

# Institutionalizing Manual Vacuum Aspiration Abortion in Central and Eastern Europe and the Former Soviet Union



*The National Abortion Federation's mission is to ensure safe, legal, and accessible abortion care to promote health and justice for women.*

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## PREFACE

This report documents the results of the Manual Vacuum Aspiration (MVA) project in building support to improve the quality of abortion care within medical, governmental, and non-governmental organization (NGO) sectors; in strengthening the institutional capacity of service and training programs; and in identifying strategies for future work in abortion quality in the regions of Central and Eastern Europe and the former Soviet Union.

Although there is a significant body of evidence demonstrating the greater safety of aspiration abortion in comparison to sharp curettage, without a decrease in effectiveness (at gestational ages suitable for comparison), the latter has remained the primary method of abortion care in these regions, as in many other countries. Manual vacuum aspiration (MVA) entails the use of a hand-operated syringe and flexible cannula to aspirate the uterus, thus offering a gentle, effective technology ideal for use in low-resource settings. Studies comparing electric vacuum aspiration (EVA) and manual vacuum aspiration (MVA) have found equivalent levels of effectiveness between the two techniques.<sup>1</sup>

In June 1999, participants at a Special Session of the United Nations General Assembly agreed, “in circumstances where abortion is not against the law, health systems should train and equip health-service providers and should take other measures to ensure that such abortion is safe and accessible.” In keeping with this international goal of ensuring safety and access for abortion care, the National Abortion Federation (NAF), in collaboration with Ipas<sup>2</sup> and funded by the Open Society Institute (OSI), developed a plan to extend abortion-related quality assurance concepts to interested health care providers in nations of Central and Eastern Europe and the former Soviet Union. NAF’s North American experience in developing and setting evidence-based guidelines, measuring quality, promoting quality improvement, and developing accredited continuing medical education programs created the basis for the international training model.

### Advantages of MVA:

- equal or slightly decreased risk of complications in comparison with EVA;
- ability to be provided under local rather than general anesthesia and pain may be more easily managed;
- equipment is portable, not electric;
- equipment is easy to maintain, reusable, and much less expensive than surgical or electric equipment;
- abortions may be provided outside of an operating room, decreasing the cost and use of expensive medical personnel and facilities;
- allows for easy examination of the products of conception to confirm completion;
- operative technique is not complicated to teach to qualified providers; and
- excellent tool for management of early pregnancy failure and endometrial biopsy.

### Introduction

This project was implemented over a two-and-a-half-year period and included seven training sites: one site each in Moldova, Macedonia, Kyrgyzstan, Georgia, and Albania; and two sites in Russia: St. Petersburg and Moscow. The goal of the project was to improve the quality of abortion care and promote patient-centered care concepts within the framework of clinical safety and reproductive rights through the following measurable objectives:

1. to introduce MVA instruments and techniques to practitioners and organizations;
2. to build awareness and acceptance of a model of evidence-based care utilizing a woman-centered approach; and
3. to provide assistance to participants in planning the institutionalization of MVA and patient-centered care.

<sup>1</sup> Greenslade, FC, Benson J, Winkler J, Henderson V, Wolf M, Leonard A. “Manual vacuum aspiration: a summary of clinical and programmatic experience worldwide,” *Advances in Abortion Care*, 1993;3(2):1-4.

<sup>2</sup> Ipas is a global leader in MVA technology. Their instruments are used in more than 100 countries worldwide and Ipas provided the MVA devices used in this project.

Project developers and managers found it critical to develop and incorporate common clinical concepts and values into the assessment and planning phase in order to determine feasible goals and strategies for measuring achievements. As part of this process, economic, political, and bureaucratic fluctuations within national, regional, and international policies influencing reproductive health care issues were considered. In order for economic decision makers as well as individuals providing direct care to agree on proposed changes to service delivery, rationales for change also needed to be relevant to the setting. For instance, process-assessment demonstrated that public facilities required more time and commitment to make a successful impact by implementing crucial health system improvements. Ultimately, training participants and organizers were able to identify primary strategies to guide future work in quality abortion care, and agreed that building on the acceptance and integration of new abortion care models within public and private health systems would strengthen future efforts.

## Overview of MVA Project

Each site in the program was visited three times. First, a needs assessment was performed; then the training program was conducted; and an evaluation followed. These visits were conducted at each site by the NAF program coordinator, training faculty, and in a few sites with post-doctorate family planning fellows and OSI representatives. Trainings were carried out using a comprehensive patient-centered curriculum developed by NAF specifically for the project. Initial trainings were undertaken in three countries in 2002 by one physician and a certified physician assistant (PA-C) for each site, utilizing a framework for training future trainers. Trainers in the program were experienced North American abortion providers and teachers of abortion care, well-grounded in MVA technique. During the second cycle of four trainings (2003–2004), the original North American physicians were paired with physicians from Moldova, the initial training site.

