ABORTION AND CONTRACEPTION IN ROMANIA

A STRATEGIC ASSESSMENT OF POLICY, PROGRAMME AND RESEARCH ISSUES

Report of a Strategic Assessment Undertaken by

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Abortion and contraception in Romania. A strategic assessment of policy, programme and research issues

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The cover combines a Romanian folk art pattern and the twin-hemisphere circle created by the famous Romanian artist Constantin Brancusi in his sculpture, the Gate of the Kiss.

The traditional Romanian pattern is part of a wool and cotton Maramures-style carpet, hand woven in Sighetul Marmatiei. This design is unique to the rural northern region.

Carved in stone between 1937 and 1938, the Gate of the Kiss is part of a three-monument ensemble (the other two are the Endless Column and the Table of Silence) situated in the Public Gardens of Targu Jiu, the seat of the sculptor's native county. The twin-hemisphere circle, which appears on both the columns and the horizontal portion of the gate, is the representation of lovers' eyes. This symbol of spiritual love embodies young people's common understanding and vision of the world. Interestingly, the twin-hemisphere circle resembles the first division of an egg cell, which also makes it a symbol of human reproduction.

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PREFACE

Since 1989, elective abortion has been used often as a replacement for contraception in Romania, due to new liberal policies, widespread acceptability, easy access, and low cost. Romania had the highest abortion rate in Europe during the early 1990s. Since that time, official statistics show that the annual number of abortions has decreased gradually. Despite this reduction, abortion still represents a major method of fertility control in Romania. The unacceptably high number of abortions also triggers soaring medical and economic costs for the healthcare system.

Although first-trimester pregnancy termination is legal and widely available throughout the country, within both public and private clinics, there are still a significant number of unsafe, illegal abortions (200 reported in the year 2001). In addition, illegal abortion continues to lead to maternal deaths (37 cases reported in 2001).

In 1994, Romania, along with 178 other countries and numerous civil society organizations, signed the Programme of Action of the International Conference on Population and Development, held in Cairo. The Programme of Action acknowledged the need for governments and relevant non-governmental organizations to reduce the need for abortion by offering quality, comprehensive family planning services, and clearly stated that where abortion is legal, it should also be safe.

In this context, the Ministry of Health and Family considers sexual and reproductive health a priority and quality family planning and safe pregnancy termination services as primary areas of intervention in its national strategy. Although we do not believe that abortion is the ideal fertility control method, the current high numbers of women with unplanned pregnancies who decide to terminate them require measures adequate to ensure quality abortion services. In the demographic context of the country, characterized by a low fertility rate and a negative demographic trend, these interventions must be seen as part of preventive medical services and as a tool to advance basic human rights regarding reproduction and sexuality.

Therefore, the Ministry of Health and Family believes that the "strategic approach" promoted by the World Health Organization could be successfully applied to assess abortion and contraception services in Romania, in order to identify adequate and sustainable program interventions that could improve the quality of abortion services in the public and private sectors and subsequently decrease the demand for abortion.

This report presents the findings and recommendations of the strategic assessment of contraception and abortion-related policies, programmes and services in Romania, conducted through a participatory process, with the involvement of the leading institutions active in reproductive health, including the Ministry of Health and Family, National Health Insurance House, National College of Physicians, technical institutes of the Ministry of Health and Family, National Society of Obstetrics and Gynaecology, as well as key relevant non-governmental organizations. The assessment benefited from the technical consultancy of experts from the Special Programme for Research. Development and Research Training in Human Reproduction of the World Health Organization, and from Ipas, an international, non-profit, reproductive health organization. It is a great achievement to have gathered all these institutions under the same umbrella.

I am certain that the assessment recommendations will offer the Ministry of Health and Family and other relevant bodies essential information to take the appropriate next steps in order to diminish the need for abortion by promoting modern contraception and – for unplanned pregnancies – to improve the quality of abortion care in Romania.

Daniela Bartos, MD

Minister of Health and Family

EXECUTIVE SUMMARY

This report presents the findings and recommendations of a strategic assessment of abortion and contraception, conducted in Romania in November 2001.

The assessment utilised a conceptual framework and strategic planning methodology known as the *Strategic Approach*, developed and promoted by the Department of Reproductive Health and Research at the World Health Organization (WHO). The assessment was implemented by a team of 19 members representing the Ministry of Health and Family (MOH), National Health Insurance House, National College of Physicians, technical institutes of the MOH, National Society of Obstetrics and Gynaecology, and relevant non-governmental organizations. Team members interviewed administrators, providers, and clients of contraception and abortion services as well as a broad range of community members, including factory employees, teachers, students, representatives of youth and women's organizations, local business owners, local government officials, Rroma representatives, etc. The report includes respondents' knowledge and perspectives on availability of and access to services, cost of services, quality of care in service delivery, and contraceptive and abortion technologies.

The assessment was initiated by the Romanian Ministry of Health and Family as an important component of developing a national strategy for sexual and reproductive health. The team leader from the MOH initiated the process by procuring funding and technical support from the WHO and Ipas, an international, non-profit, reproductive health organization. The process of conducting the assessment included, preparation of a background paper, convening a national planning meeting, developing strategic questions and interview guides, conducting field-based observations and data collection, and disseminating the findings and recommendations to a national audience.

The MOH is committed to implementing priority recommendations, including development of national standards and guidelines for abortion care and development and testing of interventions designed both to reduce the need for abortion and to improve the quality of abortion and contraceptive services for all Romanians.

Historical Context

Since 1989 elective abortion has been a primary method of fertility regulation in Romania. This is due in part to a perceived lack of affordable, high-quality contraceptive services, the absence of post-abortion contraceptive services, the lack of incentives to doctors who are paid for performing abortions but not for providing contraception, and an abortion culture that developed out of years of draconian, pronatalist politics that banned contraceptives and heavily restricted access to, and availability of safe abortion services. Following the demise of Nicolae Ceausescu in 1989, one of the first acts of the new government was to overturn the restrictive abortion law.

During the early 1990s, Romania had the highest abortion rate in Europe, but abortion-related deaths had dropped dramatically from pre-1990 levels. Over the past decade official figures show that contraceptive prevalence has increased and abortion rates have dropped considerably, although underreporting, especially in the private sector, remains a problem. The MOH considers that the number of abortions remains unacceptably high, resulting in unnecessarily high costs, both to women and the health-care system. Also, due to a number of social, educational, and economic reasons Romania continues to have a relatively high number of illegal (and unsafe) abortions as evidenced by the high number of hospital admissions for abortion complications.

In 1994, Romania, along with 179 other countries and numerous civil society organizations, signed the Programme of Action defined within the International Conference on Population and Development at Cairo. The Programme of Action acknowledges that governments and other stakeholders should help reduce the need for abortion by expanding and improving family planning services and clearly states that where abortion is legal, it should also be safe.

The Romanian MOH considers sexual and reproductive health a priority and is in the process of finalising a national reproductive health strategy. This strategy, informed by the strategic assessment, highlights comprehensive family planning and safe pregnancy termination services as key areas of programmatic intervention.

Knowledge, Attitudes and Behaviours related to Abortion and Contraception

Field-based observations and interviews conducted during the assessment suggest that despite major improvements in the national family planning programme over the past five years, abortion remains one of the most common methods of fertility control in Romania. Women consider abortion to be a traditional, safe, accessible, quick, and relatively cheap procedure, even if unpleasant and stressful. They see abortion as a means of resolving an already existing unwanted pregnancy, while contraception is regarded as a less accessible, more costly and complicated way to prevent a possible problem (a future unwanted pregnancy).

Gynaecologists also consider abortion to be a common, simple procedure, which does not require special attention. They admitted that abortion is a good source of income, especially for those who limit their professional activities primarily to performing abortions. The cultural tradition of giving gifts to physicians for the services they provide helps to perpetuate this situation. Some women interviewed during the assessment said they felt obliged to give additional gifts to physicians, hoping for improved quality of the abortion procedure.

Access to and Availability of Abortion and Contraceptive Services

Abortions are widely available in Romania and are provided exclusively by obstetrician/gynaecologists in both public and private facilities. However, nearly all obstetrics and gynaecology departments, private abortion clinics, and family planning clinics are located in urban areas. Consequently, the urban population has a much wider range of services and choices than the rural-based population. Also, women in rural areas with no services must bear the additional cost and time required to travel to cities where services are available.

The high number of abortions indicates continued unmet need for high-quality contraceptive services. Although more available now than in the early 1990s, contraceptive services remain difficult to access and expensive when compared to the availability and cost of abortion. Contraceptive prevalence rates are still low compared to other European countries. Access to contraceptive services is poorer in rural areas; and, "youth-friendly" services are virtually non-existent even in urban areas.

The MOH, in collaboration with the United Nations Population Fund (UNFPA) and the United States Agency for International Development (USAID) funded John Snow Research and Training, have begun training family doctors (general practitioners) over the last two years to provide contraceptive counselling and methods. The process is rapidly expanding, and trained family doctors usually only provide oral contraceptive pills and/or condoms. Some doctors visited during this assessment reported poor stocks of contraceptives. Women who desire to have an IUD can only get it from an obstetrician/gynaecologist.

Both public and private abortion facilities provide pregnancy termination services for a nominal cost. Elective abortion is a procedure performed at the client's request and thus, is not reimbursed by the national health insurance system. The price of abortion varies between public and private facilities, among hospital departments, and

among private facilities, due to institutions' autonomy in setting fees. Generally, both providers and clients believed that public abortion fees do not cover the real costs, and that private abortion fees more accurately reflected the actual cost of abortion.

Although they agreed that the "official" abortion fee did not cover the actual cost of the procedure, the majority of women interviewed believed that abortion fees and prices of contraceptives were too high when compared to their disposable income. Many persons interviewed thought that an increase in abortion fees would lead to an increase in illegal abortions.

The team thought it would be useful to reassess abortion fees based on actual costs of a standard procedure, according to established guidelines, and to establish a new fee accordingly. The team members unanimously agreed to recommend the establishment of a sliding fee scale that would not create barriers for women with low socio-economic status. Also it was recommended that at least some of the funds derived from abortion services should be reinvested to improve the quality of services, including post-abortion contraception.

To improve contraceptive prevalence and reduce the need for abortion, the assessment team recommended a concerted strategy to (1) accelerate expansion of contraceptive services within primary health care, (2) make services more youth-friendly; (3) provide better information and education about prevention of unplanned pregnancy, availability of free contraceptives and abortion for poor women, and dangers of unsafe abortion, through clinic brochures, primary and secondary school classes, and the media; (4) increase the involvement of men in family planning; and, (5) improve access to abortion-care services for women with low socio-economic status and those living in rural areas.

Furthermore, changes should be made to the medical school training curricula to improve general provider-client interactions, provider counselling skills, and providers' evidenced-based knowledge of modern contraceptive and abortion methods. Also, the national abortion surveillance system should be improved to provide a more accurate accounting of the number of abortions and abortion-related complications.

Quality of Care in Abortion and Contraceptive Services

The assessment team found that most elective abortions are still performed with sharp curettage, a finding that surprised most of the MOH team members who assumed vacuum aspiration was now standard practice. A poor quality of care in the provision of abortion services was also observed, especially in terms of client-provider interaction. The assessment team's primary recommendation is to improve abortion and contraceptive services by developing and implementing the concept of *comprehensive abortion care*, including:

- National standards and guidelines;
- A focus on client-centred care, including the option to schedule abortion procedures in public clinics and maintaining strict adherence to rules of privacy and confidentiality;
- Comprehensive pre- and post-abortion counselling;
- Widespread introduction and use of vacuum aspiration;
- The introduction of medical abortion, if and where feasible;
- More appropriate use of pain- control medications;
- More appropriate recovery room protocols and conditions;
- Comprehensive post-abortion contraceptive services;
- Screening and appropriate referrals for other needed sexual and reproductive health services;
- Appropriate follow-up with clients' family physicians;
- More decentralized services; and
- A national monitoring and evaluation system to ensure high-quality contraceptive and abortion services.

Abortion and Contraceptive Technologies

Technologies are now available in Romania that can better reduce the need for abortion, offer women more choices for both preventing and terminating pregnancy and that make abortion safer and less costly.

Emergency contraception is known and used by a very small number of women, although emergency contraceptives are registered and available in Romania. However, they remain expensive (about the same price as an abortion) and difficult to obtain. Female sterilization remains an under-utilised option and services for male sterilisation are practically non-existent.

As for abortion, providers still rely mainly on sharp curettage. Vacuum aspiration technologies are not readily available in Romania despite the fact that they provide a safer, less expensive alternative to sharp curettage. Medical abortion, recently introduced through a WHO clinical trial, proved to be extremely popular with clients of abortion services; and, thus should be explored further as a possible option to surgical abortion.

The assessment team recommends that the MOH conduct research to better understand the impact of cost on choice of contraceptive methods and abortion. Many women perceive that the cost of modern contraceptives is approximately the same or in some cases even more expensive than abortion. The team also recommends that the MOH immediately replace sharp curettage with vacuum aspiration (including both manual and electric pumps) and conduct further research on the introduction of medical abortion.

Future steps

The strategic assessment corroborated many earlier study findings, such as:

- Abortion is one of the most commonly used fertility regulation method in Romania;
- Registered facilities that provide abortion generally offer safe procedures, however, the rate of complications appears to be much higher than in western countries;
- An increasing number of abortions are performed in the private sector, many of which go unreported;
- The link between abortion services and contraceptive services is very weak;
- The provision of contraceptive counselling and methods by all family doctors is still an unachieved goal;
- Illegal abortions are still a problem.

The assessment team refuted its own widely held assumption that most abortions are performed with vacuum aspiration.

And, the assessment highlighted certain limitations in abortion service delivery, including:

- The general low quality of care in service provision, including problems in provider-client interactions and lack of privacy and confidentiality;
- Deficiencies in abortion procedures, including pain management and infection-prevention practices; and,
- Deficiencies in monitoring and reporting systems in abortion facilities, especially in the private sector.

Other important conclusions of the strategic assessment are the need to develop national standards and guidelines for abortion care and to implement a national monitoring and evaluation system to ensure sustainable, high-quality services. Also, the MOH and other government ministries and institutions must work hard to address the effects that poverty and lack of information and education play on the population's sexual and reproductive health. Changing relative costs of modern contraceptives and elective abortion could facilitate changes in couples' attitudes and behaviours regarding fertility regulation methods. Pairing the availability of free or subsidized contraceptives on a large scale with information campaigns on the benefits of modern contraception may lead to both increased demand and use. At the same time, decentralising services and maintaining a standard fee for abortion at levels affordable to

women with low socio-economic status may keep poor women from resorting to unsafe abortion when unwanted pregnancies occur.

Some of the needs identified by the research team have already begun to be addressed by stakeholders who participated in or were represented by the assessment. In this regard, the assessment played an important role in raising awareness and knowledge as well as boosting government motivation to take action.

