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Perceptions and Practices of Illegal Abortion among Urban Young Adults in the Philippines: A Qualitative Study

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Abstract

This study draws on in-depth interviews and focus group discussions with young adults in a metropolitan area of the Philippines to examine perceptions and practices of illegal abortion. Study participants indicated that unintended pregnancies are common and may be resolved through eventual acceptance or through self-induced injury or ingestion of substances to terminate the pregnancy. Despite the illegality of abortion and the restricted status of misoprostol, substantial knowledge and use of the drug exists. Discussions mirrored broader controversies associated with abortion in this setting. Abortion was generally thought to invoke gaba (bad karma), yet some noted its acceptability under certain circumstances. This study elucidates the complexities of pregnancy decisionmaking in this restrictive environment and the need for comprehensive and confidential reproductive health services for Filipino young adults.

Of the 208 million pregnancies that occurred worldwide in 2008, 36 percent were unintended and 20 percent were terminated through induced abortion (Singh et al. 2009). Nearly half of these abortions were unsafe—performed by unskilled providers or in unhygienic conditions—resulting in 47,000 maternal deaths and the suffering of millions of women from ongoing complications, including infertility (Grimes et al. 2006; Shah and Ahman 2010).

To address unsafe abortion globally, accurate and reliable reports on the prevalence of unintended pregnancy[1] and abortion and on knowledge and attitudes about the procedure and the conditions under which it occurs are essential. Collection of this information is often thwarted by the stigma and shame associated with the topic. Even where abortion is legal, individuals may not be aware of its availability, may underreport its use, or may stigmatize those who avail themselves of legal services, preventing timely access and accurate measurement of abortion's prevalence and possible sequelae (Grimes et al. 2006; Jones and Kost 2007).

[1]The term "unintended pregnancy" is used throughout this article to describe pregnancies that occur earlier than desired (mistimed) or that are not desired (unwanted). For further description of these terms, see Santelli and colleagues (2003).

Setting and Background

In settings where abortion is illegal, obstacles to data collection are particularly pronounced. The Philippines, a predominantly Roman Catholic country in which abortion is illegal, is one such setting. Fertility in the Philippines has declined during the past 40 years, from a total fertility rate of 6.0 children per woman in 1970 to 3.3 in 2008, and contraceptive use increased concurrently (NSO and ICF Macro 2009). Even with these recent changes, the Philippines has a higher fertility rate and lower contraceptive prevalence (51 percent) than other Southeast Asian countries. Moreover, less effective traditional methods comprise a substantial proportion of current contraceptive use (17 percent), and more than one-third of births are unintended (36 percent) (NSO and ICF Macro 2009).

The Roman Catholic Church is a pervasive influence on reproductive health in the Philippines (Likhaan Center for Women's Health 2004; Ruiz Austria 2004). Approximately 81 percent of Filipinos are Catholic, with greater proportions in some provinces (NSO 2000). Church doctrine promotes pronatalist values, condemns premarital sex and abortion, and opposes "artificial" (modern) methods of contraception—values that are espoused and promoted by many national and local leaders and supported by national laws (Ruiz Austria 2004; Mello et al. 2006; Center for Reproductive Rights 2010). Gloria Macapagal Arroyo, who served as president until 2010, personally opposed the public provision of modern contraceptive methods and issued an order through the Department of Health to mainstream natural family planning in the government's national family planning program (Department of Health 2004; Ruiz Austria 2004; Mello et al. 2006).

These religious and political influences have restricted reproductive health information and services. Most notable is the ban on public provision of contraceptives in Manila and the exclusion of comprehensive contraceptive coverage under the national insurance plan (Guttmacher Institute and Likhaan Center for Women's Health 2010). These restrictions, in combination with the withdrawal of contraceptive commodity subsidies by the United States Agency for International Development (USAID) in 2004, highlight the precarious situation of reproductive health in the Philippines (Singh et al. 2006; Guttmacher Institute and Likhaan Center for Women's Health 2010). The 2008 National Demographic and Health Survey indicates that these concerns are warranted. Unmet need for family planning rose from 17 percent in 2003 to 22 percent in 2008, prompting some policymakers to push for legislation to mandate contraceptive coverage and to support the procurement and disbursement of contraceptive supplies (NSO and ICF Macro 2009; Guttmacher Institute and Likhaan Center for Women's Health 2010). Benigno Aquino III, who took office as president in June 2010, campaigned on a platform supportive of this legislation. Whether the legislation, which has stalled in Congress for the past several years, will gain enough support to be passed into law remains to be seen.

In addition to the legal repercussions associated with induced abortion for both women and abortion providers, abortion is highly stigmatized in the Philippines. Despite legal and social restrictions, nearly 17 percent (560,000) of the 3.4 million pregnancies occurring in 2008 were aborted (UPPI, Likhaan Center for Women's Health, and Guttmacher Institute 2009). Many of these abortions are unregulated and conducted by nonclinicians. In 2008, 1,000

women died from abortions and about 90,000 had complications leading to hospitalization (an increase from 79,000 in 2000) (Juarez et al. 2005b; UPPI, Likhaan Center for Women's Health, and Guttmacher Institute 2009). The restrictive environment in the Philippines also affects the provision of postabortion-care services to address complications related to miscarriage and induced abortion. The moral judgment of providers, and the lack of knowledge among providers and the general population regarding the legality of postabortion-care services, affect the methods used to manage complications and the prompt and humane treatment of patients seeking these services (Shire 2002; Shire and Pesso 2003; Cansino, Melgar, and Burke 2010).