The seven sites all participated in assessment, training, and evaluation visits from December 2001 through June 2004. In March of 2004, all sites were sent a self-assessment questionnaire for review by the NAF program coordinator, in order to gauge ongoing progress toward project goals.

### *Training covered all aspects of patient care, including:*

- counseling and informed consent;
- patient screening;
- method selection;
- pain management;
- clinical techniques for surgical abortion;
- tissue examination;
- complication management;
- quality improvement techniques and measurement; and
- instrument processing and infection prevention.

Fifteen physicians from the training sites attended the Networking Resource Meeting held in Budapest, Hungary on June 30 and July 1, 2004. All participants were asked to present on their progress in institutionalizing MVA since the NAF/OSI trainings. The key objectives for this meeting were to provide participants with a forum for sharing experiences, identifying common obstacles, and developing strategies for overcoming those obstacles. Activities included a discussion of best practices in training for quality abortion care and key learning points for the different sites. A final objective was to address the concerns and questions of the representatives about the future of the project and further efforts. NAF, Ipas, and OSI identified available opportunities and resources, and helped to clarify the components sites would need to accomplish individually in order to sustain and advance their work. Before adjourning, each country representative was charged with developing a concrete plan for continuing progress.

By the end of the Networking Resource Meeting, the training team assessed that training sites would benefit from continued encouragement and support in order to meet their goals. Some of the sites had already implemented additional projects and sustainability efforts, and served as examples for others. Overall, there was a strong sense that each site had made a significant effort, according to individual capacity, to achieve progress in institutionalizing MVA. All sites expressed commitment to continue working towards achieving program goals. In 2005 and 2006, NAF encouraged sites to submit information related to their progress and to include any updates on the status of MVA as well as any other training advances in their countries. The case studies included in this report reflect the responses from program participants.



*A summary of responses from the self-assessment questionnaire revealed the following:*

- patient education and counseling had been implemented in all sites; in some cases only for women who were having MVA procedures;
- a variety of training methods had been used to introduce MVA and quality abortion care concepts to new physicians and students;
- as of April 2004, 388 physicians had been involved in these trainings;
- only one site was not using routine antibiotic prophylaxis;
- post-procedure tissue exam was being used at approximately the same rate as antibiotic prophylaxis; and
- about one half of the sites were re-using the MVA cannulae.

## Summary of MVA Project

The training project successfully accomplished the goal of introducing MVA and presenting a model of evidence-based care with a woman-centered approach. It is more difficult in the short term to identify the degree of progress towards institutionalizing MVA and patient-centered models of care. The cumulative impact on public health systems and the more gradual effects on future training, medical guidelines, and policy throughout these countries will become more apparent after long-term evaluation.

Training faculty identified that, in some situations, the use of curricula primarily based on North American data and grounded in principles of evidence-based practice made it more difficult to establish a common understanding with participants on training concepts. The absence of shared values supporting the inclusion of patient-centered, evidence-based practices created occasional challenges in operationalizing certain objectives identified by program developers as important steps toward achieving the project goals. For example, counseling patients about the procedure and options for anesthesia was challenging to some providers who were accustomed to deciding these

matters for patients rather than educating and empowering patients to make choices. Some physicians expressed concern that informing women about the risks of abortion would scare them, rather than provide informed consent.

Positive aspects of the project included the opportunity to collaborate with individuals from many different disciplines, all motivated to advance the quality of abortion care for the communities they serve. One of the inspiring features of abortion care in the training regions is that it is not separate from general gynecological care, nor is it politicized in the same way that it is in North America. The training sites did not experience a shortage of trained obstetrician/gynecologists providing abortion care, and providers were not stigmatized by their colleagues for providing abortions. All the project visits were animated by discussions regarding public views on abortion issues, in particular in relation to the differences between the United States and host countries. For example, participants were largely unfamiliar with concerns relating to medical malpractice and liability, violence against providers, and an organized anti-choice movement.

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## Case Examples from Four Training Sites

The following case reports from Chisinau, Moldova; St Petersburg, Russia; Bishkek, Kyrgyzstan; and Tbilisi, Georgia exemplify training issues in a variety of settings.

### I. Chisinau, Moldova

#### Municipal Clinical Hospital N. 1



#### *Moldova*

- 33% of pregnancies are unplanned;
- 90% of these unplanned pregnancies end in abortion;
- in 2003, 37.3% of all maternal deaths were due to abortion; and
- illegal abortions are thought to contribute to 1 in 8 maternal deaths.

