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POSTABORTION WOMEN: FACTORS INFLUENCING THEIR FAMILY PLANNING OPTIONS

Georgeanne S. Neamatalla and Cynthia Steele Verme

SUMMARY

Are family planning information and services readily accessible to women who have an abortion? How do provider attitudes and program design affect the kinds of information and services available postabortion? Are women being pressured to accept specific contraceptive methods as a condition for getting a safe abortion?

AVSC International conducted an informal study to learn more about the systems and structures that determine how family planning information and services are provided to women who have had an abortion.

Through observation of client-provider interactions, discussion with providers and others knowledgeable about services, and review of records and written protocols, the authors constructed profiles for the provision of family planning and abortion services in three countries.

The study was conducted in India, Turkey, and a South American country[1]—countries chosen for their geographical and sociological differences and for their differences in the legal status of abortion. The country profiles were not designed to be representative of services in each country as a whole, but rather to highlight similarities found in a variety of settings.

The findings identified a number of factors that have a profound effect on family planning provision postabortion. Through a review of these findings, the authors identify specific recommendations that programs can implement to improve service quality, overcome institutional barriers, improve provider attitudes, and learn more about the kinds of information and services clients want and need.

INTRODUCTION

A woman who has an abortion signals a very clear wish not to be pregnant. A woman who seeks an abortion in a country where abortion is not legally available—as is the case for an estimated two-thirds of women in the developing world (excluding China)—may do so at significant risk to her life (Henshaw and Morrow 1990). That so many women who seek abortions overcome formidable social, legal, and personal obstacles is a testament to their will to discontinue an unwanted pregnancy (Castle et al. 1990; Jamshedji et al. 1990). Yet little attention has been paid to reaching these women with information and services that can help prevent future pregnancies. As a result, the cycle of risk, unwanted pregnancy, and abortion may remain unbroken.

There are notable reasons for the gulf between abortion and family planning services. One important obstacle in recent history was the policy known as the Mexico City clause. This policy, issued by the U.S. delegation to the United Nations Conference on Population in Mexico in 1984, banned U.S. funding for all foreign nongovernmental organizations (NGO's) providing or promoting abortion as a method of family planning. Since the United States

[1] Because of the controversial nature of abortion services in the South American country where this research was conducted, the authors have chosen not to disclose its name in order to avoid negative repercussions for the clinics providing safe services.

Our concern was to understand the circumstances under which postabortion family planning is provided

is the largest bilateral funder of population activities, this policy had a pronounced chilling effect on abortion-related activities, including linkages between family planning and abortion services. The Mexico City clause prevented integration—in the case of NGOs—by making providers reluctant to establish links between abortion services (whether legal or illegal) and family planning services and by throwing a shadow on links with services that treat abortion complications. The Mexico City clause was rescinded by U.S. President Bill Clinton in January 1993.

Other reasons why abortion and family planning are not more closely connected include: the fact that these services are provided through different providers, sectors, or institutions; the differences in legal status that may make family planning providers wary of being associated with abortion; the perceived threat to future earnings if private providers of abortion provide contraception; and the failure to recognize the natural linkages in clients' needs for both services.

In late 1991 and early 1992, before the revocation of the Mexico City clause, we undertook a study for AVSC International in India, Turkey, and a South American country to learn more about the family planning information and services offered to women who have an abortion. Initially, our interest in this study stemmed from concerns, based on anecdotal reports from several countries, that some women were being pressured to accept contraception, particularly long-term or permanent methods, as a condition for getting a safe abortion.[2] Inquiry into this area led us to a broader exploration of the connections between family planning and abortion services.

Our concern was to understand the circumstances under which postabortion family planning is—or is not—provided in order to help ensure that women who seek an abortion can make free and informed choices about controlling their fertility.

This exploratory review focuses on the factors that determine whether abortion and family planning services are linked, on the strength of that link, and on the factors that may influence clients' access to and choices about postabortion family planning methods. It examines the issues of provider training in and experience with postabortion contraception, provider attitudes toward providing family planning for postabortion women, and women's access

[2] One criterion for pregnancy termination in Indonesia is "a statement indicating [the pregnant woman's] willingness to use contraception afterwards" (Djohan et al.1993).

