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PROBING THE DECISIONS BEHIND INDUCED ABORTION IN THE PHILIPPINES

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Abstract

Often a subject of emotional debates that unleash strong and opposing views, abortion, in particular, induced abortions, remain a health concern deserving public health policy action. While there have been several studies on the causes and consequences of abortion, data on a scale that would generate reliable estimates of the prevalence of abortion for the whole country remains scarce. This paper uses a mix of available data on abortion in the Philippines and compliments the profiles of women who have had abortions with life stories to give the abortion statistics the needed human face. The compelling circumstances surrounding the hard decisions to terminate unwanted pregnancies show that Family Planning Program interventions on preventing unwanted pregnancies have a potential of reducing induced abortions. Given the combination of the secrecy of abortion decisions and procedures and the limited capacity of our health system to provide post-abortion care and treatment due to limited resources to meet competing health needs, it is crucial that imperfections in the use of the more effective methods of family planning are addressed to prevent unwanted pregnancies, an event in women's lives that push them into preventable complications and ill health effects of induced abortions and at worst, maternal deaths.

Keywords: induced abortion, health policy, unwanted pregnancies, post-abortion care

Introduction

Often times the subject of emotional debates, abortion continues to be controversial, especially in nations where conservative views of some Catholics clash with radical views of women's groups who espouse the liberalization of restrictive laws that stipulate abortion as illegal. The divisive nature of discussions on abortion is best exemplified by the 1994 International Conference on Population and Development (ICPD) where respected and prominent national leaders and civil society groups came together to resolve the growing tensions between ideals of reproductive health and the realities of women's lives and reproductive health.

In September 1994, 179 nations of the world, including the Philippines, promised to cooperate to improve the health of the world's women during the ICPD. Together, they negotiated a 16-chapter Programme of Action that listed a series of recommended actions for a number of critical and often controversial issues, including reproductive health. The delegates succeeded in reaching a consensus of what reproductive health is and what it is not. They went on to state:

> "*Reproductive health is a state of complete physical, mental, and social well-being and not merely the absence of infirmity, in all matters related to the reproductive system and its functions and processes.*"

The implications of such a definition on individual reproductive health are far-ranging: from people's ability to have a satisfying sex life to their ability to reproduce that entails the freedom to decide if, when, and how often to do so. These innate abilities of individuals imply the right of women and men to be informed and have access to safe, effective, affordable, and acceptable methods of family planning of their choice based on their private conscience.

This paper takes off from this worldwide pledge. It focuses on unintended pregnancies and abortions among Filipino women based on currently available studies. Data from the relatively thin literature on abortion is discussed to present evidence on a most alarming public health concern that needs to be brought out to the public policy arena. Stories of Filipino women who have experienced abortions, culled from the few qualitative studies currently available are presented in relevant sections. The stories provide the necessary context in which unintended pregnancies and abortion occur in relevant sections. The notion that effective use of effective contraception reduces abortion is discussed supported by data from other studies that examined the relationship between contraceptive use, unplanned pregnancies, and incidence of induced abortions. The final section presents policy recommendations that might help pre-

vent unintended or unwanted pregnancies, reduce abortions and at worst, maternal deaths due to abortions.

The Unkept Promises of ICPD

Today, nine years after ICPD, we still hear stories of deaths of women while pregnant or within days of induced pregnancy termination carried out in unsanitary conditions, with unsafe practices, and often done clandestinely because of punitive laws for abortion practitioners and women who seek their services.

A global study by the Global Health Council in 2002 reveal that during the 6-year period 1995-2000, the world's 1.3 billion women of childbearing age experienced a total of more than 1.2 billion pregnancies. Of these, more than 300 million, or more than a quarter of the pregnancies in the whole world, were unintended. Sadly, 700,000 women lost their lives as a result of these unwanted pregnancies: more than one-third died from problems of pregnancy, labor, and delivery; more than 400,000 died as a result of complications arising from abortions.

