

NATIONAL BASELINE REPORT

Claiming the Right to Safe Abortion:
Strategic Partnerships in Asia



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



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**Exploring Medical, Nursing,
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and Attitudes towards Abortion in the
Philippines**

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AUTHORS

Christelyn Sibugon
Marevic Parcon

RESEARCH TEAM

Christelyn Sibugon
Marevic Parcon
Joralen Wenceslao
Abigail R. Matres
Benily Dimabuyu

COVER PHOTO

Sarah Jane Biton

LAYOUT

Ron Villegas

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LIST OF ACRONYMS

AO	Administrative Order
BSN	Bachelor of Science in Nursing
BSM	Bachelor of Science in Midwifery
CEDAW	Convention on the Elimination of Discrimination Against Women
DOH	Department of Health
DSWD	Department of Social Welfare and Development
FGD	focus group discussion
ICPD	International Conference on Population and Development
MCW	Magna Carta of Women
MD	Doctor of Medicine
MDG	Millennium Development Goals
MMR	maternal mortality ratio
OOP	out-of-pocket
PAC	postabortion care
PCW	Professional Regulation Commission
PINSAN	Philippine Safe Abortion Advocacy Network
PMAC	Prevention and Management of Abortion Complications
POGS	Philippine Obstetrical and Gynecological Society
RPRH	Responsible Parenthood and Reproductive Health
SRHR	sexual and reproductive health and rights
SRH	sexual and reproductive health
WGNRR	Women's Global Network for Reproductive Rights
WHO	World Health Organization

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EXECUTIVE SUMMARY

The restricted legal environment on access to safe abortion and the stigma against abortion has historically driven the issue of safe and legal abortion underground and marginalized abortion in the rights discourse in the Philippines. As a result, the healthcare system has failed to comprehensively address the sexual and reproductive health and rights (SRHR) of women. Healthcare providers are constrained by the stigma, normative gender concepts, personal belief systems, ambiguity of the law, and limitations of the healthcare system from adequately providing humane, non-judgmental, and compassionate sexual and reproductive health (SRH) services to women.

The Philippines is one of the few 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, prevent disability or for other health concerns. But with such ambiguity, many healthcare providers continue to be fearful of criminal liability, and women are forced to undergo unsafe abortions that lead to life-threatening complications and contribute to high maternal mortality and morbidity. Since abortion is highly stigmatized, even women who had spontaneous abortion and need postabortion care experience abuse and discrimination.

Healthcare professionals are critical since women need skilled and empathetic service providers to address their SRH needs. Especially in a country where access to safe abortion is limited, 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 the full exercise of their 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 towards 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 among the respondents regarding the legal status of abortion and whether healthcare providers are required to report women who had abortions. There was high awareness of the mistreatment and abuse of women seeking postabortion care in facilities.

They understood abortion mainly as a biomedical issue, that is, 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 towards the issue. While they acknowledged abortion as a medical issue, much of their discourse was grounded in their religious and moral beliefs. They generally recognized abortion as a necessary medical procedure for obstetric emergencies and that medical and professional ethics require them to prioritize the patient's life. However, there was still stigma towards abortion due to religious beliefs; beliefs about the role of healthcare providers; ideals regarding womanhood; and concepts of responsibility. This has created among student respondents ambivalence towards abortion service provision and abortion law reforms.

The notions of women's choice and access to reproductive health service were supported by the students based on their statements. They recognized women's reproductive autonomy, although this 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 non-medical reasons. There were students, however, who believed that a woman has the right to decide over her body, including based on her given circumstances. They also strongly believed that women have a right to humane, non-judgmental, compassionate postabortion care. It has to be noted that given their many qualifications and contradictory elements, these beliefs are inchoate and need to be nurtured and reinforced in a supportive environment, whether in health education institutions, in health facilities where they train and will eventually work in, or in professional associations and organizations.

The findings point to the need to further examine how the educational environment prepares medical, nursing, and midwifery students to navigate complex, contemporary SRHR issues such as abortion and to collaborate with educational institutions in providing alternative learning spaces or platforms where future healthcare providers can learn more about the contexts of women who have abortions, the legal policies on abortion, and postabortion care. There is also a need 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 to continue to deepen conversations regarding 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

Abortion¹ is restricted and stigmatized in the Philippines. Because of this, women end up undergoing unsafe abortions², which can cause health complications and have led to maternal deaths and morbidity. 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

The Women's Global Network for Reproductive Rights (WGNRR) conducted a study on the knowledge and attitudes towards 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 such as the medical, nursing and midwifery students understand abortion and how their views are shaped by their educational institution, among others.

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 rights⁴ (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 health⁵ (SRH).

- 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%2f%2fid%2f%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](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> 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.

We focus our efforts on the most critical SRHR issues, including advancing access to safe abortion⁶ 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.

Abortion is stigmatized in the Philippines and service provision is driven underground, making it more dangerous for women who need treatment and care, and closing further public and policy 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's access to quality care, and attainment of overall SRHR. They are also a key sector that could contribute to an open and rational discourse on abortion. Thus, it is important that SRHR issues, including abortion, are integrated comprehensively in medical and health education and training.

Similar studies on the knowledge and attitudes of healthcare students regarding abortion and how abortion has been included in their training have been done in countries that have liberalized abortion, albeit in varying degrees. A similar study was also done in Argentina, where the law, although restricted, 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. From the beginning, we recognized the difficulty of studying the issue, particularly how abortion is taken up in the healthcare education and training programs within the existing legal context. Hence, this study was designed to be exploratory and to provide initial insight on which to build future researches and advocacy strategies. It is expected that, at the very least, this study could 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 to the provision of SRH services. The study explored their knowledge of and attitudes towards abortion, and how these knowledge and views were shaped. This study can provide insights and inform recommendations on how healthcare education programs can better address critical SRHR issues such as abortion; identifying opportunities for abortion stigma reduction; and organizing SRHR advocates among healthcare students and professionals. Findings from the study may have implications on existing approaches to advocacy on safe abortion rights in the restricted context of the Philippines.

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/

Specifically, the objectives of the research are to:

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 (MD), Bachelor of Science in Nursing (BSN), and Bachelor of Science in Midwifery (BSM) 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 possible refusal of institutions to be involved in a study on a very polarizing issue, as evidenced by WGNRR's previous engagements with various institutions during our national campaign to demystify and destigmatize abortion. An equal number of public and private institutions as well as of participating program of

studies; i.e. two schools each for medical, nursing, and midwifery students were initially planned. The final study sites, however, were determined by which colleges provided timely Ethics Committee approval. For institutions that did not have any ethics committees in place, ethical approval was secured from school administrators.

The study was conducted in three institutions 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
		Bachelor of Science in Nursing

This research employed a survey and a series of focus group discussions (FGD). We requested the participation of all fourth year students from the identified study programs in answering the survey questionnaire; at least seven students from the same population were selected to participate in the FGDs. Final year students were selected as participants since they have completed or almost completed the curriculum for their respective programs of study. Both the survey and FGDs were conducted in the school premises. Given the relatively small population size of final-year students in each school, the study aimed for a census sampling. However, since final year MD students in School E (Region 8) were attending a clinical clerkship in various facilities, the school at the time was only able to arrange the participation of seven students in both the survey and FGDs. In addition, due to project timeline limitations only a survey was conducted with the nursing students in School B (Metro Manila). Of the total population of 305 final year students from the three schools (62 medical students, 180 nursing students, 63 midwifery students), 190 students or 62% participated in the study. The participation rates for each program of study were 11% for medical students, 79% for nursing students, and 41% for midwifery students. (See Table 2)

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 in 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 undertaken in each study site and the corresponding 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

To clarify, BSM is a ladderized degree program. A student earns a Diploma in Midwifery or an Associate in Midwifery after successfully completing the two year course, and is eligible to take the Midwife Licensure Examination conducted by the Professional Regulations Commission (PRC). We learned in the course of data gathering that midwifery students in the final year of their Bachelor program might already be practicing their profession and providing health care.

Methods

Survey

A structured questionnaire was developed based on the research questions and informed by previous similar studies. The instrument covered: a) socio-demographic background and sexual and reproductive health 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 conducted 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 face-to-face. The questionnaires were collected anonymously and responses were entered and analysed using the online survey tool and SPSS Statistics.

Focus Group Discussions

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

DATA ANALYSIS

Data from the survey were analyzed using SurveyMonkey and SPSS and descriptive statistics were generated. Mean and percentages were used to summarize categorical data important in describing knowledge and attitudes.

Interviews were digitally recorded, transcribed, and analyzed. Recordings were reviewed by a second person, who then edited the transcripts for consistency and accuracy. The edited transcripts were then reviewed to identify emerging codes. Codes were organized into categories and sub-categories. The coding and initial analysis was done by the first author. Initial results and analysis 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 might have interpreted the questions and answer options in the self-administered survey differently. For example, it was observed during the conduct of survey that several respondents, in tackling the item on sexual orientation, were uncertain about how to describe their own orientation. The answer options in the Likert-scale might also have had different meanings to different respondents.

Second, social desirability bias might have influenced the responses. It was observed that some students started asking each other or peering over the paper of the persons seated 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. Social desirability bias might have had a higher influence in their responses.

Third, due to the challenges and limitations in getting approval of institutions and getting respondents, sample sizes from the sites were highly unequal which limited our ability to make generalizations regarding the entire population of the medical, nursing, and midwifery students of the five schools. Data is skewed highly towards nursing students who comprise a dominant majority of the entire sample. More so, since the schools included in the study were selected based on convenience sampling, 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 those of nursing and midwifery students, due partly to the longer and specialized education of the former group. Many of the midwifery students who participated in the study were also experienced health service providers, thus their knowledge and views may be significantly different from the nursing and medical students. Any comparison to be made among the different study programs needs to have this context in mind.

2. COUNTRY PROFILE: SOCIO-ECONOMIC AND POLITICAL CONTEXT

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 are 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 in 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 the 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 of and access to health services across the country, with health services concentrated in relatively affluent urban areas.¹⁷ While human resources for healthcare are identified to be at par (at one per 10,000 Filipinos) with other upper-middle income countries and higher-income countries, there has been stagnation in the public sector in the recent years partly due to migration of trained health professionals overseas.¹⁸

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 Stiftung Website, 2013. https://www.fes.org.ph/wp-content/uploads/2014/03/1._FES_Healthcare_2013_Zeta_Final_LowRes3.pdf.

15 Cetrángolo et al., “Healthcare,”

16 Alberto G. Romualdez, Jr. et al., “The Philippines Health System Review,” 1, no. 2 (2011) (*World Health Organization*, 2011).

17 Cetrángolo et al., “Healthcare,” 7

18 Romualdez et al., “Philippines Health,”

The problem in the healthcare system is characterized by a 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 have resulted in high-levels of OOP payments especially among the poorest households.¹⁹ From 2014 to 2016, out-of-pocket health expenditure was 54.2%, while government schemes and compulsory contributory health financing schemes were 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 in 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 have passed policies that prevent 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 of health services and its resulting gaps in health and family planning services; to discriminatory gender norms and misconceptions about modern contraceptives; and to the strong 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 is recognized as having one of the most vibrant and advanced civil societies globally; it has the largest number of civil society organizations (CSO) per capita in Asia.²⁵ Since the post-Marcos dictatorship, 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 government accountable. It is in this spirit that women's organizations, RH advocacy groups, grassroots community groups sustained for over a decade their campaign for the passage of the RPRH Law. When the Manila City government signed Executive Order 03 in 2000 declaring its "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,²⁶ challenged the EO at the CEDAW Committee level. As a result, the CEDAW Committee report in 2015 called on the Philippine government to respect, protect, and fulfill women's

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 Department of Health, "The Philippine Health System At A Glance, Chapter 1," Department of Health, Accessed February 15, 2019. <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](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 (September 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>.