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AVSC International
79 Madison Avenue, New York, NY 10016
Telephone: 212-561-8000 Fax: 212-779-9439
e-mail: info@avsc.org; World Wide Web: http://www.avsc.org

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to family planning counseling and services following an abortion. The research focused primarily on services for "scheduled abortions" (induced abortions provided in safe settings, regardless of the legal status of abortion in the country), although many of the findings can also apply to facilities that primarily treat "incomplete abortions."[3]

METHODOLOGY

After reviewing the literature from the field and the research plans of agencies that work with abortion and family planning and after assessing our capacity to contribute to the current understanding of postabortion care, we decided to focus our study on the systems for providing abortion and family planning services and providers' attitudes toward these services.

While we recognized the importance of talking to women to learn about their experience with, interest in, and need for postabortion family planning services, other organizations are currently investigating these client perspectives. Through observations of client-provider interactions and through discussions with providers and others knowledgeable about abortion and family planning, we felt we could gain other important information about the caregiving process and services' responsiveness to women.

The study was designed to collect information from India, Turkey, and the South American country that would serve as case examples. We chose countries from regions that differ in geography, culture, religion, and the legal status and practice of abortion and family planning.

Within each country, we visited four urban facilities, from both the governmental and nongovernmental sectors, where abortions are available (or where incomplete abortions are treated, as in the case of one public-sector hospital in the South American country). We did not select sites within countries to be representative of their region, as we did not plan to do cross-national comparisons with this research. Rather, our aim was to examine the operations of different programs in different settings.

We limited site selection to programs where there was potential for intervention—that is, where AVSC International would be able to provide assistance to organizations based on the study findings.

Data were collected using the following qualitative research methods:

- Observation of the provision of family planning and abortion services
- Review of client records and written protocols regarding postabortion contraception
- In-depth interviews with providers of abortion and family planning services and with researchers and policymakers familiar with abortion, family planning, and postabortion contraception

We observed provision of services at facilities visited in each country. We also observed counseling sessions, performance of abortions, provision of contraception, client flow, and overall quality of services at each facility.

Client records were reviewed to identify the information facilities collect concerning use of, interest in, and referral for postabortion contraception. We reviewed protocols to identify the national or institutional norms that govern the delivery of postabortion contraception.

Interviewers used an interview guide with a set list of topics; however, wording of the questions used in interviews varied, and probing questions were occasionally added.

We chose countries from regions that differ in geography, culture, religion, and the legal status and practice of abortion and family planning

Country Profiles

India, Turkey, and the South American country have sharply contrasting profiles with respect to abortion and family planning. In the South American country, which is a Catholic country, abortion is illegal. However, safe abortions are provided in a few urban centers through a limited number of nonprofit and feminist-oriented private clinics. Awareness of family planning is very high, and a wide range of contraceptive methods are available and used. Sixty-six percent of women in the South American country use a contraceptive method (Demographic and Health Survey 1991).

The situation is very different in predominantly Hindu India, where abortion was legalized in 1971 and is available up to 20 weeks from the first day of the last men-

[3] Incomplete abortion occurs when placental or fetal tissue remains in the uterus following an induced or spontaneous abortion. Incomplete abortions are often self-induced or provided by "back-alley" providers, and emergency treatment may be required to protect the woman's health or life.

strual period (LMP). Although abortions are performed free of charge in public-sector facilities, a large portion of women who seek abortion turn to unlicensed providers. Abortion services are widely available in urban areas, but service provision is uneven in rural areas. Contraceptive prevalence in India is 51%, with heavy reliance on sterilization (India et al. 1994). Method choice is limited: Norplant implants, injectables, and diaphragms are not yet part of the national program. Awareness of family planning is virtually universal, but misinformation is prevalent.

Abortion was made legal in Turkey in 1983, though only up to 10 weeks LMP. Services are widely available, and the population, which is mostly Muslim, relies heavily on abortion to limit family size. A 1988 survey found that 42.2% of Turkish women have had at least one abortion (Turkey 1988). Up to 60% of abortion services are provided in the private sector, and contraceptive prevalence is 63% (Turkey 1993). Withdrawal is the most widely used method of contraception in Turkey, and the IUD is the second most commonly used. The public is generally aware of family planning, but knowledge of specific methods is low, and myths about side effects are common.

