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MINISTRY OF HEALTH



Expanding Access to Postabortion Care Services in Rwanda

FINAL REPORT

Ministry of Health, Republic of Rwanda

The main goal of the Ministry of Health is to provide and continually improve the health services of the Rwandan population through the provision of preventive, curative and rehabilitative health care thereby contributing to the reduction of poverty and enhancing the general well-being of the population.

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Executive Summary

The Rwanda Ministry of Health (MOH) is deeply committed to improving maternal health and reducing abortion-related morbidity and mortality in Rwanda. In collaboration with Venture Strategies Innovations (VSI), the MOH introduced misoprostol for the treatment of incomplete abortion and miscarriage as part of its comprehensive postabortion care (PAC) strategy and conducted a pilot program in four districts to demonstrate feasibility and inform program scale-up. Through the implementation of the pilot program, health centers were able to provide PAC services for the first time, making these services more accessible to women.

Approximately 47% of all pregnancies in Rwanda are unintended, and almost 30% of women who experience complications from unsafe abortion do not receive needed treatment. Postabortion care addresses complications related to spontaneous and induced abortions and includes family planning counseling and services. Postabortion care also includes referral linkages between health facilities to ensure comprehensive service provision. It has been globally endorsed as an important intervention to reduce maternal mortality.

Misoprostol and manual vacuum aspiration (MVA) are two treatment methods recommended by the World Health Organization (WHO) for the treatment of incomplete abortion and miscarriage. Misoprostol is a safe, effective, heat-stable and inexpensive treatment method for incomplete abortion and miscarriage. Misoprostol has been shown to be as effective as MVA for the treatment of incomplete abortion and miscarriage, and it can be administered by mid-level providers in facilities that lack capacity to provide MVA or other surgical methods.

In February 2012, the Rwanda Ministry of Health launched its comprehensive PAC pilot program in four districts (Bugesera, Kicukiro, Gisagara and Nyabihu) with the aim to expand it nationally to the remaining 26 districts after the completion of the pilot. All public health centers and hospitals in the four districts participated in the pilot program. The goals of the pilot were to establish comprehensive postabortion care services through the use of both medical and surgical methods and ultimately reduce maternal mortality and morbidity due to complications of unsafe abortion in Rwanda. Additionally, the program aimed to develop and test indicators, data collection tools, and a system of information flow, as well as to identify logistical components and other service delivery implications for scale-up of comprehensive PAC services.

The comprehensive PAC program included two components: 1) strengthening of facility-based clinical PAC services, and expansion of services to health centers through integration of medical treatment with misoprostol; and 2) a community awareness campaign.

The pilot demonstrated that provision of misoprostol for use in PAC is feasible at hospitals and health centers in Rwanda. A total of 1,024 women presented with incomplete abortion between March 2012 and October 2012 at the public health facilities in the four participating districts. Overall, misoprostol was used to treat 83% of all women seeking postabortion care. As soon as misoprostol was introduced, providers began using it to treat the majority of incomplete abortion and miscarriage cases (90% in the first month), and it remained the predominant treatment method throughout the pilot program.

Enabling health centers to provide PAC services through the integration of misoprostol as a treatment method increased the availability PAC services and brought PAC services closer to women. Before the pilot, only two health centers provided PAC, and the remaining health centers had to refer women to hospitals for treatment. By the end of the pilot, in October 2012, health centers were treating 91% of PAC cases and referring only 9% to hospitals. Nurses at health centers were able to successfully provide PAC services, and treated 100% of PAC cases at the health center level.

Comprehensive PAC treatment was safe and effective for women. Less than 2% of the 921 women who were treated for incomplete abortion or miscarriage experienced complications due to treatment. Of the 345 women (67% of women treated) who returned for follow-up at a health center, approximately 13% were referred to hospitals (per the comprehensive PAC treatment protocol) due to treatment failure.

Overall, 59% of women were discharged with a contraceptive method, but family planning uptake varied substantially by district, ranging from 35% in Nyabihu to 84% in Bugesera. Many mission health centers did not offer modern family planning services. Women who came for PAC services at these facilities were referred to secondary family planning posts for services.

The system of data collection and monitoring was successfully implemented and can be used to inform scale-up. Service delivery indicators, which were tested during the pilot, provided data that were essential to monitoring the components of the PAC program and are suitable for inclusion in the Health Management Information System (HMIS). Some gaps in service delivery occurred because not all providers at each facility were trained. Although community sensitization activities were successfully implemented, providers identified opportunities to increase community awareness of postabortion care through additional community sensitization activities.