Other recommendations of the assessment are detailed in the body of the report and will be addressed, pending funding and agreement among members of the consultative group for reproductive health who advise the MOH in establishing priorities and defining the interventions needed to improve sexual and reproductive health care. Action on these recommendations will provide additional follow-up to the strategic assessment and other efforts aimed at helping Romanians realise a future with improved sexual and reproductive health outcomes.

INTRODUCTION

This report presents the findings and recommendations of a strategic assessment of abortion and contraception, conducted in Romania in November 2001.

The assessment is the first phase of a three-phase conceptual framework and strategic planning methodology known as the *Strategic Approach*, developed and promoted by the Special Programme for Research, Development and Research Training in Human Reproduction (HRP) of the World Health Organization (WHO). The strategic assessment is a participative process involving strong leadership from the Ministry of Health and active partnership with other key stakeholders, including professional reproductive health and related specialist organizations; women's health, family planning, education, adolescent, and reproductive rights organizations; and clients and providers of abortion-care and contraceptive services.

The Romania strategic assessment focused broadly on the following key strategic questions:

- How to reduce the need for abortion?
- How to improve access to and availability of abortion care and contraception?
- And, how to improve the quality of abortion-care and contraceptive services?

The strategic assessment produced recommendations for a second phase of work that will focus on policy change and action (intervention) research, including:

- Development of national standards and guidelines for abortion care and contraceptive services; and,
- Development, implementation and testing of interventions to address the key strategic questions.

A third and final phase in the strategic approach will involve expanding and scaling-up services; that is, adapting successful, sustainable model interventions and expanding them regionally and/or nationwide and developing and implementing monitoring and evaluation systems to ensure ongoing access, availability, quality, choice, and sustainability in abortion-care and contraceptive services.

Since 1989 elective abortion has been a primary method of fertility regulation in Romania. In the early 1990s, Romania had the highest abortion rate in Europe. Over the past 10 years official statistics suggest that abortion rates have gradually declined. The estimates show a decrease from 177.6 abortions per 1,000 women aged 15 to 49 in 1990 to 43.81 per 1,000 women in the year 2001. Just over three quarters of these procedures were elective; the remaining number was incomplete abortions and a small fraction (0.03) was illegally induced abortions. Despite the downward trend, abortion remains one of the main fertility-regulation methods in Romania. According to the Ministry of Health and Family, abortion rates are unacceptably high, resulting in soaring medical and economic costs to the health-care system.

In the context of East European countries, including those in the Commonwealth of Independent States that have adequate demographic records, the Romanian abortion rate is comparable to that found in the Russian Federation and higher than those in most former Soviet countries. The high rate of abortion points to a considerable number of unwanted pregnancies. The total abortion rate, which is the number of abortions that a typical woman would have in her lifetime given the current age-specific abortion rate, is 70% higher than the total fertility rate (2.2 compared to 1.3). According to current estimates, for the period 1996 to 1999, the elective abortion to live birth ratio was 1.6.

In 1994, Romania, along with 178 countries and numerous international and domestic civil society organizations, signed the Programme of Action defined within the International Conference on Population and Development, at Cairo. This conference highlighted the interdependence between

population and development and underscored that demographic objectives can be best attained by observing human rights and by meeting individual needs for sexual and reproductive health services, rather than through coercion or state-imposed control. In addition, the Programme of Action acknowledged the need for governments and other relevant stakeholders to reduce the need for abortion by expanding and improving family planning services and clearly stated that where abortion is legal, it should be safe.

The Romanian Ministry of Health and Family has made sexual and reproductive health a priority, and is in the process of finalising a national strategy on sexual and reproductive health. In accordance with the Cairo Programme of Action, the goals of the strategy are to improve sexual and reproductive health status and to provide all Romanian residents with the opportunity to exercise their sexual and reproductive health rights throughout their lifespan in order to:

- Enjoy healthy sexual development and maturation, including the ability to have responsible relationships and attain sexual fulfilment;
- Have the desired number of children, safely and healthily, if and when desired;
- Avoid sexually transmitted infections (STIs) and benefit from quality health care when needed, and to;
- Avoid being subject to or affected by, violence or other abusive practices related to sexuality and reproduction.

To achieve this goal – within the sexual and reproductive health strategy of the Ministry of Health and Family – the provision of high-quality family planning services, including contraceptive counselling and methods for safe pregnancy termination services represent key areas for intervention. In the demographic context of Romania, which is characterized by low fertility and a negative demographic trend, the national family planning programme must be seen as part of preventive health-care services and as a tool to promote choice and basic human rights related to sexual and reproductive health.

The aim of the strategic assessment was to identify areas for policy change as well as appropriate and sustainable programme interventions that can be implemented to improve the quality of abortion and contraceptive services in the public and private sectors in Romania and subsequently decrease the need for abortion.

This report presents findings and recommendations obtained through data collection conducted by a team of key stakeholders of abortion and contraceptive services in Romania. The assessment included the analysis of available data, interviews conducted with numerous information sources, and observation of abortion and contraceptive services. The assessment benefited from the technical consultancy of experts from the Special Programme for Research. Development and Research Training in Human Reproduction (HRP) at the WHO and from Ipas, an international, non-profit organization specialised in the field of abortion and reproductive health.

The goal of the assessment is to provide appropriate recommendations for policy change and action research that will facilitate the expansion of successful, sustainable programmatic interventions. It is our hope that this assessment can help the Ministry of Health and Family, the National Health Insurance House, the National College of Physicians and other governmental and nongovernmental institutions to better coordinate their resources in order to develop innovative approaches and improve abortion and contraceptive services in Romania.

The strategic approach facilitates improved access, availability, quality, choice, and sustainability in service delivery by addressing needs for new standards and guidelines, infrastructure, technology, programmes, and monitoring and evaluation systems (see Figure 1).

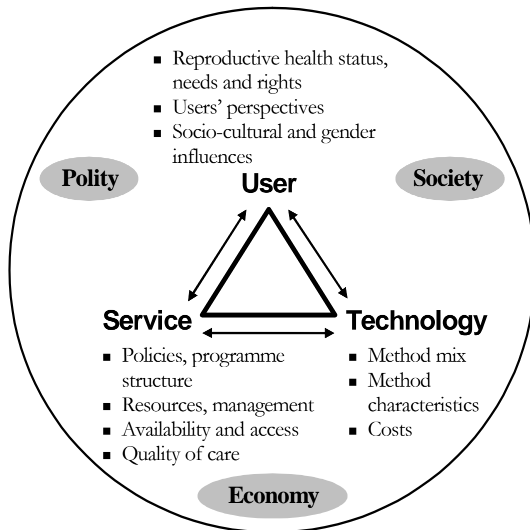

Figure 1. Systems Framework Guiding the Strategic Approach

The process is an interdisciplinary exercise derived from the medical, social and management sciences, and from the operational expertise of service providers and program managers. As this report goes to press, the strategic approach has been used in 20 countries with the support of the WHO and other organizations. Although the strategic assessment methodology was initially designed for family planning, it has been adapted to assist governments in addressing other reproductive health issues, such as STIs, including HIV/AIDS, maternal, child and teenager health, abortion and post-abortion care, and cervical cancer.

METHODOLOGY

Assessment Team

The assessment team consisted of 19 members representing the major reproductive health stakeholders, including representatives from the Ministry of Health and Family, the National Health Insurance House, the National College of Physicians, the technical institutions of the Ministry, the National Society of Obstetrics and Gynaecology, relevant non-governmental organizations, and both public and private abortion service providers. Experts from the WHO Special Programme for Research, Development and Research Training in Human Reproduction (HRP) in Geneva and Ipas, an international, non-profit reproductive health organization provided external technical support and facilitation. Overall coordination and management of the assessment was provided by the East European Institute for Reproductive Health. A list of assessment team members is presented at the end of the report in Annex 1.

The team designed the assessment plan and tools, conducted the fieldwork, analysed the findings, prepared the assessment report and disseminated the results to key decision-makers and relevant reproductive health stakeholders.

The involvement of high-level government personnel, with policy-making and programme management responsibilities, helped to ensure the future implementation of recommendations made by the assessment team. The team also included representatives from the non-governmental sector, for example: family planning associations, women's and youth organizations, and allied research institutes. The external consultants provided the team with additional skills, perspectives, and expertise based on their prior experience with the strategic approach. They added new experience, knowledge, and perspectives to issues that might have otherwise been considered uninteresting or accepted socio-cultural norms by local investigators. *Judet* (provincial) and local health authorities, managers, and service providers were active collaborators as the team undertook the assessment.

Background Paper

During the initial stage of the assessment the research team prepared a background document that reviewed existing data, available literature, unpublished research reports, and the national legal framework concerning abortion and contraception. This report was distributed to participants who attended an assessment planning workshop. The background paper had several principal aims. It provided a summary of existing data on the national reproductive health environment, identified gaps in existing knowledge, assisted in the generation of key questions to be addressed, provided a common body of knowledge for the assessment team and other stakeholders, and promoted debate and discussion among the participants during the planning workshop. Throughout the fieldwork, analysis and report writing phases, the document helped the team focus on key issues and provided reference to relevant literature and information.

Planning Workshop

A one-day planning workshop involving all relevant reproductive health stakeholders was held in Bucharest in October 2001. The main goal of the workshop was to determine priorities and programmatic issues to be highlighted during the assessment. Participants included members of the advisory group, senior decision-makers, programme managers from national and *judet* levels, health-care service providers, representatives of women's and youth groups, and researchers.

The planning workshop had the following key objectives: (1) to introduce stakeholders to the strategic approach, including the assessment goal and process; (2) to review the background paper and identify gaps and key issues for information gathering during the assessment; (3) to exchange ideas and

perspectives on abortion and abortion services; (4) to identify the strategic questions that would guide the assessment; (5) to identify the geographical areas where the assessment would be conducted; (6) to serve as an open forum to revise the assessment design; and (7) to introduce the assessment team to stakeholders. The planning workshop closely followed the WHO strategic assessment guidelines with participants making modifications and revisions where appropriate.

Regions and sites for field visits were selected based on the following criteria: (1) they allowed examination of all levels of the service delivery system from the *judet* hospital down to the local family clinic; (2) they included a wide range of service delivery points (i.e., those with both strong and weak services and those with both easy and difficult-to-access sites); (3) they reflected major regional, cultural and programmatic variations (i.e., urban and rural areas, areas with high and low maternal mortality, a range of outreach services, and services both with and without substantial international donor agency support); (4) they had the potential to fill in gaps in existing research studies (i.e., places where little was known about the population's sexual and reproductive health beliefs and practices).

Preparatory Work

Immediately following the planning workshop, members of the assessment team spent the following week designing data-collection instruments and reviewing the technical requirements and time commitments associated with participation in the assessment. Members decided the composition and the coordinators of the two sub-teams. During the preparatory meeting, the full team developed an assessment agenda consistent with the recommendations and priorities set at the planning workshop. They planned how to generate information on current abortion and contraceptive services, document gaps in knowledge and services, and make suggestions for continuing research and programs to improve abortion and contraceptive care in Romania. The team set their agenda and timetable, identified field sites (health-care facilities, communities, etc.), and determined the process for deciding which team members would visit each site. The team also planned the logistical aspects of the fieldwork, including the timeframe and content of the field visits and travel and lodging arrangements. The assessment coordinator, supported by the Ministry of Health and Family and *judet* authorities, scheduled appointments with all those to be interviewed in the field.

The team also identified the key groups to be interviewed during the assessment period, designed and field-tested the interview guides and observation checklists and finalised the geographic regions, *judets* and sites to be visited.

During the weeklong preparatory meeting, the team members developed a common understanding of the research issues that would be addressed during the fieldwork, as well as the rationale behind each question in the interview guides. Since the field assessment is a qualitative exercise, familiarity with the issues provided team members with greater confidence to depart from the scripted text to follow-up interesting points and explore emergent issues. Structured questionnaires were avoided in order to allow team members freedom to pursue new leads not originally envisioned and to rephrase questions that might be poorly understood by a particular audience.

After a comprehensive review of the critical issues identified during the planning workshop, the assessment team determined the categories of individuals likely to yield valuable information during field interviews. Respondents included decision-makers, programme managers, abortion and contraception service providers, key administrators, representatives of women's and youth groups, and community members. For each main category of respondents (e.g., policymakers, service providers, clients, and community members) the team developed interview guides to facilitate systematic data collection and to allow interviewers to probe for clarifications, explanations and additional information on issues that might emerge during the interview process.

The team pre-tested the assessment instruments in Bucharest.

Fieldwork

Fieldwork was conducted in Bucharest and eight *judets* (Braila, Constanta, Dolj, Hunedoara, Iasi, Mures, Teleorman, and Vaslui). There are 42 *judets*, or administrative units, in Romania. The assessment team was split into two sub-teams which travelled to different regions, one going to the east and the other going to the west. Members of each sub-team worked in groups of two or three conducting interviews before reconvening at day's end to discuss their findings with the larger group.

Field sites within the assessment *judets* (i.e., cities, towns, or villages) were selected to reflect geographic diversity in service provision and client perspectives. Unlike surveys with random samples, the qualitative approach relied on a purposive, non-probability sample. During the fieldwork preparatory meeting, the team defined the criteria for selecting field sites with an eye toward obtaining data that could address the strategic questions. Once in the field, the team consulted with *judet*-level health managers to select the specific communities to visit. Details on the sites and institutions visited, and individuals interviewed are presented in Annex 2. Overall, there were 515 interviews conducted with selected reproductive health stakeholders.

Data Collection Methods

The assessment teams used three approaches to collect information during field visits.

1. Individual and group interviews with reproductive health decision-makers, programme managers, public and private abortion and contraception service providers, representatives of women's and youth groups, NGOs, and academics working in the field of reproductive health. These are critical stakeholders for improving contraception and abortion services; previous studies suggest that the majority of women (and men) in Romania have some experience with abortion.
2. Exit interviews with women immediately following abortion in order to discuss their perspectives on contraception and abortion, as well as their experience with the service delivery system.
3. Observations of abortion procedures performed at various levels of the public health service-delivery system, as well as at non-governmental and other private service-delivery sites. One or two members of each assessment sub-group participated in the observations.

The criteria for selecting individuals for interviews included experience, position, knowledge, and willingness to participate in the assessment. The interviews usually lasted between 30-60 minutes.

Data Analysis and Report Writing

The ongoing analysis of field data was an integral part of the data-collection process. After each day of data collection, the sub-teams reconvened to discuss their findings, analyse responses to the key assessment questions, and revise their plans for the next day. After discussing new issues or leads that appeared during data collection, the team would revise the structure of future interviews accordingly. At the end of the second week of fieldwork, the full assessment team met in Sinaia for two days to exchange experiences and lessons learned from the data collection process and findings. At the conclusion of the fieldwork, the full team met again in Bucharest for a week to complete the data entry and analysis. During this meeting, the team produced a draft report of the two assessment teams' findings and recommendations.

A consensus-building exercise helped prioritise findings based on the team members' perceptions and on the priorities identified during the planning workshop. Each team member identified the most salient points encountered during the fieldwork period and presented their points with supporting examples from their interviews and observations.

