

Strengthening Women's Reproductive Healthcare

A Policy Brief Review and Recommendation
Following Multi-sectoral Consultations
**on Humane, Non-Judgmental and
Compassionate Post-Abortion Care**



WOMEN'S
GLOBAL NETWORK
FOR REPRODUCTIVE RIGHTS

W G N R R

Copyright © 2025

Women's Global Network for Reproductive Rights



**WOMEN'S
GLOBAL NETWORK
FOR REPRODUCTIVE RIGHTS**

W G N R R

📍 3 Marunong Street, Barangay Central, Diliman, Quezon City, 1100 Philippines

☎ + 63 (2) 928 7785 local 105

📘 WGNRR 🌐 @wgnrr.bsky.social

📠 +63 (2) 928 7992 local 108

📧 wgnrr_ 🌐 www.wgnrr.org

Permission to reproduce extracts from this publication for non-commercial purposes is freely granted, provided that users exercise due diligence in ensuring the accuracy of the materials reproduced and that the WGNRR is credited as the source.

Executive Summary

The Department of Health's 2018 National Policy on post-abortion care has guided medical professionals in the delivery of care and has served to provide them vital learning curve in the management of post-abortion cases. However, after an adequate period of its implementation, the need for an improved policy has become more apparent. The current state of post-abortion care is not as empowering as anyone would have liked. Issues regarding accessibility, implementation and monitoring cannot lead to high-quality care. Meanwhile, stigma surrounding abortion is still prevalent. Stigma could mean the difference between patients availing care or not, and health workers providing care or not.

This collaborative paper aims to draw lessons from past and present policies, as well as from the experience of experts and professionals in their respective fields. It wishes to shed light on the circumstances of women, both leading to the pregnancy, to the varying contexts of abortion and the subsequent scenarios.

The Women's Global Network for Reproductive Rights, together with partner organizations, strongly urges the immediate review of the current national policy in keeping with the common goal of advancing women's sexual health and reproductive welfare. All in all, the WGNRR strongly believes that a rights-based approach should address the significant legal, cultural and systemic challenges that hinder humane, compassionate and non-judgmental post-abortion care. Resulting from a series of consultations with other women's rights advocates and medical professionals, this recommendation is a call to decisive action. Crafting a new and improved policy on this life-or-death matter is among the highest service the Health Department could extend to women and their families.

Post-abortion care or PAC should speak more about the continuation of life rather than the termination of one; but that is not what is happening.

In the Philippines, more or less 1,000 women die each year from abortion complications and this contributes to the already high maternal mortality ratio. Additionally, tens of thousands of women are hospitalized each year for complications from unsafe abortion (Finer & Hussein, 2013).

In fact, though abortion is absolutely illegal without exception, around 1.1 million induced abortions occur in the country every year. This rate was estimated to increase by 14.6 percent last 2020 (Kabamalan et al, 2020).

Twenty years ago, the World Health Organization already estimated that 70 percent of unwanted pregnancies in the Philippines end up in abortion (Conde, 2005).

Aside from death, women who undergo intended or unintended abortion suffer from severe stigma and could be criminalized. Health-care providers who attend to them could potentially be considered accessories to the purported crime. This makes PAC difficult to access and challenging to provide.

Yet, despite the alarming data, the WGNRR believes that PAC is and should be a life- saving service for women. For it to be provided to women in a manner that is humane, compassionate and non-judgmental, it requires a national policy that extensively prioritizes women and creates the space and mechanisms for stakeholders to prioritize women's health. To get to that state of PAC and as part of its advocacy to advance women's sexual and reproductive health rights, it initiated discussions, gleaned lessons from actual experiences and challenged stakeholders to envision a new and improved Administrative Order on PAC.

Background and rationale

The policy on post-abortion care in the Philippines is a lengthy process of continuous improvement and constant struggle. The implementation of the present Department of Health policy, the 2018 National Policy on the Prevention of Illegal and Unsafe Abortion and Management of Post-Abortion Complications, is part of that ongoing struggle. The Administrative Order 2018- 003 governs the delivery of PAC to Filipino women, despite its use of the term 'illegal' that reinforces the stigma surrounding abortion. Opting to enforce an 'absolute prohibition on abortion' also spreads the same chilling effect of criminalization and punishment. Utilizing negatively loaded terms does not eliminate negative attitude, which is crucial to the provision of PAC.