In combination with restrictive reproductive health policies, recent and rapid changes in the social environment may also place adolescents and young adults at increased risk for unintended (mistimed or unwanted) pregnancies. Rapid urbanization and modernization, in conjunction with increases in the rates of cohabitation and premarital sex, indicate that young adults are experiencing a "lengthening of adolescence" (similar to other settings around the world), with a greater period of time between engaging in sexual behavior and entering into formal unions (Calvès 2002; Kabamalan 2004). Higher rates of unintended pregnancy in an environment in which abortion is illegal and highly stigmatized may result in increased morbidity and mortality as a result of unsafe abortion. Adolescents and unmarried young adults may be at particular risk for the negative consequences of unsafe abortion because of the greater likelihood of their delaying recognition of pregnancy and disclosing pregnancy status, and their seeking services when the pregnancy is of later gestational age (de Bruyn and Packer 2004).

Amid recent social change and public debates regarding provision of reproductive health education and services in the Philippines, the need exists to understand the realities of young adults' lives and the challenges they face in navigating sexual and reproductive well-being. Although a few studies have focused on quantifying unintended pregnancy and abortion in the Philippines, few investigations using qualitative research methods have been conducted to more fully explore and situate these phenomena (Melgar 2004; Juarez, Cabigon, and Singh 2005a). Studies from other settings, however, highlight the importance of qualitative inquiry to better understand culturally defined notions of conception, pregnancy and pregnancy termination, the processes of abortion decisionmaking and disclosure, and how religious and sociopolitical contexts shape the way abortion is defined, discussed, and undertaken (see, for example, Whittaker 2002; Rossier 2007; Gammeltoft et al. 2008; Gipson and Hindin 2008).

This study seeks to gain insight from people directly affected by the Philippines' restrictive policies and to determine the extent to which these public controversies are manifested in personal or couple-level conceptualization and decisionmaking. In-depth data collection with young men and women was employed to address five main research questions: What are the local terms used to describe pregnancies that occur earlier than desired or when not desired at all? How and when are these terms used? Who is involved in the decision to terminate a pregnancy? How is the decision to terminate a pregnancy made? What is the process that women (and partners) undergo when attempting to terminate a pregnancy?

Methods

Qualitative data were collected through focus group discussions (FGDs) and in-depth interviews (IDIs) in 2007–08 from a sample of urban young adults in the Philippines. Two male and three female interviewers from the local area were hired and trained for data collection. During training, all interviewers took the Abortion Values Clarification Survey to determine their personal views on abortion and to assess their comfort in eliciting information in an open-ended and nonjudgmental manner (National Abortion Federation 2005). The interviewers also participated in role-playing exercises and pretested and refined the field guides prior to study initiation. All research protocols and instruments were approved by the Philippines collaborators, the Institutional Review Board of the Johns Hopkins Bloomberg School of Public Health, and the Office for the Protection of Research Subjects of the University of California, Los Angeles.

Nine FGDs were conducted with single and in-union/married young men and women aged 21–29 from four urban communities *(barangays)*. Four FGDs were conducted with each sex, and participants were grouped according to marital status. Difficulty completing one of the male FGDs because of inclement weather resulted in the conducting of an additional FGD, for a total of nine. Participants were selected through convenience sampling; the study staff visited each community and worked with community leaders and health clinic staff to identify local residents who matched the selection criteria (age and marital status). Each FGD ranged in size from 6 to 11 participants, for a total of 75 FGD participants: 32 women and 43 men. As part of the FGDs, participants were read locally developed vignettes depicting three situations in which an unintended pregnancy might occur (described in Table 2). The participants were then asked to comment on and discuss the acceptability of abortion in each of these cases. This method was integrated to explore the nuances of abortion decisionmaking and to elicit participants' opinions regarding the acceptability of abortion in specific cases (Whittaker 2002).

Preliminary findings from the FGDs were subsequently explored via in-depth interviews with a separate group of young adults. IDI participants were selected based on residence in an urban barangay and self-reports of a negative reaction to a past unintended pregnancy. Permission was asked of those IDI participants who were in a partnership at the time of the interview to interview their partners (even if the past pregnancy did not necessarily occur with that partner). Each participant was interviewed twice, because of the sensitivity of the topic and the desire to establish trust and provide an opportunity to follow up on inconsistencies. The follow-up interviews provided additional depth and insight into topics discussed in the first interview. In some cases, inconsistencies emerged between the two interviews, and further exploration was carried out to determine potential reasons for these differences (for example, initial shyness or shame in reporting socially undesirable behavior, ambivalent feelings, and so forth). These inconsistencies were noted and included as part of the data analysis.