The team grouped key issues raised during discussions into categories (e.g., socio-cultural context of reproductive health; availability of and access to services; quality of care; etc). These categories form the principal chapters and sub-headings of this report. Various team members took

responsibility for writing one or more sections of each chapter. The draft report was circulated amongst all team members for additional comments and suggestions. The assessment coordinator incorporated suggested changes and was responsible for final editing and production of the report. In consultation with team members, the coordinator also filled in gaps that emerged during discussions with stakeholders and technical advisors.

Dissemination

In April 2002, the assessment team presented the findings at a national symposium organized in Bucharest. A broad range of policymakers, programme managers, service providers, representatives of women's and youth groups, relevant non-governmental organizations, and representatives from international donor agencies attended the symposium, as well as representatives from many of the *judet*-based institutions visited during the fieldwork period.

The national dissemination conference included the following objectives:

- To disseminate the assessment findings and recommendations and to build support for actions to improve policies and programmes;
- To allow participants to challenge and assess the relevance of the findings for their respective constituencies and/or *judets*;
- To discuss, modify, and agree upon the recommendations and to solicit additional input from participants for incorporation into the final assessment report;
- To prioritise the recommendations in terms of policy, programme, and research issues, based on their feasibility and potential impact, and to initiate planning for designing and implementing a range of follow-up activities;
- To obtain public commitment to action from policymakers and programme managers.

The symposium also facilitated discussions on the draft report and recommendations made by the assessment team. After the symposium, the assessment team held a meeting to discuss possible follow-up (Stage II) activities.

Following the dissemination symposium, the assessment coordinator incorporated modifications or additions recommended at the symposium in order to edit and finalise the draft report. The final report was presented to the Minister of Health and Family and approved for printing.

ABORTION AND CONTRACEPTION IN ROMANIA

Demographic Context

Romania has a population of 22.3 million inhabitants, of which just over five million are women of reproductive age (15-44 years). Since 1990, due to a decreasing birth rate, intensified migratory flows and increased adult mortality, the population growth rate has decreased, marked by an aging population, especially in rural areas. In 1991, the total population dropped for the first time in a period of peace. In July 1999, the population was almost 45,000 less than in July 1998. These rates are thought to be largely influenced by the current social and economic situation in the country.

Statistical data from the year 2001 showed a birth rate of 9.8 per 1,000 inhabitants and a general mortality rate of 11.6 per 1,000 inhabitants, leading to a natural increase of -1.8% (as compared to +5.3% in 1989). The total fertility rate for the period 1993-1999 was 43.8 births per 1,000 women aged 15 to 44. This represents a decreased of almost 20% compared with the period 1990 to 1993. In turn, the latter period showed a 30% decline as compared to the 1987 to 1990 data. The decline was almost entirely due to lower fertility among young adult women (15 to 24 years old) whereas the fertility of women aged 25 or older remained unchanged. Nevertheless, 52% of the total fertility rate is attributed to women aged 15 to 24, and 83% by women aged 20 to 24. According to the Reproductive Health Survey (1999), women aged 35 to 39 and 40 to 44 make minimal contributions to total fertility, with age-specific fertility rates of 5% and 1% respectively.

Historical and Cultural Context

Romania is often cited as an example where abortion liberalisation had immediate and dramatic impacts on reducing maternal morbidity and mortality. Abortion has been a common and widespread fertility regulation method in all of the former communist countries of Eastern Europe. Following the Soviet model, Romania first legalized elective abortion in 1957 in order to support a new communist society and to acknowledge the equal status of women. The fact that modern contraceptives had not yet been developed meant that abortion was the main method of fertility control. This situation led to an extremely high abortion rate and had long lasting consequences on the attitudes and practices of women and men.

When the fertility rate fell below the replacement level, one of the measures taken by the newly enshrined Ceausescu regime was to ban abortion and contraception, while at the same time making provision for childbearing incentives. In October 1966, a restrictive law, issued by the Romanian government, reversed the legal status of abortion decreed in 1957. This law permitted modern contraceptive use and allowed for induced abortions in limited medical and social circumstances. Although extreme measures were taken to enforce compliance with the law, ultimately, the resulting fertility increase was far below the government's expectations. In December 1985, a new decree further restricted women's access to abortion and contraception. Additional measures were also taken, such as stopping the importation of contraceptives, making contraceptives available only by prescription, and limiting surgical contraception. Abortion-related mortality soared to 545 deaths in 1989.

In December 1989, following the change in political regime, the restrictive abortion law was among the first laws to be abolished. In the first year after liberalisation, abortion-related mortality dropped two thirds (from 545 to 181 maternal deaths). Today in Romania, access to abortion is relatively unrestricted and procedures relatively inexpensive.

Legal Issues

Elective abortion is legal in Romania if it is performed by a gynaecologist, upon a woman's request, up to 12 weeks after the date of conception (14 weeks from the last menstrual period). Abortion is illegal if performed outside an authorized medical facility, by a person who in not a gynaecologist, or if gestational age is more than 14 weeks. Abortion can be performed at any time by a gynaecologist if:

- it is necessary to save the life, health or bodily integrity of the pregnant woman from a serious and imminent danger which cannot be avoided by other means; or
- the abortion is necessary for therapeutic reasons and the pregnant woman cannot express her will.

There are no specific laws concerning the sale and distribution of contraceptives and the laws and regulations for drugs in general apply to contraceptives as well. All contraceptives sold in Romania are registered as drugs obtainable by medical prescription.

The latest Romanian Reproductive Health Survey, conducted in 1999, provides interesting data on the costs of elective abortion. At the time of the survey, the official fee for first-trimester abortion procedures was 60,000 lei (approximately $2). Data showed that the average amount of money paid for an abortion was 92,000 lei (approximately $3), ranging from no payment at all to one million lei. This average was higher than the official fee because roughly one-third of abortions were performed in private settings, where charges are not regulated and are usually higher than in public hospital facilities. A recent evaluation of funds spent for reproductive health in Romania showed that public funding for abortion is higher than private funding, unlike family planning, where private funding is overwhelmingly more important. In addition, "curative" reproductive health areas, for example women's health, safe motherhood, and abortion, absorb more public resources than the more preventive and educational domains of contraception and IEC campaigns.

Policies, Programmes and Services

The Ministry of Health and Family is implementing health sector reform in Romania, and is responsible for the coordination of the entire health-care system. Along with the Ministry of Health and Family, the National Health Insurance House and the National College of Physicians are also involved in reforming the health-care system. The Ministry of Health and Family, through the Department for Family and Social Assistance, coordinates the National Programme for Child and Family Health, which includes the family planning programme. Reproductive health services, including contraception and abortion services, are available as integral parts of health care provided not only by public health-care facilities, but also by private or non-governmental facilities.

Abortions are provided within the public system as one-day hospital or clinic care or as outpatient care in obstetrics-gynaecology clinics. Within the private system, this service is provided as outpatient care in obstetrics-gynaecology clinics. Heavy caseloads can sometimes lead to poor quality of care for abortion services. Abortion counselling and post-abortion contraceptive counselling are not routinely provided in most settings.

Family doctors provide people who have health insurance and low risk for contraindications with basic family planning services, namely family planning consultations and recommendations of contraceptive methods. In the public system, specialised family planning services are provided in outpatient family planning clinics and in obstetrics-gynaecology units. To a lesser extent, family planning services are also provided in non-governmental and private clinics.

Most women, especially those in urban areas, have good access to health care, including contraception and abortion services. A distinct aspect of Romania's policy in family planning is the focus on practitioners rather than gynecologists to provide contraceptive counselling and methods and the expansion of the family planning services to the primary health care, especially in rural areas.

In order to increase access to contraceptive services for as many women as possible, especially for those living in rural areas, the Ministry of Health and Family has initiated a programme intended to expand family planning services within the primary health-care level, with a special focus on rural areas. The family planning programme aims to increase access to contraception for all women and to decrease the number of abortions. The mechanisms used to achieve this goal are a) the provision of subsidised contraceptives and the distribution of free contraceptives to disadvantaged population groups, through governmental family planning clinics and family physician clinics, b) training of physicians and nurses, and c) behavior change campaigns.

Contraceptive Use Patterns

According to the 1999 Romania Reproductive Health Survey, the overall contraceptive prevalence rate among women in unions was 63.8%, of which 29.5% of women used modern contraception and 34.3% used traditional methods. These numbers have practically doubled since the 1993 survey. Among modern methods used, the condom was most frequently cited (8.5%), followed by oral contraceptives (7.9%) and intrauterine devices (7.3%). Less commonly used modern methods include spermicides (2.8%) and female sterilization (2.5%). Traditional methods still ranked high (28.7% for withdrawal and 5.6% for rhythm). Moreover, almost one out of two women interviewed said they intended to use modern contraception in the future.

Estimated failure rates varied considerably by the contraceptive method used. IUDs had the lowest failure rate (between 1.5% and 2.1%) followed by oral contraceptives (between 4% and 6 %) and the condom (these figures being comparable to failure rates in the published literature). Women who used traditional methods (rhythm and withdrawal) had the highest failure rates; almost one out of three of these women became pregnant within the first 12 months of using the method. Approximately half of them became pregnant after two or three years of using one of the two traditional methods. The reasons for not using any contraceptive method were related chiefly to their cost or to the logistic difficulties of getting to a family planning clinic.

Data from the 1993 Romania Reproductive Health Survey showed that over two-thirds of all pregnancies that occurred between 1990 and 1993 were unplanned and the vast majority of them were unwanted. Similar data were collected in 1999 for the previous three-year period. Although unintended pregnancies have decreased from 68% to 60%, the number of unwanted pregnancies continues to be high. Both surveys show that nine out of 10 pregnancies reported as mistimed or unwanted were aborted and only six to eight percent of unwanted pregnancies were carried to term.

Abortion Rates Since 1989

In the early 1990s, Romania had the highest abortion rate in Europe. Once elective abortion became legal in 1989, the rate of reported abortions doubled to 3.4 per woman. Recently, the number of abortions has declined, perhaps as a result of information and education campaigns, as well as increased access to and availability of contraceptive methods, which can now be found in drug stores and in contraceptive clinics. Official statistics indicate that abortion rates have declined from 177.6 abortions per 1,000 women aged 15 to 49 in 1990 to 43.81 per 1,000 women in the year 2001, out of which 34.05 were elective. It is important to note that, between 1993 and 1999 the rate of elective abortion decreased from 92 to 34 abortions per 1,000 women aged 15 to 49 (according to the Ministry of Health statistics), concurrently with an increase in modern contraceptive prevalence rate from 13.9 to 29.3 (documented by the 1999 Reproductive Health Survey).

The most recent Reproductive Health Survey (1999) showed a rate of 2.2 abortions per woman for the period 1996 to 1999, 70% higher than the total fertility rate. The ratio of elective abortion to live births remained unchanged at 1.6:1 according to survey estimates for the past three years. This estimate is roughly twice that registered in official statistics, indicating serious under-reporting in the health-care system, probably due to the private sector. According to a limited survey conducted in 2001 through Public Health Directorates, approximately 80,000 elective abortions performed in

private clinics in 2000 were not reported in official government medical statistics. The real number of abortions performed in the private sector may be even higher because not all *judets* have reported the number of abortions in the private sector and among *judets* that have reported there may be considerable underreporting from private facilities. The lack of clear regulations concerning reporting requirements for private health-care units and the scarce interest of local health authorities in supervising the reporting system may explain this situation.

Abortion data from the 1999 Romanian Reproductive Health Survey shows that the highest age-specific abortion rate occurs among women aged 25 to 29. Within each age group the elective abortion rate was higher among married women. The total rate of induced abortions was inversely correlated with education, social, and economic levels.

Slightly more than one-third (39%) of all women of reproductive age reported having had at least one elective abortion. Women who reported multiple abortions were more likely to be from a lower socio-economic stratum, older, and poorly educated. Many of them belonged to the Rroma community. The elective abortion to live births ratio was directly correlated with pregnancy rank.

Almost all pregnancy terminations (89%) were performed during the first trimester of pregnancy. However, information gathered from women on abortion procedure timing may be influenced by their reluctance to admit that the abortion was performed beyond the legal gestational limit. Late abortions were more often reported by women in rural areas and were inversely correlated with their education and socio-economic level; late abortions were much more common among Rroma women.

Data from the 1999 Reproductive Health Survey show that 53% of all abortions were performed to limit child bearing, 30% for economic or social reasons (low income, unemployment, fear of job loss), 11% for partner-related reasons (including 6% of abortions to women with extramarital relationships resulting in pregnancy or separated from their partners), 4% for medical reasons (life-threatening pregnancy), and 3% for reasons related to foetal abnormalities. In a recent survey on the determinants of use of fertility regulation methods, family planning providers identified low socio-economic status, low education levels, lack of information, and an inappropriate balance of cost between contraception and abortion as the most important reasons for the high number of abortions. The relative availability or unavailability of modern contraceptives was not perceived as a problem.

Reproductive Tract Infections

Intrauterine interventions performed during the abortion can cause a pre-existing infection to spread from the inferior reproductive tract to the superior tract, which can lead to both early and late infectious complications post-abortion. There are no specific national data on the prevalence of reproductive tract infections among abortion and family planning clients.

As was the case in other Eastern European countries, Romania witnessed an increase in the incidence of sexually transmitted infections (STIs) during recent years, especially for syphilis and HIV infection, through adult heterosexual transmission. Diagnosis, treatment and reporting of syphilis are done through the dermato-venerology network, while HIV infection and AIDS is handled by the infectious diseases network. All other sexually transmitted diseases (gonorrhoea, trichomoniasis, and Chlamydia infections in women) can be diagnosed and treated by obstetrics-gynaecology specialists and by family planning clinics. Due to a lack of privacy/confidentiality and especially to possible social stigma, some patients with symptoms of sexually transmitted infections prefer private care. Therefore, with the exception of syphilis and HIV/AIDS, the real prevalence of other STIs might be higher than reported, since data originating in the private sector are not centralized at the national level.

Knowledge about HIV/AIDS is very high in Romania, among both women and men – most likely because the AIDS epidemic among children received broad media coverage – but their ability to identify other STIs is limited. Virtually all women and men were aware of AIDS (99.5%) and syphilis (94% to 97%), but few were aware of other common STIs. While male respondents were

usually aware of gonorrhoea (91%), female respondents showed only moderate levels of awareness (62%). Only one in two women (54%) and one in six men (18%) knew about trichomoniasis. Only one in three women (34%) had heard of Chlamydia; one in five acknowledged that genital warts are transmitted sexually and only 11% had heard of genital herpes. Less than one in two men (46%) had heard of genital herpes and 27% knew about genital warts. These statistics were reported in the 1999 Romania Reproductive Health Survey.

