The 3rd Regional Conference
“Self-care in reproductive health: family planning and safe abortion according to WHO recommendations in Eastern Europe and Central Asia”

Chisinau, Moldova
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The Background: The Regional Reproductive Health and Rights Coalition

With the aim to unify the efforts to promote and advocate for sexual and reproductive rights and universal access to comprehensive reproductive health care, professionals and SCOs members with expertise on safe abortion and family planning from 12 countries from Eastern Europe and Central Asia (EECA) created The Regional Reproductive Health and Rights Coalition (RRHRC). The Coalition was launched during the First Regional Conference "Bringing the WHO Recommendations on Safe Abortion and Family Planning Closer to Women in Countries of Eastern Europe and Central Asia" organized on 16 November 2018, in Chisinau, Moldova.
The mission of Coalition is to promote, respect and advance Sexual and Reproductive Rights, universal access to comprehensive SRH services, including to safe abortion, to align them to WHO recommendations, focusing on the needs of women and men in Countries of Eastern Europe and Central Asia. RRHRC activities are coordinated by the Regional Training Center (Reproductive Health Training Center from Moldova) and financially supported by the Safe Abortion Action Fund (SAAF).
Coalition activities included a series of training of trainers in safe abortion in all participating countries and creation of national professional teams, updates to university curricula – inclusion of safe abortion training modules, support for participation of colleagues from member countries in regional and international SRH and safe abortion conferences and meetings, numerous information articles, news, manuals translated into Russian and distributed via Workplace. In the first three years, the main efforts of the Coalition were focused on improving access to and quality of safe abortion services in the region through the alignment of national safe abortion guidelines and protocols with the most recent WHO recommendations. Experiences and lessons learned by EECA countries in the process of updating and implementing national safe abortion guidelines and protocols were presented and discussed during the 2nd edition of the Regional Conference "Bringing WHO recommendations on safe abortion and family planning closer to women in countries of Eastern Europe and Central Asia" organised by RRHRC on December 16-17, 2021.

The 3rd Regional Conference "Self-care in reproductive health: family planning and safe abortion according to WHO recommendations in Eastern Europe and Central Asia"

The 3rd edition of Regional Conference "Self-care in reproductive health: family planning and safe abortion according to WHO recommendations in Eastern Europe and Central Asia" was organized on May 15-16, 2025, in Chisinau, Moldova. Participants of the 3rd edition of RRHRC Regional Conference were politicians, service providers, activists, NGO leaders from 11 Eastern Europe and Central Asia (EEAC) countries, international and national experts in the area of safe abortion and family planning, as well as representatives of WHO, IPPF, UNFPA, DKT International, ESC, Gynuity Health Projects and other international organizations. The conference took place in a hybrid format: with physical presence for participants in Moldova and online, through the Zoom platform.

Objectives of the conference:

1. Exchange of experience and discussion of lessons learned in EEAC countries on the implementation of WHO recommendations on self-help in the field of reproductive health, including abortion and family planning. Identify gaps and opportunities for practical application and integrate them into the national protocols.
2. Addressing critical issues and exploring resolution mechanisms in the area of safe abortion and family planning. Obtain up-to-date information from partners and colleagues on support for the de-medicalization of family planning and abortion services.
3. Discuss possible next steps to expand access and improve the quality of services in the field of reproductive health, family planning and safe abortion in the EEAC region.

The conference was organized with the support of the Safe Abortion Action Fund (SAAF) within the project "Women's Reproductive Health Services in line with the latest WHO recommendations".

The recent WHO recommendations and tools on quality comprehensive abortion care, self-managed Medical Abortion and the use of Telemedicine

At the start of the Conference Dr. Caron Kim (WHO) and Dr. Rodica Comendant (Director of RHTC) presented latest WHO activities and recommendations on quality comprehensive abortion care, including on self-care in safe abortion and post-abortion family planning. It was stressed that WHO has included comprehensive abortion care in the list of essential health services, considering abortion a safe, effective and non-complex health care intervention. Also, WHO recommends that abortion should not be regulated differently to other forms of health care activities, such as regulated under criminal law: women and girls risk their lives and health resorting to unsafe abortion in countries in which pregnancy termination services are unavailable and/or legally restricted.

In the 2022 WHO Abortion care guideline, recommendations are presented across three domains that are essential to the provision of abortion care: Law and policy, Clinical services and Service delivery. The new guideline clearly outlines law and policy recommendations as individual recommendations on specific aspects of law and policy, including: criminalization, grounds based approaches, gestational age limits, mandatory waiting periods, third party authorization, provider restrictions, and conscientious objection.

Law and policy WHO recommendations:

1. WHO recommend the full decriminalization of abortion.
2. WHO recommend against laws and other regulations that restrict abortion by grounds.
3. WHO recommend that abortion be available on the request of the woman, girl or other pregnant person.
4. WHO recommend against laws and other regulations that prohibit abortion based on gestational age limits.
5. WHO recommend against mandatory waiting periods for abortion.
6. WHO recommend that abortion be available on the request of the woman, girl or other pregnant person without the authorization of any other individual, body or institution.
7. WHO recommend that access to and continuity of comprehensive abortion care be protected against barriers created by conscientious objection.
8. WHO recommend against regulation on who can provide and manage abortion that is inconsistent with WHO guidance.

Clinical service recommendations address methods of abortion and related clinical care: provision of information, counselling and pain management: methods and regimens for abortion and provision of post-abortion care, including all methods of contraception.

Service delivery recommendations include those relating to settings where abortion procedures can be performed and to which categories of health workers can provide the relevant clinical services. WHO consider all methods of vacuum aspiration (MVA, EVA) for induced abortion at gestational ages < 14 weeks as simple and safe medical procedures: vacuum aspiration can be performed in a primary care facility and on an outpatient basis by a wide range of providers, including traditional and complementary medicine professionals, nurses, midwifes, associate/advanced associate clinicians and generalist and specialists medical practitioners. WHO maintain the recommendation that dilatation and sharp curettage (D&C) should be replaced with vacuum aspiration. According to WHO, additionally to those mentioned above, a wider range of providers can safely offer medical abortion at gestational ages < 12 weeks: community health workers, pharmacists, auxiliary nurses/ANMs.