Based on the results of this report, the main recommendations are: 1) expand PAC services to all health facilities by training all providers of reproductive health services in comprehensive PAC; 2) strengthen family planning provision and referral systems at all levels; 3) increase community awareness about prevention of unwanted pregnancy, dangers of unsafe abortion, availability of PAC services, and the importance of follow-up; 4) train providers on the use of MVA; and 5) integrate all service delivery indicators into the HMIS. Providers would also benefit from refresher trainings and additional reference materials or job aids.

Acronyms and Local Terms

D&C	Dilatation and curettage
HMIS	Health Management Information System (HMIS)
IEC	Information, education and communication
M&E	Monitoring and Evaluation
MOH	Ministry of Health
MVA	Manual vacuum aspiration
PAC	Postabortion care
TOT	Training of trainers
VSI	Venture Strategies Innovations

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1. Introduction

The Rwanda Ministry of Health is deeply committed to improving maternal health in Rwanda. Globally, 47,000 women each year die from complications due to unsafe abortion (WHO, 2011b). In 2009 more than 16,700 women received care for abortion complications in Rwanda, representing only two-thirds of those in need of treatment (Basinga *et al.*, 2012). Postabortion care (PAC) programs aim to address complications related to incomplete abortion and miscarriage and provide postabortion family planning services. The 1994 International Conference on Population and Development (ICPD) Programme of Action urged all governments and organizations to “strengthen their commitment to women’s health” and “deal with the health impact of unsafe abortion as a major public health concern” (United Nations, 1995). Since then, PAC has been widely embraced as an important intervention to reduce maternal mortality. As part of a larger reproductive health strategy, PAC can also be vital in preventing unintended pregnancies, thereby additionally reducing maternal morbidity and mortality.

The Ministry of Health collaborated with Venture Strategies Innovations (VSI), a US-based nonprofit organization, to introduce misoprostol for the treatment of incomplete abortion and miscarriage as a complementary treatment method in the national comprehensive PAC program. An “initial phase” rollout, which is also referred to as the pilot program in this report, was conducted in four districts. The most innovative component of the pilot program was the introduction of misoprostol at health centers for the first time, which meant PAC services were made available at this level of the health facility, bringing these services closer to women in their communities, especially those living in rural areas. In addition, the program was designed to strengthen existing referral systems and shift services to health centers in order to reduce the PAC caseload at higher-level facilities. Furthermore, by increasing the range of treatment methods available at hospitals, the program aimed to reduce the use of dilatation and curettage (D&C) and replace it with safer methods. Unlike misoprostol and manual vacuum aspiration (MVA), D&C is not a method recommended by the World Health Organization (WHO).

This pilot program is instrumental for the MOH to reach the long-term goal of reducing maternal mortality and morbidities due to complications of unsafe abortion through provision of comprehensive PAC services. The goal and specific objectives of the comprehensive PAC pilot program are shown in Box 1 below. The MOH will use the results and lessons learned from the pilot program to guide the national PAC scale-up efforts, which it is currently planning.

Box 1: Comprehensive PAC program goals and objectives

Pilot Program Goals

- 1) Establish comprehensive postabortion care services through the use of both medical and surgical methods.
- 2) Reduce maternal mortality and morbidity due to complications of unsafe abortion in Rwanda.

Pilot Program Objectives

- 1) Provide evidence for introducing misoprostol into Rwanda's comprehensive PAC strategy.
- 2) Demonstrate that the provision of misoprostol for PAC is feasible at hospitals and health centers in Rwanda.
- 3) Identify the logistical components and other service delivery implications of scaling up comprehensive PAC services.
- 4) Develop and test indicators, data collection tools, and a system of information flow and reporting during this initial pilot phase to inform scale-up of the comprehensive PAC strategy after the completion of the pilot.
- 5) Develop PAC program implementation tools, protocol, training materials, and Information, Education, and Communication (IEC) materials.
- 6) Understand postabortion contraceptive uptake, method choice and client characteristics after treatment of incomplete abortion and miscarriage with misoprostol.