Policies and Legislation

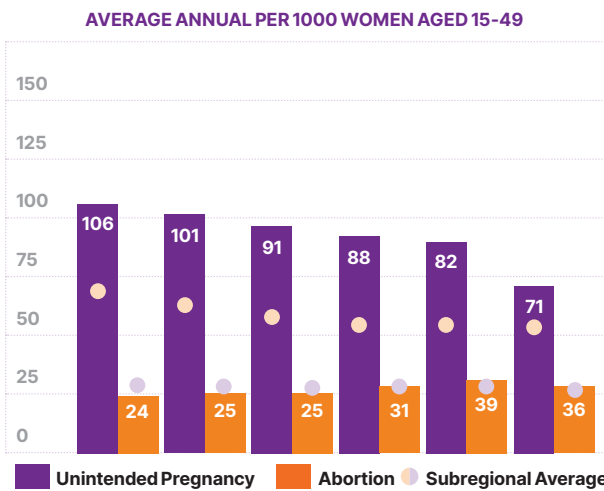
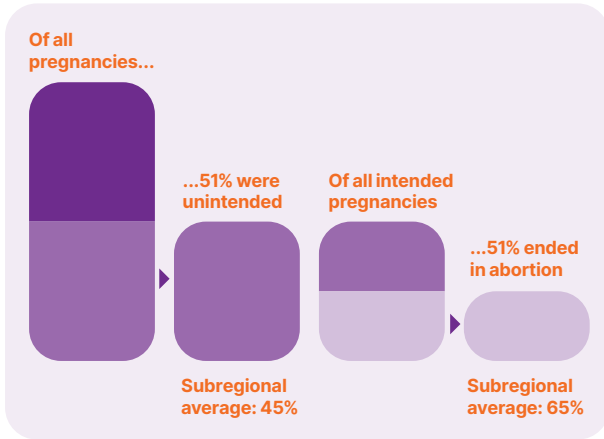
Yet, before the 2018 policy came a more progressive and women-centered policy. The AO 2016- 0041 Prevention and Management of Abortion Complications operated under restrictive laws on abortion rather than an absolute ban. It also relied on manual vacuum aspiration, a proven safe and practical post-abortion treatment. Lower-level health facilities had responsibilities beyond mere patient referral. It stated that all care providers are duty-bound to protect patient confidentiality. Healthcare providers were to take into account that there isn't any law requiring them to report the patients to the authorities. There were complaints mechanisms and provisions to uphold the

Anti-Hospital Deposit Law and to allow for PAC even without third-party consent.

Several policies and laws already uphold the importance of Filipino women's health even before these two conflicting AOs. In 2009, the landmark law Magna Carta of Women was enacted. It mandated the prevention of pregnancy-related complications to protect women's right to health. Its Section 17 emphasized the State's obligation to provide comprehensive, culture-sensitive and gender-responsive health services that address the major causes of mortality and morbidity throughout a woman's life cycle.

Then in 2012, the Responsible Parenthood and Reproductive Health Act was signed into law. Considering PAC as a necessity and a vital element of RPRH, it specified that the state must 'ensure that all women needing care for post-abortive complications and all other complications arising from pregnancy, labor and delivery and related issues shall be treated and counseled in a humane, nonjudgmental and compassionate manner in accordance with law and medical ethics.' The duty of healthcare facilities to conduct PAC in a non-judgmental approach was guaranteed in Rule 5 of its Implementing Rules and Regulations. PAC was thus coded as part of the continuum of care for women. Adding to these, the DoH already preceded these pieces of legislation when it introduced the 2000 Prevention and Management of Abortion and Its Complications in an effort to support Filipino women who have undergone abortion, regardless of the context. There even was a 1998 version before it.

Data



Among women aged 15-49 in Philippines, **2,200,000** give birth each year and many do not receive needed care

- 360,000** make fewer than four antenatal care visits
- 390,000** do not deliver in a health facility
- 210,000** do not receive the care they need following a major obstetric complication
- 260,000** have newborns that do not receive needed care for complications

In 2022, the United Nations Human Rights Committee recommended that abortion be decriminalized in the Philippines, along with the improvement of sexual and reproductive health services for women. It reasoned that considering abortion as a crime leads women to induce abortion in a manner that is clandestine and unsafe. This endangers women’s lives and health.