KNOWLEDGE, ATTITUDES AND BEHAVIOURS RELATED TO ABORTION AND CONTRACEPTION

Abortion

The strategic assessment demonstrated that Romanian women still think of abortion as a traditional, accessible, cheap, and quick procedure. Women accept abortion easily and consider it a safe method, even if unpleasant and stressful. The danger of complications is not considered as long as abortion is performed in a specialised facility.

Service providers also tend to consider abortion to be a common, simple procedure. Generally, women are not asked to return to the facility for post-abortion follow up, and a majority of those who are asked do not return. This practice, which has been a finding in all relevant studies conducted over the past ten years, has not changed.

The team identified two common attitudes towards abortion among the women interviewed. Most women who had had an abortion said it was an unpleasant, stressful, and accidental event, which they would not repeat. These women desired more information on abortion and contraception and they tended to actively search for this information. The team found that these women consider abortion to be a safe, risk-free procedure.

Other women, especially those who had had many abortions and still did not use contraception, did not regard the procedure as traumatizing, even if they did not consider it a pleasant experience. These women, who are used to abortion as a means of family planning ("I find it better like that, the pain is not that bad") already label their next pregnancy as an abortion. This attitude is often associated with opposition to using modern contraceptive methods, especially the IUD and the pill, and is maintained by inaccurate information circulating among women.

Many women said that the pain they felt during the abortion procedure was an important factor in generating a pro-contraception attitude. They suggested that pain could provide a deterrent that would lead to increased use of contraceptive services.

An explanation for this attitude is that, for many women, abortion is a means to resolve an urgent problem that had already occurred (the current unwanted pregnancy). Contraception, on the other hand, is viewed as a way to prevent a problem (a future unwanted pregnancy) that is less accessible, more costly, complicated to use, and can have unpleasant side effects. Women feel that, as long as they had a readily available simple and acceptable way to deal with a (potential) unwanted pregnancy, there was no need to resort to a more complicated prevention measure.

There are also perceived differences regarding the effects abortion and contraception have on one's health. Some people considered contraception healthier than abortion, but others claimed the opposite. Most women considered contraception to be better than having an abortion, saying, "It is better to use a contraceptive method than to have an abortion every three months". Yet, a few women said that if the interval between abortions is long enough (at least three years) it is better to have an abortion than to use contraception (i.e., "It is better to have one abortion every three years than to take contraceptives every day").

Generally, the men interviewed thought they should play an equal role with their partners in planning family size. Both clients and providers thought that male partners should be more involved in family planning and counselling, because they often influence women's decisions to use contraceptive methods.

Recommendations

- *Develop information, education, and communication campaigns aimed at changing women's attitudes that abortion is a common routine procedure that is more convenient than using contraception.*
- *Display educational materials in all abortion facilities.*
- *Help women become more aware of their reproductive rights and obligations.*
- *Involve the male partner in abortion and family planning counselling when appropriate.*
- *Develop information, education, and communication campaigns focused on the risks of illegal, unsafe abortion.*

Contraception

The 1999 Romania Reproductive Health Survey indicated that virtually all women (99%) had heard about at least one modern contraceptive method and most had heard about at least one traditional method (93%). Awareness of pills, condoms and intrauterine devices (IUDs) was very high (98%, 93%, and 91%, respectively), followed by awareness of withdrawal and periodic abstinence (85%). Almost three in four women (72%) knew about female sterilization (tubal ligation). The least-known methods were those that are seldom available (vasectomy and injectables). Awareness of emergency contraception was also very low, in spite of the relative wide availability of combined oral contraceptives.

Although levels of overall awareness of either modern or traditional methods did not vary significantly by residence, some urban-rural differences regarding women's awareness about specific contraceptive methods were notable. For example, awareness of IUD and pills is more than 11% higher among urban residents than among rural residents. Similarly, awareness of female sterilization is 25% higher among city dwellers, awareness of spermicides is 71% higher, and the gap is even wider for lesser-known methods, including vasectomy and emergency contraception.

The assessment team found that inaccurate information (i.e., myths) about contraception persists among the population. The most frequently mentioned myths include: pills cause weight gain, cancer, hepatitis, and hair growth; and, the IUD causes bleeding, cancer, dizziness, weight gain, and can be lost. The lack of accurate information about modern contraceptive methods contributed to misunderstandings like, "The golden IUD is better than the copper IUD" and, "It is like a piece of jewellery".

Some of the widespread myths were thought to be accurate information by both highly educated and less educated women. It was obvious, however, that younger people had more open attitudes toward using new technologies. Those women who did not use a modern contraception method were often convinced that they were not at a significant risk of becoming pregnant, even if they had already had one or more abortions in the past.

Generally, women felt more favourably about pills than IUDs, which are regarded with some fear. Women know that pills are available in all pharmacies, but some noted that one should not buy pills without a medical prescription and without seeing a doctor for testing.

Condoms are popular especially among young people because they do not require prescription, are easily obtainable, and ensure privacy. In addition, one can avoid paying for a medical consultation by using condoms.

Recommendations

- *Develop information, education, and communication campaigns to promote family planning services and increase the area covered by these campaigns at the different health, education, and community system levels.*
- *Develop information, education, and communication campaigns to promote modern contraceptive methods and publicise the means to procure them, with a particular emphasis on information about the categories of women eligible to receive free contraceptives.*
- *Conduct operations research to identify the most effective information, education, and communication methods.*
- *Conduct a qualitative study to identify the main barriers to using family planning services.*
- *Conduct information, education, and communication campaigns directed toward men in order to encourage them to be more responsible with respect to preventing unwanted pregnancy.*

Young People

Young people (aged 14-24) comprise approximately 21% (approximately 4.5 million people) of the total population of Romania. The 1999 Reproductive Health Survey showed that women in Romania start their sexual life relatively late (in 1999 almost a quarter of the Romanian teen-age girls have ever had a sexual experience); however, the percentage of women aged 15 to 19 who reported being sexually active rose by 62% (from 16% to 26%) from the time of the 1993 survey. And, more than three out of four women who were sexually active had had premarital sex.

Nearly 50% of young women who reported they were sexually active in 1999 said they used some kind of contraception during their first sexual intercourse (as opposed to 20.6% in 1993). Withdrawal (24%), closely followed by the condom (22%), were by far the most frequently used methods.

Data show rates of 101 abortions per 1,000 women aged 20 to 24, and 26 abortions per 1,000 women aged 15 to 19. These figures (compared to the absolute number of women in each age category) are less than those for the age groups 25 to 29 and 30 to 34. However, considering the percentage of women who are sexually active in each age group, the frequency of abortions reported per 1,000 women is comparable between women aged 15 to 19 and women aged 25 to 29, where the frequency of abortions is the highest.

In view of this, the assessment aimed to explore young people's perceptions, opinions and attitudes towards using contraceptive methods and existing abortion services.

The team found that young people were open to and interested in discussing these issues. Although the level of knowledge of reproductive health information among people aged 15 to 24 seemed to be higher than among other age categories, information was often partially accurate and mixed with myths and prejudices ("A lot of people know, but few are aware"). An important factor mentioned by young people was the lack of adult confidants for discussion. Young people believed that most adults around them (e.g., parents, teachers, doctors, etc.) create and reinforce barriers to communicating about sexuality. Young people often do not have the courage to overcome these barriers on their own ("Young people do not get informed because their parents and teachers make it a taboo issue"). In turn, adults acknowledge that young people lack information on sexuality and reproductive health, but are generally reluctant to overcome existing communication barriers. The fear of opening themselves to ridicule and the fear of being stigmatised by the parents of their students or by their colleagues caused teachers to avoid raising sexuality and reproductive health issues in class.

Young people, especially high school students, avoided visiting the family doctor or school clinics for advice regarding reproductive health and sexuality. This contradicted most of the statements they made, which indicated that they considered doctors to be the most reliable source of information ("doctors know best"). What keeps them from turning to medical staff is their assumption that these people lack empathy and understanding. Young people also have fears about privacy, given the very public locations of many medical and family planning clinics. Additionally, a family planning consultation requires undergoing a pelvic exam, which most young women fear and try to avoid until pregnancy.

Consequently, the main sources of information for young people are the media and peer groups, because they ensure a safe environment for receiving information. Generally, in every group there is one person who seems to be better informed than others, who becomes the group "mentor" or "educator". Frequently, the information they have is false or partially accurate, but it is taken in full confidence by the rest of the group.

Teen-age girls view the beginning of their sexual life as "a stepping stone" physically, emotionally, and socially. Frequently, the decision to become sexually active is not well thought out, but is made when faced with spur-of-the-moment circumstances and pressures. In fact, according to the 1999 Reproductive Health Survey, the second most frequent reason for not using contraception during the first sexual intercourse is that it was not planned.

Lack of information and the challenge of honest communication with adults prevent adolescents from making informed decisions about sexual activity. Furthermore, communication with one's partner on this topic is often a sensitive matter. Adolescents are often incapable of foreseeing, controlling and/or preventing possibly negative physical, emotional and social consequences of becoming sexually active.

Condoms are the most popular modern contraceptive method among young people because they are easy to use and are relatively discrete, given that use is tied to the incidence of sexual intercourse, which is a less frequent event among young couples who do not live together. Moreover, the condom is a widely available method, does not require a visit to a doctor, and has a relatively affordable price. On the other hand, it has to be purchased in pharmacies or in stores, which may be "embarrassing".

Oral contraceptives are the second most popular modern contraceptive method among young people. Several barriers limit their usage, however, including the existence of certain myths (they cause weight gain, excessive hair growth, cancer or other diseases, "They are harmful to one's health"). Other barriers include the need to see a doctor before using them, the fear that they may be found by parents and the irregularity of sexual activity that is typical for younger people.

Young women generally see abortion as a terrifying experience, especially those who have never experienced the procedure. The idea of a pregnancy, even if it is desired, triggers some fear of the unknown. Pregnancy, and to an even greater degree abortion, are associated with embarrassment and pain. Details regarding the abortion procedure and possible complications are not known, although many assume that abortion is harmful to one's health. Information on abortion is more limited than information on contraception or STIs. Usually, contraception and STIs are discussed in sexual education classes held in schools, but abortion is not.

It is likely that most abortions outside marriage occur in this age group. The existence of a pregnancy and its termination by abortion triggers not only the fear related to the surgical procedure and potential complications, but also fears about privacy and confidentiality. In addition, young women have fears about how pregnancy may affect their relationship with their partner, who "can leave you when he finds out you are pregnant, and then you have to deal with the problem yourself".

The cost of abortion is another problem for young people. Due to fears associated with the procedure and confidentiality concerns, many young people prefer private abortion services. The cost of private services, however, may be more difficult for young people afford since most do not have their own income.

The assessment found that young women who have their first abortion usually have the procedure performed toward the end of the first trimester, sometimes very close to the legal limit. First, the young woman has to discover, admit and accept that she is pregnant. After acceptance, she may discuss it with her partner or her friends. Afterwards, the young woman, alone or with her partner, has to settle on a solution. If abortion is chosen, the next step is to identify the proper place for abortion. Choosing a private clinic (thought to provide "better conditions", psychological comfort and confidentiality) may delay the procedure further, due to the time needed to obtain the money to pay for the abortion service. All these difficult moments added together can cause a young woman to exceed the legal gestational limit for undergoing elective abortion. After that, the only options are illegal abortion or giving birth to the baby.

Gynaecologists who perform abortions were not particularly careful with young patients who were undergoing their first pelvic exam or their first abortion. The amount of time doctors devote to discussions, performing the exam, and performing medical procedures was usually similar to that given to older patients. The first pelvic exam or abortion is a frightening moment in a young woman's life; most of the girls interviewed said these experiences were difficult, embarrassing and/or even traumatising. The medical staff often did not offer enough psychological support to help young women through these moments. Usually, there was no procedural pre- or post-abortion counselling component, including referral to a family planning clinic or prescription of a contraceptive method.

Discussions during the dissemination symposium emphasised the need to devote special attention to cervical dilatation at first abortion in young women; and, including this principle in practice guides was recommended.

Also, the assessment teams noted that all but one of the providers interviewed do not ask for parental/guardian consent before performing abortion on young women under the age of 18.

Recommendations

- *Develop and promote reproductive health services focused on the needs of young people aged 15 to 24.*
- *Services should be youth-friendly and offer full confidentiality and privacy (including the location).*
- *Guidelines for pelvic exams and abortion should include supplemental pre-procedure counselling for first time users.*
- *Educational programmes on reproductive health should be conducted in schools, in order to provide young people with information on contraception, pregnancy, STIs and to encourage them to embrace responsible sexual behaviours.*

AVAILABILITY OF AND ACCESS TO ABORTION AND CONTRACEPTIVE SERVICES

The fieldwork conducted in hospitals and clinics that provide abortion services corroborated data presented in the previous chapter revealing a high number of abortions. Despite the fact that family planning programmes have been relatively successful at increasing the contraceptive prevalence rate during the past few years, abortion continues to represent an important fertility-control method for Romanian women. Many of the abortion clients interviewed had had multiple abortions and were still not using modern contraceptives. Based on personal experience, most physicians and managers thought that the number of abortions performed in the public sector is higher than in the private sector. All respondents agreed that the number of elective abortions performed in Romania is too high and that high-quality contraceptive programmes are necessary to decrease this number.

The high number of abortions was seen as an indication of the unmet need for contraceptive information and methods among the population at risk for unplanned pregnancy. The main explanations for the high number of abortions were limited access to contraceptive services in rural areas and limited availability of free contraceptives for financially disadvantaged population groups. Legal or regulatory barriers to contraceptive or abortion services were not mentioned. All respondents agreed that improving family planning must be a public health priority. Most interviews highlighted the need to improve sex and reproductive education in schools and most thought that the media could do a much better job providing accurate information about use of contraception.

Availability of Abortion and Contraception Services

Elective abortion is available in Romania and performed exclusively by obstetrics and gynaecology specialists in both the public and private sectors. Many physicians work in private clinics following their scheduled hours in the public system. Generally, women know where abortions are performed in both the public and private sector and they know the fee for abortion services. The assessment team did not find a connection between the number of abortions in a certain area and the number of facilities providing such services. However, in one *judet*, where there was only one hospital department that provided abortion services, the number of illegal abortions was higher.

Obstetrics-gynaecology departments and private abortion and family planning clinics are located almost exclusively in urban areas. Consequently, the urban population enjoys relatively easy access to and choice of abortion and contraception services.

The situation is different in rural areas where abortion facilities are virtually non-existent. This severely limits rural women's access to these services. Many of these women encounter logistical and financial problems when they require abortion services. Many of the rural women interviewed stated that they had not used contraception. Furthermore, many of these women had not used abortion services because of the high costs involved in travelling from their homes to the nearest towns.

Modern contraceptive methods are also less available in rural areas; they can only be found in rural pharmacies (in the relatively few places where such facilities exist) and in the clinics of family physicians that have been

trained and supplied to provide family planning services. Condoms can be purchased from many sources, including shops. For few women, the alternative source for purchasing oral contraceptives is the black market, where they can find contraceptives for low prices.

