



# SAVING WOMEN'S LIVES

## *in refugee and other crisis situations*

### MANUAL VACUUM ASPIRATION

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#### Reproductive health care for women in crisis

Women invariably assume the burden of reproductive health responsibilities and risks. For refugee and displaced women, the disruptions caused by war, civil conflicts and natural disasters further complicate reproductive health management (WHO, 2003).

In addition to losing their social support networks, millions of refugee and displaced women and men lose access to their preferred contraceptive methods and other basic health care (Austin et al, 2008). As the crisis escalates, the problem may be exacerbated by high rates of sexual violence and exploitation that lead to unwanted pregnancies. Moreover, it is estimated that 4 percent of refugee women are pregnant at the time of displacement from their homes and healthcare services (Women's Commission, 2006) and that 15 percent of all pregnancies will end in a spontaneous abortion, perhaps more in areas with endemic malaria, malnutrition, conflict and stress. A high proportion of women, particularly those who have become pregnant as the result of rape and those unwilling to bear children in the uncertain and unstable situation of displacement, may also seek to terminate their pregnancies under dangerous conditions.

The World Health Organization (WHO) estimates that 42 million pregnancies end in abortion each year, and nearly 20 million of those are thought to be unsafe — abortions provided by unskilled persons, performed under unhygienic conditions, or both. An estimated 66,500 women die each year from unsafe abortions, representing 13 percent of annual maternal deaths. Additionally, hundreds of thousands more suffer serious injuries and disabilities (WHO, 2007). The United Nations Population Fund (UNFPA) estimates that 25-50 percent of maternal deaths in refugee settings are attributable to unsafe abortions (UNFPA, 1999). Making pregnancy safer includes timely and appropriate management of unsafe and spontaneous abortion for all women, and the provision of or referral for safe abortion services to the full extent allowed by law.

In response to these needless deaths and disabilities, WHO and other international organizations have provided technical guidance to governments, policymakers and program managers. This technical assistance includes information on how to train and equip health-care providers to ensure that abortion care is safe and accessible at all levels of health systems, in both stable and displaced communities (WHO, 2003). Even in countries where abortion is heavily restricted or politically sensitive, governments recognize their obligation to provide treatment and related interventions, known as postabortion care (PAC), for women who would otherwise die from incomplete or septic abortions.

### **Manual vacuum aspiration: an essential and innovative reproductive health technology for conflict-affected populations**

Manual vacuum aspiration (MVA) has been used worldwide for more than three decades, enabling millions of women in developed and developing countries to undergo safe and effective uterine evacuation for treatment of incomplete abortion and first-trimester abortion, as well as endometrial biopsy. More than 30 years of clinical and programmatic research in multiple countries has shown vacuum aspiration for uterine evacuation (UE) to be safer than, and as effective as, sharp curettage, also known as dilatation and curettage (D&C).

The WHO guidance recommends vacuum aspiration – manual or electric – and medical methods as the preferred methods for induced abortion in early pregnancy (WHO, 2003). MVA is also recommended by WHO as a preferred method for uterine evacuation in the treatment of incomplete abortion and evidence now supports the use of misoprostol for this indication (Blum, 2007; Clark, 2007) as well as for induced abortion. A combined regimen of mifepristone and misoprostol for induced abortion is now on the WHO Essential Medicine List. Clinical protocols often combine methods, such as using misoprostol for cervical ripening prior to MVA (for example for adolescents) or

treating prolonged bleeding after medical abortion with MVA. Where both vacuum aspiration and pharmaceutical technologies are available, training can be combined.

### **The value of a low-cost, simple and portable instrument in conflict settings**

In contrast to sharp curettage, which can only be provided by physicians in surgical theaters, MVA is appropriate for use in primary health-care facilities in almost any low-resource, crisis or camp setting. It is a simple, low-cost and handheld plastic device. MVA is easy to use, clean and reprocess, and requires no electricity.

For use in cases of postabortion care, MVA provides many benefits when compared with sharp curettage (SC). MVA reduces the risk of additional complications, does not require general anesthesia and typically entails a shorter facility stay compared with sharp curettage. Use of MVA decreases medical complications and unnecessary referrals, reduces procedural and maintenance expenses, and shortens periods of discomfort and pain for women, all of which are important considerations in conflict situations.

With appropriate training, supportive protocols and supervision, it can be used by midlevel providers, such as trained midwives, nurses and emergency medical technicians. MVA is well established in health settings in countries as varied as Bangladesh, Bolivia, Kenya, Mexico, Nigeria, South Africa, South Korea, Turkey, the United States and Vietnam.

In refugee camps and host communities, a simple introduction of MVA technology and training intervention will allow for more efficient use of resources, increase the capacity of local providers and trained health-care workers, and produce longstanding sustained improvement in displaced and settled communities. MVA has already been introduced and used in refugee and other humanitarian relief settings, including Sudan, Ethiopia, Thailand, Kenya and Pakistan.

### **Advocacy and persistence in Sudan**

Improving and integrating postabortion (PAC) services into existing reproductive health services often requires both skill-building and advocacy efforts. Planned Parenthood Federation of America International (PPFA-I) started an Extended Reproductive Health (RH) Program in Sudan in 2001. Within this comprehensive RH program the postabortion care (PAC) component was one of the most important but also the most challenging services. The concept of PAC was not known and the field of abortion was and still is a very sensitive topic in Sudan. Advocacy work was needed to encourage PAC training for the first group of Sudanese nurses and doctors.