During the past decade, abortion rates in Moldova have gradually declined from 75/1000 reproductive-aged women in 1990 to 17.3/1000 in 2003, making the abortion-to-live-birth ratio about 0.5 abortion for each live birth. This may be underestimated, as abortion reporting may not reflect the total number of procedures. Abortion is used as a primary means of controlling family size or spacing childbirth. Despite the fact that it is a relatively common procedure, there has been a high rate of abortion-related maternal mortality and morbidity—8.3 per 100,000 live births. Additionally, many women suffer from abortion-related complications. During almost fifty years of legal abortion in Moldova, many aspects of abortion services have not met the clinical practice

recommendations established by the World Health Organization (WHO).

The Moldovan Ministry of Health's regulations on abortion care were outdated, allowing vacuum aspiration to be provided only up to five weeks' gestation. The regulations also required additional costly tests, including cervical cancer screening and fluorography. There were no systems in place to monitor quality of care, nor was continuing medical education offered for new abortion technologies.

In December 2001, abortion service delivery at the Municipal Clinical Hospital N.1 in Chisinau, Moldova was assessed by NAF staff and faculty and a program officer from the New York office of the Open Society Institute.

#### *Prior to the MVA project:*

- the most common method of pregnancy termination in the first trimester consisted of sharp curettage with general anesthesia, despite WHO recommendations favoring vacuum aspiration with local anesthesia;
- many physicians were hesitant to provide abortions at very early gestational ages;
- facilities did not observe patient-centered care policies such as confidentiality and informed consent; and
- a lack of information on post-abortion family planning led to high rates of repeat unwanted pregnancy and abortion.

NAF then utilized the findings from this initial visit to customize a ten-day training curriculum for high-quality abortion care using MVA. In May 2002, three NAF trainers and seven gynecologists joined together for the initial training. The prior experiences and skills of the trainees, composed of Moldovan health care leaders including hospital physicians, representatives from the state medical university, and the Ministry of Health, ensured the best opportunity for improvement of abortion services within the overall health care system and proved to be an invaluable tool to assist in improving systems.

The training emphasized a patient-centered approach to improving abortion techniques as well as the general quality of services. The primary training methods included a combination of didactic and hands-on training with models and patients. Following the training, the participants created the MVA National Training Center of Excellence; this Center's goal is to organize and evaluate activities to implement MVA in Moldova. In April 2004, the Moldovan Ministry of Health developed the first evidence-based guidelines for abortion care, and began requiring that all hospitals in the public health system use MVA.

The Training Center currently evaluates abortion care by gathering data on procedures, including complication rates, patient satisfaction, and pain-control techniques. In 2003 there were 1250 abortions procedures provided at the Training Center. Analysis of these procedures revealed the following:

#### *Services:*

MVA abortions: 1230 (98.5%)  
 Local anesthesia use: 887 (72.1%)  
 General anesthesia or deep sedation: 363 (27.9%)

#### *Complications:*

Retained tissue: 12 (0.8%)  
 Ongoing pregnancy: 7 (0.56%)  
 Hematometra: 3 (0.24%)  
 Endometritis: 4 (0.32%)

Overall, a single MVA was completely effective in 98.1% of procedures. Ninety-two percent of women were very satisfied with MVA, reporting that they would recommend the method to others or request it again.







The admission process for women requesting abortion was simplified and women now receive care without unnecessary delays and laboratory tests. The system now includes the routine provision of confidential counseling and informed consent before each procedure, and contraceptive information is offered to all women. To increase public awareness of a woman's right to access better quality abortion services, an information campaign was launched through the family medicine centers and NGOs involved in the field of women's health. The campaign included a hotline and webpage, radio and television broadcasts, educational materials, and posters. From 2002 to 2003 the number of women obtaining abortions at the Center increased 3.6 times.

The adoption of MVA technique and concurrent changes in Ministry of Health guidelines for Moldova indicate that providing high-quality abortion services in conjunction with efforts to reduce the need for abortion (particularly repeat abortion), and to link abortion services with other components of reproductive health care, has become a national priority in Moldova. The increase in women receiving abortion care at the Center indicates that when given a choice and access to information, Moldovan women prefer patient-centered care using MVA.



In 2005, the World Health Organization conducted a strategic assessment of abortion services in Moldova and developed a plan of action to implement the following recommendations:

- 1) improve and enforce policies and regulations;
- 2) enhance information, education, communication, and abortion prevention measures;
- 3) improve the quality of abortion services;
- 4) improve access to fertility regulatory services for socially vulnerable women and teenagers;
- 5) meet young people's needs for contraception and abortion;
- 6) improve management of abortion and contraceptive service providers;
- 7) improve the reporting system, the implementation of the monitoring system, and the evaluation of service function;
- 8) continue training providers;
- 9) decrease maternal mortality and morbidity connected with abortion; and
- 10) organize operational studies on reproductive health care in Moldova.