The MOH, in collaboration with the UNFPA and with the USAID-funded John Snow Research and Training, is currently carrying out a program for training family physicians and nurses working in primary health care to provide contraceptive services. Within this program, more than 1,000 physicians in all *judets* have already been trained to provide family planning services.

Most respondents knew that modern contraceptive methods could be purchased from pharmacies, family planning clinics, and obstetrics-gynaecology clinics, as well as from local shops. Very few women said they obtained contraceptives from their family physician. The team found that current or potential contraceptive users do not consider the family physician as an important link in the family planning service system, even though the family doctor should be the gatekeeper to the health-care system, which includes contraceptive services.

Many women, especially those living in rural areas, were convinced that family planning and contraceptive services would be much more accessible and modern contraceptive use would increase if these services were provided by family physicians. Interestingly, many family physicians that provide contraceptive services have reported an increase in the overall number of consultations, including those unrelated to contraception.

The team also found that the level of access to abortion and contraceptive services depends on one's socioeconomic status. Proof of financial status and administrative formalities necessary to demonstrate eligibility to receive free public health services can be barriers to accessing both abortion and contraception. Some low-income women interviewed were unclear either about their right to free abortions or the administrative requirements for receiving free services. Clinics' opening and closing times were found to be another barrier to accessing abortion services. Public abortion services are available only in the morning. Most private clinics are open only in the afternoon, which facilitates access for women who work in the morning or for those who want a higher degree of privacy/confidentiality in their service provision. Many women welcomed the idea of extending abortion service working hours in the public sector. Both public and private family planning clinics are extending their opening hours as well.

Recommendations

- *Expand contraceptive services within primary health care, especially in rural areas.*
- *Conduct operations research to demonstrate the effects of increased access to free contraceptives for disadvantaged groups.*
- *Increase access to abortion services for women who have low socio-economic status, especially for those living in rural areas.*
- *Train family physicians in family planning and provide them with free contraceptive supplies.*
- *Set afternoon hours for public abortion services.*

Illegal Abortion

In Romania, an illegal abortion is performed either outside of authorised locations, by a layperson, or after 14 weeks of gestation (without a legal indication). Providers of illegal abortion can receive six months to three years imprisonment. The period of imprisonment increases if the abortion is performed without the consent of the pregnant woman, if during the illegal abortion the woman is injured, or if the abortion results in the death of the pregnant woman. Doctors who perform illegal abortions may also lose their medical license. A woman who has an illegal abortion does not suffer any legal consequences.

Even though legal and safe elective abortions are widely available throughout the country, there are still a significant number of unsafe, illegal abortions (200 reported in the year 2001). There are no statistics for unsafe abortions performed outside the formal public or private health system, but existing data show that a relatively high number of hospital admissions are due to complications of illegal abortion. This suggests that the total number of unsafe abortions is unacceptably high.

Data collected during the 1999 Romanian Reproductive Health Survey show that less than one percent of abortions are performed outside the health system. Since unsafe abortions (self-induced, performed by laypersons, or performed by doctors outside of the formal medical system) are illegal, it is very likely that women were reluctant to admit to these abortions, in spite of the interviewer's assurance of anonymity.

Moreover, there is a relatively high rate of maternal deaths due to unsafe abortions. This is the main reason why Romania has a maternal mortality rate considerably higher than other countries in the region with similar health-care system quality. According to official MOH statistics, Romania leads Europe in abortion-related maternal mortality, with 16.79 maternal deaths per 100,000 live births in 2001.

Interviews conducted during the strategic assessment confirmed that there continues to be an unacceptably high number of illegal abortions. Women interviewed identified various methods, which include many illegal practices used before 1990 (mechanical methods such as massage, spindles, quills, and probes used to insert solutions such as oxygenated water, spirits, the roots of various harmful plants, etc.). Both medical staff and patients agreed that unsafe abortion is performed by laypersons (usually an elder women in the village) or in some cases by the pregnant women themselves. In many cases, these interventions result in bleeding or infections that force women to go to the hospital immediately.

Both physicians and clients felt that the main reasons women do not use contraception and inevitably resort to unsafe abortion are lack of complete and accurate information on the risks of illegal abortion, lack of information on the advantages of contraception, and a lack of financial resources. In many hospitals, the team found that illegal abortions were recorded as miscarriages and the police were not notified. When the police were informed, the doctors complained that no measures were taken unless the woman's life was threatened or the illegal abortion resulted in the patient's death. All doctors interviewed stressed that abortions performed by unauthorised persons and outside of medical facilities is a crime that should be dealt with by the police authorities.

Recommendations

- *Develop information, education, and communication campaigns on the risks of illegal/unsafe abortion.*
- *Report and prosecute providers of illegal abortion.*
- *Develop a protocol for handling all cases of illegal abortion (Ministry of Health and Family and Ministry of Domestic Affairs).*

QUALITY OF CARE IN ABORTION AND CONTRACEPTIVE SERVICES

Information, Counselling, and Informed Choice

During the assessment, the team found that many women did not know specific details about the abortion procedure, including how the procedure would be performed, pain-management issues, and possible complications that could result. Physician and nurse respondents declared that they provided their patients with this information. However, during observations of abortion procedures, the assessment team found that the information provided was insufficient, both in terms of quantity and quality.

Women, especially those who were having their first abortion, were not sufficiently informed about the process. They were not told about the method of pregnancy termination, the stages of the procedure, the possible risks and complications, and the signs and symptoms that warrant emergency health care. These concerns caused anxiety and fear, which were exacerbated by discussions among the women in the waiting room prior to the abortion, some of whom shared their previous abortion experiences.

Women are not given the choice to select the abortion method or type of pain medication, especially in the public services. Some abortion facilities do have educational materials produced by the government family planning programme and by various non-governmental organizations but these materials are not always offered to all patients.

In many family planning clinics, educational materials on contraception are available, although the assessment team believed improvements in content were necessary. As in previous studies, female respondents stated that they would like to receive more detailed information about both the abortion procedure and modern contraception.

The assessment teams also found that, with the exception of family planning doctors, many pharmacists, family doctors, and some gynaecologists have little, outdated, or inaccurate information about modern contraception. Many doctors still note "contraindications" based on dated information. The current university curriculum (like those in the past) includes only a few classes on contraception, and the information taught is not always current. Respondents also said that university education is almost exclusively technical and does not focus on communicating and interacting with the patient.

Providing appropriate information is only one component of the counselling process. Clients must also be engaged in an interactive process that encourages questions and alleviates fears and concerns. Women must also have immediate access to contraceptive methods post-abortion. In all but one of the facilities visited (i.e., a Marie Stopes clinic), counselling was not an integral part of the abortion procedure. Provider-client interactions routinely consist of a brief interview about the client's medical history and of concerns that are relevant to the procedure. Sometimes, the provider offers brief advice about post-abortion care. Only rarely are women encouraged to ask questions, due to time constraints limiting the interaction.

This scenario is also likely to occur prior to any other surgical procedure or intervention, due to the lack of clear guidelines and protocols for counselling. The physicians and nurses interviewed reported not having adequate training to engage in high-quality provider-client interactions. They acknowledged having only technical information and skills acquired during their medical training.

Generally, the team found that contraceptive method choice was based on better information than abortion method choice and family planning counselling was found to

be more systematic and thorough than abortion counselling. Considering the major role that counselling plays in the family planning consultation, some physicians suggested that the insurance system should identify separately and award points for counselling. However, representatives of the National College of Physicians argued that this change was inadvisable, because it would result in an inflation of points.

The assessment team noted that most abortion facilities do not require proper informed consent for procedures; often patients are not even asked to sign an informed consent form. In settings where written consent is required, there was no standard text, but rather a brief declaration of acceptance of the procedure and the possible risks involved. This situation is common for most surgical procedures performed in Romania, which are only accompanied by a vaguely worded informed consent form or, more often than not, only require the patient's signature on the medical record.

Recommendations

- *Standardise and introduce pre- and post-abortion information and counselling as an integral part of the abortion procedure.*
- *Introduce standardised written informed consent forms to be signed by all patients.*
- *Establish a curriculum in medical schools focused on provider-client interactions and contraceptive counselling and technologies.*
- *Train physicians and nurses to engage in good provider-client interactions and interactive counselling.*
- *Produce, publish and distribute better educational materials on the abortion procedure and post-abortion care.*

The Pregnancy Termination Procedure

The assessment teams found a wide range in quality of abortion services offered by the different departments and clinics visited.

The assessment team found that formal protocols, standards, and guidelines do not exist for elective abortion services. In fact, the concept of "abortion care", as defined by the World Health Organization and other institutions such as Ipas, does not exist in Romania. The concept of "abortion care" includes:

- Links and referrals between the client's first point of contact with the health-care system (e.g., the family doctor) to facilities where abortion care is provided;
- Choice of abortion methods (where feasible). E.g., this would include a choice between manual and electric vacuum aspiration or medical abortion where it is offered;
- Provision of contraceptive counselling and methods following the abortion procedure;
- Screening and referral for other health concerns such as STIs, domestic and sexual violence;
- And appropriate follow-up measures, including communications with family physicians.

The assessment team also identified the need for a high-quality national monitoring and evaluation system for abortion services to ensure basic quality standards are met and needs for improvements are addressed.

THE FLOW OF ACTIVITIES

The assessment teams found that access to abortion services does not require a referral from a family physician, even though it is common practice to obtain one. Some women do bypass the referral system. Although abortion is considered a medical act provided on request and is therefore not reimbursed by the health insurance system, the referral is important for both the family physician and the gynecologist to justify the reimbursement for the consultation, since consultations are financed from social health insurance funds. The team noted that the referral process could also be a useful link between the family physician and the gynaecologist, for both pre- and post-abortion care.

The assessment team also found that most public abortion clinics are not using an appointment system and that abortion is provided after the pregnancy is diagnosed

based on women's order of arrival and availability of beds and necessary instruments, drugs, and supplies. In some facilities this results in overbooking patients for abortion procedures on certain days and at certain hours, which creates crowded conditions and results in poorer quality of care. However, most women and physicians interviewed think that an appointment system might cause unnecessary delays in service that could possibly lead to a rise in illegal abortions. This concern is especially valid for women who present at a late gestational stage, close to the upper legal limit of twelve weeks.

The management boards of public hospitals visited generally consider that abortion-care activities do not require special management or coordination. The lack of proper management and/or coordination can result in long waiting times, crowded waiting and recovery rooms, and ultimately poorer provider-client interactions. However, some gynaecologists stated that if the activities of the abortion department were more tightly controlled, with an organized appointment system and strictly defined responsibilities, many of their colleagues would become less interested in performing abortions

Conversely, the vast majority of private clinics are using an appointment system, which makes the services more client-friendly, more efficient and of higher quality. Generally, in private clinics patients receive more attention than those in public settings; however, the quality of the abortion procedure is similar. The increased attention is linked mainly to the lower number of patients waiting in the clinic at the same time, and to better management of the abortion procedure.

Concerning post-abortion care, the assessment team noticed that patients left the department or the clinic shortly after the procedure. In most cases women left the same day; overnight hospitalisation occurred only for women with procedural complications. This corroborates data from the Reproductive Health Survey (1999); most women (94%) who had elective abortions were released the same day the abortion was performed. Overall, one percent of women required one night of hospitalisation, one percent two or three nights, and five percent four or more nights. The duration of hospitalisation varied according to the woman's gestational age and the severity of abortion complications. Most doctors interviewed believed that under normal circumstances, an abortion patient should remain under observation in the department or clinic premises for at least two hours following the procedure.

In the public abortion facilities visited, recordkeeping ranged from completing an observation record for one-day hospitalisation to simply providing a receipt confirming payment of the abortion fee. Some abortion facilities have developed specific observation records, which include administrative and medical information required for case management. The assessment team found this measure to be useful and recommended that it be standardised and expanded to all abortion facilities.

Following the procedure, some doctors do not inform the patient in detail of either the need for or the recommended time of the post-abortion follow-up visit; post-abortion home care, including hygiene; complication warning signs; symptom identification and management; resumption of sexual activity; and/or use of post-abortion contraception. Some physicians argued that there is no need to provide this information since many patients do not comply with the follow-up instructions when requested to do so.

The lack of attention to follow-up care was also reflected in the failure by some doctors to provide any formal medical record about the procedure. Sometimes the only document to authenticate an abortion is a receipt that shows the fee has been paid. In none of the facilities visited had the attending physician written letters to patients' family physicians with information on the diagnosis and treatment provided, even though recent regulations require them to do so.

Recommendations

- *Develop standards and guidelines on abortion care, including procedure management, equipment/instruments, pain management, infection prevention, staffing, space, provider-client interactions, counselling, privacy and confidentiality, minimal recovery period, post-abortion contraception, and follow-up communication with clients' family physicians.*

- *Develop monitoring and evaluation procedures to ensure that standards are observed in order to increase the quality of care provided by abortion services.*
- *Review the standards clinics must meet to be authorised to provide abortion services.*
- *Develop and implement a mandatory standardised patient record containing information on the abortion procedure.*
- *Require abortion providers to send relevant information about abortion procedures to patients' family physicians.*

SPACE

In public facilities, abortions were performed in spaces specifically designated for such purposes, located in specialist outpatient care settings, hospital outpatient care units or, in some cases, the obstetrics-gynaecology inpatient department. The size and location of abortion facilities varies considerably among sites; some spaces are efficient and well organized while others are totally inappropriate wards located in windowless basement rooms. Prior to the abortion, some clients must wait in wards that are also used for post-abortion recovery, usually located near the abortion procedure room. This created stress and psychological discomfort for some clients, especially first-time abortion clients, and did not allow for solitude and privacy.

The number of beds in the abortion facility does not always accommodate the number of patients, especially on busy days in settings without an appointment system. In some cases, there were considerably more clients than beds, which obliged two or more women to share the same bed before and/or after the procedure.

Interviews with physicians and facility managers highlighted some possible reasons for overcrowding, including the possibility that demand for services was not anticipated, an absence of appointment schedules, a failure to partition spaces, and also a lack of effective management.

Public abortion facilities were appropriately clean. Abortion procedures were performed in clean (not sterile) rooms, in accordance with current regulations. Generally, private clinics offered better conditions than public settings, with the exception of some well-known clinics that had a higher caseload and conditions similar to public facilities. Some private-clinic clients thought the differences in terms of space, cleanliness, and accommodation justified the higher cost for abortions. However, the actual abortion procedure was not perceived as being different in terms of quality of care than those performed in public facilities.

In public hospitals patients were transferred back to the ward or initial waiting room following the procedure; post-abortion medical monitoring was limited because medical personnel were responsible for both procedure and post-procedure activities. The assessment team found that patients often left the facility on their own initiative, without notifying medical staff. This was particularly true where women were not provided with clear information regarding the recovery period and potential complication signs and symptoms, and where the facility caseload was heavy.

In settings where a family planning unit was available nearby, or where post-abortion counselling was properly organized, the team found that the recovery period was used to provide patients with information on post-abortion care and family planning.