25 Asian Development Bank. Civil Society Briefs Philippines. (Publication Stock: February 2013), <https://www.adb.org/sites/default/files/publication/30174/csb-phi.pdf>. Padilla and Visbal, *Advancing reproductive Rights Using the Inquiry Procedure of the OP CEDAW and the UN Procedures: The Philippine Experience*, EnGendeRights, Inc (2010)

26 Clara Rita A. Padilla and Anita B. Visbal, "Advancing Reproductive Rights Using the Inquiry Procedure of the OP CEDAW and the UN Special Procedures: The Philippine Experience," *EnGendeRights, Inc* (2010).

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 003²⁷ and 030,²⁸ decriminalize abortion, and sensitize government representatives towards eliminating ideological barriers that limit women's rights.²⁹ The CEDAW recommendation formed the basis for advocacy work on the decriminalization of abortion.

27 Lito Atienza. "Declaring Total Commitment and Support to the Responsible Parenthood Movement in the City of Manila and Enunciating Policy Declarations in Pursuit Thereof." Executive Order No. 003, Series of 2000. Office of the Mayor: Manila.

28 Lim, Alfredo. "Further Strengthening Family Planning Services." Executive Order 30, Series of 2011. Office of the Mayor: Manila.

29 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 fulfill 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 law³⁰ and the Magna Carta of Women (MCW),³¹ women and girls in the Philippines still continue to 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 a high incidence of unintended pregnancies, due in part to high unmet need for contraception, with many cases leading to maternal deaths and unsafe abortions.³²

The maternal mortality ratio (MMR) has remained persistently high compared to the average for the Southeast Asia sub-region.³³ While maternal deaths went down from 152 per 100,000 live births in 1990 to 114 in 2015,³⁴ it is more than double than the Millennium Development Goals (MDG) target of 52 deaths per 100,000 live births.³⁵ The main causes of maternal deaths are pregnancy complications, including hypertension, during labor, delivery and peripartum; postpartum hemorrhage; and abortion-related complications.³⁶

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%,³⁷ falling short of the MDG target of 100% by 2015.³⁸ Women, especially those in the poorest quintile, face barriers to contraceptive use such as costs, poor-quality services, lack of awareness of or access to a source of contraceptive care, and lack of awareness of methods.³⁹

30 Department of Health, "Memorandum Circular 2013-0011." *Philippine Commission of Women*. March 21, 2013. Accessed April 18, 2018. https://www.pcw.gov.ph/sites/default/files/documents/laws/republic_act_10354_irr_0.pdf.

31 Department of Health, Memorandum Circular 2013-0011

32 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>

33 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

34 WHO et al., Maternal mortality in 1990-2015, Philippines. https://www.who.int/gho/maternal_health/countries/phl.pdf

35 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>

36 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>.

37 Philippine Statistics Authority. "2017 National Demographic and Health Survey." Philippine Statistics Authority Philippines, accessed on December 19, 2018.

38 Philippine Statistics Authority, "2017,"

39 Guttmacher Institute and Likhaan Center for Women's Health, "Facts on Barriers to Contraceptive Use in the Philippines," May 2010, <https://www.guttmacher.org/sites/default/files/factsheet/fb-contraceptives-philippines.pdf>

About 17% of married women have unmet need for family planning.⁴⁰ 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%).⁴¹ This means that these women do not want a child in the immediate period or they 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).⁴²

The misguided idea that poor families still choose to have more children despite not having the capacity to support them still persists. In fact, women from poor households in the lowest wealth quintile favor family planning and actually have a higher demand for it compared to women in richer households. The total demand for family planning⁴³ in the lowest and second lowest wealth quintiles are 73% and 76%, respectively, while those in the highest wealth quintile is 65%.⁴⁴

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 a higher unmet need for family planning compared with women with higher education and income. Location, wealth and education level also determine a woman's access to proper medical attention and facilities. The proportion of those 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.⁴⁵

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.⁴⁶ One in 10 girls aged 15-19 have already given birth or are pregnant with their first child.⁴⁷ 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 contraceptive use among young people, especially adolescents.⁴⁸ Despite increasing levels of sexual activity, majority of young people expressed having inadequate knowledge about their sexual and 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.⁴⁹ 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.⁵⁰ While use of

40 Philippine Statistics Authority, "2017,"

41 Philippine Statistics Authority, "2017,"

42 Philippine Statistics Authority, "2017,"

43 Total demand for family planning services is the sum of the met and unmet need for family planning

44 Philippine Statistics Authority, "2017," 21

45 Philippine Statistics Authority, "2017," 21

46 the Asia-Pacific region declined in the last two decades except in the Philippines.

47 About 9% of young women aged 15-19 are either pregnant with their first child or have had live birth.

48 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).

49 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).

50 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.

contraceptives has been encouraged through policies, they are given only to married individuals of reproductive age;⁵¹ 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.⁵²

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.⁵³ 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."⁵⁴ President Duterte signed an executive order in 2017 calling for universal access to modern family planning methods and the accelerated implementation of the RPRH Law.⁵⁵ But the Catholic Church immediately reiterated its position against "any law that promotes natural and artificial family planning methods."⁵⁶

51 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->

52 Gideon Lasco, "Inside the Philippines' long journey towards reproductive health," *The Conversation*, (May 9, 2017), www.theconversation.com/au.

53 James M. Imbong and Lovely Ann C. Imbong v. Hon. Paquito N. Ochoa, Jr., et al., GR 204819, April 8, 2014, https://www.lawphil.net/judjuris/juri2014/apr2014/gr_204819_2014.html.

54 Tarra Quismundo, "High court stops DOH contraceptive implants," *Inquirer.net*, July 4, 2015, <https://newsinfo.inquirer.net/702730/high-court-stops-doh-contraceptive-implants>

55 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/>.

56 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.⁵⁷ Estimates of the number of abortions has increased from 560,000 in 2008 to 610,000 in 2012⁵⁸ 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.⁵⁹ 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.⁶⁰ 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”⁶¹ and may be interpreted to allow abortion when the life or mental health of the woman or girl is at risk.⁶² Even the Philippine Commission on Women (PCW), despite stating that the Constitution has an “anti-abortion” policy, concedes that the equal protection clause can be used to argue that therapeutic abortion⁶³ is allowed when the life of the mother is in danger.⁶⁴

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.⁶⁵ The Civil Code clearly states that legal personality begins only at birth, thus, the embryo or fetus does not hold the same equivalence as the life of the woman and is not accorded the same rights and protection as a legal person.⁶⁶ It is also argued that prenatal protection as provided by the

57 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>.

58 Guttmacher Institute, *Unintended Pregnancy*

59 Guttmacher Institute, *Unintended: Context*.

60 Center for Reproductive Rights, *Forsaken Lives*.

61 The Constitution of the Republic of the Philippines. Official Gazette. <https://www.officialgazette.gov.ph/constitutions/1987-constitution/>

62 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

63 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.

64 “Laws, Issuances and other Legislation on Women,” Philippine Commission on Women, accessed on April 30, 2019, <https://pcw.gov.ph/laws?page=14>.

65 Clara Rita A. 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*.

66 Clara Rita A. Padilla, “Philippine Constitutional,”

Constitution cannot be taken in a way that abrogates women's rights, including her rights to health, life, privacy, religion, equality, and equal protection of the law.⁶⁷

However, the Philippine Revised Penal Code criminalizes abortion without any exemptions, making it one of 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"⁶⁸ to perform abortions with six-year imprisonment. So are pharmacists who give out "any abortive" without "proper prescription from a physician."⁶⁹ 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.⁷⁰ 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.⁷¹ It must be emphasized that current interpretations of the law have not completely foreclosed the argument allowing for an exception in the case of saving the woman's life. With such ambiguity, however, healthcare providers have remained fearful of criminal liability.

The RPRH Law of 2012, although a landmark legislation on Filipino women's reproductive health rights, does not recognize abortion and access to abortifacients in its definition of reproductive health rights,⁷² the legality of medical treatment for women with postabortion complications, however, is clear:

*"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."*⁷³

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.⁷⁴

The postabortion care policy of DOH was first articulated in its Administrative Order (AO) 45-B series of 2000. The order provided for medical services for "women who have had an abortion, regardless of cause."⁷⁵ In 2016, the government issued 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 RPRH Law on humane, nonjudgmental and compassionate postabortion care, and adding a penalty clause to the provision, the policy also clearly stated, "no

67 Clara Rita A. Padilla, "Philippine Constitutional,"

68 Revised Penal Code, Act 3815, Articles 258-259 (1930).

69 Revised Penal Code, Act 3815, Articles 259 (1930)

70 Revised Penal Code, Act 3815, Articles 258 (1930)

71 Dalvie S., Barua A., AP Luczon C., and Tadiar F., "A Study of Knowledge, Attitudes and Understanding of Legal Professionals about Safe Abortion as a Women's Right," Asia Safe Abortion Partnership. Accessed January 10, 2019. https://asapasia.org/pdf/Philippines_Abortion_Booklet_Update.pdf.

72 Responsible Parenthood and Reproductive Health Act of 2012 (2012).

73 Responsible Parenthood and Reproductive Health Act, Act 10354, Section 2 (J) (2012).

74 Republic Act 9710 The Magna Carta of Women. Accessed December 15, 2018, <https://www.officialgazette.gov.ph/2009/08/14/republic-act-no-9710/>

75 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.

woman or girl shall be denied appropriate care and information on the ground that she is suspected to have induced an abortion.”⁷⁶

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.⁷⁷

But in 2018, DOH issued AO No. 2018-0003 entitled “National Policy on the Prevention of Illegal and Unsafe Abortion and Management of Postabortion Complications.”⁷⁸ 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.”⁷⁹ 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 abused⁸⁰

The current policy is feared to prevent healthcare providers from providing ethical and medically appropriate postabortion care and reinforce negative attitudes towards women needing postabortion care.⁸¹ 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.⁸² 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.

76 Department of Health, *National policy on the Prevention and Management of Abortion Complications* (PMAC) Administrative Order No. 2016-41. (Philippines: 2016). Department of Health, Accessed January 10, 2019. <https://www.scribd.com/document/344526773/DOH-AO-2016-0041-Prevention-and-Management-of-Abortion-Complications-AO-2018>

77 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>.

78 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),

79 Melissa Upreti and Jihan Jacob, “The Philippines rolls back advancements in the postabortion care policy,” *International Journal of Gynecology & Obstetrics* 142 no.2 (May 2018). <http://doi.org/10.1002/ijgo.12530>.