Data for the Philippines mirror the same picture of grief and stinging pain that penetrates even the sacred chambers of Church policy decision-makers. During the period 1995-2000, the global study shows about 2,132,762 unintended births. More appalling is that 8,853 women died due to complications of abortion and 12,564 women died due to complications of unintended pregnancies. Comparing the deaths due to unintended pregnancies in the Philippines and in Thailand show that deaths among Filipino women are three times more than deaths among Thai women. Such a difference speaks of the wider reach of an effective Family Planning Program in Thailand that has succeeded in narrowing the gap between actual and desired number of children, achieved high levels of use of effective contraceptive method and low levels of unmet needs for family planning.

Table 1. Number of Abortions, Maternal Abortion Deaths, Unintended Pregnancies, Unintended Births and Deaths Due to Unintended Pregnancies in Selected Asian Countries, 1995-2000.

Asean Country	Abortions	Maternal Abortion Deaths	Unintended Pregnancies	Unintended Births	Deaths Due to Un-intended Pregnancies
Indonesia	12,984,943	20,092	15,481,176	2,496,233	30,176
Malaysia	1,160,069	2,171	1,719,306	559,237	2,171
Philippines	2,724,087	8,853	4,856,849	2,132,762	12,564
Singapore	104,501	197	113,443	8,942	197
Thailand	3,783,098	4,106	4,666,475	883,377	4,106
Vietnam	9,396,277	6,772	10,617,241	1,220,964	7,126

Source: Daulaire et al. (2002).

Abortion in the Philippines

Even prior to the 2002 global study that has recently caught the attention of the world, the first study of a national scale on the magnitude of induced abortion in the Philippines was conducted by Perez et al in 1996. Based on hospital records admission data from retained hospitals of the Department of Health in all regions of the country, the rate of annual hospitalizations for induced abortions for every 1,000 women aged 15-44 during 1993-1995 was estimated. This, however, is an underestimate of the actual numbers of abortions since it did not include women who did not go for treatment at the hospital and survived and also did not include women who died of abortion complications not captured in the hospital record. These women died even before getting post-abortion care in the hospital.

Using a systematic and accepted indirect method of estimation of induced abortion, the study came out with an estimate of 400,500 induced abortions a year. Converting this estimate into an annual abortion rate shows 25 induced abortions for every 1000 women aged 15-44 each year during the period 1993-1995 and a ratio of 16 induced abortions for every 100 pregnancies. This is about the same as that in the United States of America in 1992 obtained by the Allan Guttmacher Institute.

Differentials in abortion rates across broad regions show Metro Manila exhibiting the highest abortion rate of 41 per 1000 women per year, followed by Luzon with 30 abortions per 1000 women per year. It was substantially lower in Mindanao and Visayas, with estimates of 18 and 11 abortions per 1000 women per year, respectively.

Table 2. Estimated number of women hospitalized for complications of induced abortion, and estimated total number of abortions, abortion rate per 1,000 women aged 15-44 and abortion ratio per 100 pregnancies, calculated using three multipliers, Philippines, 1994.

Area	Estimated number of women hospitalized for treatment of induced abortions	4			5			6		
		No. of abortions	Rate	Ratio	No. of abortions	Rate	Ratio	No. of abortions	Rate	Ratio
Philippines	80,103	320,413	20	13	400,515	25	16	480,618	30	19
Metro Manila	20,917	83,668	33	28	104,585	41	33	125,502	50	37
Rest of Luzon	38,899	155,596	24	15	194,495	30	18	233,394	36	21
Visayas	6,895	27,580	9	6	34,475	11	7	41,370	13	8
Mindanao	13,392	53,568	14	9	66,960	18	11	80,352	21	13

Source: Perez, et al. (1997).

A more recent study employing triangulation of evidence among women who experienced abortions, service providers, and the general population of women in the reproductive ages is a rich source of additional information necessary for understanding abortion. The study sites were limited to the highly urbanized areas of Metro Manila, Cebu, Davao and in Tuguegarao, a predominantly agricultural area. This study conducted by Raymundo et al (2001) provided data that enriched knowledge on the women who sought abortion, their circumstances, their pregnancy histories, their fertility, their contraceptive use and the consequences of abortion on them. These individual-level information was not available from the study of Perez et al; but the estimates of the level of abortion derived from this study is confined to Metro Manila only. The resulting prevalence rate for Metro Manila is 16.6 per cent and is not representative of the entire country. It is much lower than the estimated induced abortion rate for Metro Manila in the 1996 study of Perez et al.