For medical abortion at <12 weeks (using the combination of mifepristone plus misoprostol or using misoprostol alone) WHO recommend the option of self-management of the medical abortion process in whole or any of the three component parts of the process: self-assessment of eligibility (determining pregnancy duration; ruling out contraindications), self-administration of abortion medicines and management of the abortion process outside of a health-care facility and without the direct supervision of a trained health worker and self-assessment of the success of the abortion. Recommend the option of self-administration of injectable contraception in the post-abortion period.

In the 2022 WHO Abortion care guideline were included two new important service delivery recommendations: one regarding telemedicine and one - on models of service delivery. Guideline states that there is no single recommended approach to providing abortion services. The choice of specific health worker(s) (from among the recommended options) or management by the individual them-self, and the location of service provision (from among the recommended options) will depend on the values and preferences of the woman, girl or other pregnant person, available resources, and the national and local context. They also point out that, regardless of the service delivery approaches used in any setting, the total range of options together must ensure certain elements, including access to accurate information and quality medicines, referral support, and linkages to post abortion contraception for those who want it.

WHO abortion care guideline, derivative products and training toolkit

WHO abortion care guideline: https://www.who.int/publications/i/item/9789240039483
Executive summary in Russian: https://www.who.int/ru/publications/i/item/9789240045163
Operational guidance products
Clinical Poster and Pocket card: https://iris.who.int/handle/10665/329411
Clinical Practice Handbook: https://www.who.int/publications/i/item/9789240075207
Law and Policy Recommendations Evidence Brief: https://www.who.int/publications/i/item/9789240062405
Digital Decision Support Tool: https://play.google.com/store/apps/details?id=com.out2bound.dds&hl=en&pli=1
Linked product
FP/CAC Competency Toolkit: https://www.who.int/publications/i/item/9789240063884

The 2022 WHO Abortion care guideline recommend the option of telemedicine as an alternative to in-person interactions with the health worker to deliver medical abortion services in whole or in part. The recommendation of telemedicine applies to assessment of eligibility for medical abortion, counselling and/or instruction relating to the abortion process, providing instruction for and active facilitation of the administration of medicines, and follow-up post-abortion care, all through telemedicine. In studies comparing telemedicine with in-person medical abortion care services, there was no difference between the two groups in rates of successful abortion or ongoing pregnancies; referrals for surgical intervention were fewer among women who used telemedicine; satisfaction with telemedicine services was high and comparable to the usual clinical services.

Aligning national policy documents to WHO recommendations on self-management. The successful country case studies on using the Formative research and pilot studies results, leading to the institutionalization of the Medical Abortion via telemedicine in EECA countries

As initial steps before implementation, several countries and territories, members of RRHR Coalition (Armenia, Azerbaijan, Georgia, Moldova, Kazakhstan, Kirgizstan, Ukraine, Uzbekistan and Transnistria region of Moldova) conducted formative research and/or pilot studies on appropriateness, feasibility and acceptability of Medical Abortion via telemedicine or self-care. These activities were conducted under the guidance of RTH (RHTC, Chisinau, Moldova) with technical and financial support of SAAF and Gynuity Health.

The main aims of formative research on MA via telemedicine or self-care were: to evaluate awareness and preparedness of population and providers to accept implementation of MA via telemedicine and self-care, identify possible legal, regulatory and service conditions and barriers and develop appropriate strategies for introducing telemedicine abortion services. Formative research involves gathering data useful for the development and implementation of intervention programs. Data were collected through interviews with a variety of health care providers (obstetricians-gynaecologists, pharmacists, midwifes, nurses and primary health care professionals), various women groups and potential service users. Formative research, conducted in Kazakhstan, Kirgizstan and Armenia revealed a very high level of awareness among women about medical abortion – more that 90% and between 60 and 72% of women stated that they will be able to cope with the process of medical abortion on their own.

A very high proportion of women, potential users of services (between 78 and 100%) declared that they are ready for implementation of MA via telemedicine, and more than two thirds believe that this approach can be implemented in their countries. Vast majority of providers also support implementation of MA through telemedicine (94%) and declared that it is possible to implement this approach (84%).

A number of countries (Azerbaijan, Kirgizstan, Moldova, Ukraine, Uzbekistan and Transnistria region of Moldova) conducted, disseminated at national level and presented at this conference results of open label, observational pilot studies on feasibility and acceptability of MA via telemedicine. Number of participants varied between 50 and 500 in each of the studies. In these clinical trials, one, several or all steps of medical abortion (initial assessment - confirmation of pregnancy and determination of eligibility, pre-abortion counselling and/or instructions relating to the abortion process, confirmation of completeness of abortion, pregnancy test after 4 weeks and post-abortion counselling) were offered distantly, via telemedicine.

Result of these studies confirmed that telehealth medication abortion is highly safe and effective. Success rate and safety outcomes were similar to those reported in literature for in-person abortion care: rates of complete abortion varied between 97 and 100%, surgical evacuation rates and incidence of serious adverse events was very low. Additionally, medical abortion through telemedicine was highly acceptable to women and providers: more than 90% of women were satisfied or very satisfied with telemedicine procedures; also more than 90% of women declared that they would select the same approach in the event of another unwanted pregnancy and would recommend MA via telemedicine to their friends. Majority of women consider that MA via telemedicine have several advantages over face-to-face approach: more convenient for women, respect privacy and confidentiality, fewer women would miss school/work, no need to arrange child care, less expensive for women, and greater access for rural women.

Health care providers stated that telemedicine medical abortion can improve access to pregnancy termination services and ensure women's safety during a crisis, telemedicine medical abortion is feasible and acceptable for women in EECA countries, women can safely follow instructions received remotely, thereby reducing the burden on health care staff and clinics.

It is worth to mention that result of studies on MA through telemedicine conducted in several EECA countries (Moldova, Georgia, Ukraine, Uzbekistan and Azerbaijan) were published in prestigious medical journals. Dissemination and discussion of results of these studies at country level and experiences obtained by providers while conducting them, helped local experts, policy-makers and ministries of health to revise national abortion guidelines and include MA via telemedicine in national abortion standards/protocols in Moldova, Kazakhstan, Kirghizstan and Ukraine.

