultant<br>Sarah Jane Biton, RN, Consultant<br>Joralen Wenceslao, Research Coordinator<br>Abigail R. Matres, Research Coordinator<br>Ladylyn Mangada, Research Coordinator |

The study will be conducted in different universities and colleges in Metro Manila and other locations to look for fourth year medical, nursing and midwifery students.

The study will utilize the following methods:

a. Focus Group Discussions (FGD) with up to seven (7) students each group *(1 to 1.5 Hours)*
b. Survey with **all** 4th year students *(survey tool can be completed approximately 6-9 minutes)*
c. Key Informant Interview (KII) with 3 faculty members teaching courses relevant to the study topic *(Each interview is approximately 45 mins to 1 hour)*

The questionnaire and succeeding discussions will have the following themes:

1) Knowledge of abortion's prevalence, methods, consequences, laws, and reasons, among others.
2) Students' attitudes towards provision of abortion services and postabortion care, laws and policies on abortion, and social mores on abortion.
3) Sources of knowledge of abortion from the school setting to their personal experiences.
4) Innovative advocacy strategies towards achieving a more responsive, just, and women-sensitive health care system.

By joining the study, you will be able to share your experience and insights, including recommendations, that will contribute to the development of policies and programs for healthcare education settings and to the wider health service system. Results of the study will be share with your school and you can be furnished a copy upon your request.

You are free to ask questions about any concerns within the whole duration of the study and you have the right not to respond or decide to leave the study. Your participation is purely voluntary. We will keep your identity confidential in our reports. We will provide a small token (non-monetary) for you as well as refreshments during the FGD and KII.

This study is in partnership with The Asian Pacific Resource and Research Centre for Women (ARROW), and funded by The Swedish International Development Agency (SIDA) through the Swedish Association for Sexuality Education (RFSU). After this study we will submit a report to ARROW and RFSU. In our reports, we will acknowledge the contribution of all stakeholders or groups that participated in this study. We are expecting that the results will be used by groups and agencies involved in the provision of a just and more responsive policies on abortion in the Philippines, thus we might prepare various reports for presentation in public forums and scientific conference and write articles for scientific journal about the results of this study.

If you have any questions or suggestions about this study, do not hesitate to tell us anytime. You can contact the following for your questions:

**Office:** Women's Global Network for Reproductive Rights (WGNRR)
**Address:** 3 Marunong Street, Barangay Central, Diliman, Quezon City
**Telephone:** +63 2 928-7785

This study has been approved by the <INSTITUTION> Ethics Review Committee and may be reached through the following contact for information regarding rights of study participants, including grievances and complaints:

<NAME OF APPROVING INSTITUTION>
<CONTACT NUMBER>
<CONTACT EMAIL>

# CONSENT

I have read and understood the information provided in this informed consent document which was administered by **_____.** I understand my role and responsibility as a participant in this study. I am confirming that I have made careful consideration of all this information, and I am joining voluntarily.

I understand that:

- ☐ The researcher will protect the privacy and confidentiality of information collected by the study especially my personal information
- ☐ Information coming from me during the FGD will be included in the data on which the study results will be based
- ☐ I am free to retract or remove statements I already made
- ☐ My participation is voluntary
- ☐ No statement will be attributable to me personally unless I gave explicit permission to do so
- ☐ I will not be personally named in any publication unless I gave explicit persmission to do so
- ☐ There is no penalty if I decide to withdraw from the study anytime
- ☐ I will be provided a summary of results of the study upon my request

SIGNATURE OVER PRINTED NAME OF RESPONDENT : _____

SIGNATURE OVER PRINTED NAME OF PERSON OBTAINING CONSENT : _____

WITNESS : _____

DATE : _____

**ANNEX 2. FOCUS GROUP DISCUSSION GUIDE (HEALTHCARE STUDENTS)**

Introduction

Facilitator shall: a) lay down the objectives and significance of the research; b) seek informed consent from participants; and c) give assurance of confidentiality and anonymity of discussion.

The facilitator shall then: a) set the allotted time and schedule of the FGD; b) seek permission to use identification mark or number and voice recording; c) explain the rules of conduct; and finally d) encourage the free participation of each participant.

A round of introduction of participants shall take place before going to the discussion.