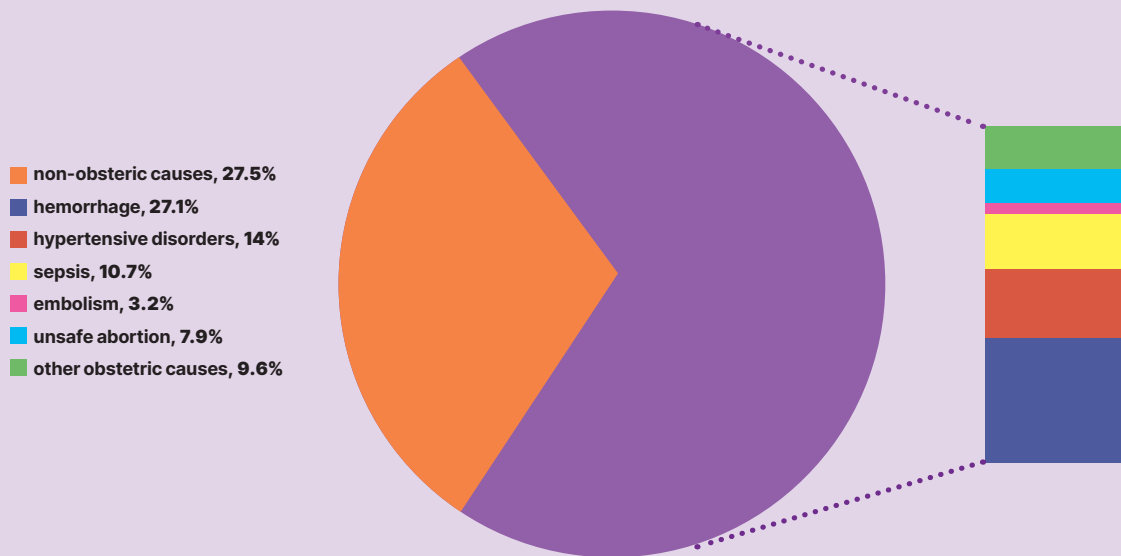
Fifty-one percent of pregnancies in the country during the period of 2015 to 2019 is unintended. And 51 percent of the unintended pregnancies end up in abortion (Guttmacher Institute, 2022).

For comparison, the Southeast Asia average for unintended pregnancies during the same period is lower at 45 percent. Sixty-five percent of these end up in abortion, a figure which is higher than the Philippines’ presumably because Southeast Asian countries already permit abortion in varying contexts. In Southeast Asia, only the Philippines and Laos have absolute prohibition on abortion.

In the Philippines, the increased rate of unintended pregnancy coupled with the inaccessibility of safe abortion procedures lead to higher maternal mortality and morbidity rates. In 2000, unsafe abortion is the cause of 12 percent of maternal deaths in the Philippines. To compare, the corresponding worldwide data is eight percent.

The rate of unintended pregnancy is inversely proportional to the rate of abortion. Between the period of 1990 to 1994 and the years 2015 to 2019, unintended pregnancies did decline. Yet, abortion rates rose despite its illegal status in the country. As early as 2000, nearly one out of every four of the 2,039 hospitals recorded induced and spontaneous abortion as among the top ten causes for admission.

WHO Global Causes of Maternal Death, May 2014
citing 2003 to 2009 global, regional and sub-regional estimates



According to the World Health Organization, only 27.5 percent of maternal deaths are not caused by obstetric conditions. The rest, 72.5 percent, are due to various obstetric illnesses. Denying safe and legal abortion for therapeutic reasons endangers women's lives.

Modern contraceptives can reduce unintended pregnancies and thus affect abortion rates, but they still do not eliminate the need for abortion. The question of access to contraceptive information, supplies and services, plus the odd chance of non-effectivity, contribute to unintended pregnancies and abortion incidents.

Thirteen million women aged 15 to 49 wanted to avoid pregnancy for various reasons. Only 57 percent of them had access to modern contraception. An average of more than two million women gave birth each year of that period.

Women and girls can also get pregnant as a result of rape. Government data records that one woman or girl is raped every 58 minutes. Thirteen percent of women who had an abortion were impregnated due to sexual abuse.

Meanwhile, women who continue with unintended pregnancies suffer from the effects of pregnancy itself. Increased workload to the heart, hypercoagulable state of the blood, preeclampsia, venous

thromboembolism—all these could be managed with high quality prenatal care but only for those who can access and avail of it.

Other factors commonly found in women could lead to pregnancies that risk their well-being: (1) less than 18 or greater than 35 years; (2) less than 4'9" in height; (3) fifth pregnancy; (4) three consecutive miscarriages; (5) previously bearing stillborn infant/s; (6) postpartum hemorrhage in past pregnancies; and (7) medical conditions like tuberculosis, heart disease, diabetes, bronchial asthma and/or goiter.

The inaccessibility of both safe and legal abortion and high quality PAC is a public health issue. Without the proper procedure and the aftercare, more than 4/5 of women who induce abortion experience complication, with more than a third suffering from severe symptoms. The risk for women and their families is too great. A better national policy ensuring humane, compassionate and non-judgmental post-abortion care is thus urgent and of utmost importance.