80 Upreti and Jacob, “Philippines rolls,”

81 Upreti and Jacob, “Philippines rolls,”

82 Clara Rita A. 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/>

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.⁸³

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.⁸⁴ 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.⁸⁵

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.⁸⁶

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 uses 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.⁸⁷

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 to perform

84 Center for Reproductive Rights, *Forsaken Lives*, 30.

85 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)

86 Susheela Singh, *Unintended pregnancy and induced abortion in the Philippines: Causes and consequences* (New York: Guttmacher Institute, 2006). <https://www.guttmacher.org/sites/default/files/pdfs/pubs/2006/08/08/PhilippinesUPIA.pdf>

87 Singh, *Unintended*; Center for Reproductive Rights, *Forsaken Lives*

daily activities including going to work.⁸⁸ 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.⁸⁹

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.⁹⁰

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.”⁹¹ 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.⁹² This definition is interpreted that it is not only life that women can give but also death, which is deeply disturbing to social mores.⁹³ Abortion stigma is also defined “a shared understanding that abortion is morally wrong and/or socially unacceptable,”⁹⁴ 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.⁹⁵

Applying the theory of stigma as social process with a four-component model,⁹⁶ abortion stigma is described to manifest in: 1) labeling women who have had 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.⁹⁷

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

88 Raymundo et al., *Unsafe Abortion*, 86-93

89 Center for Reproductive Rights, *Forsaken Lives*

90 Anibal Faúndes and Laura Miranda, “Ethics surrounding the provision of abortion care,” *Best Practice & Research Clinical Obstetrics & Gynaecology* 43, no.50-57 (August 2017),

91 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>

92 Kumar, Hessini and Mitchell, “Conceptualising,”

93 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>.

94 Kate Cockrill 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>.

95 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>.

96 Bruce G. Link and Jo C. Phelan, “Conceptualizing Stigma,” *Annual Review of Sociology* 27, (August 2001): 363-385.

97 Kati LeTourneau, *Abortion Stigma Around the World: A Synthesis of the Qualitative Literature* (2016).

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.⁹⁸

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."⁹⁹ The four reiterations of Responsibility 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.¹⁰⁰

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.¹⁰¹ 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.

In the Philippines, just like many other contexts, abortion stigma manifests in the provision of therapeutic abortion¹⁰² and the treatment of women with postabortion complications. Even when medical providers believe that therapeutic abortion is legally provided for by the law¹⁰³ resistance in policy reforms is ultimately rooted in the view that "termination of pregnancy is morally wrong at all times."¹⁰⁴ The dominant discourse on abortion is described as fundamentalist in nature, centered on the fetus rather than on the woman who have the right to bodily integrity and autonomy.¹⁰⁵ While the fetus figures prominently in legal discourse, terms like "child" and "baby" are used far more often in

98 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>.

99 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>.

100 McDaniel, "The Responsibility," 293

101 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).

102 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>

103 Dalvie S. et al, "A study of knowledge"

104 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

105 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

popular discourse.¹⁰⁶ 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.¹⁰⁷ 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.¹⁰⁸

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.¹⁰⁹ 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.¹¹⁰ 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.¹¹¹

In Pew Research Center’s 2013 Global Attitudes survey in 40 countries, abortion tops as the most morally unacceptable issue for Filipinos.¹¹² 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.¹¹³

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.¹¹⁴ 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.

106 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](https://doi.org/10.1016/S0968-8080(04)24013-7).

107 Tan, “Fetal,”

108 Tan, “Fetal,” 160

109 Raymundo et al., *Unsafe Abortion*, 95

110 In a master’s thesis, “*Aborted Stories: Maternal Health Crisis in Eden*,” Efenita Taqueban, University of the Philippines, 2010.

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

112 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/>

113 Perez, “Policy,”

114 Jessica D. Gipson, 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>.

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.¹¹⁵ 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.

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."¹¹⁶ 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.¹¹⁷ 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 many other societies, healthcare professionals generally have reservations about abortion. Religious convictions, beliefs about professional roles and ethics, and 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.¹¹⁸ 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.¹¹⁹

Studies in other countries have also looked into health students' knowledge and attitudes towards 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 restricted.

115 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.

116 Center for Reproductive Rights, Forsaken Lives, 66

117 Center for Reproductive Rights, Realizing, 2

118 Ulrika Rehnström Löf 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>.

119 Lori Freedman, *Willing and unable: Doctors constraints in abortion care* (Nashville: Vanderbilt University Press, 2010)

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 counseling, postabortion care, or abortion access, law, or policy.”¹²⁰ 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.¹²¹ It has been suggested that age may influence opinion because “life experience gives medical students a broader understanding of the vagaries of existence that make abortions at times unavoidable.”¹²² Women were also found to have more favorable attitudes towards the provision of wider reproductive health services including abortion.¹²³ Some studies however, did not find conclusive evidence that age, sex or study program influence attitude towards abortion.¹²⁴ 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 have liberal views towards a woman's right to an abortion.¹²⁵

Beyond socio-demographic characteristics, correlations were seen with students' attitudes towards abortion with their opinion on the beginning of life;¹²⁶ 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.¹²⁷ 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,¹²⁸ medical students described a fear to provide abortion in their future

120 Tara A. 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](https://doi.org/10.1016/s1701-2163(16)34905-2).

121 Roger A. Rosenblatt et al., “Medical Students' Attitudes Towards 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 Towards 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>;

122 Rosenblatt et al., “Medical Students,”

123 Rosenblatt et al., “Medical Students,”

124 Maria Sol Rodriguez-Calvo, Isabel Maria Martinez-Silva, Jose Luis Soto, Luis Concheiro, and Jose Ignacio Muñoz-Barús, “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>.

125 Sara D. Rominski et al., “Attitudes towards 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>.

126 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>.

127 Rodriguez-Calvo et al., “University,”; Trninic et al., “Attitudes of Students,”; Wheeler et al., “Attitudes,”

128 Guttmacher Institute, *Appendix Table 1. Status of the world's 193 countries and six territories/nonstates, by six abortion-legality categories and three additional legal grounds under which abortion is allowed*, Guttmacher Institute, 2017, https://www.guttmacher.org/sites/default/files/report_downloads/aww_appendix_table_1.pdf

practice.¹²⁹ 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.¹³⁰ 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.¹³¹ To address the ethical dilemmas of future healthcare providers, it was 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.¹³²

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.¹³³ 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.¹³⁴

The existing literature describe how the mutually reinforcing abortion stigma and criminalization of abortion creates general conservative, at times negative, attitudes towards 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.¹³⁵ 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 issue¹³⁶ and calling for

129 Susanne Sjöström et al., "Medical students are afraid to include abortion in their future practices: In-depth interviews in Maharashtra, India," *BMC Medical Education* 16, no. 1 (January 2016), <https://doi.org/10.1186/s12909-016-0532-5>

130 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>.

131 Loi et al., "Healthcare,"

132 Loi et al., "Healthcare,"

133 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>.

134 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>

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

136 PINSAN, "Telling Truer Stories: An anthology for safe and legal abortion," PINSAN, 2018. Accessed March 1, 2019. <https://pinsan.ph/wp-content/uploads/2018/10/anthology-colored.pdf>

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 2018.¹³⁷ A Facebook post¹³⁸ 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.

137 Shared by Atty. Clara Rita Padilla of EnGendeRights during sharing of initial baseline findings in January 2019

138 Clara Rita Padilla, "While priests have their pulpits, I have the ever reliable mic... Gave my 10th 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 among final year students of Doctor of Medicine (MD), Bachelor of Science in Nursing (BSN), and Bachelor of Science in Midwifery (BSM) in five schools located in major and highly urbanized cities in Luzon and Visayas.

1.1 Profile of study areas

Participants were from three schools in Metro Manila (Luzon); one school in Region 4A (Luzon); and one school in Region 8 (Visayas). Metro Manila or the National Capital Region (NCR) is the country's capital and is entirely urbanized (100% level of urbanization).¹³⁹ It is the most densely populated region in the country, with a population density 60 times higher than the national level.¹⁴⁰ The total population of the NCR accounted for 12.8% of the Philippine population in 2015.¹⁴¹ While the national poverty incidence among families is placed at 16.7%, poverty incidence among families in NCR is estimated at 2.7%.¹⁴² For the current study, the participating institutions from NCR were two public schools (one with BSN program and the other BSM) and one private school (BSN program).

Region 4A (Luzon) has a 66.4% level of urbanization.¹⁴³ The total population in the region accounted for 14.3% of the Philippine population in 2015.¹⁴⁴ The poverty incidence in the region is at 6.8%.¹⁴⁵ The study was conducted with students of BSN program in one private school in Region 4A.

Meanwhile, while Region 8 (Visayas) has only an 11.9% level of urbanization,¹⁴⁶ the study site in Region 8 was in one of the highly urbanized cities in the region. The total population of Region 8 comprised 4.4% of the Philippine population in 2015. Poverty incidence among families in the region is 30.7%, which is almost twice the national rate.¹⁴⁷ The current study was conducted in one private school with MD and BSN students.

139 Philippine Statistics Authority. "Urban Population in the Philippines," Philippine Statistics Authority, March 21, 2016. <https://psa.gov.ph/population-and-housing/node/138311>.

140 Philippine Statistics Authority. "Philippine Population Density," Philippine Statistics Authority, September 1, 2016. <https://psa.gov.ph/population-and-housing/node/62690>.

141 Philippine Statistics Authority. Population of the National Capital Region. May 31, 2016. Philippine Statistics Authority. <https://psa.gov.ph/content/population-national-capital-region-based-2015-census-population>

142 Philippine Statistics Authority. 2015 Full Year Official Poverty Statistics of the Philippines, Philippine Statistics Authority, 2015. <https://psa.gov.ph/sites/default/files>.

143 Philippine Statistics Authority. "Urban Population,"

144 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>.

145 Philippine Statistics Authority. *2015 Full Year*

146 Philippine Statistics Authority. "Urban Population,"

147 Philippine Statistics Authority. *2015 Full Year*

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 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 39% were from public schools. (See Table 3)

The mean age of the participants was 23 years; with the minimum reported age were 18 years and the maximum at 49 years. The most common (mode) age was 20 years.

Majority of the respondents across all the three study programs were female (71%). Majority were Catholic (78%), and reported to attending religious services "about once a week" (48%). In terms of family income, more nursing (57%) and midwifery (46%) students reported belonging in the two bottom income brackets. Most of the students were single (87%) and with no children (84%). Of the participants who reported as single, majority were in a relationship (46%). Combining the number of married participants and those in cohabitation (live-in) with those single and are in a relationship or no current relationship would reveal that participants who reported having relationship experience was 61%. (See Table 4)

Table 5 and 6 describe sexual and reproductive health experiences of the respondents.¹⁴⁸ Majority described themselves as heterosexual (64%). About 41% reported to have had sexual experience; almost half (45%) of the respondents said they never had any sexual experience; and about 15% indicated unwillingness to answer this question. The most reported contraceptive choices among those who reported to using contraception were male condoms (56%) and pills (23%). 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, Non-Sectarian/ Non-Religious	100% (7)	61% (87)	0 (0%)
Public	0 (0%)	39% (55)	100% (41)

¹⁴⁸ 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 n=7	Nursing n=142	Midwifery 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)
<i>Relationship status among single:</i>	<i>[n=7]</i>	<i>[n=134]</i>	<i>[n=25]</i>
In a relationship		46% (61)	68% (17)
No current relationship	6 (86%)	35% (47)	24% (6)
Never been in a relationship	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)
Php 100,000 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)*
<i>Types of contraception used among contraceptive users</i>	<i>(n=48)</i>
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.¹⁴⁹ 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.