In total, 66 IDIs were conducted with 20 young adults and 13 partners. Each IDI and FGD was conducted in the local language, lasted 60–90 minutes, and was digitally recorded after consent was obtained. Each FGD and IDI transcript was reviewed after completion to

provide constructive feedback to interviewers and moderators and to inform subsequent data collection. The audio recordings from the IDIs and FGDs were transcribed and translated into English. Each transcript was uploaded into NVivo 8 for coding and analysis. The coding structure was created and revised with input from all authors. Each transcript was coded by at least two coders, and these codes were merged and compared to assure consistency. Any inconsistencies in coding were discussed and used to revise the coding scheme. Coding was conducted using the constant comparative method (Glaser 1965) in which similar pieces of text from each transcript are coded and grouped together, then are further refined and explored to identify the range of situations and develop theories about the interrelationships of the dominant themes through the review of transcripts, research team discussions, and development of research memos.

Results

By design, all FGD participants lived in urban barangays and were 21–29 years old, with an average age of 23.5 for females and 24.5 for males. The majority of the participants in the married female FGDs had completed high school and had at least one child. Compared with these participants, unmarried female FGDs had higher levels of education and were less likely to have a child. Women were most often homemakers or street vendors. Among the male FGD participants, educational levels were more diverse, ranging from third grade to college graduate. Approximately one-third of the male participants were unemployed; others were *trisikad* (bicycle with sidecar) drivers or day laborers (for example, construction workers). All of the male and female participants were Catholic, except one man who belonged to the Church of Latter Day Saints and one woman who belonged to the Church of Christ.

Characteristics of IDI participants mirrored those of FGD participants with respect to religion and education. IDI participants ranged from 21–31 years old, with an average age of 23. All 13 of the couples were or had previously been in some form of union/partnership (10 living together/informal union; 1 unmarried/not living together; 1 separated and living apart; 1 formally married); all of the couples had 1–3 children, either from the current partnership or from a previous one. Of the IDI participants who were employed, most men worked as day laborers and most women worked in the service industry or at home.

Unintended Pregnancy

When asked about the timing and occurrence of pregnancies, study participants readily acknowledged that some pregnancies occur at inopportune times or in unstable partnerships. These pregnancies were referred to by a variety of terms: *wala sa plano nako* (not planned), *disgrasya* (accident), and *sipyat* (a pregnancy that occurred despite use of natural family planning or modern contraceptive methods). FGD participants relayed stories from the media of babies abandoned at churches or left in trash cans; they also recounted personal experiences and those of family members and friends who had been faced with pregnancies that occurred earlier than desired or were not desired.

In both the FGDs and IDIs, participants discussed the circumstances that were likely to influence the characterization of the pregnancy. For unmarried noncohabiting couples, the

level of involvement and support of the male partner and parents was integral to the decision regarding the resolution of pregnancies. For married or cohabiting partners, short birth intervals and the inability to provide adequate food and medical care for their children were cited most frequently as reasons why a pregnancy might be considered unintended. Although some pregnancies could not be characterized as entirely wanted or unwanted, participants acknowledged that some pregnancies are clearly unwanted, as illustrated by this participant who recounted having been concerned that her partner would abandon her if she became pregnant:

> *Interviewer (I)*: What entered your mind [when you found out] about your pregnancy?
>
> *In-depth interview participant (IDIP)*: At first I was happy although a bit scared because he told me, “So what, we will just accept it if you become pregnant.” I said to him, “If you truly want it, then why are you hiding from me?” At that point I wanted to jump, kill myself, because I couldn’t accept it. It was difficult being in my situation. [23-year-old unmarried woman, no surviving children]

Methods of Pregnancy Termination

When FGD and IDI respondents were asked what people do when faced with an unintended pregnancy, they indicated that people either accept the pregnancy or try to terminate it using one or more abortive techniques or substances.[2] Participants mentioned several ways in which a pregnancy could be terminated (see Table 1).

Although several participants mentioned someone they knew who had used *hilot* (massage) to successfully terminate, few tried this method themselves. Many perceived *hilot* to be painful, requiring the fetus to be “crushed” or “crunched” in order for the abortion to be successful.

Herbs gathered from trees were considered easier and less costly to obtain. Bitter herbs (*pait)* taken on an empty stomach were thought to be most effective, at least when consumed within the first three months of pregnancy. Most of the herbal methods involved boiling leaves or roots, then ingesting the bitter substance until passing a “clump of blood” (*dugo).*

Medicinal methods were also mentioned frequently in the FGDs and IDIs. Several study participants relayed personal stories or those of family members or friends who had used over-the-counter medicines such as Cortal (aspirin) or Biogesic (paracetamol) in their attempts to terminate a pregnancy. These products can be purchased in pharmacies without suspicion of their intended use. Participants often indicated a specific manner in which these medicines should be ingested—on an empty stomach and with a warm, clear soft drink such as 7 Up® or Sprite®.

Taking Cytotec was another commonly reported medicinal method. Cytotec is the brand name of misoprostol, a drug indicated for many purposes, including prevention of gastric ulcers and prevention and treatment of postpartum hemorrhage, and is included in the World

[2]Adoption was mentioned briefly in one FGD and one IDI as a less desirable and less stigmatized option.