Discussion Guide:

PART 1. *Medical/nursing/midwifery education on abortion*

1. How are issues related to women's sexuality and reproductive health such as contraception, family planning, teen pregnancy, and abortion discussed or integrated in your training/program?

2. How do you understand sexual and reproductive health and rights? Do you support that abortion is part of women's SRHR?

3. How is abortion discussed in your medical/nursing/midwifery curriculum/program of studies? What would you say are the ethical issues/considerations in discussing abortion as part of medical/nursing/midwifery education?

*PART 2. Read/Show story of case of a woman seeking therapeutic abortion*

4. In the situation shown in the story, do you think it was right for the woman to get abortion?

5. If you were the doctor/nurse/midwife in the situation, what would you do and advice the woman?

6. In the case of therapeutic abortion, do you believe that woman have the right?

7. What is a health providers' responsibility in the case of therapeutic abortion?

8. How about in other circumstances?

*PART 3. Read/show story of postabortion care story*

9. What are the health providers' responsibilities in the situation shown in the story?

10. Do you think health providers have the right to refuse care if he/she founds out that it was a result of **induced** abortion? If yes, why? If no, why? Is it legal in the Philippines for the providers to refuse care (based on the policy on Postabortion Care guidelines)?

*PART 4. Abortion*

Taking off from the discussion of induced abortion above:

11. How do you see abortion? Should it be considered as the right of women? If yes, why? If no, why? How do you see women who choose to have abortion? How do you see health professionals who provide abortion?

12. In the Philippines, abortion in permitted to save a woman's life, but the law does not state this explicitly. Therefore abortion is seen as "generally illegal" because the law does not provide explicit exceptions when abortion is allowed.
    a. How does this (legal situation) affect women?
    b. How does this affect/limit health providers can give to women?
    c. Do you think there is a need to change the law? Why or why not? If yes, what changes do you think are needed?
    d. How do you think abortion should be addressed in the medical/nursing/midwifery education?

**ANNEX 2. SURVEY TOOL**

# EXPLORING MEDICAL, NURSING, AND MIDWIFERY STUDENTS' VIEWS AND ATTITUDES ON ABORTION IN THE PHILIPPINES

Thank you for agreeing to take part in this important survey. Women's Global Network for Reproductive rights is conducting an exploratory study on the knowledge, views and attitudes on abortion of healthcare students in the Philippines.

We are looking forward to learn from you! We hope to gain preliminary information to support further research and design of appropriate advocacy strategies in healthcare educational settings to open conversations on abortion in the context of sexual and reproductive health and rights.

All the information provided will be kept strictly anonymous. Please do not skip any items.

Thank you for your participation.

## PART 1

| | | |
|---|---|---|
| 1.1 | **Gender** | 1 ☐ Female 2☐ Male<br>2☐ I identify/self-describe as<br>_____<br>_ |
| 1.2 | **Age** | _____(in number of years ) |
| 1.3 | **Program** | 1 ☐ Doctor of Medicine<br>2 ☐ Bachelor of Science in Nursing<br>3 ☐ Bachelor of Science in Midwifery |
| 1.4 | **Year Level** | 1 ☐ 4$^{TH}$ Year<br>2 ☐ 3$^{rd}$ Year<br>3 ☐ 2$^{nd}$ Year<br>4 ☐ 1$^{st}$ Year |
| 1.5 | **Type of university/school** | 1 ☐ Public<br>2 ☐ Private/Non-sectarian/Non-religious<br>3 ☐ Private/Sectarian/Religious |
| 1.6 | **Are you a member of any organization/association in school?** | 1 ☐ Yes 2 ☐ No |
| 1.7 | **What type of organization?** (tick all that applies) | 1 ☐ Academic<br>2 ☐ Cause-oriented |