Sarmuldayeva Sholpan (KPMA, Kazakhstan) included in her presentation detailed statistical[RC1] data on abortions in the country, showed results of formative study on telemedicine MA in Kazakhstan and presented steps of preparation for pilot study on telemedicine and challenges faced by organisers during preparatory process.

After presentation of results of formative and pilot telemedicine studies, **Raisa Asilbasheva (MoH Kirghizstan) and Baktygul Bozgorpoeva[RC1] (Family Planning Alliance, Kyrgyzstan)** talked about unsolved problems in the area of abortion and contraception and proposed activities to expand access to medical abortion and telemedicine in Kyrgyzstan.

Anna Hovhannisyan (Women's Resource Center, Armenia) presented in details recent modifications[RC1] of legislation on abortion in Armenia. Medical termination of pregnancy for up to 8 weeks of pregnancy now is permitted in Armenia not only in hospital, but also in community based settings in medical organizations licensed for obstetric and gynaecological medical care and services.

Formative research on telemedicine in Azerbaijan **(Gulnara Rzayeva (Scientific Research Institute of Obstetrics and Gynecology, Azerbaijan))** investigated also policy maker's views on next steps necessary to accomplish to implement telemedicine. Most policy makers mentioned changes in legislation, inclusion of MA through telemedicine in national guidelines on safe abortion, training of service providers and information campaign for service providers and women.

Najmutdinova Dilibar (Tashkent Medical Academy, Uzbekistan[]) talked about experience of Uzbekistan in community involvement in improving knowledge of population and its access to safe abortion and contraception. They trained women activists from “mahalea” - a unique institution of civil society, which main role is propaganda of the principles "Healthy Family Healthy Society".

Galina Maistruk (Women’s Fund, Ukraine) presented experience of her country in remote provision of abortion care in the conditions of Russian full-scale invasion of Ukraine. The demand for telemedicine and self-management methods of pregnancy termination substantially increased during war and associated severe disruptions of health care services, especially in the invaded regions. Despite overall decrease in number of registered abortions, proportion of medical abortions is higher than in pre-war years.

Ceban Oxana (RMCC, Transnistria, Modova) presented a series of activities done in collaboration with RHTC to implement concept of ”Comprehensive abortion care” in Transnistria region. She described perspectives of further collaboration, including institutionalization of telemedicine MA, validation of Clinical guidelines for family planning (including Levoplant) and initiation of MA management by mid-level medical staff (midwives).

Abortion and family planning services in Belarus and Tajikistan: achievements and challenges

Oksana Teslova (State Medical University, Belarus) presented detailed statistical data on abortions and family planning in Belarus. Medical abortion via telemedicine is not available. Despite many efforts to promote modern methods of contraception, more than 20% of couples in Belarus do not use ant contraceptive method; highly effective methods (pills and IUDs) – only by 14,4% and 5,9% of couples. Many modern methods of contraception are not available in the country: injectable contraceptives, vaginal rings, combined hormonal patches and hormonal implants.

Kurbanov Shamsidin (Tadjik Family Planning Association, Tajikistan) mentioned that despite substantial decrease of number of abortions, pregnancy terminations continue to cause maternal deaths and severe post-abortion complications in Tajikistan, remaining a pressing medical and social problem for society and the healthcare sector. Medical abortion via telemedicine is not available. It is necessary to mobilize existing human and other resources to expand and ensure access to safe abortion services and management of post-abortion complications.

Conclusions:

In order to expand women's access to MA via telemedicine, countries' representatives proposed a number of steps: share telemedicine experience in other regions/pilots, training additional teams of doctors and nurses in this approach, develop and approve by Ministries of Health guidelines/algorithms for performing termination of unwanted pregnancy using telemedicine, develop training modules with information on MA via telemedicine for students of medical colleges and institutes, and conduct information campaign for service providers and women.

New opportunities in the field of safe abortion and family planning: updates from partners and colleagues

Several international organizations collaborate with and offer technical and financial support to EECA countries in the field of safe abortion and family planning.

Safe Abortion Action Fund (Maite Matos, director) is the only global funding mechanism solely dedicated to abortion that supported from the beginning creation and activities of The Regional Reproductive Health and Rights Coalition. SAAF is doing this in the difficult global context in which abortion is still a much stigmatised topic and EECA countries are in the region that is usually neglected by other donors. SAAF grant making is based on values: trust, accountability, commitment to abortion rights and solidarity.

SAAF has committed to offer its grants to the maximum length of time possible (some of current grantee partners from in this region have been funded by SAAF for many years); to offer flexible grants supporting all sorts of abortion related initiatives with no restriction on what can be funded and to support all sort of organizations, including some who have not worked on abortion before. In new cohort of grantees, SAAF will try integrates new organizations from this region. Beyond money, SAAF provides technical support in the form of trainings, and opportunities to network with other global organizations working on abortion. RHTC for example has regularly shared their expertise on medical abortion and self-managed abortion with other SAAF grantees during webinars and meetings. Maite Matos ensured Conference participants that despite the difficult funding and political context for abortion work, SAAF remains determined to keep supporting members of RRHR coalition in their efforts to increase safe abortion access in Eastern Europe and Central Asia.

Lena Luyckfasseel (IPPF European Region) presented results of a research done by network of national Member Associations and Collaborative Partners in Europe and Central Asia on access to abortion care in their countries, with a particular focus on the economic burden that women face. The research found that although almost all the countries surveyed legally allow abortion on request, nearly half of them fail to cover it through national health insurance (14 out of 30 countries, including 6 EU Member States). This forces many women to pay out-of-pocket to access essential healthcare. Shockingly, many countries deny women financial support for abortion care even when it is needed in the following specific cases: to save a woman's life (24% of countries), to preserve a woman's health (27%), in cases of fetal impairment (30%), and when a woman is a victim/ survivor of rape (39%).