Health Organization Essential Medicine Library as a safe and essential drug for induction of labor and the medical termination of a uterine pregnancy up to 63 days gestation (PubMed Health, United States National Library of Medicine, and NIH 2010; WHO 2011). Misoprostol is considered an "unregistered drug product" by the Philippine Bureau of Food and Drugs (BFAD) because of its abortifacient properties; distribution, sale, and use of misoprostol are thus reportable to BFAD and police authorities (Republic of the Philippines BFAD 2010).

Even though Cytotec is restricted in the Philippines, study participants indicated that it is available from some street vendors and pharmacies and through informal networks of friends and neighbors.[3] The drug was mentioned spontaneously in the majority of FGDs (6 of 9) and IDIs (20 of 33 participants). Cytotec was always mentioned in the context of pregnancy termination, though some participants mentioned its use for ulcers and treatment of male kidney problems. Compared with other methods, Cytotec is more expensive and difficult to obtain. Participants indicated that Cytotec costs 100–200 pesos (US$2.25–$4.50) per pill, with a recommended dosage of one to ten pills. Some participants indicated that they took fewer than the recommended number of pills because of the cost.

Choice and Perceived Efficacy of Methods

In addition to discussions regarding the availability and perceptions of abortion methods, FGD participants described the choice and use of specific methods by friends or family members. No FGD participants discussed a personal abortion attempt. In the IDIs, however, six of the female participants indicated that they attempted an abortion and four of the male participants indicated that a past or current partner had either attempted or completed an abortion. These discussions indicated that the choice of abortifacient, as well as the timing and sequence of use, was influenced by a constellation of factors: awareness and perception of the method, cost and ease of acquisition, necessity of disclosure, gestational age, and notions of the fetus.

Knowledge of abortifacients often came from informal sources, such as neighbors, friends, and relatives. Some women indicated that their choice of method was informed by conversations prior to the pregnancy; others sought information from trusted confidants after a pregnancy was suspected or confirmed.

Compared with herbal and over-the-counter medicinal methods, using Cytotec required added levels of disclosure and support to find someone who knew how to get the pills and someone who could purchase them. Because of the women's desire to protect their privacy (and perhaps because of its association with male kidney problems), a male friend or relative was often involved in the purchase of the drug, though in some cases the pills were acquired through older female friends or family members. Cytotec was also perceived to be a stronger, quicker, and more effective method of terminating a pregnancy up to five months gestation, as compared with herbal methods. Although all of the methods were associated

[3]Because misoprostol is an illegal, unregulated drug in the Philippines, knowing whether products sold by black-market vendors are legitimate is not possible. One resident expert informed us that batches of drugs have been confirmed to be counterfeit or impostor pills.

with some degree of risk to the health of the woman (and of the unborn child if the attempt was unsuccessful), participants associated Cytotec, in particular, with bleeding and potential death for the woman, especially if gestational age was advanced (that is, beyond four months).[4]

Perceptions of the fetus also influenced a woman's choice of method. Some study participants believed that life begins at conception; others referred to the fetus as an "innocent angel" untouched by the sins of the world. The termination of a pregnancy was seen by many as taking a life, and the pregnancy was seen as the punishment for the parents' sin (especially in cases of premarital sex). Other participants referred to the fetus at earlier gestational ages (one to four months) as *dugo* (a clump of blood). When talking about the fetus in the womb, however, participants always used the term *bata* (child). Some participants were only comfortable using herbal methods early in the pregnancy, even though they acknowledged they were less powerful than Cytotec. In addition to the ease with which herbal substances could be acquired, they were also thought to be less dangerous and could be used earlier.

This confluence of factors often determined the initial method of abortion and whether other methods were used if the first attempt failed. The 23-year-old unmarried female IDI participant with no surviving children mentioned above described her attempt to abort an unintended pregnancy as follows:

> *IDIP:* I was told to fill a glass with warm Sprite® and then mix in the five pieces [of Cortal], and that I would start to bleed after that, but it did not work. I said to myself, "Never mind, come what may. I'm leaving everything to chance."
>
> *I:* So when did you drink Cortal?
>
> *IDIP:* It was a little more than a month [into the pregnancy]…. It did not work because the baby was already big.
>
> *I:* What else did your friends suggest?
>
> *IDIP:* Cytotec. [They said] I should insert it. I said, "No, I won't, I'm scared of that. What if I die?" So I never tried it.
>
> *I:* Why did you try Cortal and not Cytotec?
>
> *IDIP:* It was expensive. You can't buy it from the pharmacy, only in secret places. They said that you buy it from a pharmacy somewhere in [location omitted for confidentiality]. I wanted to try, but then I said, "No I won't. Never mind."

Regardless of method used, most participants believed that effectiveness was contingent on several factors: the position of the fetus in the womb, the will of the fetus, God's will, and gestational age. Participants often attributed an unsuccessful attempt to the "fighting spirit"

[4]Biomedical studies indicate that although bleeding after the use of misoprostol may be more intense than regular menstrual bleeding, it is usually not different from bleeding that occurs after a spontaneous abortion (Schaff et al. 2000). Prolonged and serious side effects associated with the use of misoprostol are rare; however, intensive bleeding is estimated to occur in 1–10 percent of women (Faúndes et al. 2007), and uterine rupture has been indicated in a few cases, mostly within the second trimester (Clark, Shannon, and Winikoff 2011).

of the fetus or to "God's plan." As described by some participants, no matter what methods or actions were attempted, some fetuses would "cling on" (*kapit/kupot)* to prevent being aborted, or were "well-positioned" in the womb so as to overcome any abortion attempts.

