



## Changing Policies and Attitudes: Postabortion Care in the Philippines

Can a Ministry of Health with no history of supporting postabortion care services (and some ambivalence about it as well) develop the political will and administrative structure to do so? Can health care providers find a way to square negative personal beliefs about induced abortion with the need to offer compassionate, high-quality medical care to postabortion clients? Evaluations of a program called Prevention and Management of Abortion Complications (PMAC), which was developed and implemented in the Philippines by EngenderHealth, suggest that both are possible. Sanctioning postabortion care as a public health issue at the highest policy level permitted vast changes to occur in provider services. The result: Women suffering complications from incomplete abortion were managed with a greater degree of clinical safety, efficiency, and humanity. Moreover, an evolution in providers' attitudes and values led to improved counseling skills, better care for postabortion clients, and increased use of manual vacuum aspiration (MVA) in the clinical treatment of complications. And as a result of the PMAC program's early successes, it has been expanded to more facilities in the Philippines, further increasing women's access to compassionate and high-quality postabortion care.

### What the Project Involved

Induced abortion is illegal in the Philippines, and public attitudes toward it among the country's devoutly Catholic populace are generally very negative. Yet substantial numbers of unsafe abortions are performed in the Philippines each year, most in a clandestine fashion and by unskilled practitioners (see box, page 2). Indeed, abortion complications are a significant public health problem in the Philippines and a major cause of maternal morbidity and mortality. Unfortunately, despite the potentially severe risks that incomplete abortion can pose to health and life, some Philippine hospitals have reportedly refused outright to serve women experiencing abortion complications (Raymundo et al., 2001).

A client is counseled about family planning.



Photo: Richard Lord

Until recently, prevailing social attitudes about abortion in the Philippines had hindered the development of any formal program for coordinating the treatment of such women. In December 1999, amid heightened concern about high rates of abortion complications and attendant maternal deaths, EngenderHealth's Philippines program conducted a series of needs assessments at eight health care facilities. The assessments revealed that hospital management of abortion complications often focused on medical treatment alone, and that the majority of clients received no family planning or other reproductive health services or referrals. Further, while providers generally treated abortion complications appropriately, they sometimes behaved harshly toward clients—for example, by delaying procedures, denying clients analgesics, making them pay for expensive medications, or threatening to report them to the authorities (Tandingan et al., 1999).

Equipped with this information, EngenderHealth approached the Philippines Department of Health with a proposal for strengthening the health system's ability to offer quality postabortion care services. Collaborating within a working group made up of members of the Department of Health, academics, physicians, and representatives of nursing and midwifery associations, non-governmental organizations, and tertiary hospitals, EngenderHealth helped spearhead the drafting of an administrative order mandating PMAC as a government health program. This administrative order, signed by the Department of Health and effective as of July 2000 (Department of Health, 2000), was an enormous step forward in legitimizing postabortion care as a public health issue worthy of program services and attention. At the same time, members of the working group developed a country-level work plan for postabortion care during an EngenderHealth-sponsored workshop on taking postabortion services to scale. Together, these two documents provided the seminal policy and programmatic blueprints for PMAC's subsequent development.

Based on the needs assessment and with a Packard Foundation-funded proposal for PMAC services approved by the Department of Health, during 2000 EngenderHealth staff conducted a number of interventions at eight Department of Health sites:

- An intensive five-day skills-building course in post-abortion counseling that emphasized both supportive and family planning counseling
- A seven-day course for physicians focusing on the clinical management of abortion complications, including the use of MVA to treat incomplete abortion
- Training for facility staff in infection prevention
- Introduction of staff to participatory quality improvement approaches and tools

### Abortion complications in the Philippines

The most current data on the health impact of clandestinely induced abortion in the Philippines (Perez et al., 1997) underscore that induced abortion is a significant public health problem and a major cause of maternal morbidity and mortality:

- Among the estimated 400,000 women annually who are thought to have an induced abortion, one-quarter are hospitalized for complications.
- During the period 1994–1998, abortion was the third leading cause of hospital discharge in Department of Health facilities in the Philippines.
- The Department of Health reports that 12% of all maternal deaths in 1994 were due to abortion.

In addition, staff were encouraged to undertake minor facility renovations to set up working spaces where MVA and counseling could be performed in privacy.