In countries where governments do not cover access to abortion care on request in national health insurance, women, their families and communities, are left to pick up the cost. Currently, the cost of this essential healthcare in public medical facilities is very high, ranging from 13.8% of the monthly income in Austria for medical abortion, up to 103.6% in Croatia for surgical abortion. In countries that do cover abortion care in the national healthcare system, either on request or in certain cases, women and girls who are excluded from national health insurance coverage are still forced to pay to access abortion care.

Typically, this affects people from marginalised groups, such immigrants, refugees, as well as people who cannot afford to pay for health insurance, and young people who don't yet have their own health insurance. Excessive costs can lead to impoverishment, forcing people to reduce spending on other basic living expenses and may also force people to seek abortion care outside the formal healthcare system.

In addition to direct costs, women also face indirect costs (such as travel, accommodation, taking time off work, childcare) when accessing abortion care that may have a significant impact on the accessibility of care. Some countries exacerbate these indirect costs by imposing additional unnecessary barriers that force women to travel more. Among these are: mandatory waiting periods, mandatory counselling, multiple referrals or follow-up appointments, lack of access in some regions and refusal of care by doctors. Telemedicine, meaning the possibility to access consultations with healthcare professionals and treatment through remote communication technologies, increases the accessibility and affordability of abortion care, by removing the need for travel to medical facilities, together with other indirect costs. Self-management techniques, whereby women can self-manage any component of a medical abortion at home, can also help to reduce obstacles to care. Currently only 6 of the surveyed countries allow telemedicine, while 14 countries allow some component of self-management.

Governments have a responsibility to safeguard free and safe reproductive lives without economic barriers. IPPF calls on decision-makers to: expand national health insurance coverage to include abortion care, to ensure abortion policies include coverage of indirect costs of care and remove any unnecessary obstacles that may exacerbate fees, to prioritise equitable access for marginalised groups and to guarantee consistent availability throughout the country in the public system and regulate fees in private facilities.

Gynuity Health Projects: Medical abortion through telemedicine is a service delivery option that is increasingly used in many countries as an opportunity to increase accessibly to and affordability of pregnancy termination services. **Tamuna Tsereteli, Senior Consultant Associate**, presented **Gynuity Health Projects** support for countries of EECA region in the piloting and institutionalisation of telemedicine medical abortion, as well as results of latest research on effectiveness, safety and acceptability of this service delivery approach.

Since 2019, Gynuity provided technical assistance to its partners in piloting MA telemedicine services in Moldova and Georgia. Between 2020 and 2022, Gynuity, in collaboration with local partners in Ukraine, Uzbekistan and Azerbaijan, conducted another pilot clinical study "Safety and Acceptability of a Telemedicine Medicine Abortion Service Using a "No Testing" Protocol". After local dissemination of results of pilot studies, Ministries of Health of Moldova, Georgia and Ukraine included medical abortion via telemedicine in the revised versions of national standards/protocols on safe abortion.

An USA project to expand access to medical abortion through telemedicine not only demonstrated high effectiveness, safety and high level of satisfaction of users and providers with this approach, but also debunked some myths related to telemedicine MA: it does not delayed excessively treatment, it does not lead to breach of confidentiality, no study package with drugs was lost and abortion drugs were not used by any other person than the patient.

Mifepristone is under constant attacks from anti-choice entities and an alternative drug is needed to ensure continuous supply of MA drugs. Ulipristal acetate, approved for emergency contraception, shows potential in animal studies as an abortion drug. Gynuity conducted two randomised control trial in Mexico, to determine effectiveness and safety of Ulipristal acetate for MA up to 63 days of pregnancy. Results of these studies showed almost identical effectiveness of Ulipristal acetate as Mifepristone, no serious adverse effects and high level of user's satisfaction.

Low success rate of MA due to the use of uncertified, low-quality drugs is a frequent problem of quality of abortion services in a number of EECA countries, disqualifying this method among both women and providers. Petra Procter (Concept Foundation) stressed the importance of quality drugs for women's health, including abortion. Quality assured drugs are considered products approved and listed by a stringent regulatory authority (SRA), prequalified and listed by WHO Prequalification of Medicines Programme, or WHO Listed Authority listed at maturity level 4 for medicines. Quality testing that was done by Concept Foundation in 11 low-middle income countries, including Moldova and Kyrgyzstan, demonstrated ongoing quality issues with non quality assured misoprostol and mifepristone.

Poor quality reproductive health drugs can have long term health, social and economic impacts on women, girls, their families, communities, governments, health systems, especially in the context of increased provision of self-care for medical abortion.

To safeguard medicine quality, collective market reform is required, from all market actors. Unfortunately, global financing mechanisms are currently changing drastically the unravelling of the UN system, UNFPA, USAID and other bilateral funders reducing funds. Global health infrastructure that has championed quality of contraceptives, maternal health medicines and medical abortion drugs is now likely to shift to domestic and private sector supply that could severely compromise quality standards.

DKT WomanCare Global works closely with leading manufacturers to expand access, availability, and affordability of family planning and safe abortion to provide couples with affordable, high quality and safe options for family planning, safe abortion, and contraception.

Florencia Cecilia Ardes, Marketing Director, France and **Nodar Gvetadze[, Regional Sales Coordinator**, presented new products for women's health, launched recently in the EECA region. These include: medical abortion drugs („Miso-Fem" and „MifeMiso-Fem"), emegency contraception drug „Postpil", long acting implant „Levoplant" and IUDs: „Etherena T Cu 380A", „Silverline™ Cu 380Ag" and „Eloira".

Among many promotion activities, DTK conducted recently a series high-quality trainings on Levoplant for doctors in Kyrgyzstan, Moldova (+Transnistria region), Azerbaijan and Georgia and plans to expand training courses in other countries of the region.

Sharing best practices: Medical abortion via telemedicine in France

Removing unnecessary legal barriers and covering costs improve access to abortion and family planning services. Dr **Danielle Hassoun, the expert from France**, informed participants how law and service delivery modifications lead to better access to abortion and family planning services in France.

Currently, abortions on demand are permitted in France till 16 weeks of gestation; pregnancy terminations can be done outside of hospitals, in private clinics and primary health centres; nor only by specialists obstetrician-gynaecologists, but also by midwifes and general practitioners (GPs). Cost of abortion, as well as for contraceptives with prescription is fully covered by the health insurance.