> *IDIP:* I have a friend who attempted to abort but then no matter what she did, it was never aborted. It depends on how he/she clings to the womb.
>
> *I:* So, are those that can be aborted not clinging enough?
>
> *IDIP:* No. They aren't [kapit]. [19-year-old female IDIP with two children, living with partner]
>
> If the child is clinging well, if the child is positioned properly in the womb, it's what they say. If the child is positioned properly, it will never be aborted no matter what you do. [20-year-old female IDIP with one child, living with partner]
>
> *IDIP:* It depends on the situation inside the womb. Some are really clinging, sticking. Others are easy [to abort]. Those whose uterus is lower than normal … they're easy.
>
> *I:* You mentioned clinging. What is it, is it the will of the child or of God?
>
> *IDIP:* Those two. [24-year-old female IDIP with two children, separated from partner]

Gaba and Perceptions of Harm to the Woman and Fetus

Moral and religious statements permeated the discussions of abortion in FGDs and IDIs. In addition to religious characterizations of the fetus and the belief in God as a powerful force in both the occurrence and resolution of a pregnancy, study participants frequently mentioned the notion of *gaba* (punishment or bad karma), which abortion could invoke.[5] Gaba emerged most prominently in discussions of situations or behaviors that were perceived to be deviant or undesired, appearing to be closely linked, if not synonymous, with stigma.

Stigma includes the "identification of differentness, the construction of stereotypes, the separation of labeled persons into distinct categories, and the full execution of disapproval, rejection, exclusion, and discrimination" (Link and Phelan 2001: 367). As with stigma, study participants described various domains in which gaba would arise as a result of an unintended pregnancy or abortion.

Despite study participants' acknowledgment of the frequent occurrence of unintended pregnancies (even among themselves), the FGDs and IDIs revealed prevailing negative notions regarding the "type" of people who have unintended pregnancies and abortions. These sentiments were more often expressed in the FGDs when talking generally about others, as compared with the IDIs, wherein participants were more likely to discuss personal experiences or those of close friends and neighbors. Premarital pregnancies were depicted as

[5]Gaba has been described in social science studies in the Philippines as the belief that individuals will suffer repercussions from "infractions against morality." These infractions may include the use of birth control (perceived as being against God's will) and a child's disrespect of an elder (Garcia 1976).

the punishment for being a "wanderer" or "tramp." Women who have an abortion were characterized as careless and "loose," or as drug users or sex workers. Abortion was described as a "double sin" for unmarried young adults, because they had premarital sex *and* considered or attempted abortion. Female and male FGD participants also spoke disparagingly of family members who are supportive of abortion.

> There are some parents and other family members who advise to have the baby aborted, because they do not want to bring shame to their family. They want to protect their family's honor and they are afraid that their neighbors will say bad things about them. There are also parents who are insane, because instead of providing moral support to their pregnant child, they advise that she have an abortion. [Participant in FGD among unmarried females]

Several of the male participants reported experiences with unintended pregnancy, some of which occurred in previous relationships. The degree to which these men were involved in their partner's decision regarding resolution of the pregnancy varied. Some men were involved, assisting their partner with acquiring and/or paying for the method(s). In cases in which a girlfriend decided to terminate her pregnancy without her partner's consent, however, the male partner often distanced himself from his partner, both physically and in their interactions, describing his female partner's actions as "criminal" and "immoral."

According to study participants, gaba was also likely to cause health consequences if a woman thought of or attempted an abortion. A common notion was that women (and supportive male partners/families) are likely to have ongoing guilt and anxiety resulting from their engagement in "criminal" or "sinful" behavior. Although some participants described the perceived physical health effects of the ingestion of abortifacients or the abortion procedure (hemorrhaging, poisoning, "thinning" of the uterus), other health effects were perceived to be directly related to gaba, as illustrated in the exchange below among single men.

> *FGDP1*: These are the consequences of violating her conscience. She should not have done it (had sex) if she's only going to abort.
>
> *FGDP2*: She is being haunted by her conscience. That is why she feels weak and pale.
>
> *FGDP3*: All of these feelings are because of gaba.
>
> *FGDP4*: This is her gaba. Later, when she wants a child, she will no longer be able to get pregnant.

Fear of gaba was also mentioned as a common reason why women did not attempt an abortion, or did not repeat an attempt after an unsuccessful try. Although women seemed to acknowledge that herbal and over-the-counter medicinal methods were less effective than other methods such as Cytotec, the use of these readily available methods seemed more acceptable and commonly used as a first step in testing the susceptibility of the fetus to these less invasive methods. An unsuccessful abortion attempt was often attributed to "God's will" or the fetus's "will to live," rather than the inefficacy of the method. Repeat attempts or the use of a more powerful method could invoke more gaba, because of the woman's

additional deliberate actions to contradict the will of God and/or the fetus. Some women seemed more determined to try multiple methods, at least up to the gestational age of five to six months. If, despite these efforts, the fetus was not aborted, some women accepted the pregnancy, determining that it was "meant to be." As part of this acceptance process, some women reported going to church to atone for their "sin" of attempting an abortion.