## II. St. Petersburg, Russia

### A. Ott Scientific Research Institute

### B. Women's Antenatal Clinic #22



The Ott Institute is a large academic research hospital in St. Petersburg. The Women's Antenatal Clinic #22 is a multi-service women's clinic operated by the city of St. Petersburg. In February 2003, a NAF physician and project coordinator made an initial visit to the principal training sites, meeting with academic leaders and observing clinical practices. The purpose of these visits was to assess the sites' capacities to undertake the training, to make the training program as specific to their needs as possible, and to ascertain the commitment of the academic leaders to change clinical practice. At the conclusion of the needs assessment visit, the team decided that there would be adequate numbers of patients for a successful training and that there was also a commitment from the Institute decision makers to consider change in clinical practice.

Prior to the training, physicians at the Ott Institute had very limited access to EVA, and most abortions were provided using sharp curettage. In contrast, at the An-

tenatal Clinic, abortions were primarily provided using EVA, although one physician did occasionally use MVA. In both facilities, patients received mandatory counseling by physicians encouraging them not to have abortions, particularly if it was their first pregnancy. Once a woman decided to have an abortion she was given an extensive work-up, which included HIV and syphilis testing, Rh typing, and screening for cervical cancer and cervicitis. However, due to financial constraints, screening for chlamydia was not included.

In June 2003, a seven-day training program was offered to nine participants, who were either experienced gynecologists with many years of abortion experience or junior staff who had recently completed a residency training program in gynecology. A variety of training methods were used, including didactic presentations, small-group discussion, role playing, case discussions, and hands-on practice with pelvic models and patients. The teaching methods took into consideration

the different skill and experience levels of the participants. All participants had an opportunity to be observed doing at least two MVA procedures with patients. A participant handout covering all sections of the curriculum was translated and made available to all participants. Throughout the training, materials were presented keeping in mind that there was an expectation that the participants would be future trainers. Training techniques and resources were shared with the group.

At the evaluation visit in February 2004, considerable progress had been made in expanding the use of MVA. At the Ott Institute all physician trainees' first-trimester abortions were being provided using MVA, instead of sharp curettage. The Antenatal Clinic reported a significant increase in their number of MVA procedures, with no increase in complications. Physicians from a third clinic, Antenatal Clinic #9, had been trained in turn by two of the original participants, and were providing abortions using MVA up to twelve weeks' gestation. Significantly, this clinic had not provided abortion services of any kind prior to the dissemination of this training.

#### *Services:*

##### **Ott Institute:**

*September 2003 to December 2003:*

98 MVA abortions

##### **Antenatal #22:**

*January 2003 to June 2003 (prior to MVA training):*

528 abortions total: all EVA

*June 2003 to December 2003:*

491 abortions total:

223 EVA; 268 MVA

123 endometrial biopsies using MVA

##### **Antenatal #9:**

*September 2003 to December 2003:*

100 MVA abortions

The sites reported that women were given the choice of which abortion technique and method of anesthesia they preferred. Following the June 2003 NAF training, two of the senior gynecologists involved in that program had organized





three subsequent training sessions. Participants for these secondary trainings came from a variety of practice locations, both inside and outside the St. Petersburg area. Several of the participants had successfully introduced MVA at their own facilities.

The NAF evaluation team observed abortion practice at one such site, Antenatal Clinic #9, and was able to confirm that policies, procedures, and techniques met the standards outlined during the initial training. Physicians and patients reported satisfaction with the service. At the time of the visit, the local health authority was reviewing new patient education materials, and professional medical journals had accepted two academic articles related to abortion for publication. At least one of the participants had been asked to present the training program and their accomplishments at a national conference.

The participants were successful in overcoming many barriers and challenges to changing the clinical care offered to patients, and the institutionalization of the MVA technique in St. Petersburg.

### *Institutional Barriers to Institutionalization of MVA:*

- since abortions were provided in various locations, even within the hospital, training participants found little opportunity to influence the practice of their colleagues;
- there appeared to be some competition for patients, even within the hospital;
- physician participants found they were not necessarily in a position to influence budget, purchasing, or other administrative decisions; this appeared to be true in both clinic and hospital settings; and
- moving innovations through the layers of bureaucracy within the institutions and at regional, city wide and national levels was cumbersome; for instance, regional health authority approval was required before any patient education materials could be distributed.