| | | |
|---|---|---|
| | | 3 ☐ Faith-based<br>4 ☐ Others<br>_____ |
| 1.8 | **What is the average monthly income of your family?** | 1 ☐Below Php 10,000<br>2 ☐Php 10,000-19,000<br>3 ☐Php 20,000-39,000<br>4 ☐Php 40,000-59,000<br>5 ☐Php 60,000-79,000<br>6 ☐Php 80,000-90,000<br>7 ☐Php 90,000-100,000<br>8 ☐Php Over 100,000 |
| 1.9 | **How many are you in the family?** | _____ |
| 1.10 | **What is the highest level of education your father has completed?** | 1 ☐ No Education<br>2 ☐ Elementary<br>3 ☐ High school<br>4 ☐ Vocational<br>5 ☐ College<br>6 ☐ Graduate studies |
| 1.11 | **What is the highest level of education your mother has completed?** | 1 ☐ No Education<br>2 ☐ Elementary<br>3 ☐ High school<br>4 ☐ Vocational<br>5 ☐ College<br>6 ☐ Graduate studies |
| 1.12 | **What is your religion?** | 1 ☐ Catholic<br>2 ☐ Protestant<br>3 ☐ Muslim<br>4 ☐ Buddhist<br>5 ☐ Others<br>_____<br>6 ☐ No religion |

| | | |
|---|---|---|
| 1.13 | **How would you describe your attendance in religious services (e.g. mass, prayer meetings, etc)?** | 1 ☐ Every day<br>2 ☐ Once a week<br>3 ☐ Once a month<br>4 ☐ Occasional<br>5 ☐ Not applicable |
| 1.14 | **What is your civil status?** | 1 ☐ Single<br>2 ☐ Married **(Skip to 1.16)**<br>3 ☐ Live-in **(Skip to 1.16)**<br>3 ☐ Separated **(Skip to 1.16)**<br>4 ☐ Widowed **(Skip to 1.16)** |
| 1.15 | **If single, how would you describe your relationship status?** | 1 ☐ Single, in a relationship<br>2 ☐ Single, no current relationship<br>3 ☐ Single, never been in a relationship |
| 1.16 | **How would you describe yourself?** | 1 ☐ Heterosexual<br>2 ☐ Homosexual<br>3 ☐Bisexual<br>4 ☐ Others<br>_____<br>5 ☐Prefer not to answer |
| 1.17 | **Do you have a child or children?** | 1 ☐ Yes<br>2 ☐ No |
| 1.18 | **Please describe your sexual experience** | 1 ☐ I have had sex<br>2 ☐ I never had sex **(Skip to PART 2)**<br>3 ☐ Unwilling to answer **(Skip to PART 2)** |
| 1.19 | **If you have had sex, do you use contraception?** | 1 ☐ Yes<br>2 ☐ No **(Skip to PART 2)** |
| 1.20 | **How would you describe your use of contraception?** | 1 ☐ More often than not, I use contraception<br>2 ☐ More often than not, I do not use contraception<br>3 ☐ I always use contraception |

| | | |
|---|---|---|
| 1.21 | **What are the types of contraception do you rely the most for the last three years?** (Choose up to three answers) | 1 ☐ Rhythm method (or calendar method)<br>2 ☐ Withdrawal<br>3 ☐ Male condoms<br>4 ☐ Pills (oral contraceptives)<br>5 ☐ Implants<br>6 ☐ Injectable<br>7 ☐ Vasectomy<br>8 ☐ Intrauterine device<br>9 ☐ Others |

## PART 2

| | | |
|---|---|---|
| 2.1 | **According to the latest National Demographic and Health Survey, what percentage of women age 15-49 have unmet need for family planning?** | 1 ☐ About 50%<br>2 ☐ About 17%<br>3 ☐ About 5%<br>4 ☐ About 10%<br>5 ☐ I don't know |
| 2.2 | **Abortion is among the Top 5 leading causes of maternal deaths in the Philippines.** | 1 ☐ True<br>2 ☐ False<br>3 ☐ I don't know |
| 2.3 | **According to the law, when can a woman access an abortion in the Philippines?** | 1 ☐ Always, there are no restrictions<br>2 ☐ Never, abortion is totally prohibited<br>3 ☐ Sometimes, depending on the circumstances<br>4 ☐ **Only** when it is necessary to save a woman's life (i.e. therapeutic abortion)<br>5 ☐ I don't know |
| 2.4 | **Are health professionals and other service providers required by law to report to the police a woman who sought postabortion care after an induced abortion?** | 1 ☐ Yes<br>2 ☐ No<br>3 ☐ I don't know |
| 2.5 | **Do you know how medical abortion is done?** | 1 ☐ Yes<br>2 ☐ No |