So, in France, abortion are available in different sites, offered by different providers and by variety of methods. In hospital, abortion center is part of ob-gyn department and offer abortions up to 16 weeks, medical abortions at gestations more than 9 weeks and in more complicated cases. In private office or primary health center abortions are performed by GPs and midwives up to 9 weeks of pregnancy. This option has several advantages over hospital setting: more convenient for women, who need a more personalized care, it is closer to home, and faster than in the hospital. It should be noted, that in 2022 79% of voluntary abortions were MA, 51% of abortions were done in hospitals and 49% - in private offices and primary care centers, 47% were performed by midwives and 26% - by GPs.

Law modifications in France to increase access to abortion services

2001

Exclusion of mandatory parental authorization for minor for abortion as well as for contraception

Mandatory women counselling before abortion is excluded

Medical abortion permitted outside of hospital in private office and primary care centers

2014

Requirement to be in a “distress situation” to get an abortion has been erased from the law

2015

Mandatory waiting period before an abortion is exluded

Midwives are allowed to perform medical abortion

2022

Midwives are allowed to perform surgical abortion

Legal term for voluntary abortion extended to 16 weeks LMP

One of the options for abortion in France is MA by teleconsultation that can be offered by doctors and midwives from community practices, health centers, and family planning centers (not hospitals). These abortions are permitted up to 9 weeks LMP with medication dispensed in a local pharmacy. Teleconsultation is used also for contraception being adapted to the discussion around the choice of contraception, the evaluation of contraindications and the adequacy of needs. Teleconsultation is offered through a special private platform (not via mail or telephone); the platform manages the payment of the consultation and send prescriptions, on line. For telemedicine services provider is paid directly by the health insurance for the consultations and the pharmacist is paid directly by the health insurance for the pills.

Dr Danielle Hassoun also described new trends in contraceptive practice in France were IUD became the most widely used method and use of hormonal contraception substantially declined. This situation is considered the result of generational changes in a climate of mistrust towards all medical products and increased concerns about health risks. Young women do not agree with the idea that 'the pill allows women to have a more fulfilling sexuality'. Pills are regarded more as a constraint, a burden than a freedom, which was not the state of mind of previous generations. New generations resist to the medicalization of their bodies and wants more autonomy in their contraceptive choice.

Postabortion family planning

Gabriele Merki Feld, European Society of Contraception, **Switzerland** and **Irina Sagaidac, associate professor, Moldova** talked about post-abortion contraception that is one of the most important component of abortion services due to several important reasons: fertility returns very quickly after modern and safe methods of pregnancy termination, at least fifty percent of women report that they already have sexual intercourse, within the first two weeks after abortion and, immediately after abortion is the best moment when a woman has already faced the problem of unwanted pregnancy and realizes the consequences of not using a contraceptive method.

Evidence shows that the number of pregnancies (abortions, births) registered in the first year after an abortion is substantially higher in women who did not start using a method of contraception immediately, than in those who started using a method of contraception immediately.

From a broad range of contraceptive methods that are available today for post-abortion contraception, speakers emphasised importance of long acting reversible contraceptives (LARCs): IUDs and implants. These methods are reliable, effective, cheap and reversible, are not user-dependent and are suitable for a much larger number of patients than other hormonal methods. To ensure high effectiveness and compliance, it is desirable for a woman after an abortion to leave the facility having already received the proposed method or with an IUD inserted into the uterine cavity. WHO abortion guide recommend governments to ensure the availability of a wide range of modern, safe and affordable contraceptive methods and adequate access to affordable essential medicines without discrimination. Also of paramount importance is to cover the costs of post-abortion contraceptives especially for poor and marginalised women. As good example, in Moldova, women who have had an abortion in the last year is one of the categories of persons eligible to receive free contraceptives.

Anti-choice manifestations in the region and mechanisms for addressing them

Globally, most maternal death and severe post-abortion complications occur in the countries in which abortion on request is not permitted at all or severely restricted. When legal restrictions and other barriers to safe abortions exist, many women find it difficult or impossible to access quality abortion care and they may induce abortion themselves using unsafe methods or seek abortion from unskilled providers or lead to abandonment of new-borns and infanticide. In vast majority of EECA countries, abortion on request is permitted up to 12 weeks of pregnancy and access to abortion services was improved by allowing pregnancy terminations in outpatient settings and in private clinics, by cancellation of mandatory referrals and examinations unrelated to abortion safety, and simplified procedures to obtain abortion in the second trimester.

Unfortunately, due to increasing influence of anti-choice movements and organisations, in several countries of EECA region many legal and other unnecessary barriers were recently imposed to restrict access to abortion. **Medea Khmelidze (Real People Real Vision, Georgia)** said that in Georgia, in the last decades, there were already some legal and service delivery barriers to access abortion services: mandatory 5 dais waiting period with moralising counselling, limited access in rural areas, costs not covered by state, provider stigma.

But recently, without any consultation with professional associations, women's organizations and advisory bodies, a number of amendments of the abortion laws were imposed. It include: mandatory counselling with 3 professionals: an obstetrician-gynaecologist, social worker, and psychologist; mandatory ultrasound after waiting period, before procedure; new restrictions by facility level for performing abortions. Additionally, 5 day waiting period was strictly enforced and doctor's liability for violation of this rule emphasized. Consequences of these amendments to abortion legislation are multiple: compromised confidentiality as much more professionals are involved; access worsens because fewer rural facilities are qualified to do abortions and due to scarcity of psychologists/social workers; increased costs as a result of extra procedures imposed and travel.

A significant setback for women's right to access abortion care in Moldova was presented by **Stelian Hodorogea (RHTC, Moldova)**. At the end of 2024, Ministry of Health of Moldova issued an order banning medical abortions via telemedicine, citing the absence of a regulatory framework for these services. This decision forced medical institutions offering these crucial services to discontinue them, leaving many women without essential healthcare options. The decision followed the receipt of an anti-abortion petition signed by just 18 individuals from various fields, which is concerning given the limited number of signatories.