In October 2005, the International Federation of Professional Abortion and Contraception Associates (FIAPAC), held a conference on Abortion, Contraception and Women's Health at the Research Centre of Obstetrics, Gynecology and Perinatology in Moscow, Russia. Presentations by Russian physicians on issues related to abortion demonstrated recognition of the concepts of quality abortion care reviewed in the MVA training in 2002, and the WHO publication, "Safe Abortion: Technical and Policy Guidance for Health Systems." Participants from the Ott Institute attended the conference and discussed with the lead trainer and NAF program coordinator that the use of MVA continues in the training sites in the St Petersburg region. There were about 500 attendees at the conference, the majority Russian physicians from Moscow.

"Reasons for the high abortion rate include the long history of reliance on the method in the Soviet Union, in turn due to the relative isolation from Western medical developments, the costs of imported modern contraception, attitudes of the medical profession, and 'relative ignorance and fatalistic attitudes toward health issues, a medical system that promoted curative rather than preventive care, compounded by a widespread availability of abortion services and high tolerance of pregnancy termination.' A direct inquiry into the reasons for the continued high abortion rate and low contraceptive prevalence that is part of this report indicates a combination of serious supply issues and the financial interests of medical practitioners."

Olds S, Westoff C. "Abortion and Contraception in Georgia and Kazakhstan," *OSI Report*, June 30, 2004.



### III. Bishkek, Kyrgyzstan

#### A. Kyrgyz Science Research Institute

#### B. Kyrgyz Russian Slovenian University Clinic



Family planning in Kyrgyzstan consists primarily of abortion, although intra-uterine devices, oral contraceptives, and spermicidal film are available. One explanation for the low rate of contraceptive use is that oral contraceptives are provided for free for only two months at the United Nations Population Fund (UNFPA) family planning centers. Usage then decreases due to the out-of-pocket cost to patients. Counseling and informed consent are not required by the Ministry of Health, and are not offered. Some educational materials are presented in the hallways of the hospital in the form of posters about contraceptives, the risks of abortion, and sexually transmitted diseases.

Abortion is legal in Kyrgyzstan up to twelve weeks, and allowed up to twenty to twenty-two weeks for medical reasons; ultrasound use is widespread. Officially, gender-selection abortion is not allowed; however, many families have a preference for male offspring.

Women planning to have an abortion come to the Kyrgyz Science Research outpatient clinic based on referrals from regional clinics and carry medical information cards. All women receive an ultrasound performed by a specially

trained physician. Screening for anemia (reported to be as high as eighty percent), syphilis, HIV, and cervicitis are also required prior to an abortion. Women typically wait about two days for test results and then are permitted to have their procedures.

Women having “mini-abortions” are offered local anesthesia. Ketamine is the induction agent of choice for general anesthesia. Post abortion, women stay in the hospital for two to six hours, depending on their anesthesia method. Women experiencing discomfort following their procedures are offered analgesics. Prophylactic antibiotics are not routinely prescribed; infection has been reported in as many as one-third of all patients. Typical follow-up involves a return to the clinic two days later for an ultrasound to confirm the abortion is complete.

Prior to the trainings, physicians at the Kyrgyz Science Research Institute provided abortion with EVA for gestations up to five weeks LMP, using sharp curettage for procedures from six to twelve weeks LMP. Several doctors were familiar with MVA, and had obtained aspiration syringes during a previous family planning training. The assessment team



*Primary recommendations for training following the assessment were:*

- 1) emphasize MVA over EVA for procedures from 5–12 weeks;
- 2) conduct tissue examination following terminations to confirm completion instead of return for ultrasound;
- 3) increase the use of local anesthesia with MVA up to 12 weeks; and
- 4) implement counseling/informed consent and more direct patient education on contraception.

concluded that if trainings were provided at this site, long-lasting changes would be implemented, additional training would be provided, and safer abortion services would be offered to women. Key coordinators in Bishkek expressed hope that participation in the MVA project would help to institutionalize MVA as a common practice by increasing the number of trained physicians, and improving access to the MVA instruments.

Approximately twenty senior doctors participated in the program for five days, following which the majority of participants were able to demonstrate their skill by providing two to three abortions. Several participants acknowledged that counseling and patient education were key skills they obtained. Training procedures demonstrated the effectiveness of local anesthesia for pain management, as participants remarked how comfortable the women were and how quickly they recovered. By the end of the training, primary decision makers had instituted changes regarding the introduction of comprehensive counseling, MVA instruments and techniques, local anesthesia, tissue examination, and instrument processing. The group discussed future plans for the implementation of additional training throughout the country, and were concerned about the likely expense of maintaining an



adequate supply of MVA syringes. Physicians expressed progressive attitudes toward abortion care and identified nurse midwives as potential providers of early abortion care using MVA technique.