The Weakness of Available Abortion Statistics

The estimates on abortion rates in the country during the period 1993 – 1995 may be a surprise to some but an even more crucial issue is the extent of unsafe abortion. We still do not know how many women suffer complications for which they get no treatment or unable to get treatment, how many die before getting medical attention, how many become infertile or how many are left with other health risks. It is clear, however, that induced abortion is as real as the birth of a baby, no matter what length of debate goes on with what leads Filipino women to abort and why some sectors of society still think it is as sinful to discuss abortion in public.

The underestimation of the incidence of abortion is rooted in the fact that there is a social stigma with the admission of abortion by women. This stigma emanates from the illegality of abortion in the country and from the prevailing perception that all women who seek abortion and all those who provide abortion services are immoral and essentially criminals. Thus the limitations in the quantitative measurement of induced abortion create a demand for qualitative studies that probe into the question of why might women want to have abortions and be labeled criminals?

Why Women Seek Abortion

Accounts of abortion in the country show that there is a chronology of events in a woman's life that leads to the hard decisions to go through abortion. Indeed, abortion does not occur in a social vacuum; it happens in particular contexts and hard decisions are made after some deliberation on the matter.

Evidence underscore the pathway to an abortion, among those in legal sexual relationships as married couples, begins with a woman's dilemma of

having to choose between sexual activity that is likely to lead to a pregnancy she is not prepared for or having to deal with her sexual partner's searching for another sexual partner and having to be abandoned. This is especially noted among married women of older ages who have had several children.

Among those in illicit relationships, keeping the relationship unknown to the community often compels women to terminate pregnancies so as not to invite more problems than she can handle. In the case of commercial sex workers, getting pregnant can mean economic loss in a competitive present-day commercial sex industry.

For the generation of younger adolescents, the combination of increased length of time between sexual awakening and the number of years spent in exclusive relationships while in school, uninformed about exactly when they could get pregnant, and increasing age at marriage easily unlock the gateways to unplanned teenage pregnancies. Some private catholic schools deny the pregnant adolescent female the right to continue schooling. Again, there is the hard choice between not finishing schooling and terminating the unplanned pregnancy.

In all instances, the connection between unplanned pregnancies, whether mistimed or unwanted, and the decision to go through abortion imply some deliberation and some calculation of risks by women, alone or in consultation with their sexual partners. Unwanted or unplanned pregnancies is a crucial predisposing factor to induced abortion, as clearly shown by evidence from the Raymundo et al study where 402 cases of the total 1,116 pregnancies of the hospital respondents interviewed were declared as unwanted. Of these unwanted pregnancies, a majority (83 per cent) or 334 out of the 402 unwanted pregnancies ended in induced abortions. This is made clear in Figure 1.

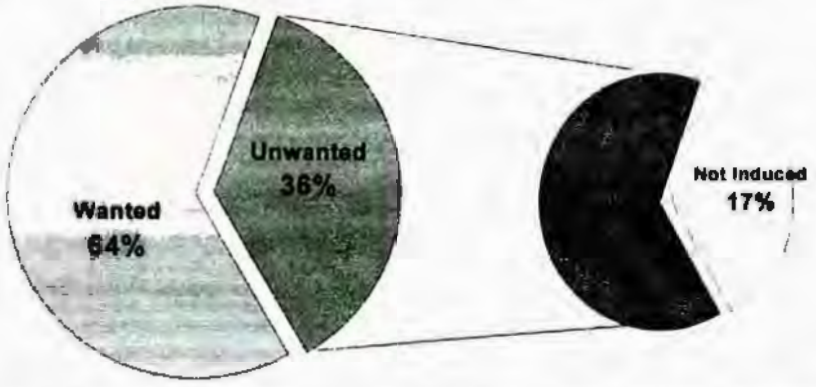

Figure 1. Wanted vs. unwanted pregnancies and proportion of induced abortions among unwanted pregnancies, hospital follow-up group.