Medical abortions via telemedicine was launched in Moldova in 2020, immediately before COVID-19 pandemic, when the RHTC received funding from the Canadian government to conduct a pilot study on the safety, acceptability, feasibility, and satisfaction of women with this approach. In 2020-2021, during a time of crisis, when most health care facilities offering abortions were closed, this vital service was a lifeline for many women in Moldova. After presentation of results of pilot study that included almost 500 women, a group of specialists revised the national safe abortion standards, incorporating telemedicine medical abortions in 2021, following WHO recommendations. This progress is now at risk due to the recent ban.

Currently, Moldova is facing many service delivery problems to ensure good access to high quality abortion services: lack of providers, especially in rural areas; refusal to terminate pregnancy resorting to conscientious objection or other reasons; some facilities do not provide safe methods of pregnancy termination continuing to offer only D&C. MA via telemedicine could be a solution, having many advantages over face-to-face abortion: it can reduce geographical disparities and heterogeneity of the care offer regarding the choice of the abortion methods, can allow a more rapid and earlier interruption of unwanted pregnancy, can facilitate access by avoiding travel and transportation; offer more confidentiality and freedom for some specific groups of women with unwanted pregnancy – teenagers, those caring for small children, or unable to quit work.

The controversial and regressive decision to ban abortion by telemedicine undermines the accessibility and safety of abortion services in Moldova, highlighting the ongoing struggle between traditional views and modern healthcare practices.

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Conference conclusions:

Participants highly appreciated possibility to be part of RRHR Coalition and organisation of the III-rd edition of Regional Conference. They mentioned that such king of meetings of health care providers, policy makers and experts in the field of abortion are very important for the EECA region. Despite so many advances and improvements in the last 15-20 years, there are still a lot of problems and barriers for those seeking safe, affordable and user-friendly abortion and family planning services in most countries of the region.

For country delegates, this meeting was an excellent opportunity to meet colleagues, experts from different countries and representatives of partner organisations to hear about the successes and achievements, as well challenges in ensuring good access safe abortion, and a platform to discuss different innovative solutions and interventions that are being promoted in the region and worldwide to improve the quality of abortion services and to respect reproductive and sexual rights of women and families. Also, many participants appreciated the opportunity to talk about people with special needs who might not have possibility to access these services on equality base.

Participants promised to share all these ideas and experiences with ministries of health, academic institutions and professionals in their own countries to be used and implemented for the benefit of women and local communities.

Necessity to strengthen regional cooperation and the networking in the field of abortion was also emphasized. It was considered important to ensure a fruitful and effective cooperation not only during periodical conferences, but as a sustainable and continuous process using RRHRC on-line Platform.

AKNOWLEDGEMENTS:

We would like to thank the Safe Abortion Action Fund (SAAF) for their generous support of the project and the Conference, DKT International, Concept Foundation, State Medical and Pharmaceutical University "Nicolae Testemitanu", Moldovan Obstetricians-Gynecologist Association, Art Poligraf, Tetis International, which have made possible the organization of this conference.

Annex I Conference evaluation

Conference Participants' Feedback

The 3rd Regional Conference on Self-care in Reproductive Health, held in May 2025 in Chișinău, brought together experts, advocates, and practitioners from across the Eastern Europe and Central Asia region. Participants praised the event for its insightful content, practical approaches, and strong emphasis on medical abortion (MA) and telemedicine.

Ratings:

Section	Score 5	Score 4	Score 3	Score 2	Score 1	Average
Content - Objectives of the conference were clearly defined	15	1	0	0	0	99%
Methodology - The material was clear and well organized	13	3	0	0	0	96%
Methodology - Sufficient material was presented	11	5	0	0	0	94%
Methodology - Enough time for module presentation	11	5	0	0	0	94%
Methodology - Enough time for discussions and questions	10	6	0	0	0	93%

Very Good Ratings Across Key Areas

Feedback was positive. Participants gave top marks to nearly every aspect of the conference:

- **Objectives of the conference were clearly defined** – 99% average satisfaction
- **Material was clear and well organized** – 96%
- **Sufficient material presented** – 94%
- **Adequate time for module presentation** – 94%
- **Time for discussion and questions** – 93%

What Participants Found Most Valuable

Medical abortion was clearly the central area of interest and learning. As one participant shared:

- "All medical evidence was useful, especially for someone without a medical background."
- The session led by Dr. Danielle Hassoun received multiple mentions as a highlight:
- "Danielle Hassoun."
- "First day and Danielle's session."
- Other participants emphasized the practical relevance and regional perspectives:
- "Experience of different countries on MA."
- "MA details via telemedicine."
- "Telemedicine use for MA."
- "Medical and organizational aspects of health service delivery."
- "Almost everything was useful."

Challenges and Areas for Improvement

While nearly all components were appreciated, a few participants shared minor difficulties:

- “For me, contraception and post-care parts were hard to follow, but I still gained key insights relevant to advocacy.”
- “Room coordinators.”
- “The conference ran smoothly.”
- Looking Forward: Participants’ Recommendations
- There was a strong call to action for aligning regional protocols with WHO guidelines and increasing cross-country collaboration:
- “We should strengthen efforts to align protocols with WHO, involve local and regional experts so that the government hears the voice.”
- “Continue dialogue with countries, involve Ministries.”
- “Side conversations and networking emphasized that promoting MA through remote support is crucial where it is currently unavailable.”

There were also practical suggestions for future editions:

- “Future conference should be hosted in another country.”
- “Need support with training for 2nd trimester surgical abortion.”
- “Ready to participate in new projects!”

Conclusion:

Participant feedback confirmed the conference’s real-world impact and relevance, emphasizing the ongoing need for platforms to exchange evidence, practice, and strategies.
The 2025 Chisinau conference successfully established a strong foundation for future collaboration across the region, boosting progress in self-managed abortion and reproductive health care initiatives.