Majority of the students believed that abortion is among the top major causes of maternal deaths in the country, with most 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 are aware that abortion is common and a significant contributor to maternal mortality. However, there were a considerable

¹⁴⁹ Department of Health, "Maternal Deaths,"

percentage of respondents (29% medical students, 20% nursing students, 20% midwifery students) reported not knowing. (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 of reproductive health age women has unmet need for contraceptives, a high percentage of respondents in all study programs (57% medical students, 56% nursing students, 49% midwifery students) 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 have abortions are married or in a consensual union. Majority 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 assessed their theoretical knowledge as "Fair" or "Good". More medical students rated their knowledge as "Fair" over "Good" (57% and 43% respectively). For nursing students, more than half (53%) rated their knowledge as "Good" and 32% rated it "Fair." Meanwhile, more midwifery students reported having "Good" knowledge (63%) and only around two in ten (22%) indicated a "Fair" level. (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 the respondents in all study programs rated themselves as either having “Fair” or “Good” knowledge as well (See Table 11). On their self-assessment 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)

Queried about the recommended method for medical abortion, none of the medical and midwifery students identified the correct answer (i.e Mifeprestone 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 (86%) and nursing (58%) 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. It is important to note though that there were still a relatively small percentage of students, even within the medical students sample that earlier reported knowing how surgical abortion is done, which mistakenly identified in "Intake of Cytotec" as a safe surgical method for abortion. (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, more than half of the medical students believed that abortion is legally available only on the grounds of saving a woman's life (57%). However, a considerable, although a lesser percentage, also said that abortion is totally prohibited (43%). Among nursing students, the majority also regarded it is only legally available in cases when a woman's life needs to be saved (55%), while only a little over a fifth said it is totally prohibited (26%). Similar to nursing students, the midwifery students also held beliefs that were spread out across the different choices. While close to half (46%) held that the legality of abortion can only be applied to save a woman's life, a fifth (20%) believed that it was totally prohibited, 17% said they did not know. Although in a minority, it is still interesting to note that a number of nursing students (9%) and midwifery (17%) said they did not know and that there were those who were in the opinion that it is legally available with no restrictions (2% nursing students and 5% midwifery students). (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, most respondents believed that healthcare providers are not required by law to report the women (57%). Among nursing (39%) and midwifery (29%) students, though, many believed otherwise. Again, a considerable percentage, particularly among nursing (32%) and midwifery (32%) students, reported not knowing the current regulations. (See Table 18)

TABLE 18. KNOWLEDGE OF LEGAL REQUIREMENT ON 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, 96% 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).

A high percentage of students (29% medical students, 37% nursing students, 61% midwifery students) 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, to the fact 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 some 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 assisted in.

TABLE 21. EXPERIENCE OF ASSISTING ABORTION PROCEDURE DURING CLINICAL TRAINING

In the course of your training, 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 to would describe the extent that SRH has been covered in their respective study program, 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)

1.5 Attitudes towards abortion

Presented in Table 24 are the responses to the attitudinal statements. The statements aimed to determine 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 on their support for abortion procedure training as part of their education.

Most of the students agreed with 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 TOWARDS ABORTION

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

Students' beliefs in 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, more nursing student

respondents disagreed (59%), rather than agreed, that students should be excused from such training on the basis of moral beliefs.

The legalization of abortion under specific circumstances got the most support from medical students (71%) while non-support for legalization was most felt among the midwifery students (51%). Smaller gaps between those who do not support and those who accept abortion under certain conditions were observed, though, among nursing and midwifery students, suggesting a more polarized take on the issue within these programs.

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)

Of those who supported the legalization of abortion under certain circumstances, majority of the respondents across study programs believed it should be done to save a woman's life. To a lesser extent, there was also support for the legalization of abortion if the fetus has been assessed with severe impairment and is likely to die. 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 economic 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 poverty (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 decreased. 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 skip this question. Of those who answered the item, 71% of the medical students indicated that they would absolutely not perform abortion, while 29% said they would only under certain circumstances. Of those nursing students who answered, there were slightly more who would be willing to assist under specific situations (41%), than those who would absolutely not (33%). Among midwifery students, majority (57%) would absolutely refuse to assist in abortion. The few who indicated willingness to assist under all circumstances were from the 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
Medicine (n=7)		71% (5)	29% (2)	
Nursing (n=97)	5% (5)	33% (32)	41% (40)	21% (20)
Midwifery (n=37)	5% (2)	57% (21)	24% (9)	14% (5)

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 plurality of medical students (43%) indicated that they are unwilling, while 29% indicated willingness, and 29% were unsure. Most nursing students (51%) indicated willingness. An equal number of midwifery was either unwilling or unsure (37% each) while only a fifth of them expressed willingness (20%).

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 willing 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" might have skewed the responses as it connoted a more restrictive policy environment.

Socio-demographic characteristics of the respondents were cross tabulated with their attitudes and opinions on abortion. The following sub-sections discuss how respondents' responses varied based on family income, type of university, gender, and sexual and contraceptive experience. Due to the homogeneity of respondents' religion, this variable was not included in the discussion.

Family income

There were no observable trends in attitudinal responses of students and opinion on the legalization based on their reported average monthly income. For example, those who tended to agree with women's reproductive autonomy were students with family income of Php 60,000-79,000 (middle tier), followed by those with income of lower than Php 19,000 (lowest tier). The percentage of those belonging in "Below Php 19,000" income bracket that did not agree that abortion is morally wrong was also the same percentage as those in bracket Php 80,000-99,000 (highest tier). (See Table 29)

Also, both the highest and lowest percentage of support for legalization of abortion on all grounds was students from the highest tier (Php 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
<i>Total responses</i>		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
<i>Total responses</i>		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 than those from public schools tended to support women's reproductive autonomy (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)
<i>Total responses</i>		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 on any grounds. There were slightly more private school students than public school ones who supported legal abortion on all grounds (4% versus 1%). A difference of three (3) percentage points was also found among public and private school respondents who supported legal abortion under certain circumstances, only this time there was more support from the former than the latter. (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 program 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	
		Public	Private (Non-sectarian/Non-religious)
<i>Total responses</i>		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 respondents, in general, tended to agree with women's reproductive health autonomy, a higher percentage of male students (94%) agreed compared with females (85%) and with those who identified as neither female nor male (71%) (In the table referred to as 'Others'). In the same way, a higher percentage among males (29%) agreed with women's right to abortion (6% of females, 14% of others). There were also a lesser percentage of male respondents (77%) who agreed that abortion is morally wrong compared with other genders (90% of female, 86% of others). (See Table 33)

TABLE 33. GENDER AND ATTITUDINAL RESPONSES

		Gender of respondent		
		Female	Male	Others
<i>Total responses</i>		134	48	7
Women should 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 of male students (7%) compared with other genders (2% of females, 0% of others) also supported legal abortion provision under all circumstances, while more females (46%) tended to support only under certain circumstances (compared to 33% of males and 43% of others). (See Table 34)

TABLE 34. GENDER AND OPINION ON LEGALIZATION

		Gender of respondent		
		Female	Male	Others
<i>Total responses</i>		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 (93%) and those who never had sex (87%) were slightly more supportive of women's reproductive autonomy than those who reported to have had sex (83%). However, the belief that abortion is morally wrong was highest among those who never had sex (98%). The percentage of those who agreed with women's right to an abortion in cases of unintended pregnancy, while low, was nevertheless also higher amongst those who had sexual experience and those who were unwilling to disclose (21% each) compared with those who never had sex (16%). (See Table 35)

The support for availability of legal abortion under all grounds and under certain circumstances was also relatively higher among those who have had sex and those 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
<i>Total responses</i>		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		
		Have had sex	Never had sex	Unwilling to answer
<i>Total responses</i>		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 a “choice,” a right to decide, freedom from violence, and access to information and services to meet a person’s, particularly a woman’s, SRH needs. According to them, SRHR means having the choice to practice safe sex and use contraceptives. For them, a woman has the right to decide when to have children and how many by using family planning or contraceptive methods.

The SRH needs that students identified 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 as needed were contraceptives and family planning (including commodities and counseling) and testing for STI and cancer.

While demonstrating limited knowledge of the concept of SRHR—with some students even admitting that they “don’t have clear idea” of what SRHR is—the respondents seemed to imply choice as a recurring theme in their answers: choice to use contraceptives, to have sex, to practice safe sex, to have children, and to decide the number of children.

They focused on women’s right to choose and access services, recognizing 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, they affirmed women's right to "informed consent," that is, 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. (You need to get her consent. They have the right to say no or yes. If they do say yes, they also have the right to know what that option entails. I'm referring to family planning, so whatever method they choose, they need to know what will happen to them so you'll also have to explain every second.)

– 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 be induced by surgical and medical methods. In this context, abortion was discussed by participants as a medical procedure to "save the mother," in "life and death situation," or in "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.¹⁵⁰ Hence, we asked the students of their familiarity with the term, and if they would consider termination of pregnancy using the medical indicators they mentioned as sufficient criteria for therapeutic abortion. Only participants from three out of the five FGD groups reported familiarity with the term therapeutic abortion and affirmed that such cases mentioned fall within it.

The 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 of medical indicators, including determining fetal viability, 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. An often mentioned procedure is dilation and curettage. There was less familiarity with how medical abortion is done; only mentions of "Cytotec."

¹⁵⁰ Clara Rita A. 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/>

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. Dependeng lang po. There are a lot of ways actually. Alam namin kung paano pero yung pagtuturo sa amin is hindi para mag abort kundi paano mag induce ng labor like that. (What was taught to us is not abortion per se, but how to induce labor. Since if it was induced, we are delivering the baby, so you can have surgical and medical action for that one. You can use oxytocin for contraction or progesterone also for smooth muscle contractions, then you can use dilation and curettage. There's also medicine that you insert. It depends. There are a lot of ways actually. We know how but what was taught to us is not to abort but how to induce labor like that.)

– Female, medical student, Region 8

2.1.3 Reasons for abortion

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

TABLE 37. REASONS FOR ABORTION

“Unintentional”	“Intentional” / Induced
<ul style="list-style-type: none"> • Spontaneous/miscarriage • Increased endural risk • Eclampsia • Ectopic pregnancy • Molar pregnancy • Cardiovascular disorder • Bleeding disorder • Neural tube defects 	<ul style="list-style-type: none"> • Rape • Economic reasons • Mental and psychological • Avoid disruption of studies • Stigma on teenage pregnancy • Left by their husbands/partners • To work • To work overseas • Unwanted pregnancies due to: <ul style="list-style-type: none"> ◦ Risky sexual behaviour ◦ Lack of knowledge ◦ Curiosity to sex among young people ◦ Not using or discontinued use of contraceptives/family planning methods ◦ Extramarital affairs

“Unintentional” abortion was also sometimes referred to in relation to “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 where women fail to use contraceptives. For instance, women tended not to 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 failed to return on their scheduled visit to get contraceptives such as pills and injectable. Despite their awareness on the complex reasons why women do not use contraceptives, when probed on their perception of why women do not return to their facilities, there was a consensus within the midwifery group that it was usually because of “laziness.”