The strength of referral systems is a direct determinant of access to services

FINDINGS

Our findings revealed that a host of factors affect family planning information and services for women who have had an abortion. Some of these factors, including policies that determine the contraceptive methods included or excluded by the national program and method-specific targets and payments that may bias providers toward particular methods, affect all potential family planning users.

However, this paper focuses on the factors that specifically affect postabortion clients. These factors include service-delivery and administrative structures, service standards and training, service-delivery factors, provider attitudes, and client factors.

Institutional Factors: Service-Delivery and Administrative Structures

The structure and administration of services affect postabortion clients' choice of and access to family planning services. Service programs that are integrated under one administrative authority enhance access to family planning services postabortion, while vertical programs may result in fragmented service-delivery systems that are more difficult for clients to negotiate.

In India, abortion and family planning services fall under the same ministry and are fully integrated at the service level in government hospitals. Yet in Turkey, services for temporary contraception fall under one ministry directorate, while sterilization and abortion services fall under another. This results in different staffs, facilities, policies, and fees for services. Because abortion is illegal in the South American country, it is not included under any governmental authority.

Administrative authorities determine the assignment of staff responsibilities, which in turn influences service availability. Regulations that limit provision of certain services to specific categories of health professionals can restrict access to certain methods of family planning. For example, in Turkey, only hospital-based obstetrician/gynecologists may perform female sterilization, whereas abortions are generally performed in outpatient units by family practitioners and general practitioners. Clients who want to obtain both abortion and contraceptive services face barriers if different staff provide these services in separate locations.

If abortion and family planning services are not integrated into one service unit, referral linkages are critical. The strength of referral systems is a direct determinant of access to services. In the sites we visited in Turkey, there was no systematic referral between these services. In the South American country, referrals between sectors that provide abortion and those that provide family planning services have been in one direction only: sites that provide abortion refer clients to facilities that provide the contraceptive methods (such as Norplant implants, female sterilization, or vasectomy) that abortion providers do not have the capacity to provide.

Service Standards and Training

In the absence of national or institutional norms, providers determine what is appro-

priate for the client. This results in disparate practices with regard to postabortion contraception among providers and within institutions. Decisions about what methods can be provided and when are left to the individual clinician or facility. No protocol ensures that postabortion clients will have access to family planning services or to the contraceptive method of their choice.

In all three of the countries we studied, national guidelines that regulate the provision of postabortion contraception are lacking. Of course, since abortion is illegal in the South American country, its provision is not covered by national health policy. In Turkey, no national service standards governed the provision of contraception (much less postabortion contraception) at the time of this study, which means that postabortion clients in Turkey are not assured access to a family planning method before discharge. Although not a service standard, it is common practice in India's government program to urge abortion clients to accept either sterilization or an IUD at the time of the abortion procedure.

Training in contraceptive technology

We found that some providers in the South American country and Turkey had outdated information about postabortion contraceptive technology. This is not surprising because, until recently, the medical literature has provided little consistent information about postabortion contraceptive use, and medical textbooks and physician training seldom cover this topic.[4]

One common confusion about postabortion contraceptive use concerns the timing of the IUD insertion (the IUD is a very popular method in Turkey). Turkish service providers had a strong bias against postabortion IUD insertion because providers feared that the IUD would increase clients' risk of infection. Providers were also concerned that they would be unable to diagnose the cause of postabortion bleeding in women who receive an IUD (that is, whether bleeding results from the device itself or signals an incomplete abortion).

Another factor that affects the linkages between family planning and abortion services in the South American country and Turkey is that the training for those who provide abortion and those who provide family planning services is usually separate. Because of this, abortion providers are not regularly exposed to new family planning information and may not have the most current information about contraceptive methods.

In the South American country, for example, because of strictures caused by implementation of the Mexico City clause, abortion providers have not been routinely included in contraceptive-update seminars. In Turkey, although physicians attend a postgraduate course on abortion, many are not specifically trained for family planning. These providers are therefore less likely to be knowledgeable about, committed to, and comfortable with contraceptive technology.

Similarly, family planning providers may know little about how abortion procedures are performed and therefore may not be aware of the conditions under which female sterilization or IUD insertion can be performed immediately after an abortion.

Furthermore, if family planning and abortion providers are not trained together and do not work collaboratively, they have few opportunities to establish professional connections that can help bridge the two different services.