Annex 2, Agenda

Day 1, 14 April 2025

09:00 Registration and coffee
09:30 Connect to Zoom call
09:35 Housekeeping details. Interpretation, microphones, recording.
09:35-10:00 **Opening remarks:**

- **Ministry of Health of the Republic of Moldova**: **Minister Alla Nemerenco**
- **Association of Obstetricians and Gynecologists of Moldova, President, Prof. Friptu Valentin**
- **World Health Organization: Country Office in Moldova, Head of Office Grbic Miliana;**
- **UNFPA Regional and Country Office in Moldova, representatives (tbd)**
- **Regional Training Center**, Rodica Comendant, RTC Director: Conference Objectives

10:10-10:15 **Opening speech**: WHO work on safe abortion. **Dr. Caron Kim, HRP, WHO, Geneva**
10:15-10:30 WHO recommendations on self-care in RH, safe abortion, family planning
Rodica Comendant, Director RHTC, Moldova

Session 1. Aligning national policy documents to WHO recommendations on self-management. **Country case studies I**: The successful advocacy stories starting from GCC Formative research, pilot studies and protocols updates: **Kazakhstan, Kyrgyzstan and Armenia, Facilitator Rodica Comendant**
10:30-11:30

- **Sarmuldayeva Sholpan**, Kazakhstan Association on Sexual and Reproductive Health - KPMA, Kazakhstan
- **Raisa Asilbasheva** Chief Reproductive Health Specialist Ministry of Health and Social Development and Baktygul Bozgorpoeva, Director, Family Planning Alliance, Kyrgyzstan
- **Ruzan Martirosean**, Head of the MOH Department of Maternal and Child Health) and **Anna Hovhannisyan**, Women Resource Center, Armenia
- Q&A, Discussion

11:30-12:00 COFFEE BREAK
12:00 -12:45 **Country case studies II**: Pilot studies as advocacy tool: results of the pilot projects in **Azerbaijan, Uzbekistan and Ukraine** coordinated by **Gynuity Health Project**: impact on maternal mortality, policies and acceptance of MA via Telemedicine.

- **Gulnara Rzayeva**, Head of Ambulatory diagnostic department, Scientific Research Institute of Obstetrics and Gynecology, Azerbaijan (online)
- **Dilbar Najmutdinova** Professor, Head of the Department of obstetrics and gynecology, Tashkent Medical Academy and Dilfuza Kurbanbekova, Deputy Director, Women's Wellness Center, Uzbekistan
- **Galina Maystruk**, Director Women's Fund, Ukraine (online)
- Q&A, Discussion

12:45-13:30 **Country case studies III**: Abortion and family planning services in Turkmenistan, Belarus, Tajikistan and Transnistria, Moldova: achievements and challenges

- **Oksana Teslova**, Associate Professor Head of The Simulation and Attestation Center of Belarusian State Medical University, Belarus
- **Qurbanov Shamsidin**, President of the Family Planning Association of Tajikistan, Tajikistan
- **Guncha Otuzova** (or Shemshat Bayjanova), Turkmenistan (online)
- **Ceban Oksana**, Head of RHFPC Tiraspol a part of State Institution "Republican Center for Mother and Baby", Transnistria
- Q&A, Discussion

13:30-14:30 LUNCH BREAK

Session 2. New opportunities in the field of safe abortion and family planning: updates from partners and colleagues, Facilitator **Dr Stelian Hodorogea**

14:30-14:50 Supporting projects on CAC globally and in the EECA region
- **Maite Matos**, Director, Safe Abortion Action Fund (SAAF) (online)
- **Lena Luyckfasseel**, IPPF European Region

14:50-15:15 The most recent data on the provision of MA
- **Tamar Tsereteli**, Senior Consultant Associate, Gynuity Health Projects

15:15-15:45 RTC work in EECA region, RHR Coalition
- **Rodica Comendant**, Director RHTC

15:45-16:15 Q&A, Discussion

16:15-16:30 Wrap-up for the day. Group photo

18:00 Group dinner

DAY 2, 15 April 2025

09:00 Coffee

09.30 Connect to Zoom call

Session 3. Pertinent issues, anti-choice manifestations in the region, mechanisms for addressing them and new opportunities. Facilitator **Olga Cernetchi**, Professor, Vice-rector of the State Medical and Pharmacy University "Nicolae Testemitsanu"

09:30-10:10 Advancements in abortion services: Medical abortion via telemedicine in France. Service provision algorithm.
- **Danielle Hassoun,** Expert on safe abortion, Center for Reproductive Health Training, Paris
- Q&A, Discussion

10:10-10:40 Abortion situation in Georgia: turning back the wheel? The role of SC organizations
- **Medea Khmelidze**, Program Manager at Real People Real Vision, Georgia
- Q&A, Discussion

10:40-12:10 Achievements and challenges in safe abortion field in Moldova.
- **Stelian Hodorogea**, Associate professor, State University of Medicine and Pharmacy "Nicolae Testemiţanu" of Moldova, Deputy Director, RHTC
- Q&A, Discussion

12:10-12:30 Self-care in post-abortion family planning: the recent recommendations.
- **Irina Sagaidac** Associate professor, State University of Medicine and Pharmacy "Nicolae Testemiţanu" of Moldova
- Q&A, Discussion

12.30-13.30 LUNCH BREAK

Session 4. Updates from partners and colleagues, continuation. Facilitator Catalina Comendant

13:30-13:50 New products for women's health, launched in the EECA region. Plans for the future
- **Florencia Cecilia Ardes**, Training Director, DKT, Women Care Global, France (online)
- **Nodar Gvetadze**, Regional sales Coordinator
- Q&A, Discussion

13:50 -14:10 The importance of quality drugs for women's health
- **Petra Procter**, Concept Foundation, Switzerland
- Q&A, Discussion

14:10-14:30 New contraceptives for post-abortion care (online)

- **Gabriele Merki** Feld, Board member, European Society of Contraception, Switzerland
- Q&A, Discussion

14:30-14:50 Discussion: Potential next steps and countries needs in further improving access to and quality of safe abortion in EECA

14:50-15:10 Closing: Feedback and Evaluation. Certificates.