Consultations and Research Efforts

The WGNRR, together with women's rights organizations, healthcare providers, public agencies and advocacy groups, has dedicated time and effort to learn about the experience of women when they seek PAC. It has also invested significantly in consultations with prestigious organizations within the medical and legal field to study the challenges in delivering PAC. It has partnered with women's leaders and organizations to amplify the call for better sexual and reproductive health services for Filipino women.

In fact, it helped conduct a Policy Study on the 2018 AO. Headed by Assistant Professor Devralin Lagos and using the Health Rights of Women Assessment Instrument as framework, it explored how to promote women's health better and recognized that local issues are connected to national level processes and systems. It connected what actually happens to what should happen according to human rights obligations. The study explored government accountability in the realization of women's rights.

By March 2023, after six years of learning sessions, stakeholder dialogues, policy research and information dissemination campaigns, the WGNRR and its collaborators

reached the consensus of advocating for policy reform via the DoH's administrative order. Together, women and their care providers recommended a national policy on PAC that is aligned with human rights ideals and best global standards.

This is in sync with the Commission on Human Rights' own recommendations after recently conducting a Monitoring of the Situation of Post-Abortion Care in the Philippines. Among the CHR's recommendations is the improvement of the national policy to include clear, standardized protocols across all healthcare facilities, supported by a national guideline that ensure consistent, high-quality care, including in geographically isolated and disadvantaged areas.

The Multi-sectoral Consultation for Post-Abortion Care Policy Review and Recommendations is the most recent forum that aims to draw important lessons and resolutions. Held in February and attended by hospital officials, health department heads from local government units, representatives from various government agencies, civil society leaders and women's advocates, the gathering of experts discussed research findings, experience from the ground, hospital policies vis-à-vis the current national policy. The delegation identified gaps in the system and formulated recommendations to address the challenges in the delivery of PAC.

Key Findings

Stakeholders and duty-bearers agree that women's health and human rights must be front and center to any PAC policy. The reality, however, paints a different picture for women. Stigma, if not the risk of legal repercussions, is a considerable factor in hindering women from accessing care while also holding back care providers from giving effective service to their patients. Lack of proper training, of appropriate referral systems and of the standard life-saving medicines are other common factors hindering high-quality care. Some of these factors, such as the following, were already present in the 2016 AO of the Health Department:

- 1) Anchored on human rights and respectful maternal care that save women's lives by increasing access to quality, humane, nonjudgmental, compassionate PAC.
- 2) Recognized that maternal mortality and morbidity due to unsafe abortion complications is a public health, medical ethics and human rights issues.
- 3) Complied with national laws like the Magna Carta of Women and the RPRH Law, as well with international laws.
- 4) Promoted the use of MVA, a quicker and less intrusive method than D&C, requires little or no anesthetic and has a lower complication rate.
- 5) Advanced institutional safeguards and protocols that ensure patient confidentiality, privacy, protection of women's human rights.

As previously mentioned, the title itself of the present AO sets the tone of the national policy. The stigmatization of abortion and of women who have undergone different manners of termination of pregnancy is very evident. Even worse, this is further reflected on its contents.

The table below discusses the key findings from the Multi-sectoral Consultation by identifying the areas for improvement and the changes necessary to address them. The WGNRR and the rest of the delegation recommends the following to be adapted in a new national policy that better serves women in the context of PAC.

GAPS

RECOMMENDATIONS

SERVICE DELIVERY AND ACCESSIBILITY – High quality PAC must be available and accessible to those who need it. Providers must be comprehensively equipped to deliver care and render it most accessible whenever and wherever necessary.

Stigma affects the providers, not just the patients.

Additionally, there isn't any complete and focused training for PAC among medical professionals.

TRAINING. The capacities of service and care providers must be built and enhanced through skills and knowledge that is focused on PAC. A PAC-specific training can focus on achieving patient-centered and non-discriminatory care while ensuring that informed consent, confidentiality and privacy are protected.

Making this training available even to midwives, not just doctors and nurses, means that more women are given improved service. Also, opening the PAC training to barangay health workers will render this service accessible at the grassroots-level. This training should reach even the most geographically isolated and disadvantaged areas.

Midwives are part of the PAC providers but do not have the proper mandate for it.

Instead, there is no more provision for nurses and midwives to do MVAs.

ROLE OF MIDWIVES. To better provide PAC, midwives must have specific parameters on which cases are to be managed in their facilities. The plenary suggests that the national policy stipulate that midwives will be trained and certified to manage cases of uncomplicated incomplete abortion. It is also important for midwives to have the mandate to provide PAC and receive the training for it. If not through the amendment of the Midwifery Law, this could be achieved through the RPRH Law.