With few exceptions, the toilets in public abortion facilities are inappropriate and not sufficient for the caseload.

Recommendations

- *Define minimum standards for the space assigned to abortion departments/clinics, including appropriate space for waiting, procedure, recovery, clean toilets, counselling, and provision of contraception, which must be integrated into the facility authorisation criteria.*
- *Designate appropriately furnished pre-procedure waiting areas, apart from recovery wards.*
- *Create and appointment system for abortion procedures in order to avoid long waits and overcrowding. However, maintain provisions for unscheduled procedures.*

ABORTION METHODS USED

The assessment team concluded that many procedural issues related to abortion care require improvement.

Surprisingly, the team found that dilatation and curettage was the main method used (over 50% of all cases) for elective abortion, in both public and private facilities. There were some hospitals, even at the tertiary health-care level or in university clinics where vacuum aspiration was completely unavailable; in other sites vacuum aspiration equipment was available only to select specialists and their clients. Even in facilities where vacuum aspiration equipment was available to all personnel it was not routinely used for all patients. Depending on their experience and personal preferences, some gynaecologists, especially older ones, prefer to use dilatation and sharp curettage.

The majority of gynaecologists using vacuum aspiration are still using metal curettes to check and finalise the procedure. This was due mainly to the traditional and customary use of sharp curettage by most gynaecologists, and to recommendations provided during training courses held by foreign professional organizations when vacuum aspiration was introduced in Romania in the early 1990s.

The team found that in some sites the electric aspiration equipment was old, improperly maintained, and faulty. For example, in some cases the negative pressure created by the pump was ineffective, which increased the risk of incomplete uterine evacuation. Most providers believed that it was too difficult to fix these technical flaws, given the diversity of equipment supplied by different sources, the lack of maintenance and repair and the general lack of funds.

The assessment also found that the quality and number of cannulae used for vacuum aspiration was insufficient. The vast majority of facilities were re-using sterilised metal cannulae. Plastic cannulae were used in only a few facilities; where, even though they are disposable, they were sterilised or (high-level) disinfected and re-used many times up to their limit of durability. They were either disinfected by submersion in specific solutions, or sterilised by use of ethylene oxide where such technology was available.

Additionally, the team found that old surgical abortion (sharp curettage) kits are often damaged and overused, which could cause injury during the abortion procedure. The head of one obstetrics-gynaecology department stated that he had not received new surgical kits for abortion in at least ten years, although they had been requested.

With few exceptions, use of manual aspiration was not commonplace, and physicians using it had not been specifically trained in the procedure

The assessment team also noted that the evacuated uterine contents were not examined for each patient. In some cases, neither the aspiration jar nor the exam table specimen collection tray was emptied after each procedure.

For therapeutic abortion beyond 12 weeks gestation, the methods used were prostaglandins or dilatation and evacuation, depending on the doctor's training and experience. Misoprostol tablets are widely used, since the product has been recently registered in Romania for the treatment of gastric ulcers.

None of the departments or clinics visited checked routinely the patients' blood type and Rh factor, or administered anti-D immunoglobulin if the Rh factor was absent. One component of the programme for women's health in Romania, financed by the Ministry of Health and Family, requires the provision of anti-D immunoglobulin to all Rh-negative postpartum women immediately after delivery. Given the high number of abortions, the short duration of the procedure and limited funds, this measure is not yet applied to abortion clients.

Recommendations

- *Designate vacuum aspiration as the standard abortion procedure for up to ten weeks gestation.*
- *Equip abortion facilities with electric and manual vacuum aspirators and an appropriate range of plastic cannulae.*
- *Train gynaecologists in the use of vacuum aspiration.*
- *Introduce and provide training for the mandatory routine macroscopic examination of uterine contents for every abortion client.*

ANAESTHESIA

Appropriate use of analgesia and/or anaesthesia before, during, and after the abortion procedure is an important quality of

care issue. Appropriate pain management can diminish the patient's discomfort, anxiety, and psychological trauma.

During field visits, the team noted a variety of pain-management practices. These ranged from minimal analgesia, which was rare, to intravenous general anaesthesia. The method most often used was paracervical block with lidocaine. Sometimes, this was preceded by an intravenous injection of midazolam, diazepam, or less often, pethidine.

If the patient requested general (intravenous) anaesthesia and agreed to pay extra for it, physicians provided it after determining that there were no risk factors or contraindications. In such cases, an anaesthetist, whose presence is mandatory, always assisted the gynaecologist in performing the procedure.

In one hospital, the team found that all abortions were performed with intravenous anaesthesia. The team found that doctors performing abortions in both public and private settings sometimes had completely different practices regarding anaesthesia. In their private clinics, they provided clients with general anaesthesia, while in the hospital they used local anaesthesia. Physicians interviewed said the insufficient supply of drugs was the main reason for this practice.

While the pain perceived during an abortion varies from one woman to another, most of the women interviewed considered abortion to be an unpleasant experience primarily due to the pain. All patients indicated that improving the quality of anaesthesia in public and private abortion services would be a significant positive change. One patient said, "Except for the anaesthesia, which is indeed much better, the high price for abortion in private clinics is not justified". Abortion-client respondents said that the type of anaesthesia received, rather than the quality of provider-client interaction, was the major difference in quality of care between the public and private settings.

Recommendations

- *Require appropriate use of local anaesthesia, based on client needs and physician judgment, in the abortion standards/guidelines.*

INFECTION PREVENTION

Following standard precautions for infection prevention, decontamination, disinfection, and sterilisation, are extremely important for facilities that provide elective abortion care. These procedures must be understood and practiced by the entire staff due to the possibility of exposure to blood and other biological fluids.

The team noted that the abortion procedure was routinely performed in a room that was clean and hygienic, but not sterile like an operation room. In some cases, other types of consultations or procedures were performed in the areas designated for abortions. In some facilities, the sheets on the gynaecological exam table were not changed on a regular basis.

The medical staff washed their hands adequately before and after touching the patient and most used sterile latex gloves to handle instruments during the abortion procedure. However, the team members noted that some doctors did not use latex gloves during the procedure. These doctors maintained that they only touched those parts of the instruments that were not exposed to the patient. In some cases, the limited availability of supplies and disposable materials in the facility precluded the routine use of sterile gloves. None of the facilities visited, except the Marie Stopes clinic, utilised transparent protection masks, which prevent contact between potentially contaminated biological material and the physician's face.

Field observations confirmed in most cases that the vulva, the vagina, and the cervix were adequately disinfected with non-alcoholic iodine solution.

Immediately after use, instruments were decontaminated by submersion into a chlorine solution. Some facilities did not adequately disinfect plastic cannulae. Although these cannulae are meant to be disposed, they were decontaminated and then submersed in various high-level disinfecting solutions; in some cases only iodine solution was used. Sometimes these solutions were not changed frequently enough to maintain high-level disinfection. The team also found that cannulae were not always rinsed when removed from the sterilising solution. This practice could cause irritation to patients'

vaginal, cervical, and/or uterine lining. Most doctors felt that the cost of disposable supplies was too high to justify using them only once.

In public-sector facilities the autoclave was the most frequently used sterilisation method. In most hospitals, sterilisation was performed in the central sterilisation unit, which provided sterile equipment for all hospital departments. In private clinics, hot air sterilisation is used more frequently for metal or disposable instruments.

Hospitals utilised incinerators to provide adequate disposal of contaminated waste. All private clinics visited had a contract with a hospital for waste disposal.

Recommendations

- *Conduct periodic monitoring visits to observe infection prevention and other practices related to abortion care.*
- *Sterile gloves should be used during the entire abortion procedure by all medical staff handling sterile instruments (both by nurses preparing the instruments and by doctors performing the procedure).*
- *Raise physicians' awareness of the risks involved in not using face and eye protection devices.*

COMPLICATIONS

Elective abortion is associated with a small risk of post-operative complications. The incidence and severity of complications depends on gestational age, parity, abortion technology used, physician's skills, type of anaesthesia, and the patient's age and medical history. For example, abortions performed at seven to nine weeks of gestation have significantly fewer complications than those performed between 10 and 14 weeks gestation. Abortions performed by vacuum aspiration, with or without cervical dilatation result in fewer complications than those performed with sharp curettage.

Based on WHO standards, abortion facilities in Romania generally provide safe procedures performed by specialized and competent staff, in an environment that meets the minimal medical standards. Nevertheless, post-abortion complications, both immediate and delayed, occur. The complication rates vary depending on gestational age, parity, the woman's age, the surgical procedure used, doctors' skills, type of anaesthesia used, and medical history.

Interviews conducted in the field with abortion providers revealed the opinion that complications from elective abortions are still a problem in Romania. Estimates are incomplete because patients with complications do not usually return to the same doctor for treatment and follow-up appointments are not always kept. However, the general opinion was that complications occurred in approximately 10% of cases, and were mostly minor, such as post-abortion endometritis or debris. Providers view abortion as a safe procedure with a low risk of major complications.

Since there are no standard medical records containing details of the abortion procedure, and treatments or readmissions for complications can not be correlated back to the procedure, it was not possible for the team to document the incidence and type of immediate complications. Immediate complications include bleeding and cervical trauma, and can occur when less experienced physicians perform the abortion procedure. More serious complications, such as heavy bleeding or uterine perforation, were always reported and recorded on medical records; however, the incidence of such complications was very low.

The 1999 Romanian Reproductive Health Survey showed that 10% of all abortions performed between 1994 and 1999 were followed by immediate complications (8%) or late sequelae (2%). These findings are similar to post-abortion complications documented by the 1993 Romanian Reproductive Health Survey (7% and 2%, respectively).

Most of the early complications involved severe or prolonged bleeding (66%), prolonged pelvic pain (59%), pelvic infection (45%), and high fever (43%). Uterine perforations occurred in about 7% of complicated abortions and 10% of abortions were accompanied by other complications. With the exception of uterine perforation, it is difficult to assess the seriousness of early complications. An indirect approach to measuring severity is to consider early complications serious when they require overnight hospitalisation or when they are

followed by late complications. Almost half of the immediate complications (44%) required one or more nights of hospitalisation and 14% were associated with delayed complications. Early complications were directly correlated to gestational age.

Some doctors said that problems can arise when an abortion is performed in a private or NGO clinic, because these units do not always have the means (including transportation) to handle emergencies that result from complications. The team found, however, that complications were usually treated in outpatient gynaecology facilities and that serious cases were admitted to hospitals that had adequate equipment and supplies for dealing with emergencies (e.g., a blood transfusion).

Post-abortion prescription of antibiotics, anti-inflammatory, and uterotonic drugs to reduce the risk and rate of infections is rare. Doctors do not generally view such prescriptions as a component of necessary post-abortion preventive treatment.

The risk of incomplete evacuation of the uterine cavity is low because of the high level of experience of most gynaecologists and the common practice of using control curettage after vacuum aspiration. The risk of incomplete evacuation increases in proportion to gestational age. Additionally, procedures performed by less experienced doctors have an increased risk of incomplete evacuation. Team members noted the need to recommend that physicians visually examine the uterine content evacuated from each patient to confirm complete evacuation.

Most doctors did not express concern about the danger of late complications such as uterine adhesion, synechia, or infertility. To date, there are no long-term studies on late complications of abortion in Romania. Data from the 1999 Reproductive Health Survey show that most long-term side effects (occurring six months or more after the abortion procedure) were associated with menstrual changes: 26% had irregular bleeding, 11% had secondary amenorrhea (absence of menses), and 5% had dysmenorrhoea (severe cramping pain just before or during the menstrual period). All of these conditions are consistent with pelvic infections and intrauterine adhesions and, interestingly, 11% of patients with late complications were diagnosed with pelvic infection. Chronic pelvic pain was reported in 16% of cases of late complications. About one in six (18%) of them were followed by secondary sterility.

Recommendations

- *Require physicians to visually inspect uterine contents to confirm complete evacuation.*
- *Develop standard and procedures for recording abortion complications and correlate them to the abortion procedure.*
- *Conduct long-term follow-up studies to determine the rate of late complications from elective abortions.*

PRIVACY AND CONFIDENTIALITY

The team found that, in most cases, both lack of space and the absence of specific guidelines contributed to low levels of privacy during the abortion procedure. As mentioned earlier, abortion patients often waited for the procedure in a common space. Sometimes patients even outnumbered the beds available, which made privacy and confidential provider-client interactions impossible.

Personal information about patients was not especially protected; some patients were even called by their names. However, some departments and private clinics had adequate private waiting and post-abortion recovery areas and, in some facilities, separate counselling areas.

Recommendations

- *Require providers to respect client privacy and protect confidentiality.*
- *Include standards for appropriate spaces allowing privacy of information and counselling, procedure, and recovery in the authorization criteria for providing abortions.*

COUNSELLING AND PROVISION OF POST- ABORTION CONTRACEPTION

The team found that very few hospitals and clinics provide post-abortion counselling and contraceptive services. The majority of sites that provided post-abortion contraception are situated near a family planning clinic.

Only a few gynaecologists who perform abortions discuss contraceptive issues with their patients, due to time constraints and the lack of a formal protocol providing guidelines for post-abortion counselling and contraception. Given that physicians are very busy, the team agreed that a trained nurse could provide post-abortion contraception and counselling. At the majority of sites visited, however, there are not enough medical personnel to be able to dedicate a nurse to this activity.

During discussions, physicians and nurses recommended various post-abortion contraception models, depending on the setting. Acknowledging that many abortion patients do not return to the facility for follow-up visits, most physicians agreed that counselling and post-abortion contraception should not be postponed until the follow-up visit. The team found that any post-abortion contraception programme must include private facilities in order to be completely effective.

There are ongoing debates about post-abortion IUD insertion; however, the general opinion of gynaecologist respondents was that if the abortion is performed correctly and there is no risk of complications, then an IUD can be inserted immediately following the procedure. This would be especially useful for women who want to postpone a pregnancy for a longer period of time, and women for whom hormonal contraception is not appropriate.

Recommendations

- *Require nurses and physicians who offer abortion services or family planning clinic staff, if appropriate, to provide post-abortion information, counselling and contraception as routine practices.*
- *Develop curricula and train providers to offer post-abortion contraception services.*
- *Conduct operations research to demonstrate the impact and cost-effectiveness of post-abortion contraception services.*
- *Clarify medical guidelines to allow the insertion of an intrauterine device, if appropriate, after the abortion.*

Provider Competency

Even though some knowledge and practices are dated, the team generally agreed that the technical competency of most gynaecologists was good overall. Abortion is one of the first surgical procedures that gynaecology residents learn, so most are fairly experienced. The estimated incidence of abortion procedural complications (approximately 10%) is, however, considerably higher than in Western countries. Most doctors view abortion as a simple and quick surgical intervention. And, generally they do not view information and counselling issues as important components of the medical procedure.

Doctors agreed that it is necessary to develop standards and guidelines for the abortion procedure that include non-technical issues related to client interaction, counselling, and other non-clinical issues. During the dissemination symposium, participants stressed that standards must cover a broad range of both technical and administrative issues and be disseminated as widely as possible.