National guidelines that regulate the provision of postabortion contraception are lacking

Service-Delivery Factors

Where, when, and how abortion services are delivered are factors that affect whether clients have access to family planning services and their choice of methods immediately following abortion. Even when family planning services are available, postabortion clients may have little interest in using the services if they are not responsive to and respectful of clients' needs.

Comfort at the site

In India and Turkey, a client-oriented perspective appears to be lacking at the service-delivery level. In some instances we observed an apparent disregard for clients' feelings and needs.

For example, in one hospital the doctor invited us into an examining room where an IUD patient was on the table with her legs in stirrups, facing the door. We were told that the patient didn't mind, but no one

[4] This information is now more widely available, as in Benson, J. et al. 1992. *Meeting Women's Needs for Postabortion Family Planning: Framing the Questions* (IPAS Issues in Abortion Care 2).

asked her about it, and no effort was made to give her privacy.

In the South American country, we observed exemplary quality of care at several of the facilities. While not luxurious, these facilities were designed to be comfortable and to put clients at ease. Staff were relaxed and friendly and made an effort to welcome clients for initial and subsequent visits.

Continuity of care

The degree to which the service-delivery system is geared to providing continuous care also affects client choice and access to family planning services. When care is continuous, there are multiple opportunities for women to seek and for providers to give information and services. However, in many areas, a woman's contact with the health care system may be limited to obtaining the abortion. Providers may try to "capture" clients at this one contact, because they fear that clients who do not leave with contraception immediately following the procedure may be lost to the system.

Timing of services

The timing of when clients are informed about and offered family planning may determine which methods are available postabortion. Some methods (particularly long-term and permanent methods) may require prior arrangements.

At different sites, we observed instances of providers informing abortion clients about their family planning options either before, during, or after the abortion procedure. However, in many settings, because clients receive no information or counseling until after the abortion, they have little opportunity to consider or receive some contraceptive options before being discharged from the facility.

Providers' attitudes are powerful determinants of clients' choices and access postabortion

Scheduling is another critical factor in determining clients' access to services. Even at facilities that offer both services, a barrier arises if abortion and family planning services are offered on different days of the week. For example, an abortion client may have to return to the facility on a different day to receive family planning services.

Integration of services

It is important for services to be physically integrated wherever possible. In Turkey, we found this was not the case: abortion, temporary family planning, and sterilization services were most often provided in different, physically separate, units of the same hospital.

For example, in one site we observed that Turkish abortion clients would have to dress, cross a courtyard, and undress again in order to obtain a family planning method on the same day as the abortion. This can make it difficult, if not impossible, for an abortion client to leave a service facility with the contraceptive protection of her choice.

If services cannot be physically integrated, good referral systems become even more important. For example, in Turkey, the fact that abortion client records in many facilities do not collect information on contraceptive method referrals or provision is symptomatic of the degree to which these two services are seen as separate.

Provider Attitudes

Providers' attitudes toward abortion, clients, their own responsibilities, particular contraceptive methods, and postabortion contraception are powerful determinants of clients' choices and access to services postabortion. Providers' religious or moral objections to abortion may be evident to clients, and their attitudes about abortion may influence the kind of services they provide.

Attitudes toward clients

Providers' attitudes about particular client populations may also be a significant factor in determining the methods they offer to women after abortion. Their views, and consequently their practices, may vary depending on whether the woman is well educated or illiterate, seeking her first abortion or returning for a repeat abortion, childless or a mother, married or single, a mature woman or an adolescent.

At some sites in India and Turkey, we found evidence that some providers have a judgmental, punishing attitude toward clients who have multiple abortions. For

example, in Turkey, we observed one provider berate a client, saying "Why did you get pregnant? Why didn't you use family planning?"

In the South American country, we noted that adolescents have difficulty getting abortion and postabortion family planning services.

Responsibility

Providers' views of their own responsibilities can affect the strength of the links between abortion and family planning services. Providers who see themselves as providing reproductive health care in its fullest sense tend to help clients prevent a future unwanted pregnancy—either by directly providing family planning services or by referring clients for services. On the other hand, providers who regard their responsibility as limited to performing a particular procedure (such as performing an abortion) may leave it to the client to seek additional services elsewhere.

Although most Indian abortion service providers regard family planning as part of their responsibility, we found quite the opposite to be true in Turkey. In the South American country, abortion providers in the private sector see it as their role to provide contraception, but this is not necessarily the case in the public sector hospitals that treat women for incomplete abortions.