2.1.4 Uncertainty of 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 a “valid” reason, that is, to save the life of the woman:

Dito sa Pilipinas, parang legal ang abortion kapag, yun nga, nanganganib yung buhay ng ina... (Here in the Philippines, it seems that abortion is legal when the life of the mother is in danger...)

- Male, nursing student, Region 4A

While others, despite acknowledging that therapeutic abortion can be done, maintained 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. (So, in abortion, in medicine they also practice that, but here in the Philippines somehow abortion is not really allowed in a sense...that it's not really allowed. It's not really allowed, really.)

– Male, Nursing student, Region 8

There was more uncertainty on whether healthcare providers are legally required to report to authorities women who sought postabortion care. Many of the students opined that women who are treated in the hospitals have the right to confidentiality and privacy and, 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 Welfare 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 in such cases. In particular, many students believed that cases of repeat abortion should be reported to the 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. They narrated how they witnessed the verbal abuse and threats women experience in hospitals. The abuse is experienced not only by women who had abortions, but even by those who access prenatal and childbirth services.

Students recounted how nurses and doctors treated women, particularly teenagers, negatively. According to them, the words were “painful” and “humiliating.” The young women were 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. (It was the nurses who said unpleasant things. Like saying 'So, you had fun, right? Now you had to give birth.' Things like that. It's not good; since, in the first place, the patient is already suffering. Their words are very painful. You can really see the face of the mother that she is suffering, and then they say all those unpleasant words, like they are destroying the person.)

- 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 are 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-se 'seduced' sila ng ano para umamin." (When I was pregnant, I was in the ER at the same time. She was bleeding. 'What have you done?' The doctors were like that. 'When did you abort it?' They were 'seducing' her to admit.)

- 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 postabortion care:

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. (I have a patient whom I accompanied to the hospital, but she was denied ... actually she was reported as well. It was good I was not involved, even though I just accompanied her. I was asked as a professional why I accompanied her, because I might have been an accessory to the crime. I told them I accompanied her because she was bleeding. That's why I was there but on the act that she did I wasn't involved. So what they did was to call the barangay. In Las Pinas, it's automatic once there's a case like that they file a complaint immediately. Because the abortion was intentional.

– Female, midwifery student, Metro Manila

2.2 Sources of knowledge

2.2.1. 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 a 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 tends to be discussed “bigla-bigla” (unplanned). When the topic is sex related 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. (In unwanted...in unwanted pregnancies with teenagers. We discuss how in there were those who come in the hospitals after getting an abortion because they are not ready yet, so it is inserted in the discussion)

– Male, nursing student, Region 4A

Their education on abortion 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. (We are like book-based, we are mainly focused on what's in the books. We don't delve further..we base 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 family planning commodities 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 these information other people, as well as in future practice, was 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 . (For our profession, we should learn more, we need to dig in some more. But for someone like me, who is a mother, I feel that I have enough knowledge as I have experiences already ... But to them, the younger ones, I do not know at what level they are.)

– 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. (My knowledge is still lacking to advise someone, then, uhm, as for personal experience ... I do not use 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 a 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. (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, what's tormenting her is the one time act that she did, she will carry it for the rest of her life until she dies. That's why I was hesitant to discuss.)

– 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. Bale, 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 saakin yung wag na lang, wag na lang ituloy. (I have a friend who had undergone in such cases. Many times that the baby was aborted because she had miscarriages. But this last time, she needed to choose between her life or the baby ...so she decided since the baby will not develop anyway inside and will have problem if the pregnancy continues because she has a heart condition... to me at that time before it happened I really didn't like abortion even for those I've watched but that's when that time the problem came to us even though I could not choose between the baby and that of my friend, but for me it should be my friend because... so for me 100% not to go ahead anymore, not to continue.)

– 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 she was an unwitting "accessory to the crime" for not knowing that her friend was pregnant when she drank the liquid concoction that, she later found out, was to induce abortion. The experience made her aware on how abortion is commonly done by women. At the same time, the shock of knowing what her friend did without her knowledge, and even witnessing her friend disposing the expelled product of conception, left a strong impression on the respondent 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 towards abortion

The participants' attitudes towards abortion and abortion as a right ranged from absolutely rejection to, conditional support, and to absolute support. This section details how they understood abortion and how it influenced their attitudes towards the issue.

2.3.1 Stigma attached to abortion

Participants described abortion as “*masama*” (bad or wrong), “mortal sin,” “unethical” and “immoral.” Negative attitudes towards 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 yun ay depende pa rin sa pananalig nila.” (Even if the life of a woman is at risk and if abortion is needed ... I still don't agree with abortion because it depends on your faith in God. Then I just thought there are situations in which when you really believe in God, I believe in what they say as miracle. It depends on what their faith is.)

–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 [and egg] 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'. (If the union of the sperm [and egg] happened, and it was taught to us that once it is united and once the fetus is formed, no one can decide whether to terminate it later because, I don't know, in the Bible verse it says '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, in what they refer to as “unintentional” abortion in order to preserve the life and health of the woman was considered “ethical” and “acceptable”

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 sa, y may instance na pipili kayo between the mother and the baby, especially on the early pregnancy. (It would depend on what type of abortion. For me, definitely for my personal stand, the only abortion that is acceptable is the unintentional abortion. Medically speaking, for example, there is increased endural risk for the mother's health, let's say, there is instance that you have to choose between the mother and the baby, 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... (If a person would suffer a heart attack, or like there's 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. It's like both of them died. So maybe, ethically they have to consider the way..)

- 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 kahit anong sitwasyon, nakalagay sa bibliya parang pumatay ka na rin ng tao di ba? (It is really bad in any situation, as it is in the Bible that it's like you killed another human being, isn't it?)

- 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. (It depends on the different countries on what their traditions are about their mindset in abortion. Here in the Philippines, it seems that abortion is legal when the life of the mother is at risk. Then it's not good for the young people when they just accidentally get pregnant.)

- 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. (Maybe in her story, a woman or someone really has the right to abortion, but in our profession it seems not, it is really not because as a midwife or being in medical field of course you need to save life. So it's a huge strike to our profession if we do an abortion because that is not within the scope of our studies or function. So, personally, I'm half-half on it.)

- 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. (Yes pro-life. Let us take for example that that the law will be passed for induced abortion, many will still hesitate because, I don't know, it's an insult to religion. It's really a no. We should preserve life at all cost. I don't know for others.)

- Female, medical student, Region 8

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

As a midwife, makita mo lang na buhay ang bata, masaya ka na. (As a midwife, just to see that the child is alive, you're happy already.)

- Female, midwifery student, Metro Manila

2.3.1c Ideals of womanhood

Expectations of how a mother should feel and act also shaped the views of those who are strongly against abortion. Some students held an essentialist view of woman as a 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.

Sa akin 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. (For me, it's a 'no' for abortion because as a mother, it is said that if you can love the children of others, what more your own child even if the pregnancy was unintended? You can learn to love; of course you will develop a mother's heart.)

– 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. (There would be other mothers who would still choose the life of their baby, unlike others. So that's OK because there are still such women 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 perceived as an outcome of woman's irresponsible sexual behaviour. Since “sex was a choice” and the woman had “pleasure,” then she should live with the consequences of her actions, a position similar to the Tacit Consent version of the Responsibility Objection to abortion as described in previous literature.

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? (For me, it depends on the circumstances. Because when it is said as abortion, it can be surgical abortion, like having ectopic pregnancy, something like that. But if the woman's will to have an abortion is just because she's not ready yet, it is not. You conceived it; you did it; you laid down; twisted to whatever position; you did it; you wanted it; then why will you refuse it after it was conceived? So you only wanted the fun?)

- Female, nursing student, Metro Manila

When the blame is placed on the woman for putting herself in a situation that led to a pregnancy, the position is consistent with 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 sina-suffer mo. Kailangan mag-isip ka muna bago mo pasukin yung pagbubuntis. Halimbawa sa barkada oh di inuman ganyan. Iisipin mo na ano ba yung mangyayari kapag nag-inuman kayong babae at lalake... (It's really a sin because you did it intentionally; it's life. You're eliminating whatever situation you suffer from. You need to think before you get yourself pregnant. For example, having drinking spree with your friends. You need to think what will happen when a woman and man have a drink together.)

- Female, midwifery student, Metro Manila

Also related to ideals of motherhood is the perception that a woman has a “responsibility to give birth” to the child. This is more aligned to the Care version of the Responsibility Objection:

Sa 'kin hindi talaga ako sang-ayon dun sa abortion na yun. Pero sa field namin pwede talaga yung abortion kasi nga minsan di ba yung mga ectopic pregnancy kinakailangan talagang tanggalin yung baby sa nanay niya? Pero yung will nga ng nanay niya na i-abortion yung bata, hindi kasi...buhay na yan eh. 'Di ba 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 [to get pregnant] eh dapat i-continue mo yan. May big responsibility ka as a mother di ba? (I really do not agree with abortion. But in our field, abortion is really allowed because sometimes there are ectopic pregnancies that really need to remove the baby from its mother, right? But if it's the will of the mother to abort the child, I do not agree ... it's already a life. Didn't the Ten Commandments say that 'thou shall not kill'? Why would you kill a life when you can who let it live? You chose that [to get pregnant], you should continue that. Don't you have a big responsibility as a mother?)

- Male, nursing student, Metro Manila

According to previous studies, 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 on economic grounds, abortion is “not a solution to poverty.”

Students who held this opinion cited other women living in extreme poverty who are still 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 the Negligence Version of the Responsibility Objection.

Ayun nga, di ba, 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. (Well, why choose to have many children when you can prevent having a child? You can plan ahead before you regret it in the end because abortion is not an answer to poverty.)

- Female, nursing student, Metro Manila

2.3.2 Increased stigma attached to 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 pangalawana, kalandian niya lang yun eh. (Maybe if she's made it a habit to have abortions; but if its only once and unintentional or just because she lacks information, that's permissible. But the second time around, that's promiscuity.)

- 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 reportedly.”

So kung pitong beses siyang lumapit sayo for postabortion, what if di ba... Parang seven times na siyang pumatay ng tao. (What if she came seven times for post-abortion...that's like she has killed a person seven times.)

- Female, medical student, Region 8

2.3.3 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. (I am really against abortion. But as my profession, it depends on the case, like if it's 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 re-recommend ako. (I am Catholic, so actually there's really a thin line to differentiate therapeutic abortion and that of illegal abortion. So, if the abortion was spontaneous abortion, but the mother decided, [but] when the pregnancy could be viable, I would not really assist on those procedures. But when it's threatened abortion and the pregnancy is really not viable, I will recommend.)

- Female, medical student, Region 8

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

Pero, halimbawa po, duty ako that time tapos may ganoong case. Halimbawa sa OR, tapos ayoko talaga ng, ano, ganoong procedure, parang pwede akong mag-decline kasi right din yun ng isang nurse na mag-decline ka sa mga procedure na yon. (But, for example, I'm on duty then a case like that comes in. Say, in the OR, then I really do not want those kind of procedures. I think it's allowed to decline because its my right as a nurse to decline in those procedures.)

- 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, di ba? 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 mas 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. (It's really bad in whatever situation; it's in the Bible and that's the same as killing a person, right? But for our profession... for example, if the mother's pregnancy is very dangerous, who will you choose, then it's mother. If I were in that situation, if it happens to my wife, then I would choose the mother. Based on my own faith, my belief, if I were the one pregnant, it's okay for me to die rather than killing my own child.)