The training identified an obstacle to the provision of competent counseling and informed consent. A minority of doctors expressed skepticism about the value of discussing patients' emotions regarding the abortion and their plans for contraception. Physicians differed markedly in their interpretations of what kind of information exchange they considered to be providing patients with options versus giving their opinion.

During the evaluation visit in February 2004, participants from the original training reported their satisfaction with the MVA procedure and the

hospital had adopted the technique for a majority of appropriate procedures. They confirmed that preliminary counseling was being conducted for all women, and that tissue examination was being used to confirm completion. The evaluation team then reviewed technical recommendations regarding the administration of local anesthesia and tissue examination.

OSI funded a second-year site, the Kyrgyz Russian Slovenian University, to continue the institutionalization of MVA. Several of the participants from the original training site were now employed at this second site. The University had recently built a freestanding clinic to provide full obstetrical and gynecological services on the outskirts of Bishkek. At this facility, the philosophy of patient care and the program for training new physicians incorporated quality of care concepts, including abortion with MVA.

#### *Services at Kyrgyz Russian Slovenian University:*

- currently 100% of abortions are provided with MVA, which is used widely in Bishkek and other parts of the country; however, reports state that hospitals cannot afford the toolkits for MVA;
- MVA is being provided independently by both experienced abortion providers and newer doctors who are comfortable with the techniques; the complication rates after MVA seem to be minimal (no data reported);
- Kyrgyzstan is reforming its public health system and is developing a National Public Health Strategy for 2006–2010; one of the priorities for this time period is to secure safe maternal and children's health; and MVA was included in this component as a critical tool for achieving the strategic goals.



## IV. Tbilisi, Georgia

### Center for Clinical Effectiveness in Reproductive Health



Abortion in Georgia is common and legal without restrictions up to twelve weeks of gestation. Reports suggest that it is used more commonly than contraceptive methods in family planning; data from 1999 reveal an abortion-to-live-birth ratio of 2.2.<sup>3</sup> Abortions provided up to seven weeks' gestation are referred to as “mini-abortions” and can be provided in state-licensed outpatient facilities (usually Women’s Consultation Centers) and in some private clinics. All other abortions must be provided in hospitals by obstetricians/gynecologists.

At the Center for Clinical Effectiveness in Reproductive Health, prior to the training project, all abortion patients were routinely given general anesthesia for sharp curettage procedures. This facility provides obstetric and gynecological services. It was renovated in 2003, and subsequently had a low patient volume. It functions as a teaching institution and a model continuing medical education (CME) program, which was initiated during the same time frame as this project. Stakeholders in the project expected that this mandate for formal CME re-

quirements and the need for opportunities to fulfill them would facilitate dissemination of the MVA curriculum in Georgia.

Ten physicians were involved in the training program. Teaching methods included lectures and demonstration and practice of MVA technique with pelvic models, followed by supervised procedures for patients. Nurses, typically involved in abortion care, also participated in this training, primarily in the area of cleaning and maintaining MVA instruments. Following the initial training, a bilingual faculty member stayed on to offer further technical assistance.

Four months following the training, the project team conducted a second visit to observe procedures and evaluate the institutionalization of MVA and safe abortion care practices. This assessment demonstrated that the site had implemented several training concepts into their practice and were responsive to issues of patient privacy and quality of care for the women at their center. The clinic established a room for counseling with patient education

<sup>3</sup> Olds S, Westoff C. “Abortion and Contraception in Georgia and Kazakhstan,” *OSI Report*, June 30, 2004.



materials and improved the process by which patients progressed from registration to recovery and discharge. A privacy curtain was used in the procedure room based on recommendations by NAF faculty. The physicians from the original training reported satisfaction with MVA provision; however, they reported some difficulty implementing effective pain management with local anesthesia. Tissue exam was routinely performed for assurance of abortion completion.

The Center for Clinical Effectiveness in Reproductive Health recently completed a year-long project in collaboration with OSI titled “Comprehensive Abortion and Family Planning Care in Georgia with MVA Abortion Technique.” This was a continuation of activities implemented in 2004 through the project supported by NAF, OSI–New York, and Network Public Health Program/Soros Foundation–Georgia to replace sharp curettage with MVA and provide safe, high-quality, affordable, and acceptable abortion care.