Timing

Abortion providers' views of when it is appropriate for women to start contraception following abortion are directly related to client access to family planning.

Indian providers consider the immediate postabortion period to be a good time to provide women with contraceptive protection. Turkish providers do not share this orientation. In fact, there is a common bias in Turkey against inserting IUDs postabortion in favor of delaying the insertion until the clients' menstrual period has resumed. Turkish abortion clients are rarely offered any contraceptive method except condoms.

Financial considerations

Finally, providers' attitudes may be shaped by financial considerations. Interviews suggest that some providers who receive fees for performing abortion may view the provision of contraception to abortion clients as jeopardizing their future income.

Several providers we met in Turkey alleged that some of their colleagues are driven by a profit motive rather than by what is best for their clients: private abortion services are lucrative, whereas family planning provision is not.

Client Factors

Although this study was not meant to be a comprehensive review of client factors related to postabortion contraception, some client factors were revealed through our discussions with providers and our observations of service delivery. Some of these factors related specifically to abortion, whereas others characterize women's contact with the health and family planning system in general.

Inadequate information and misinformation about contraception may discourage clients

Orientation to services

Clients have different orientations to health care. Many clients view health care as a curative service and seek attention only when they are unwell. This curative orientation often stems from the health system itself, where curative priorities, costs, and other barriers may discourage clients from seeking care unless they are desperate.

Because contraception is a preventive measure, clients may not be accustomed to using family planning services before the fact, dealing instead with the consequences of an unwanted pregnancy. Providers mentioned this as an issue in India, where women often see their own preventative health care as less of a priority than care for other family members, particularly the males.

Misinformation

Inadequate information and misinformation about contraception may discourage clients. While clients may know of the existence of family planning and may have information about specific methods, contraceptive prevalence surveys in all three countries show that misconceptions about particular methods abound. Clients may not know where to get some methods, and they may not have the correct information to use methods effectively.

Many women are unaware of the rapid return of their fertility after a first-trimester abortion

If women do not know how to use methods correctly and consequently experience a contraceptive failure that leads to abortion, their ability to trust the use of contraception in the future may be affected. Providers in the South American country mentioned that they routinely talk with abortion clients about the cause of their pregnancy, since those whose pregnancy resulted from contraceptive failure may otherwise be disinclined to believe in family planning.

Many women are unaware of the rapid return of their fertility after a first-trimester abortion. Clients may not seek contraception because they mistakenly believe that they cannot get pregnant for some time, while in fact they may ovulate within two weeks of the abortion.

Attitudes toward sex and abortion

Some women deny that they will resume sexual activity. The South American country's providers explained that a common emotional reaction, particularly among adolescents who have an abortion, is to claim that they will never have sex again.[5] Women who deny that they will resume sexual activity are unlikely to seek contraception, as it is tangible and planned evidence of an intention to have sexual intercourse.

Moreover, because abortion may be illegal or socially stigmatized and because of the generally low status of women in many countries, women who seek abortion may not feel entitled to high-quality services beyond the abortion (Leonard 1991).

DISCUSSION

The genesis for this study was the concern that women might be pressured into accepting certain contraceptive methods as a condition for obtaining an abortion. In each site, we explicitly addressed the question of whether clients are able to make free and informed choices, and we examined providers' attitudes and practices regarding individuals' right to choose.

Women's ability to make choices about reproduction is not automatically assured. In traditional cultures, such as in India and Turkey, women may not be empowered to make independent decisions. Husbands and other family members may influence a woman's decisions about contraception or abortion. In one clinic, we observed the clinic staff trying to persuade a woman, accompanied by her husband, to choose a course of action that her husband and in-laws favored but which she did not. The woman cried and complained that no one was listening to what she wanted.

Providers' attitudes toward clients' right and ability to make a free, informed choice about contraception may be affected by personal biases. A number of providers we interviewed in Turkey and India described their clients as ignorant and incapable of understanding how to use barrier methods and pills effectively. Some providers who believe that less-educated women are incapable of making well-considered decisions about ending fertility may set their own rigid criteria for providing sterilization—denying the procedure to some women who want it and urging it for some women who don't.