> [At first] I thought I might try [taking Cortal to induce an abortion] … but after that [failed attempt], I really thought that it was not good to do it. I then went to Church and heard mass. I asked God for forgiveness. I promised Him that I would never attempt to abort again since this is God-given. I decided that I would keep the baby and asked for forgiveness. I thought that maybe my baby would have physical or mental defects as a result of the attempted abortion. Maybe its eyes would be gone, or it wouldn't have a nose … but it turned out that there was no defect. So again I asked forgiveness and asked God to bless my baby. With God's grace, my baby was normal. [24-year-old female IDIP with two children, living with partner]

As indicated by this woman and many other participants, unsuccessful abortion attempts were also perceived to negatively affect the child, causing physical or mental abnormalities such as an ill-tempered nature, physical deformities (such as a harelip), and premature birth. The perceptions of harm for both the woman and the fetus that would ensue from an unsuccessful termination prevented some women from using more powerful methods or from using subsequent methods if the first one proved unsuccessful.

> *IDIP*: If the baby is really for you, no matter what you do to abort, it won't be aborted because it's really for you. Just like my classmate.… She got pregnant and she tried all methods of aborting, but her child was not aborted. But now, her child is abnormal.
>
> *I:* What methods did she try?
>
> *IDIP*: She let someone step on her belly a number of times, she went to a traditional healer, she ingested many types of medicines that are known abortifacients, but still it was not aborted. Now, her child is abnormal. That's why I concluded that it's not really good to have an abortion, because the one who will suffer is the child. [24-year-old female IDIP with two children, living with partner]

Situational Acceptance of Abortion

Although most discussions framed abortion as an immoral act with negative consequences, many participants indicated that abortion was more acceptable or justified in certain situations. FGD participants indicated that the story of Maricel (see Table 2, Vignette 1)—a young, unmarried university student who became pregnant after having sex with her boyfriend, Ryan—depicted a common situation. In general, participants felt Maricel should tell her parents about the pregnancy and that she and Ryan should own up to what they had done. Participants across the FGDs acknowledged that Ryan may abandon Maricel and may not take responsibility for the pregnancy; they believed, however, that Maricel's parents were eventually likely to accept and help support the pregnancy. Overall, male FGD participants were more accepting of abortion in this situation than were female participants. The unmarried female participants indicated that even if Ryan abandoned Maricel and the

child, “she is not the only one in this situation” (being a single mother). These notions were echoed in two of the female IDIs. As voiced by these women, the sin and stigma of having an abortion far outweighed the stigma of being a single mother and having an illegitimate child.

> Even if people will talk about you as not having a husband, as a *pinaangkan* (one who has a child without a husband), it doesn’t matter as long as you don’t abort…. Even if I don’t have a husband, that’s a baby already in your womb. If you have an abortion, you are already eaten by worms even if you are still alive. It’s really a big sin against God if you have an abortion. I have learned from a lecture about what the baby looks like and its position inside the womb at one month, two months, three months, four months. That is why it’s really a big sin to have it aborted, because in the beginning, it already has life. What kind of a person are you if you still abort it even if you know it’s already alive? [23-year-old female IDIP with three children, separated from partner]

> I already committed a sin just by thinking of it, what more if I do it? I’m afraid to commit a sin. I also thought, Why would I abort my child? I’m not the only one who’s going through this; there are many who are like me. If I became a single mother (pinaangkan), so what? Who knows, my child could bring luck to me. [24-year-old married female IDIP with one child]

Vignette 2 portrays the story of Catherine and Michael, a young couple with an eight-month-old daughter. In addition to financial and health concerns related to having closely spaced births, Catherine has been weakened from a health condition and Michael is unemployed. FGD participants indicated that of the three stories, this one presented the situation in which abortion was most justifiable. Several participants felt that abortion was never justified and would invoke gaba, even in this case. One male participant indicated that an abortion would be a “mercy killing” with the mother’s life chosen over the child’s, but with forgiveness asked from God. Others felt that the pregnancy should be continued and that with help from God, family, and friends, Catherine’s life would be spared and the family could be supported financially. For this and the preceding vignette, participants indicated that earlier recognition and termination of the pregnancy when it was still “dugo” was more acceptable morally because the fetus was not “formed” yet.

The last story (Vignette 3) depicts Jocelyn and Ronald, a married couple in their 30s who have four children. They have had trouble feeding their children and Jocelyn has just found out she is pregnant again. FGD participants found this situation to be the least justifying of abortion. Many felt Ronald should get another job and that the couple could ask family and friends for help. As one female participant indicated, “No matter how big your family is or how poor you are, you will still survive.”