Financial factors are but very common barriers between the poor and the medical services that they need.

SUBSIDIES AND ASSISTANCE. The PhilHealth should adopt the Philippine Obstetrical and Gynecological Society's Clinical Practice Guidelines. PAC should be included in the PhilHealth's primary care package.

IMPLEMENTING MECHANISMS – This category explores inter-agency coordination, referral pathways, task-shifting and task-sharing approaches. It also looks at current PAC services, checking if these are aligned with international guidelines and national healthcare frameworks.

There is a lack of standard referral systems in conducting PAC. Healthcare professionals attend to the patients, but they are not organized into one network focused on the task. Continuity of care suffers. PAC in practice differ from one facility to another and this has an effect on protecting patient confidentiality.

The family planning component of PAC must be improved to prevent abortion incidents.

FUNCTIONAL GAPS IN EXISTING SERVICE

DELIVERY NETWORK. There should be standardized protocols and guidelines for referral systems to ensure continuity of care. Referral pathways will link community health workers to the health system and ensure women can access emergency care if necessary. Consider that referral pathways could differ according to locality and practice. The DoH must review the referral pathways provisions from past administrative orders that are still consistent with national policies.

A back-up support is necessary for continued access. Tele-medicine could be an alternative to physical interactions with a health worker while still providing access to information and correct management.

A seamless service delivery network must be collaborative among community leaders, policymakers, legal experts and educational institutions. Financial support from non-governmental organizations and international funding agencies must be explored.

CHALLENGES OF STAKEHOLDERS IN ENSURING COMPREHENSIVE AND QUALITY CARE FOR PATIENTS.

A harmonious network of stakeholders working within a referral system could be achieved through task-specific training and reorientation of duties and responsibilities. A national policy on PAC should include the promotion of adherence to standard protocols and diligent documentation practices. Advance the full integration of family planning services into PAC as a component given to every patient, regardless of whether the pregnancy is intended or not.

Consider the correct management of pregnancies in the context of gender-based violence and disempowered women.

The illegal status of abortion causes confusion on the proper management of post-abortion cases and delivery of PAC. The 2018 Policy does not stipulate protection for medical professionals who attend to incomplete abortion or PAC in general.

PATIENTS' ASSURANCE OF RECEIVING APPROPRIATE, CONFIDENTIAL AND NON-DISCRIMINATORY TREATMENT. Firstly, implement timely and appropriate intervention for post-abortion patients by ensuring their access to information, increasing the accessibility of services and improving health infrastructure.

A policy that ensures confidentiality and non-discriminatory treatment will reduce stigma and encourage women to seek services. Healthcare providers must be trained in effective communication, empathy and respect for patient autonomy. Implement strict protocols towards privacy and confidentiality. Educate all healthcare providers and staff about their legal and ethical obligations to maintain patient confidentiality and provide care without discrimination. Create a confidential complaints mechanism where women can report mistreatment and abuse without fear of retaliation.

Life-saving drugs, like the uterotonic Misoprostol, are not widely available. The MVA or VA is not properly recommended or promoted for widespread use despite its potential to save women's lives and its cost efficiency as a procedure.

ACCOUNTABILITY OF STAKEHOLDERS. Care and service providers will be more prudent if they have continuous training and cognizant task-sharing among themselves. Capacity-building measures such as these foster a sense of responsibility.

The Health Department must enforce a policy on medical abortion. PAC must be considered in the devolution plan of the DoH. It should also reorganize the National Implementing Team to its original purpose. It should explore the establishment of local government committees related to women and health. PAC must be included in the Universal Health Care Law of 2019.

To further promote smoother provision of service, the national policy should differentiate between complicated and uncomplicated abortion, and complete and incomplete abortion. There should be clear definition of terms. Even the definition of PAC should be made consistent with the RPRH Law definition of management of post-abortion complications.

AVAILABILITY OF EMERGENCY MEDICINES AND FAMILY PLANNING COMMODITIES IN ALL HEALTH FACILITIES AND SERVICES.

The national policy must stipulate the provision of a full range of contraceptive methods, including emergency, short-acting and long-acting methods—at all facilities. Emphasis should be placed on marginalized populations and the poor.

Include PAC medicines, most especially Misoprostol, in the Essential Medicines List of the DoH. Ensure that logistics management information systems are in place to track the availability and stock-out status of essential medicines and commodities. Establish effective mechanisms of procurement, distribution and supply chain to ensure a continuous and reliable supply of essential medicines and health products.