Source: Raymundo et al. (2001).

In addition, the Metro Manila cluster survey component of the study estimated that those with unwanted pregnancies are almost twice more likely to have induced abortions compared to those not having an unwanted pregnancy.

If only for this reason, more serious thought and study should be accorded the increasing numbers of abortion and what social institutions like families, schools, government and the different church denominations, might do to help curb the practice of abortion. Its being a most divisive and emotional policy issue is not justification for ignoring the reality that it does happen. On the contrary, the policy debate should be driven by the motivation to reduce abortion rates even in an environment where it is illegal. Equally important is a careful scrutiny of the little relationship between abortion legality and abortion incidence, noted in our own country. Clearly, factors other than legality are at play here.

Who Are the Women Who Seek Abortion?

Does abortion involve only a particular group of so-called "immoral" women trapped in poverty-driven clandestine sexual relationships, which lead to criminal pregnancy terminations during the first trimester? There is evidence that women of all social classes and backgrounds are having abortion. A detailed profile of women with abortion experience from the 2001 study of Raymundo et al show that contrary to popular belief, there are more married women who have had abortion, sometimes repeated, than unmarried women with illicit sexual relationships. Even the better educated who are assumed to have access to information on how to avoid unplanned pregnancies and know better the perils and health risks of abortion show higher incidence of abortion than less educated women. On the average, the age at abortion ranges from 25 to 28 years and generally, are unemployed housewives.

Table 3. Profile of women who seek induced abortion.

Characteristics of Women	Hospital Cases	Metro Manila luster Survey
Mean Age	27.8	25.6
% Married	63.9	58.2
Mean Years of Education	9	11.2
Mean Household Size	61	n.a.
% Not Employed/Housewives	64.8	67.3

Source: Raymundo et al. (2001).

Giving Life to Statistics

The story of Manuela, compiled by A.B. Marcelo (2002), is illustrative of a married woman's situation that is not quite the picture that some misinformed critiques often project and make conclusive generalizations about the immorality of women who seek abortion. Manuela is 27 years, married, with three children and residing in an urban poor community with her husband's family, and was faced with an unwanted pregnancy.

When Manuela's husband had a regular job as a construction worker, times were better for them. That she had one child after another was something her husband boasted about during drinking sessions with his co-workers. She did not like giving birth practically each year. In fact, she also had a miscarriage before her last childbirth. They were not using any contraceptives for many reasons. They heard all kinds of "bad" stories about pills; she thinks only prostitutes should use condoms; they heard a neighbor from their home province got sick with tuberculosis after ligation and eventually died. When the economy deteriorated, her husband lost his job. They lost their rented shack and had to move in with the family of her brother-in-law.

"Life is hard. Our home is so small for two families but at least we have a roof over our heads. My children are still small and my husband has no regular employment. I sell candies and cigarettes to help put food on the table. But there are nine of us who need to eat and my sister-in-law is pregnant again. I was also pregnant. But I just could not go on with my pregnancy. I told my husband. We both asked around discreetly and tried some herbs. A friend told me to take quinine as well just to be sure. When it did not work, I went to a hilot (traditional birth attendant). After three sessions I started bleeding and she told me to go to a hospital. They are not nice here (in the hospital). But what can I do. I have nowhere else to go." (A.B. Marcelo, 2002)

When queried further on her feelings about her unwanted pregnancy, she just wished it did not happen. She was so relieved when her husband agreed to have the unwanted pregnancy terminated. When asked about the treatment at the hospital, she just wished they would be kind and understanding of her situation. She thinks that may be if she were paying, she would be treated better.

Where Do Women Go for Abortion Services?

One tenet of service provision is that where there are no services and products, there are no customers. According to the 1996 survey of a purposive sample of health professionals on abortion practices (Perez et al, 1997), women who decide to terminate an unwanted pregnancy go to one of five sources of abortion services: physicians, trained nurses and midwives, traditional birth

attendants (TBA) and other lay practitioners, pharmacists, and themselves. Segmenting the market for abortion services by geographic areas, i.e., urban and rural, and the poverty status of the women who seek abortion services, yield interesting differentials.