Discussion

Analysis of the data collected from both focus group discussions and in-depth interviews revealed the distinct contributions of these two methods and provided insight into the overlap and interconnection of findings across the methods (Helitzer-Allen, Makhambera,

and Wangel 1994). The FGDs were valuable in gathering normative responses and community-level perceptions, yielding illustrative insights into the manifestation of stigma and gaba. Similar to other studies that have incorporated vignettes to explore situational acceptance of abortion, the use of vignettes in the FGDs provided insights into the perceptions of the morality of abortion in various circumstances (Whittaker 2002). The IDIs were valuable for eliciting personal stories and revealing the influence of partners, families, and friends on women who are faced with pregnancy and potentially contemplating abortion. Considering the sensitivity of the topic in this setting, it was surprising that some FGD participants shared personal experiences with unintended pregnancy. One of the IDI participants also indicated never having talked with anyone about termination attempts prior to the interview. The disclosure of this information may have been facilitated by the inclusion of a follow-up interview, which helped establish trust and rapport. The participants may have found it cathartic to discuss these issues within a safe and nonjudgmental space.

Despite intensive training and thorough discussion of perceptions regarding abortion prior to conducting the interviews, one of the interviewers was evidently uncomfortable with the topic. This interviewer's recorded and observed interactions were nonjudgmental and the transcripts provided information useful in the final analysis; however, the depth and richness of the transcripts were limited by the interviewer's discomfort in probing and following up on leads that the participant(s) presented. This admission is presented as a reminder of the need, especially within qualitative research on sensitive topics, to thoroughly understand interviewers' opinions and prevent interviewers' biases from compromising the data collection and/or making the participants feel uncomfortable or judged. This experience also points to the difficulties involved in collecting data on sensitive topics and in restrictive settings, even with well-trained interviewers using in-depth qualitative methods.

Contrary to the presumptive need for same-sex interviewers on this topic, the use of a highly skilled, older female interviewer was found to be as effective in eliciting information from male IDI participants as was use of a male interviewer. This procedure was initially tested because of the limited availability of male interviewers; however, the collection of rich and sensitive data despite the sex mismatch between interviewer and participant indicated that this method could perhaps be used in subsequent studies, so long as the opposite-sex interviewer is highly skilled. Whether the reverse would be true—that is, a male interviewer successfully interviewing a female participant—is not known.

Abortion methods are widely known and accessible despite their illegality. The ingestion of herbal and medicinal substances, the use of *kumot* (crushing of the stomach), or the insertion of devices or objects may cause substantial harm to women, including chronic infection, infertility, and death (Grimes et al. 2006). The availability of misoprostol (Cytotec) without regulation indicates that some women may be taking potentially harmful counterfeit drugs or incorrect dosages. In most cases, women who took Cytotec ingested less than the medically indicated dosages for a pregnancy termination, either because of fear or because of prohibitive costs.[6]

Similar to studies conducted in other settings, stigma surrounding unintended pregnancy and abortion in this urban setting in the Philippines was central to pregnancy decisionmaking

(Ganatra and Hirve 2002; Varga 2002; Whittaker 2002). Stigma was intricately linked to notions of sin and gaba, serving as moral and religious parameters of acceptable versus deviant behavior. The frequent personification of the fetus furthered these perceptions of deviance for some, leading to the equating of any woman who had an abortion with a criminal or murderer. (For further discussion of personification of the fetus in the Philippines, see Tan 2004). Stigma affected disclosure of an unintended pregnancy, choice of abortion method, number of abortion attempts, perception of mental and physical consequences for the woman (and child), and treatment and characterization of women who chose to terminate an unintended pregnancy and of their supportive partners and family members. The stigmatization of abortion creates an atmosphere of secrecy and silence and can negatively influence women's health by causing delays in care-seeking, attempts to self-induce for fear of involving others, and the prompting of women to seek untrained providers for unsafe procedures (Kumar, Hessini, and Mitchell 2009). These concerns are especially pronounced for young adults who face the "dual challenge"—either aborting or confronting the stigma of birth out of wedlock (Bleek 1981; Kumar, Hessini, and Mitchell 2009). Extensive data from this study on the negative perceptions and "type" of people who have unintended pregnancies attest to this dual challenge for young adults, and particularly for young women.

Despite the stigmatization and legal restrictions against abortion, many study participants felt that abortion is more tolerated or justified under some situations than under others. Some IDI participants mentioned dire health and economic concerns and partner abandonment as legitimate grounds for considering or attempting an abortion. Focus group participants' reactions to the vignettes indicated that economic concerns are viewed as a less acceptable justification for abortion than are threats to the woman's health. Interestingly, young men were more accepting of abortion than were young women in the case of male partner abandonment. In comparison with public debates in which abortion is depicted as a uniformly malevolent and sinful act, the exploration of specific, difficult circumstances revealed a more nuanced perception of abortion among study participants. The IDIs, in particular, highlighted the complexity of this issue and the difficulties that young adults face when navigating childbearing decisions in the face of poverty, sickness, and concerns for their own well-being and that of their families.

Although this study focuses on the beliefs and experiences of urban, mostly lower-income young adults in one metropolitan area, the issues raised attest to the occurrence of unintended pregnancy and abortions in the Philippines more broadly. Given the illegality and stigmatization of unintended pregnancy and abortion in this setting, the negative effects of unsafe abortion on maternal and child health, and the documented high levels of unintended pregnancy in the Philippines, it is essential to provide access to comprehensive reproductive health education, counseling, and effective contraceptive methods for the prevention of unintended pregnancy and abortion.