Fifty-six service providers were trained in Kutasi, Gori, and Tbilisi by faculty from the Center for Clinical Effectiveness in Reproductive Health. To increase public awareness, the project coordinators arranged for educational materials for women to be printed and distributed to all women’s clinics in Tbilisi with the assistance of the local International Planned Parenthood Federation (IPPF) branch. In November 2005, a meeting was conducted with service providers through Georgian Obstetricians Gynaecologists Association (GOGA) and Ministry of Labour, Health and Social Affairs (MoLHSA) to discuss the WHO Safe Abortion Guidelines and integration into the Georgian CME curriculum.



#### *The Project goals included:*

- 1) providing further training on MVA methods to obstetricians/gynecologists, ensuring counseling and informed consent, and increasing the professional level of the staff in providing abortion services;
- 2) protecting the reproductive health of women by increasing access to quality abortion services, with respect to women’s rights to information and choice of services;
- 3) informing and providing education for reproductive age women about abortion, avoiding criminal interventions, and diminishing negative consequences after abortion;
- 4) reducing the number of unplanned pregnancies and abortions; and
- 5) discussing the WHO document at the Georgian Obstetricians Gynaecologists Association (GOGA) and Ministry of Labour, Health and Social Affairs (MoLHSA) meeting, and introducing evidence-based protocol on comprehensive abortion care.



## INSTITUTIONALIZING MVA: PROJECT RESULTS

### I. Overall Assessment

Future project goals based on anticipated change in clinical practice must consider attitudes, economic impacts, level of bureaucratic cooperation, and the targeted population's overall perspective, as these elements influence a variety of results. This premise is critical to planning any interventions aimed at improving an existing system. In the overall assessment of the project participating sites, individual countries had both similar and distinct obstacles and strengths.

#### Common strengths included:

- abortion care integrated with general obstetrical and gynecological care;
- obstetrician/gynecologists experienced in abortion care available at large public institutions; and
- minimal societal barriers to abortion care.

#### Common challenges included:

- bureaucratic precedence over clinical decision making;
- economic and social inequality of women;
- low compensation for medical personnel;
- antiquated perspective on the physician's role in patient decision making and empowerment; and
- limited accessibility to abortion in the outpatient setting, or only at early gestations.

"The problem of unsafe abortion has been neglected for at least five years as a result of the US funding ban anti-abortion policy (Global Gag Rule). According to WHO, 70,000 deaths (13% of maternal deaths worldwide) are due to unsafe abortions. The International Planned Parenthood Federation estimates that this year 19 million women will die or suffer from injury or illness because of unsafe abortions. The UK funds enable IPPF to set Global Safe Abortion Programme which will not only help to improve access to safe services but also to support other partners that have had to cut back on reproductive health services because of the impact of global gag rule."

IPPF, *Death and Denial: Unsafe Abortion and Poverty*, 2006.



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## II. Values clarification and conflicts in clinical practice approaches need to be fully understood in order to develop effective interventions.

Negative attitudes and beliefs held by both patients and physicians regarding contraceptive methods, particularly oral contraception, contributed to low usage rates. “In 1999, only 15% of women in Georgia reported contraceptive counseling before or after an abortion and only 3% were offered a method and 1% a prescription. In addition to failures with contraception, there are significant discontinuation rates. Overall, 41% of users discontinued use by the end of the first year. This rate is particularly high for users of the pill (73%) with side effects playing the main role.”<sup>4</sup> “Russian public health authorities have identified as a national problem women’s reliance on abortion as a means of achieving their reproductive goals. The contribution of abortion to maternal mortality, the use of abortion as a primary method of birth control, the misconception that abortion is safer than contraceptive methods, the high rate of repeat abortion and the lack of integrated family planning services for post-abortion women are recognized by the Russian Ministry of Health and USAID as critical health issues.”<sup>5</sup>

Participants from several facilities in the project revealed that additional payments are common practice to enhance compensation for abortion provision (and other medical services). One physician who resisted discussing birth control options with patients stated that if women received contraceptives, the doctors would not be able to collect these supplemental fees.

In many of the trainings, certain beliefs of the participants conflicted with the experiences of trainers from the United States and Canada. For example, many training site physicians commonly believe abortion causes infertility, which conflicts with research findings from North America. In some cases, the training curriculum data were not persuasive enough to trainees to support a change in practice. In several settings, formal and informal policy dictated that a woman’s first pregnancy should be carried to term to ensure that she would be able to have at least one



child. Providers working in countries experiencing decreasing fertility rates are also encouraged to persuade women to continue their pregnancies. Future discussions need to address the possibility of higher rates of infertility following post-abortion infection, more common in project regions than in North America, and prospects for conducting more definitive research in this area to establish the necessary evidence to support changes in practice. Comparison data following adoption of safer abortion methods, increased contraception access, and examination of the primary source of infection impacting women’s fertility are important to consider for future interventions.