Physicians also noted the necessity of in-service training to update and improve knowledge on contraceptive issues since this topic is not stressed in medical school. In six years of university training, contraception is only discussed for a few hours. It is taught exclusively from a technical point of view, sometimes without mention of recent scientific evidence that shows that contraceptives are safe and have few side effects. One doctor quoted a gynecology professor who used to tell his students that "the pill is one of the worst things that can happen to a woman".

All providers interviewed thought that both expanding and improving contraceptive training and providing free contraceptives to women who need them are essential steps toward increasing access to and use of modern contraception. The Ministry of Health and Family, with assistance from international donor agencies is investing considerable amounts of money in post-graduate training for physicians and nurses. The rationale is that if medical universities,

post-graduate schools, and colleges conducting the training of specialised personnel are well informed about modern contraceptive methods, then these professionals will better understand the social context of contraception and be motivated to help couples prevent unintended pregnancies.

Doctors should be more sensitive to the broader sexual and reproductive health needs of women and especially to the role of contraception in reducing the need for abortion. It was suggested that the National College of Physicians could facilitate related post-graduate training activities in preventive medicine by offering additional continuing medical education credits for those attending these courses. Additionally, financial support should be given to physicians who want to attend training sessions and have to travel and stay for the duration of the course in another city.

With regard to service providers' competency with modern contraceptive methods, the team found that gynaecologists are disinclined to believe that a general practitioner, even one with family planning training, can insert an IUD, even though international experience demonstrates the feasibility of this approach. Since many women seeking contraceptive services have already achieved the desired family size or want longer periods between births, some doctors suggested that authorizing and training family planning doctors to insert IUDs at family planning clinics might provide a solution.

Recommendations

- *Increase the time allocated to family planning in medical school training and present the subject with an approach that includes non-technical aspects of the procedure, including good provider-client interactions and interactive counselling.*
- *Update the information presented in family planning courses for medical students according to evidence-based medicine.*
- *Introduce theoretical and clinical training of physicians in the use of electric and manual vacuum aspiration.*
- *Conduct operations research to demonstrate the feasibility of IUD insertion by general practitioners with training in family planning.*

Provider-Client Interactions

The team found that provider-client interactions are unsatisfactory, especially in public hospitals, mainly due to the doctors' lack of time and/or interest and their technical/curative approach to abortion services. In most provider-client interactions (observed), the time spent on interaction and counselling with clients was very short. The interactions were often one-way; and, women were rarely encouraged to ask questions about issues that caused concern or anxiety. The lack of adequate space prevents counselling from being conducted privately, if at all. Generally, interaction was limited to questions related to patients' medical history.

The team found that, in private clinics, the physician usually paid more attention to and spent more time with each patient. Indeed most women said that private facilities gave them more comfort and attention. However, this was not always the case as some patients complained about private clinics ("There were many of us at the door and the doctor didn't have time for us"). Interestingly, most women, even the ones who were not satisfied with the quality of interaction in public services, were satisfied with the safety of services in this sector. Most women said that, when deciding where to have an abortion, the individual doctor was a major factor. Other than professional skills and reputation, these women also considered the doctor's ability to empathise with the patient.

Recommendations

- *Improve the quality of the interaction between abortion providers and patients.*

Links with Other Services

The team found no real link between abortion and contraception services. Links between abortion services and other reproductive health services, such as sexually transmitted infection (STI) screening and treatment, were also weak or non-existent.

Also, if a woman has a free abortion performed and is diagnosed with a sexually transmitted infection she is not entitled to free tests and treatment for the STI if she cannot prove that she holds medical insurance.

Many service providers stressed the importance of using appointments for abortion – which could be one of the few occasions when a patient comes into contact with health-care services – as an opportunity to provide important preventive consultations and investigations that might lead to early detection of breast and genital neoplasia, for example, or to identification of domestic violence.

It was also suggested that women who are provided abortion and are not registered with a family doctor should be provided information about becoming registered as well as the criteria required to qualify for social (and medical) insurance.

Large towns have family planning clinics that employ general practitioners with family planning training and other expertises. These clinics provide integrated services (family planning, colposcopy, ultrasound, STI screening and treatment, etc.). Thus, the client caseload is higher and contraceptive services are much more accessible at these clinics.

The team also found that communication between pharmacists and family planning providers was deficient, despite the recent efforts of family planning training programmes. It was found that pharmacies often dispense contraceptives without prescription and with incomplete or even incorrect directions for use.

Recommendations

- *Integrate abortion services with contraception and other relevant services, such as screening and treatment for sexually transmitted infections.*

Management and Reporting

Abortion-related activities do not have special organization or monitoring systems, even though the number of procedures performed is much higher than procedures for many other medical conditions treated in public hospitals and private clinics. Physicians and heads of departments expressed little, if any interest in logistical issues such as patient management or monitoring the quality of abortion care, perhaps because abortion is so common and a relatively simple procedure.

The team found major gaps in reporting both abortions and procedural complications in both public and private facilities. This was (perhaps) exasperated by the lack of any mandatory medical records. The issue of holding private clinic physicians responsible for correct and complete reporting of abortion cases is a complex problem that can only be resolved through collaboration among the Ministry of Health and Family, the National Health Insurance House, and the National College of Physicians. Discussions held during the dissemination symposium suggested that current regulations must first be enforced and strictly monitored. Other possible actions include developing and implementing clear regulations on reporting, new monitoring and evaluation systems, and guidelines for sanctions.

Recommendations

- *Require better coordination from heads of gynaecology departments for organising, implementing, and monitoring quality of care in abortion facilities.*
- *Improve the national reporting of abortion procedures and complications in both public and private facilities.*

Costs

Both public and private abortion facilities provide abortion services for a nominal cost. Elective abortion is a procedure performed at the patient's request, and is not reimbursed by the health insurance system. However, the team found cases where abortions were performed in hospital facilities as a one-day admission, with the costs reimbursed through the insurance system.

Current Ministry of Health and Family regulations on abortion fees, issued in 1997, stipulate a cost of 60,000 lei (approximately $2) for abortion. In reality, regulations have led to an increase in price in some public and

private facilities due to institutional autonomy to set prices for elective medical services. The Framework Contract for hospital health-care provision stipulates that “the insured shall cover the price of medical services on request” and that health facilities providing such services will set the fees for them. The Framework Contract for specialised outpatient health-care stipulates that “the price for the medical services provided on the client’s request will be covered by the insured for a fee established by the provider”.

Furthermore, prices reflect local conditions, the initial consultation, and additional procedures performed (ultrasound, general anaesthesia, etc.). Consequently, the prices range from 150,000 lei (approximately $5) to 450,000 lei (approximately $15) in the public sector and from 350,000 lei (approximately $11) to 1,000,000 lei (approximately $33) in the private sector. This contradicts earlier regulations that stipulate that the Ministry of Health and Family set prices and fees for consultations as well as tests and other paid medical services provided on the patient’s request in private clinics or in public health-care units.

The assessment team found that the price of an abortion varies not only between the public and the private sectors, but also from one gynaecology department to another and from one private clinic to another. In both the public and private sectors, the price paid for an abortion includes the consultation for establishing the gestational age and the abortion procedure. Gestational age is not always established by ultrasound and use of pregnancy tests is extremely rare. If the patient has a referral from her family doctor, she does not have to pay for the consultation.

In the public sector, fees vary depending on decisions made by local hospital administrators. In the private sector, each clinic sets its own fee for abortion services. The team concluded that the fee varies depending on the type of anaesthesia used and obstetrical history of the patient. Abortions performed with general anaesthesia commanded the highest price, followed by abortions for women who had had a Caesarean section, followed by abortions performed on nulliparous women. Women who had vaginal deliveries paid the lowest price.

Women who demonstrate that they qualify for free services according to Ministry of Health and Family regulations are exempt from the abortion fee. Categories of women who are entitled to free abortion services include pupils, students, unemployed women, women with no income, mothers with four or more children, women with life-threatening pregnancy-associated diseases, cases of pregnancy occurring in women with a history of malformations, women with severe physical or mental disabilities, and women who are pregnant as a result of rape or incest.

Clients interviewed were generally aware of prices for elective abortions and contraceptives. Some women said they felt they had to give additional gifts to physicians, however, in order to ensure better quality care. Some gynaecologists admitted that abortion could be a good source of income, especially for those who limit their activities to abortions and other simple surgical procedures. This situation is maintained by the cultural context and the tradition of giving physicians gifts for the services they provide.

Both providers and clients agree that the abortion fee charged in public hospitals does not cover the real cost of the procedure, however, the real cost of an abortion had never been established, except in one of the hospitals visited. In that case, the estimated cost was four times higher than the fee actually charged. Doctors interviewed thought that the fee charged in private clinics was closer to the real cost of the abortion procedure.

Although they agreed that the abortion fee did not reflect the true cost of the procedure, most women believed that the abortion fee and price of contraceptives were too high relative to their incomes. The team found that a significant number of women could not afford either abortion or contraceptive services. Abortion was thought to be more expensive than contraception if frequently used and cheaper if used once. Almost all clients, even those who were not having their first abortion, stated that the abortion they were having was an exception and would not happen again.

All interviewed women who were at risk for unintended pregnancy said they would use contraception if it were free of charge. Only a few women were reluctant to receive free contraceptives; those women stated that anything that is free of charge must be of low quality.

Almost all respondents thought that an increase in the abortion fee would lead to an increase in illegal abortions. Some hospital administrators suggested the need to recalculate the fee for elective abortion based on clear procedure standards and cost-efficiency criteria. Additionally, a few people suggested that the price of abortion should be increased to be equal to the price of six months of contraception, or that prices should vary depending on the patients' financial means; however, some noted that this could be interpreted as discriminatory. One client said, "A woman will have an abortion if she has an unwanted pregnancy; the difference will be that, if the abortion fee goes up, some women will resort to illegal abortions".

The assessment team thought it would be useful to reassess the fee for elective abortions on the real cost of a standard procedure. The procedure should be clearly defined from a technical point of view, according to established guidelines.

The team also recommended establishing a new fee structure that takes into account the real costs of the procedure while at the same time not creating a new barrier for women of low socio-economic status. Participants in the national dissemination symposium recommended that the abortion fee be set for the entire system by the Ministry of Health and Family at such a level that would avoid a potential increase of illegal abortions.

The funds derived from abortion fees were generally included in the general operating budget of the hospitals (except for some independent obstetrics/gynaecology hospitals) and were used for internal purposes according to each hospital's needs and priorities. A participant in the dissemination symposium said, "Hospitals are fed from abortion money". Many doctors and heads of obstetrics/gynaecology departments noted that funds derived from abortions were not returned to the department to address the unit's needs or to improve quality of care. In the private sector, however, the physician performing the procedure decides how to use the funds and thus can make investments that improve the quality of abortion care.

Recommendations

- *Assess the real cost of abortion and set a new fee for standard procedures, which should in no way limit women's access to abortion.*
- *Return a percentage of the money derived from abortions to gynaecology departments and use it to improve the quality of abortion care, including post-abortion contraception.*
- *Provide free contraceptives and counselling to disadvantaged women through family physicians.*
- *Establish a simplified mechanism to certify low-income women's eligibility for free contraceptive and abortion services.*
- *Include contraceptives on the list of drugs subsidised through the insurance system.*

ABORTION AND CONTRACEPTIVE TECHNOLOGIES

Provider Perceptions of Abortion and Contraceptive Technologies

The assessment teams found that the most common abortion technique was sharp curettage, although vacuum aspiration was also used at many facilities. Availability of abortion instruments and supplies plays a critical role in a physician's choice of a method. Team members were surprised, however, to find that gynaecologists were somewhat reluctant to use vacuum aspiration. Equally interesting was the team's finding that some physicians used sharp curettage in (public) hospital settings and vacuum aspiration in their private clinics.

Some respondents admitted that improvements in contraceptive technologies will lead to a decrease of the number of abortions and thus a decrease in personal income. One gynaecologist gave a highly illustrative example of his/her lack of interest in contraception by saying "If we keep encouraging contraception, we shall have no more abortions to perform". The assessment team also interviewed gynaecologists who thought that abortion was too simple a procedure to warrant their specialised surgery training. One of these doctors said, "We are sick and tired of performing curettage, abortion is nothing but a messy procedure".

The team found that local authorities and health managers did not view abortion and contraception as very important relative to other community health issues. However, in some *judets*, especially those with active local committees focusing on women's health or donor-supported family planning programmes, abortion and contraception were seen as more important services. In these *judets*, a good collaboration existed also between the local health authorities and relevant non-governmental organizations active in reproductive health.

Recommendations

- *Increase provider knowledge about the advantages of vacuum aspiration over sharp curettage.*
- *Increase abortion providers' knowledge about modern contraceptive methods.*

Manual Vacuum Aspiration

Except for a small number of respondents, the team found that manual vacuum aspiration (MVA) was not widely known or used. Those who knew of it were neither knowledgeable about the characteristics and advantages of the instruments nor its availability and costs. A small number of doctors had aspiration syringes, but said they only used them sporadically, if at all, either due to lack of appropriate training or to a lack of interest.

Nevertheless, gynaecologists who use MVA think it is better, easier for patients to bare, and cheaper than traditional curettage. Another advantage is that the use of manual vacuum aspiration is not restricted to the procedure room where the electric vacuum aspiration (EVA) machine is kept, which is often in high demand where EVA is used. A gynaecologist who has used MVA said that he is no longer forced to schedule abortions in the abortion procedure room and that he can perform abortions at any time, without a patient list, even outside the abortion room.

Recommendations

- *Provide manual vacuum aspiration equipment where appropriate and especially where electric aspirators are not available.*
- *Train gynaecologists to use manual vacuum aspiration properly.*

Medical Abortion

Given the high demand for abortion in Romania, the addition of a medical abortion alternative may be a means to expand reproductive choice and thus improve the quality of abortion care services. Medical abortion technology with mifepristone and misoprostol was first introduced in Romania in 1999 in Targu Mures as part of a multi-centre study conducted by the World Health Organization. The clinical study also assessed clients' and providers' acceptability of medical abortion services with mifepristone and misoprostol. The study demonstrated strong demand for medical abortion at the study site. Medical abortion was preferred by younger women, who had a higher level of education and fewer abortions, as well as by the women who had had negative experiences with surgical abortion. The main reasons for choosing medical abortion were the anticipated advantages (less risky, less traumatic), psychological/emotional considerations, and fear of surgical abortion. The main reasons for choosing surgical abortion were related to the low number of doctor's visits required, the distance to the hospital, and the anticipated advantages (quicker than medical abortion).

In addition, particular attention was paid to how the addition of a medical alternative would affect the overall delivery of abortion services at a major hospital in Romania. The study demonstrated that medical abortion could be integrated into existing abortion services easily and that abortion providers, on the whole, accepted the new method.

The interviews conducted within the strategic assessment showed that abortion service providers know very little about medical abortion, except for those in the *judet* where the method was used. After receiving more information about this method, however, most providers thought that medical abortion would be an excellent method for many of their patients and that its introduction should be assessed in more detail.