| | | |
|---|---|---|
| 2.6 | **What is the recommended method for medical abortion?** | 1 ☐ Oxytocin followed by misoprostol<br>2 ☐ Misoprostol alone<br>3 ☐ Misoprostol followed by mifepristone<br>4 ☐ Mifepristone followed by misoprostol<br>5 ☐ I don't know |
| 2.7 | **Do you know how surgical abortion is done?** | 1 ☐ Yes<br>2 ☐ No |
| 2.8 | **Which among these is a method for surgical abortion?** | 1 ☐ Intake of Cytotec<br>2 ☐ Abdominal massage<br>3 ☐ Vacuum aspiration<br>4 ☐ I don't know |
| 2.9 | **Most Filipino women who have abortion are married or in a consensual union.** | 1 ☐ True<br>2 ☐ False<br>3 ☐ I don't know |
| 2.10 | **Spontaneous abortion is commonly known as:** | 1 ☐ Therapeutic abortion<br>2 ☐ Stillbirth<br>3 ☐ Miscarriage<br>4 ☐ I don't know |
| 2.11 | **Counseling and family planning including contraceptive services are part of postabortion care.** | 1 ☐ True<br>2 ☐ False<br>3 ☐ I don't know |

| PART 3 | | |
|---|---|---|
| 3.1 | **Where did you hear from or learn about abortion?** (tick all that apply) | 1 ☐ Studies/school<br>2 ☐ Friends<br>3 ☐ Family<br>4 ☐ Media like TV, radio, magazines, newspaper<br>5 ☐ Social media<br>6 ☐ My own research<br>7 ☐ Church<br>8 ☐ Doctors and other health professionals<br>9 ☐ Personal experience<br>10 ☐Non-government organizations/cause-oriented groups<br>11 ☐ Others _____ |
| 3.2 | **Among your answers, what would you say are the top 3 sources of your knowledge of abortion?** (Tick up to 3) | 1 ☐ Studies/school<br>2 ☐ Friends<br>3 ☐ Family<br>4 ☐ Media like TV, radio, magazines, newspaper<br>5 ☐ Social media<br>6 ☐ My own research<br>7 ☐ Church<br>8 ☐ Doctors and other health professionals<br>9 ☐ Personal experience<br>10 ☐Non-government organizations/cause-oriented groups<br>11 ☐ Others _____ |
| 3.3 | **Has abortion been discussed in any of your subject/training?** | 1 ☐Yes<br>2 ☐No |
| 3.4 | **Have you participated in an activity such as forum, seminar, and workshop outside of your program of study where abortion was discussed?** | 1 ☐Yes<br>2 ☐No |

| | | |
|---|---|---|
| 3.5 | **In the course of your training, did you have any opportunity of assisting in a case of abortion procedure?** | 1 ☐ Yes<br>2 ☐ No<br>3 ☐ Unsure |
| 3.6 | **In the course of your training, did you have any opportunity of assisting a case of postabortion care?** | 1 ☐ Yes<br>2 ☐ No<br>3 ☐ Unsure |
| 3.7 | **Do you personally know someone who had an abortion?** | 1 ☐ Yes<br>2 ☐ No<br>3 ☐ Unsure |

## PART 4.

| | | |
|---|---|---|
| 4.1 | **How would you say has sexual and reproductive health been discussed/or covered in your program of study?** | 1 ☐ Not at all<br>2 ☐ Somewhat<br>3 ☐ Adequately<br>4 ☐ Can't say |
| 4.2 | **How would you assess your theoretical knowledge of sexual and reproductive health and rights?** | 1 ☐ Poor<br>2 ☐ Fair<br>3 ☐ Good<br>4 ☐ Very good |
| 4.3 | **How would you describe your theoretical knowledge of abortion?** | 1 ☐ Poor<br>2 ☐ Fair<br>3 ☐ Good<br>4 ☐ Very good |
| 4.4 | **How would you describe your theoretical knowledge of postabortion care?** | 1 ☐ Poor<br>2 ☐ Fair<br>3 ☐ Good<br>4 ☐ Very good |