- 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 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 was already working in a health facility, also shared that in the course of her practice she repeatedly encountered women who were considering abortion reduce their dissonance by treating the embryo as mere "blood." In such cases, the respondent said, she would insist to the patient that the embryo is already a "human."

2.3.4 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. (If the mother is suffering from something, and she cannot safely deliver the baby, I think we should terminate the baby for her safety.)

- Female, nursing student, Region 8

Fetal viability was also a precondition on whether an abortion can be deemed a right or not. They tended to be more supportive of a woman's 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. (I also agree in that we can also give the mother an option to have abortion, especially if her child is unlikely to survive or in the instance will not survive once delivered. 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. (There are really instances when it is a matter of life-and-death situation in mother and baby. But when there was rape and it resulted in pregnancy then the baby should be aborted? Never. Because it's not your fault but it's not the fault of the child either.)

- Female, nursing student, Metro Manila

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

Those who hold more liberal views on abortion exhibited more sympathetic attitudes towards women who had to go through an unintended pregnancy. Those students who expressed support for abortion on more grounds cited rape, and psychological, 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.

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-dedepress kasi naaalala nila yung pagkakarape sa kanila... (I'm for abortion, because some pregnancies are result of rape. They did not choose to have a child, why do they need to raise it? Aren't there mothers who get depressed? Aren't there patients in the center... those in the side for patients who were raped who will likely to get more depressed when they see the child that will only remind them of how they were raped...)

- Male, nursing student, Metro Manila

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 ang magiging reason na magkakaroon ako ng problema, halimbawa, psychologically, kasi hindi ko talaga siya gusto, bakit hindi ko siya ipapaabort? (If it happens to me, for example, I have an unwanted pregnancy, I will not have an abortion. But if it's the reason I'm going to have a problem, for example, psychologically, because I really do not want it, then why not get an abortion?)

- 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-abortion mo na lang kaysa naman gutumin mo yung bata. Mamatay pa sa gutom. Yun yung point ko. (And another thing, the suffering if they are in hunger. What if here's nothing to eat? What will you do? It's better to have it aborted rather than let the child starve and die from hunger. That's my point.)

- Male, nursing student, Metro Manila

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

Regardless of their moral views on abortion and support of abortion under different circumstances of pregnancies, students generally agreed 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. (For me, morally, abortion is wrong. But for women who have had an abortion, I do not have the right to judge them. I think to myself that it's their right; it's their body. It's not my body. It's not my right to tell them. But as a person in the medical field, I would suggest to undergo counseling. For me, abortion is really wrong.)

- Female, medical student, Region 8

However, as one participant stated, while, one unavoidably 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 sa 'yo, 'Kung itutuloy ko to aampunin mo ba?' (I believe that a woman has the right to decide for herself, if she wants to get pregnant or get an abortion. It's her decision. We cannot do anything about it. All we can do is make judgments... So, when you asked "Why did you have it aborted?" What if she tells you, 'If I'm going to keep it, will you adopt it?'

- Female, nursing student, Region 4A

Even those who perceived abortion was wrong still believed that a woman should not be stripped of 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. (We still need to respect because they humans, too. They may have made mistakes but they can still fix it. We must not judge them because of the one mistake that they did.)

- 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 sila. Kung hindi enough sa inyo yun, eh kung sa kanila enough na yun? (For me, they are still human. It's their option why they did it. They still have their reason for doing it. It may not be enough for you, but what if it's already enough for them?)

- Male, nursing student, Metro Manila

2.3.7 Postabortion care is a woman's right

Despite the conservative attitudes towards 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? (It's not allowed to refuse patients. When you refuse them that's the same as killing them.)

- 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 sinasabi nga nila, di ba ihiwalay natin yung personal, yung iniisip natin, problems natin sa buhay. Be professional. (Treat her as human no matter what she did – whether she is old, young; rich, poor. Deal with her as a patient who needs care. Not your anger. As they say, we leave out our personal—what we think, our problems in life. 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 exacting for the service providers. As one student mentioned, they would also need to be debriefed and to 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 counsel 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 nagustuhan. (Whatever I feel about what she did, I'd rather keep it to myself because it may affect her afterwards ... Just like you, you felt the burden of the situation where you need to tell your co-nurses, 'You know what, I was really stressed about...' Or, since you are not allowed to gossip in your workplace, you just come home get advice from your family, or your partner, or whoever you can reach out to to reduce whatever anger you felt from learning of the patient's story that you really do not like.)

- Female, nursing student, Metro Manila

2.4 Attitudes towards abortion education

There were two diverging opinions on whether abortion procedures should be included in the training of midwifery and nursing students. On one hand, there is fear that knowledge could lead to practice; on the other hand, there 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 major concern over the inclusion of abortion procedures in their training. They believed that training on the procedures is best left only to specialists (obstetricians). These students were worried 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. (As a nurse, we have the means and ways to, for example, if we know how to abort it's like... easy access to such things. So it seems like we should not discuss that in class or the procedure, we may get the idea... we can profit out of it.)

- 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. (On my part, as a girl, if I already know how to abort the baby, I could do it in the future especially when you're emotionally unstable.)

- 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 o-open ng about sex education...parang ganon yung sa abortion din. Bakit niyo po imumulat yung mata ng tao sa abortion? (It is as if you are giving someone the idea on how to kill. Previously there's an issue on... why sex education will be open to elementary student ...it's just the same for abortion...Why would you open the eyes of people on abortion?)

- 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 to provide counseling 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. (Example being nurse, we will be exposed to that scenario. Then you have to assist. We should know the procedure because if we do not know what to do we're going to look stupid in front of the doctor.)

- Female, nursing student, Metro Manila

2.5 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 clear rules that define 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 pregnancy. Pero I've heard ha iba nga countries kapag it is legal actually to abort. (A clear line, because it's very vague. There are many medical conditions that can 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 pregnancy. But I've heard that in other countries it is actually legal to abort.)

- Female, medical student, Region 8

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

Students also expressed interest in participating in seminars and forums discussing abortion. Meanwhile, they also called for sex education in order to address the issue of abortion more comprehensively.

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 only to unsafe abortion as a leading cause of maternal mortality, or the extent of students' awareness of safe abortion services in the country.

However, as discussed in previous literature, while some healthcare practitioners argue that abortion even to save the life of a woman is unethical and illegal, majority of the students recognized that there are circumstances when it is necessary to terminate 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, medical and nursing students appear to have less knowledge of postabortion care than of abortion despite the fact that postabortion care is clearly guaranteed by the law.

Students get their knowledge about abortion through their formal education, and mainly framed as a biomedical issue. Abortion is addressed in their courses as a pregnancy complication. Hence, their understanding of abortion was primarily as a medical issue and limited to the clinical procedure to preserve the life of a pregnant woman. This could help explain why they have more knowledge about the method used in surgical abortion than in medical abortion. Aside from medical and fetal indicators, the participants' discussion did not significantly reveal how these students understood the other medical aspects of abortion. This could be due in part to the lack of probing questions for this aspect in the study instrument. Students' 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 discussions about abortion are "textbook-based" and happen "bigla-bigla" (unplanned).

In this context, they understand abortion more as a pregnancy complication and less so as a woman's right to bodily integrity or as a result of a woman's decision-making over her body. The lack of awareness of the wider social context of women was apparent in their belief that most women who have abortions are unmarried or not in consensual union. Participants perceived that most women who chose to have an abortion had pregnancies as a result of irresponsible sexual behaviors. This, despite their awareness of the various reasons why women seek an abortion, including rape, extreme poverty, stigma of 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 learning abortion procedures should be included in their training, participants in the FGD expressed reservations about this due to the fear that knowledge about abortion procedures could lead to its practice—that female students could decide to have an abortion themselves when faced with an unintended pregnancy, or that as nurses and midwives, they could end up assisting women in abortion.

Results of both the survey and the discussions regarding students' 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 believed that it is allowed in order to save a woman's life. During the discussions, however, it became apparent that students were aware that abortion is a necessary medical procedure during obstetrics emergency. Students were also unsure about what is legally required of healthcare providers in terms of reporting women who had had abortions.

The students' discussions about abortion revealed how the interplay of religious, moral, socio-cultural, and ethical norms, influence their attitudes towards the issue. Thus, while they acknowledged abortion as a medical issue, much of their discourse was grounded in their religious and moral beliefs. 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 of influence in their lives. This shows that views on abortion are deeply rooted in the wider social environment and embedded in interactions of the participants. As described in previous studies, healthcare students also learn from a "hidden curriculum" that enables the creation and perpetuation of abortion stigma.¹⁵¹

Students' views and opinions about 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, for example, was limited to reproductive health, largely focused on family planning, and on contraceptives, in particular. Medical students articulated this view of reproductive health services more clearly perhaps due to their longer and more specialized education and training. Midwifery students, on the other hand, were already practicing service providers. Among nursing students, those who have no personal experience in using any methods admitted having a more limited knowledge of SRH.

Although their knowledge of SRHR was limited to reproductive health, students nonetheless showed awareness of and support for women's right to choose and to make decisions, including the right to choose whether to have children or not, and the right to determine the number of children they would have. In the survey, majority of the students in all three programs agreed that it is a woman's right to make and execute independent decisions regarding 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 motherhood. For instance, certain groups of study respondents (i.e private school students, students who never had sexual experience) tended to be more supportive of 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 autonomy and how it affects delivery of reproductive health services for women.

It can be argued also that there is recognition of women's bodily and reproductive autonomy, but this stops at abortion. This confirms that abortion remains the critical wedge that determines to what extent women's reproductive and sexual self-determination could be advanced.

¹⁵¹ Elliot et al., "Without,"

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 the students in all the programs agreed with the statement, "Abortion is morally wrong," and did not support women's right to an abortion in the case of unintended pregnancy. Students assigned personhood to the fetus and generally referred to it as "life." Moreover, respondents perceived abortion as "killing" or "taking away life." In connection to this, respondents viewed abortion as conflicting with the role of healthcare providers to preserve or "save life" at all costs.

While students supported the notion of women's right to choose and decide over their bodies, but this support for abortion is predicated on the perception of women's intentionality. In short, the support grew less when the woman is perceived to exercise a conscious and deliberate control over her decision to terminate a pregnancy. That is, when the abortion is "unintentional," such as when a pregnancy presents a risk to a woman's health, then the more acceptable the abortion becomes and students expressed more willingness to assist in the procedure. In the same vein, when the fetus is viewed as having little chance of survival, and therefore the decision to have an abortion is beyond the woman's control, then the more acceptable abortion is for the respondents.