In India we found that doctors tend to be very directive; that is, doctors tend to prescribe what they think is best for the client rather than helping the client make her own choices. It is common for doctors to urge a client to use a particular method based on a client profile, rather than treating clients as individuals and counseling them to make their own choices.

These observations are corroborated by the 1990 Jamshedji et al. study of 5,574 abortion clients in India. Researchers found that only 10.4% of clients reported a good level of counseling. The study stated that the majority of clients "did not receive information on other methods, effectiveness of the method obtained, instructions on how to use the method, and what to do in the event of problems."

Although it is not government policy, some Indian providers we met urge abortion clients to use an IUD or have a sterilization concomitant with the abortion. Clients are sometimes subject to fairly aggressive motivation; some facilities refuse to perform an abortion if the client does not agree to use one of the "surer" family planning methods.

Some providers admitted that they tell clients who return for repeat abortions that they will not perform the abortion unless the client agrees to sterilization. One Turkish provider said that she is sometimes "strict" in saying this to women who have

[5] This finding is also borne out in other research. For example, postabortion adolescents interviewed in the U.S. "expressed denial of any need for contraceptive measures... others planned to forego dating and sex until marriage." G. Burnell, et al., 1972, Postabortion group therapy, *American Journal of Psychiatry* 129(2): 135.

repeat abortions, although she never carries out her threat. We did not meet anyone who admitted to actually making acceptance of sterilization a condition for performing the abortion.

In contrast, several sites visited in the South American country demonstrated a concern for individual choice that could serve as a model for programs elsewhere. The programs in the South American country involved in this study try to ensure the woman's right to make choices about controlling her fertility. In the South American country's sites, counseling is a fundamental part of the abortion and postabortion service.

CONCLUSIONS AND RECOMMENDATIONS

Our findings suggest major inadequacies in the linkages between family planning and abortion services. Many providers and policymakers, including donors who fund health and family planning programs, have been blind to abortion clients' needs—including the need to integrate abortion, contraceptive, and other reproductive health services. As a result, women have few choices, and these are too often inconvenient or unsatisfactory, thus limiting the likelihood that women will seek contraception after abortion or that they will have true options about what method to use.

The high incidence of abortion, often performed under unsafe circumstances, demonstrates that the world's health care systems have failed to respond to women's reproductive health needs: "The reality of abortion signals a social failure--the failure of millions of individuals to prevent pregnancy through the use of contraception and the failure of governments in developing countries to fill the unmet need for family planning" (Jacobson 1988).

The inadequacy of postabortion contraception services signals a double failure—a failure to prevent the pregnancy that resulted in abortion and a failure to offer protection against future unwanted pregnancies. Although the need for safe abortion services will not disappear if women's contraceptive needs are met, the link between abortion and family planning can no longer be ignored if the epidemic of abortion is to be stemmed and if women are to have alternatives to often desperate choices.

Our findings suggest that even where abortion is legal, as it is in India and Turkey, there is a failure to provide a level of quality and convenience that make women likely to seek family planning services. Simply dispensing contraception will not address the needs of postabortion women. We propose that providers, policymakers, and funding agencies take the following actions, to help redress this situation.

Learn what abortion clients need, want, and experience

- Talk to women who do not use available family planning services to find out why. Address the issues identified.
- Find out what services clients need and how existing services could be improved. Use the findings to educate staff and alter services.

Improve provider attitudes and knowledge

- Raise providers' awareness of the particular needs of postabortion clients
- Support counseling training to foster client-centered attitudes and to enhance clients' ability to exercise an informed and unpressured choice about contraception
- Help providers understand their role in assuring access to family planning
- Update providers' knowledge of postabortion contraceptive methods to ensure appropriate delivery and to overcome biases

Overcome institutional barriers

- Integrate family planning services with abortion services, where possible, by merging or assuring complementary locations, staffing, schedules, etc.
- Establish or strengthen referral systems, particularly in locations in which integration of services is not possible

Improve service quality

- Introduce changes to better respond to women's needs and preferences. Encourage attitudes and practices of all

The link between abortion and family planning can no longer be ignored if the epidemic of abortion is to be stemmed

clinic staff to put women at ease, to encourage and answer questions, to assure a full range or services, and to ensure the quality of services provided.

Georgeanne S. Neamatalla is AVSC's area director for Turkey, India, and Egypt. Cynthia Steele Verme is AVSC's director of special programs.

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