In July 2002, a group of PAC trainers formed the PPFA-I / PAC group. These pioneers advocated for and promoted

PAC service improvements in the public and private sectors despite resistance from both the government and medical practitioners. The following year at the Conference of the Sudanese Gynecology and Obstetrics Society, they succeeded in presenting a paper that triggered a series of discussions and workshops with all stakeholders and the Federal Ministry of Health. As a result of these discussions, the MOH and the Sudanese Ob-Gyn Society agreed to allow the first training course on PAC. Subsequent achievements include the development of new guidelines, new midwife training curriculum that includes PAC and MVA, and additional trainings for health professionals serving both refugees and internally displaced persons (IDPs).

## MVA as part of the Minimum Initial Service Package (MISP)

MVA equipment is included in the Minimum Initial Service Package (MISP) sub-kit eight (complications of abortion). The use of MVA is recommended by WHO for the treatment of postabortion complications in the Interagency Field Manual for Reproductive Health (1999) and in the MISP. MVA equipment is inexpensive and can be ordered directly through the MISP procurement process. In most countries it can also be procured through the national logistics system or Ministry of Health, through in-country distributors and purchased locally in the private market.

MVA instruments have been purchased by health ministries, donors (including the UNFPA, the United Kingdom's Department for International Development, the Swedish International Development Cooperation Agency and the World Bank), non-governmental organizations (NGOs) and individual or private health-care providers. Humanitarian response organizations that have purchased or donated MVA include the International Rescue Committee and Médecins Sans Frontières (MSF).

### Reaching Undocumented Migrants on the Thai Border

Although abortion is legal in Thailand in situations where the mother's life and health are threatened, as well as in cases of rape, the reality is that abortion care is limited by stigma, facility capacity issues and provider refusal. Although they may desire to space or stop childbearing while they are in exile, Burmese refugees in Thailand experience additional barriers to access legal abortion including high health-care costs for undocumented migrants, fear of deportation, imprisonment or dismissal from work, language barriers, and discrimination. Women who experience rape must navigate the complex legal requirements for abortion in the midst of dealing with shame and stigma from sexual violence. A number of steps should be taken to increase safe abortion care for circumstances that indicate induced abortion under the Thai legal system. First, partnerships must be established with providers in adequately equipped hospitals and clinics to understand the difficulty of the situation for Burmese women and to provide them necessary care. Safe abortion and contraceptive method education should be incorporated into patient visits at local clinics. Finally, community awareness about rape, safe abortion care and contraception should be integrated into existing outreach programs to protect women's health in this highly marginalized population.

## Incorporating MVA into emergency settings improves care

Where MVA instruments are not already available, governments, donors and NGOs can work together to increase access to these vital commodities by including them in routine procurement plans and logistic distribution systems for abortion care and postabortion care, within the limits allowed by law. Program managers should ensure that primary health-care staff, including midlevel providers, are trained in the provision of abortion care allowed by law and postabortion care with MVA and that proper protocols are in place to support this service. Improving abortion and postabortion care also includes:

### Training and service delivery

- Establishing and maintaining a core group of skilled providers able to care for women in their own communities, whether at home or in displacement.
- Making MVA services for UE part of comprehensive reproductive health services (and the MISP).
- Providing MVA services at all levels of the health system, including both stable referral sites and conflict-affected areas served by primary-care facilities
- Integrating contraceptive services and counseling with UE services to help prevent future unplanned pregnancies and repeat abortions.
- Ensuring that MVA and contraceptive counseling are included in health facility, national and NGO training programs.

### Equipping staff to provide services

- Forecasting the number of MVA instruments needed in each health-care setting. Numbers will vary depending on expected caseload, processing and other factors. Ipas can provide further guidance for forecasting quantities of Ipas manufactured kits needed based on protocol and normal use.
- Facilitating resupply by including MVA instruments on Essential Supplies lists.
- Creating an institutional budget line for resupply and making long-term financing arrangements for MVA instrument supply through government, donor or NGO funding.
- Establishing contracts with local suppliers for a regular resupply of MVA instruments.

## About Ipas

Ipas is a longstanding member of the Inter-agency Working Group (IAWG) on Reproductive Health in Crisis Situations. We are an international nonprofit organization that has worked for more than 30 years to end the global problem of unsafe abortion and to provide women safe and effective options for abortion and postabortion care. Ipas's global, regional and country programs include training and technical assistance for service-delivery improvement and research and policy support to increase women's access to lifesaving care. Ipas also works with governments, donors and professional organizations to implement changes to standards and guidelines to allow midlevel and other cadres of providers to provide abortion and postabortion care.

Ipas MVA Plus® aspirators and Ipas EasyGrip® cannulae have important advantages over other uterine evacuation equipment, including greater durability and more processing options, such as steam autoclave, boiling and standard high-level chemical disinfectants. Ipas instruments meet all USFDA requirements for medical devices of their class. Ipas's quality system is ISO 13485 certified, and our products are CE marked. Information about MVA instruments and programs can be found at the Ipas website at [www.ipas.org](http://www.ipas.org). Some organizations may be eligible to obtain a limited amount of MVA instruments free of charge for humanitarian purposes through a donor-funded resource managed by Ipas.

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