After being informed about the method, the women interviewed showed unanimous interest in medical abortion, saying, "Women would appreciate the option, given that many women dream of an abortion pill". Potential side effects, such as bleeding, did not receive negative feedback. This situation is identical to the conclusions of the 1999 World Health Organization study, which indicated a high level of satisfaction among medical abortion study subjects (97.9 % were either very satisfied or satisfied with the method).

Most providers and users did not consider the fact that medical abortion requires multiple (i.e., three) visits to the doctor to be a real barrier, but the perceived high price was believed to pose a real barrier for most patients. From the health-care- system perspective, the method seemed easy to integrate into the practices of both public and private abortion facilities. However, depending on the cost, medical abortion might be accessible primarily to women with higher socio-economic and educational levels.

Recommendations

- *Conduct operations research studies to assess the feasibility and cost of using medical abortion to improve the quality of abortion services.*

Emergency Contraception

The provision of emergency contraception through existing family planning programmes and pharmacies is currently part of the strategy to help reduce the need for abortion and increase contraceptive use in Romania. The assessment confirmed that both hormonal methods (combined estro-progestin and progestin-only regimens) and IUDs are used for emergency contraception in both governmental and non-governmental family planning clinics in Romania. Because there is not a management information system, there are no exact figures on the prevalence of this method.

Before 1989, when laws were more restrictive, the pill containing 750 μg of levonorgestrel, brought into Romania from Hungary, was one of the best- selling contraceptives on the black market. Even without adequate information on the proper way to use them, these pills were often used as regular contraceptives,

especially in the northern part of the country. After 1989, due to the absence of special pills for emergency contraception, the estro-progestin combined regimen included four low-dose pills taken within the first 72 hours after unprotected sexual intercourse, followed by another four pills after the next 12 hours. The progestin-only regimen was made up of two tablets of Postinor taken 12 hours apart. Recently, a new emergency contraceptive product was registered and placed on the market. The product includes two pills of levonorgestrel of 750 µg, specially registered and packaged for use as an emergency contraceptive. The product costs 120,000 lei (approximately $4), which is higher than the cost of oral contraceptives in regular use, but less than surgical abortion would cost in many facilities. The product is available only by prescription. There were contradictory discussions with service providers and clients about the relationship between the price of emergency contraception and access to it. Some respondents considered the current price too high and suggested that this makes the method inaccessible to some women who might otherwise use it. These respondents suggested lowering the price or making emergency contraception free of charge. Other respondents suggested that, since abortion is an important fertility-regulation method in Romania, free emergency contraception could provide a further disincentive for women to use regular contraception.

Few women interviewed knew about emergency contraception or the name of the product available in pharmacies. Those who did know about the method said they had seen it advertised in magazines, fliers or pharmacies.

Doctors and nurses interviewed agreed that emergency contraceptive methods can play a significant role in convincing women to utilise a broader spectrum of family planning and reproductive health services. Emergency contraception can be a primary contact point from which to deliver counselling, information and other reproductive health services.

Currently, there is no national programme focused on promoting emergency contraception, but such a campaign is planned. In addition, there are inserts referring to this product in several magazines.

Recommendations

- *Conduct an information, education, and communication campaign to promote emergency contraception.*
- *Conduct operations research to determine the role of cost in women's decisions to use emergency contraception versus regular contraception.*

FUTURE STEPS

The experience, findings and recommendations of the strategic assessment have set the stage for policy change and action research. This, in turn, should facilitate the expansion of sustainable, high-quality services throughout the country. The interesting discussions and heated debates during the dissemination symposium revealed that participants considered the strategic assessment of abortion and contraception a necessary initiative in the current policy environment. Participants expressed their views that the assessment results would sensitise policy-makers and other stakeholders and would lead to action aimed at changing the current situation.

The strategic assessment gave added support to some earlier findings, including:

- Abortion is still one of the most commonly used fertility-regulation method in Romania, and continues to be perceived by women as a traditional, accessible, cheap, quick and safe procedure;
- Services that provide abortion generally offer safe procedures, although the rate of post-abortion complications is higher than in western countries;
- An increasing number of abortions are performed in the private sector;
- The link between abortion and contraceptive services is weak to non-existent;
- The provision of contraceptive counselling and methods by all family doctors is still an unachieved goal; and
- Illegal abortions are still a problem in Romania.

In addition, the assessment refuted some widely held assumptions, especially, the notion that most abortions in Romania are performed by vacuum aspiration.

The assessment helped policymakers identify key areas to address in order to improve access to and quality of abortion services, including:

- Issues related to provider-client interactions and a lack of privacy and confidentiality;
- Issues with procedures and protocols related to pain-management and infection-prevention practices and the heavy use of sharp curettage;
- Issues related to patient flow and scheduling procedures in abortion facilities;
- Issues in the national monitoring and reporting system, especially within the private sector.

The team concluded that safe pregnancy termination services should be available and accessible to women when they need them, staffed by well-trained providers, and situated in a well-developed infrastructure that includes adequate equipment and supplies.

One important conclusion is the need to develop national standards and guidelines for comprehensive abortion care and implement a monitoring and evaluation system to ensure that high-quality standards are achieved and maintained.

It was also stressed that poverty, low education levels, and lack of current, reliable information influence whether women use modern contraception or resort to elective abortion as a fertility regulation method. The prices of modern contraceptives and elective abortion could be important instruments for changing women's behaviours towards fertility regulation methods. Offering free or subsidized contraceptives in conjunction with activities that provide reliable information on the benefits of modern contraception may lead to increased demand for and use of modern contraceptives. At the same time, maintaining the fee for pregnancy termination at levels accessible to women with low socio-economic status is required to minimise the number of illegal abortions.

Some of the issues identified by the strategic assessment have already begun to be addressed by the institutions that took part in the assessment; clearly, the assessment played

an important role in raising team members' awareness and motivation. For example, after the completion of the fieldwork, in the process of establishing the 2002 budget for health programs, the Ministry of Health and Family earmarked considerable funds within the National Programme for Child and Family Health for purchasing contraceptives to be given free to eligible women. The categories of eligible women include: unemployed, pupils and students, women in families that receive social assistance and/or have no income, women with permanent residence in rural areas, and women who undergo elective abortion in a public health facility. The last two categories are present on this list for the first time; they have been included due to the findings of the strategic assessment. In addition, an information, education, and communication campaign has been designed specifically to inform women about the existence and availability of free contraceptives.

Another response to the findings of the strategic assessment was the inclusion (for a period of time) of oral contraceptives and injectables on the list of drugs subsidized (by 65%) by the National Health Insurance House. These two measures were a direct response to the findings of the assessment regarding the necessity of providing free or low-priced modern contraceptives in order to reduce demand for abortions.

Furthermore, the principles of the obstetrics and gynaecology hospital care rehabilitation programme in Romania, recently stated through a Government Decree, stipulate that all public obstetrics-gynaecology hospital departments will ensure safe, high-quality abortion services, including counselling and post-abortion contraception. The fee for these services cannot exceed a maximum amount set by the Ministry of Health and Family, to avoid limiting women's access to services and recourse to illegal abortion.

Priority will be given to expanding contraceptive services at the primary health-care level, especially in rural areas, training family physicians and nurses in contraceptive service provision, and making free or subsidised contraceptives available to women.

The process of establishing and defining the role of community health care will lead to the creation of a new professional category, namely the community nurse, who will have the responsibility of informing and educating women and men in the community about modern contraception and the risks of unsafe abortion.

Another recent step is the signing of an agreement between the Ministry of Health and Family and the Ministry of Education and Research for the mandatory introduction of health education in Romanian schools starting in 2003, including education on reproductive health issues.

Other findings of the assessment will soon be addressed, since they have been placed on the list of priorities of the Consultative Group for Reproductive Health, a body that supports the Ministry of Health and Family in establishing priorities and defining the interventions needed to improve reproductive health. This group includes representatives of national institutions, both public and private, as well as representatives of international donor agencies active in the field of sexual and reproductive health.

The discussions during the dissemination symposium and those during the post-assessment team meeting led to the identification of the following six priority objectives for action, derived from the strategic assessment findings (see Figure 2).

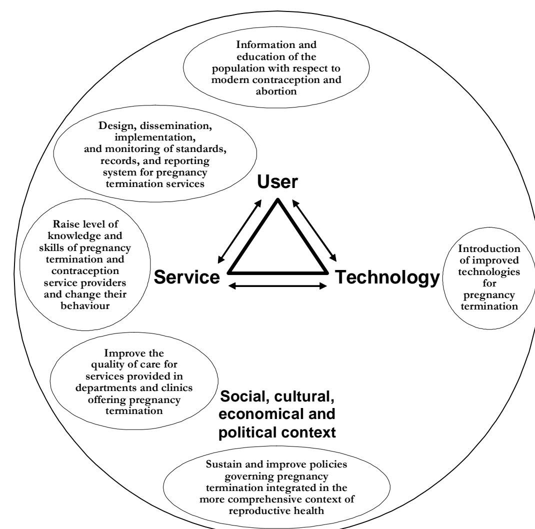

Figure 2. Priorities for Action.

Introduce/revise standards, record keeping, and reporting system

A major need identified was the design, implementation, and monitoring of standards, records, and reporting systems for abortion-care services, including post-abortion contraception and links with other reproductive health services. The following activities were proposed:

- Design technical, financial, and procedural standards for pregnancy termination procedures, including provider-patient interaction, counselling, privacy and confidentiality, as well as referral communication with the family physician;
- Improve the record keeping and reporting system for abortion procedures and complications by devising models for counselling forms, observation records, hospital discharge notes, and reporting forms.

Train service providers

Raise abortion and contraceptive service providers' level of knowledge and skills and effect behavioural changes through:

- Training activities for physicians and nurses;
- Starting training during medical school and continue post-graduate training, with a focus on pregnancy prevention and quality interactions with patients.

Improve quality of services

Improve the quality of services provided in departments and clinics that offer abortion care, starting with a focus on woman-centred care and ensuring observance of clients' rights. This objective requires:

- Regulation of pre- and post-abortion information and counselling as an integral part of the abortion procedure;
- Development of model, comprehensive abortion care services, including post-abortion contraception, integrated into a quality reproductive health-care context.

Introduce improved technologies

The assessment findings conclude that the introduction of improved abortion technologies must be a priority, including:

- General use of vacuum aspiration up to ten weeks of gestation in all facilities providing abortion (except for clients with contraindications); and
- Feasibility study on introducing medical abortion to improve quality and choice in pregnancy termination services.

Strengthen and improve policies and regulations

The team identified the need to strengthen and improve policies governing pregnancy termination integrated in the more comprehensive context of reproductive health with a view to changing the current balance between abortion and contraception in favour of contraception. This can be achieved by:

- Advocacy for modern contraceptive use;
- Policies governing the funding of pregnancy termination and contraception; and
- Regulations governing pregnancy termination monitoring and reporting systems.

Provide better information and education to the general population

Improve informing and educating the general population with respect to modern contraception and abortion by:

- Conducting systematic information, education, and communication campaigns and activities to promote healthy changes in reproductive behaviour;
- Promoting accurate reproductive health messages through the media;
- Providing healthy lifestyles education in schools, including responsible sexual and reproductive behaviours; and
- Training physicians, hospital and community nurses, and pharmacists to provide appropriate reproductive health messages to their patients/clients.

The assessment team is convinced that meeting these objectives will play a critical role in attaining the strategic objectives of the Ministry of Health and Family to achieve universal access to high-quality reproductive health services and to integrate these services into primary health care.

ACKNOWLEDGEMENTS

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ANNEX 1. STRATEGIC ASSESSMENT TEAM MEMBERS

West Team

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Ronnie Johnson, PhD	Director of Research, Ipas
Entela Shehu, MD MPH	Europe Programme Manager, Ipas
Alina Petrescu	Translator

ANNEX 2. JUDETS, SITES, AND INSTITUTIONS VISITED

Judets and Sites Visited

Bucharest	Bucharest (capital of Romania)
Braila Judet	Braila (*judet* capital)
	Ianca Town
	Sutesti Village
Constanta Judet	Constanta(*judet* capital)
	Medgidia City
	Agigea Commune
Dolj Judet	Craiova (*judet* capital)
	Calafat Town
	Maglavit Commune
	Cetatea Commune
Hunedoara Judet	Deva (*judet* capital)
	Petrosani City
	Orastie Town
Iasi Judet	Iasi (*judet* capital)
	Pascani City
Mures Judet	Targu-Mures (*judet* capital)
	Sighisoara City
	Sangeorgiu de Padure Commune
Teleorman Judet	Alexandria (*judet* capital)
	Rosiorii de Vede City
	Plosca Commune
	Peretu Commune
Vaslui Judet	Vaslui (*judet* capital)
	Barlad Town

Institutions Visited

Public Health Directorates (9)
Health Promotion Services (3)
College of Physicians Offices (9)
Insurance House Offices (6)
Public Abortion Clinical/Hospital Departments (21)
Private Abortion Clinics (13)
National Coordinating Family Planning Centre
Governmental Family Planning Reference Centres (3)
Governmental Family Planning Clinics (12)
Family Doctors' Offices (14)
Private Pharmacies (11)
City Hall/Commune Social Services (9)
High Schools, Colleges and Universities (11)
Youth and Women's Non-Governmental Organizations (8)
Political Parties/Women's Organizations (4)
Factories (6)
Local Communities (2)
Church (1)
Rroma Communities (2)

Individuals interviewed

Institutional representatives (70)
Ministry of Health and Family (21)
- Public Health Directorate Directors
- Mother and Child Care Inspectors
- Health Promotion Inspectors

National College of Physicians (9)
Judet Health Insurance House (6)
National Commission of Obstetrics and Gynaecology (1)
National Reference Family Planning Centre (1)
City Hall/Commune social services (10)
Youth non-governmental organizations (7)
Women's non-governmental organizations (7)
Political parties (4)
Rroma ethnic minority (6)

Professionals (208)
Managers (23)
- Hospital managers
- Company/factory directors
- Human resources managers
- High school/college director

Obstetrics and gynaecology professionals (89)
- Obstetrics and gynaecology university professors
- Head of obstetrics and gynaecology clinics/hospital departments
- Obstetrics and gynaecology primary and specialist physicians
- Obstetrics and gynaecology clinics/hospital departments head nurses
- Obstetrics and gynaecology nurses

Family planning professionals (27)
- Family planning coordinating physicians
- Family planning physicians and nurses

Family Medicine/public health professionals (29)
- Family physicians and nurses
- Public health physicians

Other medical professionals (25)
- Anaesthesia and intensive care physicians
- Paediatricians
- School physicians and nurses

Pharmacists (15)
Other individuals (28)
- Teachers
- School psychologists and counsellors

Abortion and family planning users and potential users (202)
Public and private abortion clinic clients (58)
Family planning clinic clients (8)
Students (41)
Community members (89)
Rroma community members (6)