The degree of control women had over the circumstances of their pregnancy influences students' support of abortion. Students opposed abortion more strongly when a woman was described to have deliberately had sex, and more so "enjoyed" the sex. For the respondents, carrying the pregnancy to term—then—was a consequence and responsibility 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. They believed that a woman would naturally learn to love a child even if it was born as a result of unwanted pregnancy. The students described the ideal mother as someone who would choose the life of the unborn over her own. Unwanted pregnancies were often linked to irresponsible sexual behaviour, and women labeled as "promiscuous." Induced abortion was also referred to by the students as an act of "stupidity" and "selfishness." Since induced abortion was generally considered as a crime, within this framing, women end up being viewed as criminal. This was evident in the negative language used by students to describe women who had abortions as "*pumatay ng tao*" (killed a person). There was more pronounced stigma against repeat abortions and women who had more than one abortion are described as "killing repeatedly." The respondents viewed these women as not deserving of forgiveness and have to be reported to the authorities. Studies on attitudes towards abortion found that negative language is usually associated with the discourse of repeat abortion.¹⁵² The use of negative language by the students in discussing and referring to women who had abortions is related to the social process of stereotyping. The stigmatizing of abortion also links women who have experienced abortion with negative traits.¹⁵³

Although there was observable stigma towards abortion, participants' attitude towards the provision of safe abortion is best described as ambivalent. In the survey, the number of respondents who absolutely rejected legal abortion on any grounds was significantly

152 Lesley Hoggart, Victoria Louise Newton and Louise Bury, "'Repeat Abortion', a phrase to be avoided? Qualitative insights into labelling and stigma," *J Fam Plann Reprod Health Care* 43 (2017): 26-30, <https://doi.org/10.1136/jfprhc-2016-101487>.

153 Kumar, Hessini and Mitchell, "Conceptualising," 2.

fewer than the number of those who said that abortion is morally wrong. This means that a significant number of those who found abortion morally wrong still supported the idea of making abortion available in certain circumstances.

In the FGDs, respondents were less ambivalent regarding abortion when it is resorted to in the case of life-threatening pregnancies as participants acknowledged that medical ethics dictate the primacy of the life of the patient. However, there were several students who felt that abortion is inherently against their religion, regardless of the circumstances. This finding is similar to what has been described as a tendency of pro-choice healthcare providers to have a “clinical” response and view abortion as “part of the job,” whereas those opposed to abortion “found it difficult to separate their personal feelings from professional conduct.”¹⁵⁴ The few students who had the most liberal views about abortion, however, had moved away from the “clinical” reasoning on abortion. Their support of abortion went beyond the need to preserve the health and life of women; instead, they argued that women’s circumstances are complex and many need or want an abortion as well as psychological and economic support. Hence, they believed that women would decide on an abortion based on what is necessary given their particular circumstances.

However, the students believed that whatever the circumstances of abortion, any woman suffering from abortion-related complications deserves immediate, humane, non-judgmental, and compassionate postabortion care. The students have a very high awareness of mistreatment and abuse that women experience in health facilities, particularly when seeking postabortion care. This points to the potential of healthcare students to become allies and even advocates of improving postabortion care policies and services in the country.

¹⁵⁴ 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 restrictive legal context pushes women to opt for unsafe abortions, leading to maternal morbidity and mortality. As found in previous studies, many women needing postabortion care are prevented from seeking the life-saving treatment because of fear of being humiliated, abused, and possibly prosecuted. Current abortion law does not clearly provide any grounds for exemptions from criminal liability, and the ambiguity makes it harder for healthcare providers to provide the necessary medical care for women. Even in landmark legislation on reproductive health, abortion is excluded in the discussion of rights. The stigma against abortion also contributes to the negative attitudes of healthcare providers regarding women seeking postabortion care. Knowing how future healthcare providers understand and view abortion is important in order to guide advocates in opening public conversations about abortion and advancing the discourse on the right to safe abortion especially among those in the public health sector.

Perhaps owing to the differences in the length and focus of their respective trainings, their areas of specialization, medical, nursing, and midwifery students also had different levels of knowledge regarding SRH and abortion. The highly unequal sample sizes of the survey also precluded the study from making generalizations to the whole population. It can be noted, however, from the responses and in the qualitative data, that limitations in awareness and knowledge of SRH, including abortion and postabortion care, were significant among these students.

The students mostly understood abortion as a pregnancy complication. Students recognized 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. In addition, they recognized that women have a right to postabortion care. Although they agreed that abortion is legally restricted, they had different perceptions regarding the extent to which it is prohibited, or conversely, legally warranted, based on certain grounds. Most of the students believed that saving a woman's life was the only exemption allowed by the law.

Ambivalence regarding abortion and the provision of legal abortion existed among the participants. While they acknowledged therapeutic abortion is needed to save the life of the woman, there was ambivalence due to the stigma against abortion. The respondents who thought that abortion is morally and ethically wrong or unacceptable based their views on their religious and moral beliefs, their recognition of the so-called personhood of the fetus, their beliefs regarding the role of healthcare providers, their ideals of womanhood, and concepts of responsibility. Stigma was evident in the stereotyping of women who had an abortion and in labeling certain types of abortion as more acceptable than others. Students tended to support abortion more as a woman's right when it is performed to save a woman's life and to deny its legitimacy when done for other social reasons. However, students who had pro-choice attitudes towards abortion believed that

abortion is about the right of women to decide over their bodies based on their given contexts.

Prevailing attitudes towards abortion among the participants appeared to be influenced by factors other than their education. Thus, it is necessary to examine how the educational environment and programs of future healthcare providers promote or challenge existing gender and cultural norms.

Stigma reduction workshops can help resolve the ambivalence about abortion by exposing students to the complex realities of women who choose to have an abortion; clarifying what the law says about abortion and postabortion care; expounding on abortion as a necessary element of healthcare for women and the professional guidelines on abortion service provision 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 students' views remained within prevailing gender and cultural norms, a perceivable positive opinion and belief regarding women's bodily and reproductive autonomy existed 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 this and support healthcare students and providers expand their concept of autonomy within the framework of SRHR, in particular, and within women's rights, in general.

The participants also believed strongly in women's right to humane, non-judgmental, compassionate postabortion care. These attitudes should be nurtured and reinforced through supportive policies and training environment. The supportive environment should be available 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. Include PAC education in the medical, nursing, and midwifery schools as a first step towards making humane, non-judgmental, quality postabortion care accessible to women.
2. Involve medical schools, the Philippine Obstetric-Gynecological Society and other medical associations/societies, the World Health Organization, the Department of Health, public health NGOs, and safe abortion advocacy groups in equipping medical, nursing and midwifery students with knowledge and skills in new methods of PAC such as the use of MVA and misoprostol.
3. Integrate PAC in other medical disciplines or specializations such as Emergency Medicine.
4. Incorporate SRHR and safe abortion discussions in existing courses along with family planning and reproductive health modules. Integration of safe abortion discussion and education in medical, nursing and midwifery courses/curriculum would result in improved quality of reproductive health services and information for women.
5. Ensure the implementation of a rights-based PAC policy. Women and SRHR groups, medical associations, and public health NGOs should be part of the formulation of the policy.
6. Implement discussions, trainings and workshops on gender equality, women's rights and SRHR in medical, nursing, and midwifery schools. Focus on second year midwifery students rather than fourth year students. Second year students are already eligible for licensure and practice service provision after.
7. Invite safe abortion advocacy groups to conduct special courses on abortion stigma reduction with medical and nursing students, faculty members and heads of school.
8. Examine medical, nursing, and midwifery curriculum for contemporary issues of sexual and reproductive health and how educational environment influence prevailing gender norms and stigma on abortion.
9. Conduct further studies on the knowledge and attitudes regarding abortion with medical, nursing and midwifery students. Because of the differences in curriculum and length of study, it is recommended that each program be 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
(Women's Global Network for Reproductive Rights)
Contact: 09177060971 email: teta@wgnrr.org
Marevic Parcon, Co-investigator
Romeo Marcaida, RN, Co-investigator
Ma. Dulce Natividas, Consultant
Sarah Jane Biton, RN, Consultant
Joralen Wenceslao, Research Coordinator
Abigail R. Matres, Research Coordinator
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 permission 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

1. In the situation shown in the story, do you think it was right for the woman to get abortion?
2. If you were the doctor/nurse/midwife in the situation, what would you do and advice the woman?
3. In the case of therapeutic abortion, do you believe that woman have the right?
4. What is a health providers' responsibility in the case of therapeutic abortion?
5. How about in other circumstances?

PART 3. Read/show story of postabortion care story

1. What are the health providers' responsibilities in the situation shown in the story?
2. Do you think health providers have the right to refuse care if he/she finds 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:

1. 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?
2. In the Philippines, abortion is 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 3. 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. <input type="checkbox"/> Female 2. <input type="checkbox"/> Male 3. <input type="checkbox"/> I identify/self-describe as _____
1.2 Age	_____ (in number of years)
1.3 Program	1. <input type="checkbox"/> 4 th Year 2. <input type="checkbox"/> 3 rd Year 3. <input type="checkbox"/> 2 nd Year 4. <input type="checkbox"/> 1 st Year
1.5 Type of university/school	1. <input type="checkbox"/> Public 2. <input type="checkbox"/> Private/Non-sectarian/Non-religious 3. <input type="checkbox"/> Private/Sectarian/Religious
1.6 Are you a member of any organization/association in school?	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No
1.7 What type of organization? (<i>tick all that applies</i>)	1. <input type="checkbox"/> Academic 2. <input type="checkbox"/> Cause-oriented 3. <input type="checkbox"/> Faith-based 4. <input type="checkbox"/> Others _____
1.8 What is the average monthly income of your family?	1. <input type="checkbox"/> Below Php 10,000 2. <input type="checkbox"/> Php 10,000-19,000 3. <input type="checkbox"/> Php 20,000-39,000 4. <input type="checkbox"/> Php 40,000-59,000 5. <input type="checkbox"/> Php 60,000-79,000 6. <input type="checkbox"/> Php 80,000-90,000 7. <input type="checkbox"/> Php 90,000-100,000 8. <input type="checkbox"/> 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. <input type="checkbox"/> No Education 2. <input type="checkbox"/> Elementary 3. <input type="checkbox"/> High school 4. <input type="checkbox"/> Vocational 5. <input type="checkbox"/> College 6. <input type="checkbox"/> Graduate studies
1.11	What is the highest level of education your mother has completed?	1. <input type="checkbox"/> No Education 2. <input type="checkbox"/> Elementary 3. <input type="checkbox"/> High school 4. <input type="checkbox"/> Vocational 5. <input type="checkbox"/> College 6. <input type="checkbox"/> Graduate studies
1.12	What is your religion?	1. <input type="checkbox"/> Catholic 2. <input type="checkbox"/> Protestant 3. <input type="checkbox"/> Muslim 4. <input type="checkbox"/> Vocational 5. <input type="checkbox"/> Others _____ 6. <input type="checkbox"/> No religion
1.13	How would you describe your attendance in religious services (e.g. mass, prayer meetings, etc)?	1. <input type="checkbox"/> Every day 2. <input type="checkbox"/> Once a week 3. <input type="checkbox"/> Once a month 4. <input type="checkbox"/> Occasional 5. <input type="checkbox"/> Not applicable
1.14	What is your civil status?	1. <input type="checkbox"/> Single 2. <input type="checkbox"/> Married (<i>Skip to 1.16</i>) 3. <input type="checkbox"/> Live-in (<i>Skip to 1.16</i>) 4. <input type="checkbox"/> Separated (<i>Skip to 1.16</i>) 5. <input type="checkbox"/> Widowed (<i>Skip to 1.16</i>)
1.15	If single, how would you describe your relationship status?	1. <input type="checkbox"/> Single, in a relationship 2. <input type="checkbox"/> Single, no current relationship 3. <input type="checkbox"/> Single, never been in a relationship
1.16	How would you describe yourself?	1. <input type="checkbox"/> Heterosexual 2. <input type="checkbox"/> Homosexual 3. <input type="checkbox"/> Bisexual 4. <input type="checkbox"/> Others _____ 5. <input type="checkbox"/> Prefer not to answer
1.17	Do you have a child or children?	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No
1.18	Please describe your sexual experience	1. <input type="checkbox"/> I have had sex 2. <input type="checkbox"/> I never had sex (<i>Skip to PART 2</i>) 3. <input type="checkbox"/> Unwilling to answer (<i>Skip to PART 2</i>)
1.19	If you have had sex, do you use contraception?	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No (<i>Skip to PART 2</i>)
1.20	How would you describe your use of contraception?	1. <input type="checkbox"/> More often than not, I use contraception 2. <input type="checkbox"/> More often than not, I do not use contraception 3. <input type="checkbox"/> I always use contraception
1.21	What are the types of contraception do you rely the most for the last three years? (<i>Choose up to three answers</i>)	1. <input type="checkbox"/> Rhythm method (or calendar method) 2. <input type="checkbox"/> Withdrawal 3. <input type="checkbox"/> Male condoms 4. <input type="checkbox"/> Pills (oral contraceptives) 5. <input type="checkbox"/> Implants 6. <input type="checkbox"/> Injectable 7. <input type="checkbox"/> Vasectomy 8. <input type="checkbox"/> Intrauterine device 9. <input type="checkbox"/> Others