Vacuum aspiration, manual or otherwise, is intended for the management of incomplete abortion and not to induce abortion. This should also be clearly stipulated in the national policy, as well as included in the PAC-specific training, especially of midwives.

There should also be antibiotic stewardship on higher levels of PAC to ensure its rational use, prevent overuse and reduce risk of resistance among patients.

DATA AND MONITORING FRAMEWORKS – The collection, monitoring and evaluation of data are conducted to assess the effectiveness of PAC services. It included strengthening health information systems, ensuring data privacy and confidentiality, standardizing indicators and addressing data gaps that impact service improvement. For this category, participants discussed the steps to improving reporting mechanisms and evidence-based decision-making for PAC policies.

PAC patients' negative experiences regarding their need for sensitivity, privacy and confidentiality hinder them from returning or seeking care if ever they require it again.

ENSURING DATA PRIVACY AND CONFIDENTIALITY.

The need for a separate and exclusive logbook for PAC patients is reiterated. Establish which data is necessary to be shared with providers. Code names or Unique Identifying Codes could be used instead of real names. Avoid the use of the term 'blotter.'

There is a dearth of data concerning abortion and post-abortion incidents. Research and policy-making is made more difficult because of this.

ENSURING DATA PRIVACY AND CONFIDENTIALITY.

The need for a separate and exclusive logbook for PAC patients is reiterated. Establish which data is necessary to be shared with providers. Code names or Unique Identifying Codes could be used instead of real names. Avoid the use of the term 'blotter.'

STANDARDIZING INDICATORS. Mobilize a multi-disciplinary team from the academe, local government, church and other stakeholders. Establish a unified referral system, as well as clear guidelines for the implementation of PAC and specialized programs to serve as basis for the development of standard indicators.

ADDRESSING DATA GAPS THAT MAY IMPACT SERVICE IMPROVEMENT. Train medical personnel, community health workers, local government health unit staff and others in reporting PAC cases. Have a special focus on reporting sensitive cases like pregnancy due to gender-based violence. The teenage pregnancy reporting system used during the height of the pandemic could be used for the reporting of PAC cases.

ADVOCACY AND AWARENESS – There is a need to increase public, stakeholder and policy-maker awareness of PAC, especially to reduce stigma and misinformation surrounding PAC. This discussion covered community engagement, health literacy initiatives, training for healthcare providers and policy advocacy to ensure the protection and expansion of PAC services in national health policies.

There is a lack of awareness that such services exist and that access to PAC is actually among women's health rights. Fear of being punished and/or shamed is common among those who are unfamiliar with PAC.

STRENGTHENING OF POST-ABORTION CARE POLICY. Enlist the help of local executives in localizing the national policy. Conduct information dissemination and training in grassroots-level.

Some hospital staff members believe that it is part of their duty to report the incident to the legal authorities.

TRAINING OF HEALTH WORKERS. Train health care providers, especially those in reproductive health, to be front-liners in the dissemination of correct information regarding PAC. Include PAC in the curriculum of reproductive health care providers and introduce MVA as an essential tool that could save women's lives.

The general meagerness of the budget allocation for health as a social service to the people extends to PAC.

RESEARCH AND LEGISLATION. Gather data and use the information on correct budget implementation and women's health campaigns. Use it to craft better policies. Lobby for the guaranteed availability of family planning commodities. Lobby for the increase of budget for local health departments.

Coordinate with local government units.

Cultural and social barriers, like religion or shame, prevent women from seeking PAC. Trauma, either from gender-based violence or the abortion itself, is also common.

EDUCATING MAINSTREAM MEDIA ABOUT POST-ABORTION CARE, ITS IMPACTS AND EFFECTS ON MENTAL HEALTH. Counter misinformation. Maximize social media platforms in conducting educational campaigns, gathering advocates and countering stigma by normalizing talking about PAC.

COMMUNITY-LED INTERVENTIONS. Using a language that they understand, communities and schools must be educated on abortion and PAC to eliminate stigma and discrimination. Family planning is a primary component of this education.

Conduct these discussions with the appropriate level of sensitivity. Organize a peer education system. Ensure the involvement of the male sex in family planning component of PAC. Strengthen women's groups and expand the reach to other sectors of the community. Ensure the participation of the youth. Establish a hotline where civil-society organizations can have access to referral pathways.

REMOVE STIGMA, DEMYSTIFY AND DECRIMINALIZE. Adopt a national policy, beginning with the title, that does not cause or reinforce stigma against women who have undergone termination of pregnancy. Break the fear and silence on abortion topics by talking about it. Include abortion and PAC in reproductive health discussions. Support pressing issues like Comprehensive Sexual Education.