It is noted by the health professional respondents that about half of the better-off urban women would go to doctors, trained nurses or midwives. About 3 in 10 abortions in this group are likely to be self-induced and the remaining 2 in 10 are performed by TBAs or other lay practitioners. Among better-off rural women, about the same proportion would use doctors or trained nurses as would use TBAs to perform abortion and one-quarter would try to induce the abortion themselves.

The patterns among the poor women are quite different. For those in urban areas, large proportions would go to a lay practitioner or TBA or would try to induce the abortion themselves (about 4 in 10 and 3 in 10, respectively). Slightly more than 2 in 10 would use nurses or trained midwives, and fewer than 1 in 10 would go to a doctor. In rural areas, poor women are most likely to depend on lay practitioners or do a self-induced abortion; they are unlikely to go to a nurse, midwife, or doctor.

The proportion deciding to have self-induced abortion appears very similar to all groups of women. This suggests a strong desire on the part of the women, irrespective of social class, to keep their abortion a secret. However, this practice is likely to result to serious complications, which could be fatal if left untreated. The dangers of unsafe self-induced abortions to health and even to life, as told by the story of Erlinda below, have to be made known to the public.

"Abortion was induced by the insertion of a rubber catheter, removed the following day, after which curettage was done. Erlinda complained of abdominal pain. She was refused treatment at two local hospitals, and traveled another 3-4 hours to reach Manila. By this time, the infection was septic and extensive. Despite surgery and measures to resuscitate her, Erlinda dies 15 hours after the operation, five days after the abortion." (F.M. Tadiar with Omictin-Diaz, 1993)

Family Planning Practice and Abortion

It has been shown elsewhere that more effective use of contraceptive methods reduces abortion. Women who use an effective method of contraception simply are much less likely to face an unintended pregnancy. The decision to have an abortion or not is also faced by much less when compared to women who do not use effective contraceptive methods. In Turkey, for instance, the shift in the method mix toward more effective methods and more effective use of methods has considerable potential to reduce abortion levels, even in the

absence of increased use (Senlet et al, 2001). A comprehensive study of Brazil, Colombia, and Mexico concluded that as a result of increasing demand for limiting fertility over time, abortion rates may continue to increase even while contraceptive use rises but that ultimately, abortion rates will stabilize and decline. While the approaches of the studies vary, the conclusions are similar: more effective use of more effective contraceptive methods can reduce abortions (Singh and Sedge, 1997).

Replication of such studies in the Philippines is yet to be done, in the absence of trends on abortion rates at the national level. However, the work of Raymundo et al (2001) is a good first attempt at looking at the family planning behavior and practice of Filipino women who had abortions. Given the evidences from this study on why women seek abortion and on the basic profile of such women, it appears that married women with many children during the peak years of childbearing are more likely to abort unwanted pregnancies. The family planning (FP) practice of women who experienced induced abortions is interesting in light of the finding that abortion is apparently a response of women to the resolution of conflicts and anxieties associated with unwanted pregnancies. Their data show a low level of contraceptive use prior to pregnancy among those with unwanted pregnancies that ended in induced abortion. As depicted in Figure 2, The proportion who did not use any FP method prior to pregnancy among those whose pregnancies were wanted is relatively larger (81.1%) than those who used FP (19.9%). Among those with unwanted pregnancies, the proportion who used FP is relatively larger (35.6%) when compared to women whose pregnancies were wanted (19.9 per cent). However, the proportion of non-users of FP prior to pregnancy among those with unwanted pregnancies is notable (64.4%) and reflects a discrepancy between reproductive intentions, pregnancy status, and FP use, i.e., an unmet need for FP.