PART 2	
2.1	<p>According to the latest National Demographic and Health Survey, what percentage of women age 15-49 have unmet need for family planning?</p> <p>1. <input type="checkbox"/> About 50%</p> <p>2. <input type="checkbox"/> About 17%</p> <p>3. <input type="checkbox"/> About 5%</p> <p>4. <input type="checkbox"/> About 10%</p> <p>5. <input type="checkbox"/> I don't know</p>
2.2	<p>Abortion is among the Top 5 leading causes of maternal deaths in the Philippines.</p> <p>1. <input type="checkbox"/> True</p> <p>2. <input type="checkbox"/> False</p> <p>3. <input type="checkbox"/> I don't know</p>
2.3	<p>According to the law, when can a woman access an abortion in the Philippines?</p> <p>1. <input type="checkbox"/> Always, there are no restrictions</p> <p>2. <input type="checkbox"/> Never, abortion is totally prohibited</p> <p>3. <input type="checkbox"/> Sometimes, depending on the circumstances</p> <p>4. <input type="checkbox"/> Only when it is necessary to save a woman's life (i.e. therapeutic abortion)</p> <p>5. <input type="checkbox"/> I don't know</p>
2.4	<p>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?</p> <p>1. <input type="checkbox"/> Yes</p> <p>2. <input type="checkbox"/> No</p> <p>3. <input type="checkbox"/> I don't know</p>
2.5	<p>Do you know how medical abortion is done?</p> <p>1. <input type="checkbox"/> Yes</p> <p>2. <input type="checkbox"/> No</p>
2.6	<p>What is the recommended method for medical abortion?</p> <p>1. <input type="checkbox"/> Oxytocin followed by misoprostol</p> <p>2. <input type="checkbox"/> Misoprostol alone</p> <p>3. <input type="checkbox"/> Misoprostol followed by mifepristone</p> <p>4. <input type="checkbox"/> Mifepristone followed by misoprostol</p> <p>5. <input type="checkbox"/> I don't know</p>
2.7	<p>Do you know how surgical abortion is done?</p> <p>1. <input type="checkbox"/> Yes</p> <p>2. <input type="checkbox"/> No</p>
2.8	<p>Which among these is a method for surgical abortion?</p> <p>1. <input type="checkbox"/> Intake of Cytotec</p> <p>2. <input type="checkbox"/> Abdominal massage</p> <p>3. <input type="checkbox"/> Vacuum aspiration</p> <p>4. <input type="checkbox"/> I don't know</p>
2.9	<p>Most Filipino women who have abortion are married or in a consensual union.</p> <p>1. <input type="checkbox"/> True</p> <p>2. <input type="checkbox"/> False</p> <p>3. <input type="checkbox"/> I don't know</p>
2.10	<p>Spontaneous abortion is commonly known as:</p> <p>1. <input type="checkbox"/> Therapeutic abortion</p> <p>2. <input type="checkbox"/> Stillbirth</p> <p>3. <input type="checkbox"/> Miscarriage</p> <p>4. <input type="checkbox"/> I don't know</p>
2.11	<p>Counseling and family planning including contraceptive services are part of postabortion care.</p> <p>1. <input type="checkbox"/> True</p> <p>2. <input type="checkbox"/> False</p> <p>3. <input type="checkbox"/> I don't know</p>

PART 3

3.1	Where did you hear from or learn about abortion? <i>(tick all that apply)</i>	1. <input type="checkbox"/> Studies/school 2. <input type="checkbox"/> Friends 3. <input type="checkbox"/> Family 4. <input type="checkbox"/> Media like TV, radio, magazines, newspaper 5. <input type="checkbox"/> Social media 6. <input type="checkbox"/> My own research 7. <input type="checkbox"/> Church 8. <input type="checkbox"/> Doctors and other health professionals 9. <input type="checkbox"/> Personal experience 10. <input type="checkbox"/> Non-government organizations/cause-oriented groups 11. <input type="checkbox"/> Others _____
3.2	Among your answers, what would you say are the top 3 sources of your knowledge of abortion? <i>(Tick up to 3)</i>	1. <input type="checkbox"/> Studies/school 2. <input type="checkbox"/> Friends 3. <input type="checkbox"/> Family 4. <input type="checkbox"/> Media like TV, radio, magazines, newspaper 5. <input type="checkbox"/> Social media 6. <input type="checkbox"/> My own research 7. <input type="checkbox"/> Church 8. <input type="checkbox"/> Doctors and other health professionals 9. <input type="checkbox"/> Personal experience 10. <input type="checkbox"/> Non-government organizations/cause-oriented groups 11. <input type="checkbox"/> Others _____
3.3	Has abortion been discussed in any of your subject/training?	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> 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. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No
3.5	In the course of your training, did you have any opportunity of assisting in a case of abortion procedure?	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No 3. <input type="checkbox"/> Unsure
3.6	In the course of your training, did you have any opportunity of assisting a case of postabortion care?	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No 3. <input type="checkbox"/> Unsure
3.7	Do you personally know someone who had an abortion?	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No 3. <input type="checkbox"/> Unsure

PART 4

4.1	How would you say has sexual and reproductive health been discussed/or covered in your program of study?	1. <input type="checkbox"/> Not at all 2. <input type="checkbox"/> Somewhat 3. <input type="checkbox"/> Adequately 4. <input type="checkbox"/> Can't say
4.2	How would you assess your theoretical knowledge of sexual and reproductive health and rights?	1. <input type="checkbox"/> Poor 2. <input type="checkbox"/> Fair 3. <input type="checkbox"/> Good 4. <input type="checkbox"/> Very good

4.3	How would you describe your theoretical knowledge of abortion?	1. <input type="checkbox"/> Poor 2. <input type="checkbox"/> Fair 3. <input type="checkbox"/> Good 4. <input type="checkbox"/> Very good
4.4	How would you describe your theoretical knowledge of postabortion care?	1. <input type="checkbox"/> Poor 2. <input type="checkbox"/> Fair 3. <input type="checkbox"/> Good 4. <input type="checkbox"/> Very good
<i>For questions 4.5 to 4.10, indicate your opinion by using the scale. Encircle the number of your choice</i>		
4.5	Women should be able to make and execute independent decisions on her reproductive health, such as pregnancy.	
	1 Strongly Disagree	2 Disagree
	3 Somewhat Disagree	4 Somewhat Agree
	5 Agree	6 Strongly Agree
4.6	Abortion is an appropriate topic in my program of study.	
	1 Strongly Disagree	2 Disagree
	3 Somewhat Disagree	4 Somewhat Agree
	5 Agree	6 Strongly Agree
4.7	Abortion is morally wrong.	
	1 Strongly Disagree	2 Disagree
	3 Somewhat Disagree	4 Somewhat Agree
	5 Agree	6 Strongly Agree
4.8	A woman should always have the right to an abortion in the case of an unintended pregnancy.	
	1 Strongly Disagree	2 Disagree
	3 Somewhat Disagree	4 Somewhat Agree
	5 Agree	6 Strongly Agree
4.9	My education program should include training on abortion procedures.	
	1 Strongly Disagree	2 Disagree
	3 Somewhat Disagree	4 Somewhat Agree
	5 Agree	6 Strongly Agree
4.10	Students with moral objections should be excused from any training and discussions on abortion.	
	1 Strongly Disagree	2 Disagree
	3 Somewhat Disagree	4 Somewhat Agree
	5 Agree	6 Strongly Agree
4.11	In your opinion, at what gestational age an embryo/fetus becomes a PERSON?	1. <input type="checkbox"/> Fertilization 2. <input type="checkbox"/> Weeks 1-10 3. <input type="checkbox"/> Weeks 21-24 4. <input type="checkbox"/> Weeks 25-30 5. <input type="checkbox"/> Weeks 31-40 or 6. <input type="checkbox"/> Birth 7. <input type="checkbox"/> Other _____
4.12	Should abortion be legally available in our country?	1. <input type="checkbox"/> Yes, absolutely, in all circumstances. (Skip to Q 4.14) 2. <input type="checkbox"/> No, absolutely. (Skip to 4.14) 3. <input type="checkbox"/> Yes, under certain circumstances 4. <input type="checkbox"/> Unsure (Skip to 4.14)

<p>4.13 If yes, under certain circumstances, what circumstances? (<i>tick all your answers</i>)</p>	<p>1. <input type="checkbox"/> When it is necessary to save the woman's life 2. <input type="checkbox"/> When the fetus has severe impairment and unlikely to survive 3. <input type="checkbox"/> When the pregnancy is the result of rape 4. <input type="checkbox"/> When the pregnancy is the result of incest 5. <input type="checkbox"/> When the woman has cognitive or intellectual disability 6. <input type="checkbox"/> When the woman is in psychological distress about the pregnancy (mental health reasons) 7. <input type="checkbox"/> When the woman is living in extreme poverty and her child would also live in extreme poverty (economic reasons)</p>
<p>4.14 If abortion were made legally available in country, would you be willing to perform and/or assist in abortion service?</p>	<p>1. <input type="checkbox"/> Yes, absolutely, in all circumstances. 2. <input type="checkbox"/> No, absolutely. 3. <input type="checkbox"/> Yes, under certain circumstances 4. <input type="checkbox"/> Unsure</p>
<p>4.15 In the present legal situation where abortion is generally restricted, are you willing to assist in abortion procedure to save a woman's life?</p>	<p>1. <input type="checkbox"/> Yes. 2. <input type="checkbox"/> No. 3. <input type="checkbox"/> Unsure</p>
<p>4.16 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?</p>	<p>1. <input type="checkbox"/> Yes. 2. <input type="checkbox"/> No. 3. <input type="checkbox"/> Depends on circumstances 3. <input type="checkbox"/> Unsure</p>
<p>4.17 <i>For FEMALE respondents ONLY:</i> If you have an unintended/unplanned pregnancy in this time in your life, would you consider getting an abortion?</p>	<p>1. <input type="checkbox"/> Yes. 2. <input type="checkbox"/> No. 3. <input type="checkbox"/> Unsure</p>