2. Background

2.1 MATERNAL HEALTH AND UNSAFE ABORTION IN RWANDA

The Ministry of Health in Rwanda has supported efforts to improve reproductive health services in the last 15 years, and as a result the maternal mortality ratio has decreased considerably from 1,071 deaths per 100,000 live births in 2000 to 476 deaths per 100,000 live births in 2010 (National Institute of Statistics of Rwanda (NISR) [Rwanda], Ministry of Health (MOH) [Rwanda], and ICF International, 2012). This reduction suggests that Rwanda could be on track to meet the Millennium Development Goal of a two-thirds reduction in maternal mortality by 2015 (Abbott and Rwirahira, 2010). As part of its Vision 2020 goal, the Rwanda MOH has committed to reducing the maternal mortality ratio to 200 per 100,000 by the year 2020. Programs to accelerate the reduction in maternal mortality are still needed, particularly in the area of treating complications of unsafe abortion and miscarriage.

Complications of unsafe abortion contribute significantly to maternal mortality, and can include hemorrhaging, infection and poisoning from substances used to induce abortion (Grimes *et al.*, 2006). Unsafe abortion is defined by the World Health Organization (WHO) as a procedure for terminating an unintended pregnancy either by individuals without the necessary skills or in an environment that does not conform to minimum medical standards or both (WHO, 2011b). An estimated 21.6 million unsafe abortions occur each year, resulting in the deaths of approximately 47,000 women, almost all of which could have been prevented (Shah and Ahman, 2010). An estimated 6.2 million unsafe abortions occur each year in Africa alone, and the World Health Organization estimates that 18% of maternal deaths in East Africa can be attributed to unsafe abortion. The number of unsafe abortions worldwide has

increased in recent years, and will likely continue to increase unless women's access to contraception and safe abortion is expanded and strengthened (WHO, 2011b).

In Rwanda, unsafe abortion remains a pervasive problem. A recent study revealed that 47% of all pregnancies in 2009 were unintended and that almost 30% of the nearly 17,000 women who experienced complications from unsafe abortion did not receive needed care. The study also found that due to the scarcity of abortion and postabortion care services outside of the capital city of Kigali, the abortion rate in Kigali was three and a half times that outside of Kigali (87 per 1000 women of reproductive age compared to 25 per 1000), with many women forced to travel to the capital to receive care. While 85% of hospitals had manual vacuum aspiration (MVA) supplies, the study found that dilatation and curettage (D&C) was much more commonly used than MVA for uterine evacuation (Basinga *et al.*, 2012). The use of D&C as a primary treatment method is problematic not only because it has higher complication rates, but also in that it limits the level of providers who can perform this service. When women do not receive treatment for complications from unsafe abortion, the consequences can be severe. Globally, hundreds of thousands of disabilities are caused by unsafe abortion annually (WHO, 2007) and almost all of these occur in developing countries (Grimes *et al.*, 2006). Complications from unsafe abortions can also lead to a loss of productivity, an economic burden on public health systems, stigma, and long-term health problems such as infertility and chronic infections (Grimes *et al.*, 2006).

2.2 MISOPROSTOL FOR TREATMENT INCOMPLETE ABORTION AND MISCARRIAGE

The WHO considers the treatment of incomplete abortion, defined as the retention of products of conception after an induced abortion or a spontaneous abortion, an essential element of obstetric care (WHO, 1991). Misoprostol and manual vacuum aspiration are two of the treatment methods recommended by the WHO for the treatment of incomplete abortion and miscarriage (WHO, 2012). In recent years, misoprostol, a prostaglandin E1 analogue in tablet form, is increasingly being used in obstetrics, including for the treatment of incomplete abortion and miscarriage. For evacuation of the uterus, it has efficacy rates of 91% to 99%, which are comparable to the efficacy rates of surgical evacuation procedures (Raghavan and Bynum, 2009). Over 90% of women report being satisfied or very satisfied with treatment of incomplete abortion using misoprostol (Bique *et al.*, 2007; Dao *et al.*, 2007; Diop *et al.*, 2009), and providers also report high levels of satisfaction with the treatment (Ipas Nigeria and SOGON, 2011).

Misoprostol can be administered orally or sublingually for the treatment of incomplete abortion. Further, it is inexpensive (Blum *et al.*, 2007), easy to store, and stable in field conditions; it also has a long shelf life and excellent safety profile (el-Refaey *et al.*, 2006). The effectiveness of misoprostol means that it can be used as a safe alternative to surgical methods.

Misoprostol provision has minimal service delivery requirements; thus, it creates an opportunity to extend PAC services to health facilities where surgical capacity may not be available (Ipas and VSI, 2011). In areas where vacuum aspiration or other surgical methods are available, it provides women and providers with an additional, non-surgical treatment option. By allowing treatment to occur at health centers, misoprostol helps with expanding access to postabortion care services by bringing these services closer to women.