### What the Project Achieved

From 2000 through 2002, 1,078 health providers participated in postabortion care training—a combination of counseling, infection prevention practices, and clinical management of postabortion complications (including the use of MVA). These individuals subsequently provided postabortion care services to 15,349 clients. Of 83 service providers interviewed during a midproject evaluation (EngenderHealth, 2002), 94% believed that their PMAC training had helped improve the quality of the postabortion care services they provided.

#### *Attitudes transformed*

According to the evaluators, one of the most striking transformations attributable to PMAC was in providers' attitudes toward clients. When site staff were asked what had improved since PMAC began, all responded that they had become less judgmental toward clients, and all spoke of the counseling trainings as powerful experiences that were instrumental in engendering those changes. In the words of one nurse, "[Before training,] I thought, 'Why not condemn these patients? They have killed the baby inside.' But after, I see them not as murderers, but as people needing counseling." While nearly all staff were emphatic in their belief that induced abortion is fundamentally wrong, many also explained how important it was that they not impose their judgments on their clients. Instead, they had come to perceive women who had had induced abortions as "victims" worthy of compassion (Shire, 2002).

#### *Services improved*

As a direct result of the counseling training and of changes in the providers' mindset, the quality of counseling (both supportive and family planning-focused) improved markedly. In each MVA procedure observed by the evaluation team during site visits in 2002, providers made concerted efforts to comfort clients, both verbally and nonverbally. The initial needs assessment had revealed that few postabortion clients received family planning counseling. Thanks to technical assistance provided through PMAC, all of the facilities developed systems for coordinating the provision of family planning counseling and for referring women with other reproductive health needs. For instance, one facility set up a counseling room on the same floor as the obstetric ward; another developed a Women's Health Unit to which postabortion clients could be referred for a variety of additional services.

Clients themselves confirmed these changes and their impact. In the midproject review (EngenderHealth, 2002), exit interviews with 35 PMAC clients found that 89% were satisfied with the services they received. Post-abortion clients interviewed during the case study (Shire, 2002) all reported that staff had discussed family planning with them, either at bedside, in a separate counseling room, or in an outpatient department. Most reported that providers were nice to them, responded to their requests, and did not reprimand them—a striking change from health care providers' typical behavior. One woman who had been a postabortion client at the same hospital twice in two years remarked to an evaluator that “last year they were so rough on me, and this year they treated me like a human being.”

The PMAC program prompted a significant increase in family planning counseling at all facilities. Overall, from July 2000 to June 2002, 82% of the 15,349 PMAC clients received family planning counseling, and of these, 43% accepted a family planning method, either modern or traditional. These rates varied notably by hospital, however: At most, the rate hovered just below 50%, but a few had rates of 15% or lower, while another had acceptance rates over two years of 79% to 99%. Lower acceptance rates can be attributed to a number of issues, including reductions in family planning or nursing staff, misunderstandings about side effects, and myriad cultural factors. Facilities with very high acceptance rates may have classified as users clients who chose natural family planning not as a contraceptive method but as a means of predicting their fertility cycle and boosting their chances of becoming pregnant again.<sup>1</sup>

PMAC also helped introduce MVA into many facilities. In the Philippines, most doctors treat incomplete abortion using dilation and curettage (D&C), which is performed using general anesthesia and typically requires at least a one-night hospital stay. However, of six PMAC hospitals visited, four were actively utilizing MVA—a procedure that is quicker and less intrusive than D&C, requires little or no anesthetic, and has a lower complication rate. Relatively few postabortion clients overall (2,472, or about 16%) were treated using MVA between July 2000 and June 2002, but this number grew as providers became more comfortable with the procedure.

Most facilities elected to alternate MVA with D&C, to maintain residents' skills in both procedures. (At one hospital, staff were not comfortable with introducing MVA, because of the perceived risk of its being used for induced abortion, and continued to treat complications

<sup>1</sup> The goal in family planning counseling is not to have 100% acceptance, as there will always be women who do not want a method for a variety of reasons, including the desire to become pregnant again.

using only D&C.) Besides MVA's convenience, low cost, and effectiveness, providers commented on its ease of use, and a few noted that by utilizing MVA they had “learned to be compassionate, because the patient is awake.” However, flexibility in regard to the use of MVA was the key factor in PMAC projects: At sites that chose not to introduce or continue with MVA, the program emphasis remained on providing quality services utilizing other aspects of PMAC training.

The PMAC program also had a decided impact on costs and quality of care. One evaluation (Costello et al., 2002) found that clients' average stay was less than a third as long where MVA was used as at sites where D&C was used. Also, shifting from D&C to MVA led to a 62% decrease in per-client cost. Finally, new management methods helped staff use time more efficiently and appropriately, which allowed them to spend more time on direct client care (presumably in part due to increased counseling time) than did staff at non-PMAC sites.