Attitudinal perspectives varied quite a bit among the training participants. Consensus among trainees indicated that the curriculum and trainings offered effective information; however, they initially had moderate levels of skepticism about the abortion method, which decreased with experience and implementation.

Follow-up evaluations indicated that many participants made changes to their methods of patient interaction based on the training. Continuing to support abortion providers who demonstrate strong commitment to patient-centered, safe clinical practice will help create change now and in the future. Physicians in a position of authority and credibility are the change makers. They teach the next generation and model the future of medical care to their patients, thereby changing expectations for quality care.



<sup>4</sup>Olds S, Westoff C. “Abortion and Contraception in Georgia and Kazakhstan,” *OSI Report*, June 30, 2004.

<sup>5</sup>Savelieva I. “Post-abortion contraception: Methods choice,” Presented at FIAPAC Conference, Research Center Ob. & Gyn., Moscow, Russia, October 27-28, 2005.



**III. The assessment phase should focus on the feasibility of a given project to address baseline goals and planning should be directed toward realistic expectations for change.**

North American quality management theories establish baselines for any intervention intended to improve skills and knowledge. Goals that vary according to the setting and circumstances are set from this baseline. Expecting a group to make a change based on a given concept, e.g., evidence-based medicine, requires that this concept is accepted as a common baseline. Furthermore, identifying decision makers and effectively assessing the ability of a site to manage the challenges inherent in creating change are crucial to evaluating the capacity of project sites to achieve training goals. Without an influential stakeholder to effectively introduce new concepts into an existing system, training goals are less likely to be attained. Project teams recognized this principle in the current project by observing the routes to success utilized by certain sites which were able to implement change more quickly than other sites.

**IV. Sustainability is key to training efforts, particularly those based on a specific technology or technique. This can be a stumbling block in many instances where a tangible device is not available to trainees that have been primed to begin a new technology.**

Cost effectiveness does not necessarily sustain adequate motivation for change, especially if systems are structured around an existing service. When an anesthesiologist is always available to provide general anesthesia, safety data alone may not support a switch to local anesthesia, particularly when patients are accustomed to being asleep during a procedure. Additional payments for care may also complicate the implementation of change. Experienced physicians using ultrasonography to confirm completion of abortion may feel that the gross pathology exam of aspirated fetal tissue is an unnecessary skill, without considering this as an essential method for training providers in low-resource settings. In the context of centuries of reaching toward ever more sophisticated technology, it may be difficult to persuade medical practitioners to focus on basic, low-technology techniques. In order to obtain the necessary “buy-in” for the system changes inherent



in any meaningful project, individuals with the ability to influence bureaucratic and economic entities must support its goals and objectives. Future efforts should ensure that settings without access to international NGO projects, pharmaceutical entities, or influential connections in large institutions have feasible, sustainable access to technology and training for their setting. Clear goals for sustainability in planning for a project can help establish the appropriate settings for training and dissemination of support. Crucial to successful implementation are acceptance of new technologies by regulatory agents, for example the Ministry of Health; the organization of distribution networks; and budget allocations by an institution for new equipment or medications.

## V. Summary of Conclusions

Organizations that are concerned about women's health and justice and are interested in improving the quality of abortion care continue to monitor and assess the progress toward goals established a decade ago at the International Conference on Population and Development. Nurturing changes in clinical practice and creating networks and support with educational, financial, and clinical quality expertise are the components of long-term sustainable change. The WHO publication titled "Safe Abortion: Technical and Policy Guidance for Health Systems" (2003) and the WHO/Ipas efforts to introduce these guidelines into practice are valuable steps. These guidelines



support many of the training concepts presented in the NAF/OSI project and are important for establishing safe abortion care criteria in these regions.

Strategic assessment of policies and quality of abortion care, including access to contraceptives, is currently taking place in many of the training regions. This will assist in furthering the agenda to decrease maternal mortality and improve women's health and lives. Organizations such as WHO, Ipas, IPPF, NAF, and other NGOs involved in reproductive health are key to continuing progress toward achieving these goals, which they share with change makers from individual health systems.

The aim of the MVA project is to contribute to efforts of both public and private health systems, reproductive health organizations, and key individuals for ensuring women's health by improving the quality of abortion care. The experience reported in this document is intended to provide insight for future project development geared towards ensuring safe care in these regions. More than 30 years of professional expertise in abortion care and providing accredited continuing medical education has enabled NAF to develop evidence-based guidelines and standards for establishing, assessing, and improving the quality of abortion care in North America. Future collaborations for improving abortion care worldwide can integrate the key lessons from this MVA project and further the goal of improving women's lives and health.