[6]Suboptimal doses of misoprostol have been shown to increase the likelihood of an incomplete or unsuccessful abortion and, in rare cases (less than 1 percent), the risk of fetal malformation (Philip, Shannon, and Winikoff 2002; Clark, Shannon, and Winikoff 2011). At the population level, however, the availability of misoprostol in countries with restricted abortion laws has been associated with reductions in maternal morbidity and mortality (Faúndes et al. 1996; Costa 1998; Miller et al. 2005).

Given the Catholic Church's (and, in the past, the President's) stance on "artificial" contraception (meaning modern contraceptive methods) and the desire of many Filipinos to abide by their faith and the teachings of the Church, added focus should be placed on adequate knowledge and use of natural family planning methods. Despite the widespread support and use of natural family planning, only 35 percent of Filipino women recently surveyed correctly identified the most fertile time in their ovulatory cycle, suggesting a gap in the basic reproductive health information necessary for effective use (NSO and ICF Macro 2009). Even with perfect use of natural methods, the failure rate is high (5–27 percent) compared with the failure rates of typical use of modern contraceptive methods such as combined hormonal contraceptive pills (8 percent), Depo-Provera (3 percent), and IUDs (less than 1 percent) (Hatcher et al. 2009).

For Filipinos who are comfortable with modern methods of contraception, a full range of methods needs to be made available, accessible, and affordable. The recent termination by USAID of its subsidization of contraceptive provision has not been followed by adequate funding for contraceptive supplies on the part of the Philippine government (Guttmacher Institute and Likhaan Center for Women's Health 2010). In addition to increasing the availability of contraceptives, targeted efforts are needed to combat prevailing myths and fears regarding contraceptive use. Although the majority of Filipinos report knowledge of modern methods, roughly 21 percent report fear of health concerns and 14 percent report fear of side effects as reasons not to use contraceptives (NSO and ICF Macro 2009), and nearly half of the respondents in the 2011 Social Weather Survey (a survey eliciting opinions on economic and social conditions in the Philippines) equated contraceptive methods with abortion.

Through the use of qualitative research methods, this study provides in-depth and firsthand accounts of the beliefs and practices related to unintended pregnancy and abortion among a sample of urban young adults in the Philippines. The stories attest to the multiple forms of disadvantage they suffer—limited access to reproductive health information and services, poverty, and strong social sanctions surrounding sexuality and reproduction—and illuminate some of the reproductive health challenges that young adults face in this restrictive setting. Given persistent and high rates of unintended pregnancy in the Philippines, unmet need for contraception, and maternal mortality and morbidity resulting from unsafe abortion, provision of comprehensive reproductive health information and services, particularly for young adults, is greatly needed.

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Table 1

Methods of terminating a pregnancy mentioned by study participants

Physical	*Kumot/hilot* (“crushing” of the stomach)
	Throwing oneself down the stairs
	Getting punched in the stomach
	Riding on the back of a motorcycle on a bumpy road
	Raspa (dilation and curettage)
	Inserting a hose/catheter into the vagina
Herbal	*Marvelous* (herbal capsule)
	Mahogany seed
	Bark of the *tipo* tree
	Panyawan (vine)
	Root or bark of the *panaktakan* tree
	Kamunggay/malunggay (horseradish root)
	Leaf of the *neem* tree
Medicinal	Cytotec (misoprostol)
	Cortal (aspirin) plus warm 7 Up® or Sprite®
	Biogesic (paracetamol)
	Alaxan (muscle relaxant)
	Gardan (pain reliever)

Table 2

Vignettes presented in focus group discussions

Vignette 1: Maricel and Ryan	Maricel is aged 18 and a college student in a private university. Maricel's parents are strict, so she has not told them that she has been spending time with her boyfriend, Ryan. Her parents would not approve of Ryan. She knows that they would be angry, but she feels that she is in love with Ryan. She missed her period for the last two months. She suspects that she is pregnant, so she tells Ryan about this. Ryan is angry when he hears this and punches the wall. He asks, "Why did this happen?" During the next few days, Maricel attempts to call and text Ryan, but he does not answer. Ryan cannot be found. What do you think she would do? What are Maricel's options?
Vignette 2: Catherine and Michael	Michael is 26 years old. He and his wife, Catherine, have been married for two years and have an eight-month-old daughter, Grace. Catherine had a cesarean section when she delivered Grace and the doctors said that because of her health condition she should not have another child in the next two years. Catherine feels weak and thinks that she should not become pregnant right away. Last week, Michael lost his job and he is worried that he may not be able to find another job soon. This morning, Catherine told Michael that her period is late and that she is worried that she might be pregnant again. What do you think they would do? What if Michael is unable to find a job right away? What if Catherine's health gets worse?
Vignette 3: Jocelyn and Ronald	Jocelyn is 38 years old and married to Ronald. They have four children—two boys and two girls. Jocelyn and Ronald both feel that they have all of the children they want. Their income is barely enough to cover family expenses and to buy rice every day. They have been using the rhythm method since their last child was born, but it has been difficult to keep track of Jocelyn's irregular menstrual periods. After feeling nauseous the past few days, Jocelyn took a pregnancy test. It was positive. She believes that they will not be able to afford another child. What do you think will happen?