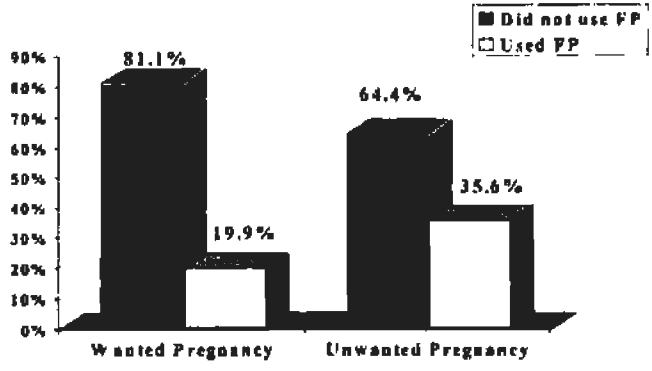

Figure 2. Family planning use prior to a pregnancy by "wantedness" of pregnancy (hospital follow-up group)
Source: Raymundo et al.

In addition, the data also imply failed efforts at preventing unwanted pregnancies among those who used FP prior to the unwanted pregnancy. This may be attributed to imperfections in use of the more effective methods or insufficient information on exactly when pregnancy can occur among those who rely on natural family planning methods. A clarification of the expected negative effect of FP use on unintended pregnancies is then necessary.

A closer examination of the FP behavior and practice of women underscore the role of discontinuing use of contraceptives. For instance, pill users averaged 19 months of continued use then switched to less effective methods such withdrawal or rhythm. For a commonly accepted 24-month pregnancy interval, there remains 5 months of exposure to risks of mistimed or unwanted pregnancies for women with 19 months of continues pill use who later on switch to either withdrawal or rhythm. It is therefore not a surprise that a larger proportion of those with unwanted pregnancies practiced family planning prior to getting pregnant but because of the pattern of method switching still described above still experienced an unwanted pregnancy. What is compelling is the imperfect dampening effect of contraceptive use on unintended pregnancies that could even be compounded by the imperfect use of even effective methods such as the pill.

Data from national demographic surveys have consistently confirmed that many women desire longer intervals when they admit mistimed or unwanted pregnancies. Yet, in most developing countries, more than 50 per cent of non-first births occur less than 36 months after the previous birth (USAID, 2002). In the Philippines, data from the 1998 National Demographic and Health Survey (NDHS) reveal that 14.5% of children born in the five years preceding the survey were born after an interval of less than 24 months. Although there is a small proportion of women with multiple risks, i.e., older than 34 years, with more than 3 children, and last child born after an interval of less than 24 months, the risks of child deaths among these multiple-risk women is almost three times more than the risk of a child death born by women not in any risk.

The manner with which this issue is addressed largely depends on program interventions for a fuller understanding of the effectiveness of each of the methods available and accessible to women and men. Likewise, there is room for improving information sharing on the health benefits of preventing unintended pregnancies and likely termination within short intervals of successive births to both mothers and children.

"After the abortion, she was hesitant about having sex with her husband. She didn't relish the thought of getting pregnant again and possibly undergoing the same ordeal. When asked if she was taking any precaution to avoid pregnancy, she said they were still using the rhythm and withdrawal methods. She seemed wary of using the more effective methods because of the stories she has heard." (A.B Marcelo, 1991)

Summary and Conclusion

Evidence presented in this paper may have answered some questions but certainly has unfolded many more that remains to be answered. An important question we now have to wrestle with besides the questions about unintended pregnancies and induced abortions is the appropriate role of government in these matters. The assumption is that government has the responsibility to help men and women not only safeguard their health but enable them to consciously plan childbearing and in so doing, achieve their family size goals without having to face the threats of unsafely induced abortions for unintended pregnancies. Two major policy actions are brought forward by the discussion.

First, there seems to be a gap between family planning use and wantedness of pregnancy. Because the number of children that Filipino women want has steadily declined , there is now a growing distance between family size goals and women's biological potential. Assuming that a woman has approximately 35 fertile years, she could bear as many as 15 children if she were to have a baby every two and half years. Thus as desired family size declines, women need to prevent pregnancy during more and more of their reproductive years if they are to avoid unplanned births and abortions. Although women and men may decide to use contraceptives to avoid an unplanned pregnancy, they do not always have the opportunity to choose the most appropriate contraceptives. This is borne out by the pattern of method switching in women's practice of FP. To succeed in having the number of children she wants when she wants them, a woman must use contracepxive methods properly for a long time. But often times, women have limited access to contraceptive services.