15.10 Tea

MEMBERS OF THE SCIENTIFIC COMMITTEE:

- Olga Cernețchi - Professor, Vice-Rector for Assurance of Quality and Integration in Education, State University of Medicine and Pharmacy "Nicolae Testemiţanu" of Moldova
- Valentin Friptu - Professor, Head of the Department of Obstetrics and Gynecology, State University of Medicine and Pharmacy "Nicolae Testemiţanu" of Moldova, National Ob/Gyn Association, President
- Iurie Dondiuc - Associate professor, State University of Medicine and Pharmacy "Nicolae Testemiţanu" of Moldova
- Sergiu Gladun - Director, Mother and Child Institute
- Rodica Comendant - Associate professor, Director, Reproductive Health Training Center (RHTC)
- Stelian Hodorogea - Associate professor, Deputy director, RHTC
- Irina Sagaidac - Associate professor, State University of Medicine and Pharmacy "Nicolae Testemiţanu" of Moldova, RHTC

MEMBERS OF THE ORGANIZING COMMITTEE

- Rodica Comendant - Associate professor, Director, Reproductive Health Training Center, Regional Training Center (RTC)
- Stelian Hodorogea - Associate professor, Deputy director, RHTC, RTC
- Catalina Comendant - Project Coordinator, RHTC, RTC
- Anghelina Gruzd - Web content manager, RHTC, RTC
- Sorin Balan – Communication officer, RHTC, RTC

QR code for conference materials:

Annex 3, List of participants

The participants included representatives of international and national NGOs, departments of obstetrics/gynecology, and ministries of health. Participants came from the following countries:

Armenia

- Ruzan Martirosyan - Head of Division of Maternal and Reproductive Health Protection, Ministry of Health.
- Anna Hovhannisyan - Advocacy and Policy Development team manager, Women Resource Center

Azerbaijan

- Gulnara Rzayeva - OBGYN Bioslis Medical Center
- Aynura Zeynalova - Head of Maternal and Child Health, Ministry of Health
- Ofelia Nazirova - National Institute of Obstetrics and Gynecology, specialist in mandatory primary health care

Belarus

- Oxana Teslova - Head of the Simulation and Certification Center of Higher Education of the Belarusian State Medical University, Associate Professor of the Department of General Medical Practice with a Course of Geriatrics and Palliative Medicine

Belgium

- Lena Luyckfasseel - IPPF, Director of Programs and Performance

France

- Danielle Hassoun - Expert on safe abortion, Center for RH Training, France
- Florencia Cecilia Arde - Marketing Director, DKT WomanCare Global, France

Georgia

- Tamar Tsereteli - Senior Consultant Associate, Gynuity Health Projects
- Medea Khmelidze - Executive Director Real People Real Vision / Eurasian Women Network on AIDS
- Nodar Gvetadze - Business Development Representative, Eastern Europe and Central Asia, DKT, Women Care Global

Kazakhstan

- Sarmuldayeva Sholpan - Member of the Kazakhstan Association on Sexual and Reproductive Health - Reproductive Health Association (KMPA)
- Salibekova Ilmira - Head Specialist of Maternity and Childhood Protection Department of the Health Department of Shymkent City, Republic of Kazakhstan

Kyrgyzstan

- Baktygul Bozgorpoeva - Director, Family Planning Alliance of Kyrgyzstan
- Raisa Asilbasheva - Chief Reproductive Health Specialist Ministry of Health and Social Development

Switzerland

- Caron Kim - WHO, Head Quarter, Human Reproductive Programme
- Gabriele Merki - Feld Board member, European Society of Contraception, Switzerland
- Petra Procter - Senior Programme Manager , Concept Foundation, Switzerland

Tajikistan

- Salokhiddin Saibov - Coordinator Tadjik Family Planning Association (TFPA)
- Kurbanov Shamsidin - President of the Family Planning Association of Tajikistan

Turkmenistan

- Shemshat Bayjanova - Deputy Director of the Department of Maternal and Child Health Protection of the Turkmenbashy City Hospital of Balkan region
- Guncha Otuzova - Chief obstetrician-gynecologist of Dashoguz region

Ukraine

- Galyna Maystruk - Chair of the Board, Woman Health & Family Planning

United Kingdom

- Maite Matos Programme Adviser, Safe Abortion Action Fund, UK

Uzbekistan

- Dilfuza Kurbanbekova - Deputy Director, Women's Wellness Center Tashkent
- Dilbar Najmutdinova - Professor, Head of the Department of obstetrics and gynecology, Tashkent Medical Academy

Moldova

- Daniela Demishcan - WHO country office
- Sergiu Gladun - Director Mother and Child Care Institute
- Olga Cernetchi - Professor,Vice-Rector for Assurance of Quality and Integration in Education, State University of Medicine and Pharmacy "Nicolae Testemitanu”
- Angela Anisei - Head of Quality Medical Service Department of the National Agency of Public Health
- Nicolae Jelamschi - Director, National Public Health Agency
- Valentin Friptu - Professor, Head of the Department of Obstetrics and Gynecology, State University of Medicine and Pharmacy "Nicolae Testemitanu”
- Iurie Dondiuc - Associate professor, State University of Medicine and Pharmacy "Nicolae Testemitanu”
- Rodica Comendant - Associate professor, Director, Reproductive Health Trening Center (RHTC)
- Stelian Hodorogea - Associate professor, Deputy director, RHTC
- Irina Sagaidac - University Assistant, State University of Medicine and Pharmacy "Nicolae Testemitanu”, RHTC
- Virginia Salaru - Associate professor, State University of Medicine and Pharmacy "Nicolae Testemitanu”
- Zinaida Sârbu - Associate professor, State University of Medicine and Pharmacy "Nicolae Testemitanu”
- Ion Bologan - Associate professor, State University of Medicine and Pharmacy "Nicolae Testemitanu”
- Daniela Seremet - Project Assistant, RHTC
- Anghelina Gruzd - Web content manager, RHTC
- Catalina Comendant - Project Manager, RHTC
- Daniela Melnic - Project Assistant, RHTC
- Sorin Balan - Communications officer, RHTC

Moldova, Transnistria

- Oxana Ceban - Director, Reproductive Health Center, Tiraspol
- Slepuha Natalia - Director of Mother and Child Center, Tiraspol