Aside from considering the reinstatement of the essential features of the 2016 AO, a new national policy on post-abortion care should have these important features.

A The new policy should include in its *general guidelines* the following:

1. Inclusion of the six key elements of the 2000 PMAC:
 - prevention of threatened abortion;
 - treatment of complications from spontaneous and induced abortion;
 - counseling;
 - family planning including contraceptive services;
 - linking of PMAC services to other reproductive health services (like evaluation for sexually transmitted infections and treatment, testing for and counseling of individuals with human immunodeficiency virus and cancer screening); and
 - community empowerment through awareness and mobilization by means of community and service provider partnerships.
2. training for doctors, nurses, midwives, counselors, support staff and security officers
 - that is gender-sensitive, with proper competency certification issued by the DoH
 - that includes teaching the use of VAs and MVAs (also, revision of the Basic Emergency Obstetric and Newborn Care guideline accordingly)
3. a clearer scope of responsibilities of the care providers
4. salient and enabling features such as:
 - guaranteed access to quality and respectful maternal care including PAC
 - integration of PAC into the (a) DoH Safe Motherhood Program; (b) Women, Men and Children's Health Development Divisions; (c) Maternal, Newborn, Child Health and Nutrition offices in DoH regional formations; and (d) local government programs
 - inclusion of post-abortion emergency cases in existing emergency hotlines
 - purchase of commodities that assist in PAC
 - supportive supervision of trained providers
 - regular monitoring and evaluation
 - inclusion of the number of PMAC providers trained per year in the quarterly and annual RPRH Law accomplishment reports
 - establishment of PAC teams, with a designated officer of the day, in Comprehensive Emergency Obstetric and Newborn Care and tertiary care facilities

B The new policy should promote *compassionate, humane and non-judgmental PAC* consistent with human rights principles and respect for women's rights and well-being. It should aim to remove stigma and discrimination. It should be based on restrictive laws on abortion instead of absolute prohibition. It should include life-saving drugs, especially MVA, and integrate PAC in the spectrum of care addressing mental health of women.

C The new policy should incorporate the following in its *specific guidelines*, including in the *implementing mechanisms*:

1. designation of the prevention of threatened or spontaneous abortion as a major component of PAC, similar to the 2000 PMAC
2. irrelevance of conscientious objections and the requirement of third party authorization in PAC cases
3. guarantee of confidentiality and privacy from and by all care providers, including the stipulation that no provider is legally required to report PAC cases to the authorities
4. stipulation that any PAC provider will not be held liable in any criminal, civil or administrative charge in the performance of this duty.

- D** The new policy should specify in its *penalty clause* the process of filing of complaints against those who violate it. Free legal services must be guaranteed and ensured by relevant government offices, including legal assistance against retaliatory actions.
-

To further supplement this table of recommendations against existing challenges, a checklist of Essentials of a Rights-Based Post-Abortion Care Policy is annexed to this document.

Conclusion

Many factors—like poverty or unpreparedness, medical condition or grave incidents—could lead to abortion. Whatever the cause, it will always be the duty-bearer’s role to minimize these factors and minimize the risk for pregnant women. In fact, on a policy-level, post-abortion care must reflect the state’s intention to empower women despite the termination of the life she carried and because carrying life is among her roles. Women’s health and reproductive health contribute to strong family ties and, thus, to a stronger nation. PAC is not a mere health issue but a vital factor to population and development.

Though the present AO on PAC generally leaves much to be desired, it is still positive that the DoH have crafted and enforced better policies before the current one. Having worked under two differing policies, stakeholders and duty-bearers are now more equipped to draw lessons from the experience.

And this is the challenge that medical professionals—doctors, nurses, midwives, community health workers—and WOMEN pose to the Department of Health, to join them in drawing the lessons and crafting an even better policy on post-abortion care.

References

- Conde, C. (2005). Philippines abortion crisis. Internet Archive Wayback Machine, <https://web.archive.org/web/20111013110053/http://carlosconde.com/2005/05/16/philippines-abortion-crisis/>
- Finer, L.B. & Hussain, R. (2013). Unintended pregnancy and unsafe abortion in the Philippines: context and consequences. Guttmacher Institute, <https://www.guttmacher.org/report/unintended-pregnancy-and-unsafe-abortion-philippines-context-and-consequences>
- Guttmacher Institute. (2022). Philippine country profile. <https://www.guttmacher.org/regions/asia/philippines>
- Kabamalan, M.M.M., Laguna, E.P., Marquez, M.P.N., et al. (2020). Estimating the potential impact of the COVID-19 pandemic on key sexual and reproductive health outcomes in the Philippines.
- University of the Philippines Population Institute, <https://www.uppi.upd.edu.ph/sites/default/files/pdf/UPPI-Impact-of-COVID-19-on-SRH.pdf>

Annex 1

What are the Essentials for a Rights-Based Post-Abortion Care Policy?
by Atty. Jihan Jacob

A rights-based approach to post-abortion care (PAC) ensures that individuals receive timely, compassionate, and non-discriminatory medical attention, regardless of the legal status of abortion.