*For questions 4.5 to 4.10, indicate your opinion by using the scale. Encircle the number of your choice*

4.5 **Women should be able to make and execute independent decisions on her reproductive health, such as pregnancy.**

| 1 | 2 | 3 | 4 | 5 | 6 |
|---|---|---|---|---|---|
| Strongly Disagree | Disagree | Somewhat Disagree | Somewhat Agree | Agree | Strongly Agree |

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4.6 **Abortion is an appropriate topic in my program of study.**

| 1 | 2 | 3 | 4 | 5 | 6 |
|---|---|---|---|---|---|
| Strongly Disagree | Disagree | Somewhat Disagree | Somewhat Agree | Agree | Strongly Agree |

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4.7 **Abortion is morally wrong.**

| 1 | 2 | 3 | 4 | 5 | 6 |
|---|---|---|---|---|---|
| Strongly Disagree | Disagree | Somewhat Disagree | Somewhat Agree | Agree | Strongly Agree |

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4.8 **A woman should always have the right to an abortion in the case of an unintended pregnancy.**

| 1 | 2 | 3 | 4 | 5 | 6 |
|---|---|---|---|---|---|
| Strongly Disagree | Disagree | Somewhat Disagree | Somewhat Agree | Agree | Strongly Agree |

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4.9 **My education program should include training on abortion procedures.**

| 1 | 2 | 3 | 4 | 5 | 6 |
|---|---|---|---|---|---|
| Strongly Disagree | Disagree | Somewhat Disagree | Somewhat Agree | Agree | Strongly Agree |

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4.10 **Students with moral objections should be excused from any training and discussions on abortion.**

| 1 | 2 | 3 | 4 | 5 | 6 |
|---|---|---|---|---|---|
| Strongly Disagree | Disagree | Somewhat Disagree | Somewhat Agree | Agree | Strongly Agree |

| | | |
|---|---|---|
| 4.11 | **In your opinion, at what gestational age an embryo/fetus becomes a PERSON?** | 1 ☐Fertilization<br>2 ☐Weeks 1-10<br>3 ☐Weeks 21-24<br>4 ☐Weeks 25-30<br>5 ☐Weeks 31-40<br>6 ☐Birth<br>7 ☐Other _____ |
| 4.12 | **Should abortion be legally available in our country?** | 1 ☐Yes, absolutely, in all circumstances. **(Skip to Q 4.14)**<br>2 ☐No, absolutely. **(Skip to 4.14)**<br>3 ☐Yes, under certain circumstances<br>4 ☐Unsure **(Skip to 4.14)** |
| 4.13 | **If yes, under certain circumstances, what circumstances?** (tick all your answers) | 1 ☐When it is necessary to save the woman's life<br>2 ☐When the fetus has severe impairment and unlikely to survive<br>3 ☐When the pregnancy is the result of rape<br>4 ☐When the pregnancy is the result of incest<br>5 ☐When the woman has cognitive or intellectual disability<br>6 ☐When the woman is in psychological distress about the pregnancy (mental health reasons)<br>7 ☐When the woman is living in extreme poverty and her child would also live in extreme poverty (economic reasons) |
| 4.13 | **If abortion were made legally available in country, would you be willing to perform and/or assist in abortion service?** | 1 ☐Yes, absolutely, in all circumstances.<br>2 ☐No, absolutely.<br>3 ☐Yes, under certain circumstances<br>4 ☐Unsure |
| 4.14 | **In the present legal situation where abortion is generally restricted, are you willing to assist in abortion procedure to save a woman's life?** | 1 ☐Yes<br>2 ☐No<br>3 ☐Unsure |

| | | |
|---|---|---|
| 4.15 | **In the present situation, if a friend, someone from your family, or a girlfriend or partner had an unintended pregnancy, are you open to help her get an abortion?** | 1 ☐Yes<br>2 ☐No<br>3 ☐Depends on circumstances<br>4 ☐Unsure |
| 4.16 | **For FEMALE respondents ONLY:**<br><br>If you have an unintended/unplanned pregnancy in this time in your life, would your consider getting an abortion? | 1 ☐Yes<br>2 ☐No<br>3 ☐Unsure |

WOMEN'S GLOBAL NETWORK FOR REPRODUCTIVE RIGHTS