Second, there is a relationship between unintended or unplanned pregnancies and induced abortion. Unplanned pregnancies by itself is not sufficient to make women decide to have induced abortions. Rather, it is the social and economic circumstances surrounding the completion to full term of an unwanted pregnancy and the immediate implications of women to support the child from birth to adulthood unimpaired by ill health and inability to secure schooling that compels women and couples to terminate unplanned pregnancies. With modernization setting in, the desire of parents to provide their children with a good education and a better standard of living are some reasons why fewer children are now wanted. It is therefore urgent that the health care system is able to help women plan their family size and the timing of their pregnancies. Not even the illegal status of induced abortion can stop women from seeking abortion services in secret to end mistimed or unplanned pregnancies.

What more can be done?

The Department of Health has policies that address family planning needs as well as post-abortion care needs of women as part of its program for women's

health. But this is not a guarantee that such policies translate to availability and accessibility of such services to women in need of them. Policies, even when adopted, do not automatically ensure quality services at the local level. Commitment to policies on family planning and post-abortion care need to be reinforced with health systems and structures that will ensure access to FP post-abortion services.

A two-pronged strategy is recommended: ensured access to FP information and services to prevent unintended pregnancies while promoting spacing of births at intervals longer than 24 months and skilled care in treating complications of abortion. The first is intended to prevent unplanned pregnancies while the second is directed to prevent repeat abortions. In both strategies, FP counseling plays a key role. For the former, midwives and obstetricians are key providers of post-partum FP counseling aimed at informing women of the benefits of longer birth intervals through use of appropriate contraceptive methods. For the latter, doctors, nurses, midwives and traditional birth attendants from whom women seek abortion can be effective providers of post-abortion FP counseling aimed at informing women of ways of preventing unplanned pregnancies and repeat abortions.

These two-pronged strategy needs to be operationalized into priority actions at the service delivery level. These recommendations are those affecting the supply and demand of the more effective contraceptives as well as those affecting post-abortion treatment and care. These actions, essentially operational policy reforms, are urgently needed in light of the forthcoming reduction of the more effective contraceptives from the USAID and other donors.

1. Advocacy for funding of the slack in the supply of the more effective contraceptive methods by local government units, given the decentralized health services and the constraints posed by national policy on the promotion of the more effective contraceptive methods. There will be a reduction in the USAID supply of oral contraceptives, the second most popular contraceptive used by women, beginning next year. USAID contraceptive commodity donations covers about 80 per cent of all the contraceptive requirements of our national FP program. The pills is a more effective temporary method that can help women space births and in preventing unintended pregnancies.

2. A restatement of the DOH national FP policy with respect to the use of the reduced free contraceptives so that the local government units' burden of financing the slack in supply is reduced. This can be done through a policy pronouncement by DOH on targeted services whereby free contraceptive commodities no longer are free for all, irrespective of whether the FP user is poor or non-poor. Rather, the remaining donated contraceptives as USAID phases-down its commodity support should be given to the neediest poor.

3. Improved information campaign on the correct and effective use of modern contraceptives by trained community health workers as well as training

on detecting side-effects of contraceptives that should be referred to higher-level care by the community health worker.

4. Training of midwives and nurses in the rural health facilities on the complications of incomplete abortions so that such cases are immediately referred to appropriate post-abortion treatment and care.

5. Improved post-abortion treatment protocols that are followed in all levels of the health system, particularly, information and counseling, on all aspects of care, including current condition, treatment plan, and follow-up needs.

In both areas of service provision, the proficiency with which the members of the health care team at all levels of the health system perform their tasks is a key element of the quality of care. The goal of the recommendations above is toward the improvement of the quality of FP and post-abortion services. However, making quality services available should not be the end goal. What is more important is that the largest possible number of women are able to benefit from such quality services in preventing unintended pregnancies and in reducing induced abortions.

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