This checklist serves as a practical guide for policymakers, healthcare providers, and advocates to assess whether existing PAC policies uphold essential human rights standards and international best practices. By addressing key elements such as accessibility, quality of care, provider accountability, and integration with broader reproductive health services, this checklist helps identify gaps and areas for improvement in PAC implementation.

CATEGORY	QUESTION	YES	NO	NOTES
Legal and Institutional Framework	Is PAC legally protected and accessible in all health facilities, regardless of abortion laws?	<input type="checkbox"/>	<input type="checkbox"/>	
	Does the policy align with international human rights standards, including WHO guidelines?	<input type="checkbox"/>	<input type="checkbox"/>	
Non-Discrimination and Patient Rights	Is stigma-free, non-discriminatory care guaranteed, with protections against mistreatment?	<input type="checkbox"/>	<input type="checkbox"/>	
	Is conscientious objection regulated to ensure patients receive timely care?	<input type="checkbox"/>	<input type="checkbox"/>	
Healthcare Provider Training and Accountability	Do healthcare providers receive mandatory training on human rights-based PAC?	<input type="checkbox"/>	<input type="checkbox"/>	
	Are there oversight mechanisms monitoring compliance?	<input type="checkbox"/>	<input type="checkbox"/>	
	Are there complaint mechanisms with penalties for rights violations?	<input type="checkbox"/>	<input type="checkbox"/>	
Financial and Physical Accessibility	Is free or affordable PAC available in public hospitals and clinics and sufficiently covered by PhilHealth insurance?	<input type="checkbox"/>	<input type="checkbox"/>	
	Are referral systems strengthened to ensure patients receive timely care?	<input type="checkbox"/>	<input type="checkbox"/>	

Public Awareness and Education	Is accurate, evidence-based information on PAC and contraception widely disseminated?	<input type="checkbox"/>	<input type="checkbox"/>	
Comprehensive Reproductive Healthcare	Does PAC include comprehensive reproductive health counseling and contraceptive access?	<input type="checkbox"/>	<input type="checkbox"/>	
	Are midwives, nurses, and other non-physician providers trained and authorized to offer PAC?	<input type="checkbox"/>	<input type="checkbox"/>	
	Are task shifting and task sharing approaches implemented to expand access to PAC?	<input type="checkbox"/>	<input type="checkbox"/>	
Essential Technologies and Service Delivery	Are essential PAC technologies, including vacuum aspiration and misoprostol, widely available?	<input type="checkbox"/>	<input type="checkbox"/>	
	Do local governments actively engage in PAC service delivery and policy implementation?	<input type="checkbox"/>	<input type="checkbox"/>	
Monitoring, Data Collection, and Policy Improvement	Is reliable data on PAC services collected and used to inform policy reforms?	<input type="checkbox"/>	<input type="checkbox"/>	

Annex 2

Multi-Sectoral Consultation for Post-Abortion Care Policy Review and Recommendations

PARTICIPATING ORGANIZATIONS

medical institutions

- Amang Rodriguez Memorial Medical Center
- Bicol Medical Center
- Bicol Regional Hospital and Medical Center
- Dr. Jose Fabella Memorial Hospital
- Eastern Visayas Medical Center
- Vicente Sotto Memorial Medical Center
- Tondo Medical Center

local health departments

Caloocan City Health Department
Quezon City Health Department

government agencies and government-linked organizations

Commission on Human Rights
Philippine Commission on Women
Barangay Council for the Protection of Children
Federation – District 5
Integrated Midwives Association of the Philippines, Inc.

advocacy groups

Catholics for Reproductive Health
Family Planning Organization of the Philippines
Filipino Freethinkers
ILAW Shared Community
Kalipunan ng Liping Pilipina Nasyonal, Inc.
Philippine Business for Social Progress
Philippine Society for Responsible Parenthood
Philippine Safe Abortion Advocacy Network
Talikalā, Inc.
WomanHealth
Women's Studies and Resource Center – Southern Mindanao
Region, Inc.
Young Advocates for SRHR



WOMEN'S
GLOBAL NETWORK
FOR REPRODUCTIVE RIGHTS

W G N R R