## Lessons Learned and Challenges Met

Postabortion care programs often begin in a grassroots fashion, when local health workers react to the problem and their efforts gradually grow across a region or nation. In the Philippines, however, where induced abortion is not legal and popular attitudes are strongly against it, the only way to establish a comprehensive PAC program was to gain confidence and commitment at the central administrative level. Once the administrative order was signed and the program had received government sanction, providers became more comfortable with offering postabortion care and, despite their religious views, relinquished negative attitudes toward women who seek medical care following an abortion.

Since an intervention is useful only as long as it can be sustained, a number of PMAC activities have focused on ensuring the program's continuity. A system was developed for transferring PMAC-related skills to new staff, with senior residents being responsible for teaching junior residents. In addition, several formal training-of-trainers courses in PMAC counseling and in the clinical management of complications were held in Department of Health and regional provincial hospitals, allowing for PMAC programs to be implemented and expanded both within these providers' respective facilities and among staff from other hospitals.

Over a six-month period in spring 2002, a working group of EngenderHealth staff and faculty from nursing and midwifery schools developed a preservice PMAC curriculum and pilot-tested it at six sites. Trainers now are poised to expand the curriculum to all 200 nursing schools and 200 midwifery schools, pending additional

funding. EngenderHealth staff are also negotiating with a distributor to ensure local availability of MVA equipment. In January 2003, staff from EngenderHealth and the Department of Health met to develop policies and guidelines on the registration, procurement, distribution, and use of MVA in the Philippines.

Yet the project's most impressive achievement may have been its ability to stimulate additional interest and grow. PMAC began as a privately funded pilot effort at eight Ministry of Health sites. In 2001, the Pangasinan provincial government expressed a desire to start its own program, modeled on PMAC but funded by the U.S. Agency for International Development (USAID). This effort gradually expanded from two pilot sites to a total of seven Ministry of Health and local health department sites, funded both by USAID and by local government monies. The early successes of the PMAC program clearly helped providers leverage public-sector financing and support to establish a program at additional sites.

Perhaps one reason for the PMAC program's early success lay in recognizing the importance of flexibility when negotiating PMAC's more controversial aspects with the Ministry of Health. Fearing MVA's potential for abuse in the provision of clandestine abortion, Ministry of Health personnel were uneasy about its use. But the concept of postabortion care inherent in PMAC is broader than simply the use of MVA and so could accommodate the varied comfort levels with MVA inside the Ministry of Health and at individual sites. Not requiring the blanket inclusion of this particular procedure obviated the all-too-common misunderstanding that "PAC equals MVA" and allowed other components of PAC, particularly counseling, to achieve equal status with clinical care. This strengthened PMAC's essential message of compassionate care and promoted a solid working relationship with key policy decision makers and providers.

An important lesson from the PMAC program is that a small-scale, privately funded effort can be leveraged into activities on a much wider scale, particularly if the key actors are involved at multiple levels, if program design is flexible, and if sustainability is a focus from the beginning. The PMAC program is a prime example of what is needed to implement comprehensive postabortion care services, and what can be achieved even in a climate that may be religiously or politically unsympathetic.

While significant challenges remain—particularly ensuring that high-quality PAC services in the Philippines can be sustained and made available to all who need them—the assessment of the PMAC program suggests that this goal can be reached. By providing a supportive context at both the policy and facility level and by introducing culturally appropriate forums in which providers can

re-examine their values and behaviors toward postabortion clients, the PMAC program has demonstrated that it is possible both to reach the "hearts and minds" of local health care providers and to scale up postabortion activities to have a broader impact.

*This issue of Compass was written by Amy Shire and Lauren Pessio. It draws on a midproject evaluation of the PMAC program conducted in August 2001 at three sites (EngenderHealth, 2002), and an in-depth case study performed in August 2002 at six sites (Shire, 2002). PMAC was supported in part by The David and Lucile Packard Foundation. The authors thank Ellen Bautista and Cynthia Garcia (of the EngenderHealth Philippines Country Team), Nerissa Dominguez (Philippines Department of Health), Joan Venghaus (EngenderHealth Postabortion Care Regional Coordinator for Asia), and Julie Solo (consultant) for their assistance with the case study. They also thank the many providers, administrators, researchers, and present and former PMAC staff whose time and insights contributed to both evaluations.*

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