In 2009, the WHO included misoprostol for the treatment of incomplete abortion in its *Model List of Essential Medicines* (WHO, 2009) and in 2011, in its list of *Priority Life-saving Medicines for Women and Children* (WHO, 2011a). Further, misoprostol has been recommended for use in postabortion care by the International Federation of Gynecology and Obstetrics (Shaw, 2007), along with many other international professional organizations and associations (ACOG, 2009).

2.3 POLICIES AND REGULATIONS ENABLING THE USE OF MISOPROSTOL IN RWANDA

The reduction of maternal mortality and investment in human resources for health and other sectors are national priorities outlined in the Government of Rwanda's *Vision 2020* document. Additionally, Rwanda's *Economic Development Poverty Reduction Strategy 2008–2012* identifies three health priorities: (1) improving access to and use of health and health-related services, especially for rural populations that face long distances to the nearest health facility; (2) increasing availability of well-qualified health professionals throughout the country, especially in under-served areas; and (3) increasing availability and affordability of drugs, contraceptive products, vaccines and other commodities. The policy landscape in Rwanda is conducive to the scale-up of effective, low-cost interventions, such as the use of misoprostol, which can have a measurable impact on maternal mortality.

Rwanda's penal code was amended in 2012 to make women and doctors exempt from criminal liability for abortion (with a court order and medical approval) in cases of rape, incest, forced marriage, or to preserve the life and health of the mother. Although a change in the abortion law now permits abortion under certain circumstances, many women are not aware of the change and may still undergo unsafe abortion.

In August 2010, with support from the MOH, VSI submitted a green paper to the Safe Motherhood Technical Working Group, and obtained the group's support for the introduction of misoprostol for PAC countrywide. Subsequently, the Safe Motherhood Technical Working Group called for the distribution of misoprostol for PAC to begin in four districts and expand nationally in subsequent phases. In addition to being used for the comprehensive PAC program covered in this report, misoprostol is being used for the prevention of postpartum hemorrhage in Rwanda in another maternal health program.

To enable the ongoing availability of misoprostol for eventual scale-up, in 2012, VSI worked with the Pharmacy Task Force of the Ministry of Health to facilitate registration of a high-quality misoprostol product labeled for treatment of incomplete abortion and miscarriage, as well as for the postpartum hemorrhage indications.

To plan for the initial phase, the MOH convened technical working groups to develop resources related to the use of misoprostol in PAC for national use in Rwanda and obtained approval from the administrative districts in Rwanda. The resources developed by the technical working group include the National Comprehensive Treatment Protocol for Postabortion Care Services; and the Postabortion Care Curriculum consisting of a Reference Manual, a Trainer's Guide, and a Participant's Guide. In addition, the technical working group developed community awareness IEC materials to be used nationwide, such as brochures for community leaders and women and posters for health centers (See section 3.1 for more information on IEC materials).

2.4 BASELINE FACILITY ASSESSMENTS OF PAC SERVICES

In December 2011 and January 2012, prior to implementation of the program in the four districts, the MOH/VSI program team assessed all 54 health facilities in these districts for their baseline capacity to provide PAC services. Through these assessments, baseline information about resources, staffing and PAC service availability was collected. The facility assessment revealed that only seven out of 54 facilities (two health centers and five hospitals) were providing treatment of incomplete abortion and miscarriage at the time of the assessment. The only method used for uterine evacuation was D&C, and none of the facilities reported providing manual or electric vacuum aspiration. The remaining 47 facilities that did *not* provide services for incomplete abortion transferred women to the closest hospital for the procedure.

The facility assessment identified two priority areas that needed to be addressed in order for comprehensive PAC services to be effectively provided to women:

- 1) Training of the providers on WHO-recommended methods to treat incomplete abortion and miscarriage: misoprostol and MVA.
- 2) Ensuring the availability of commodities required to provide treatment of incomplete abortion at the facilities (MVA kits, misoprostol tablets, family planning commodities, infection prevention supplies).

Before initiation of data collection for the pilot program, the two priority areas identified in the facility assessment were addressed. The MOH/VSI program team trained providers on comprehensive PAC with a focus on misoprostol. The training also included an introduction to MVA. All of the facilities were stocked with the supplies required for treatment of incomplete abortion and miscarriage, including misoprostol tablets. Other initiatives are currently addressing comprehensive training of providers in MVA, and planning of MVA skills training is ongoing. Additional priorities such as community sensitization and training on contraception provision were also addressed (See section 3.1 for more information on community sensitization and section 3.4 for more information on contraceptive provision training).

3. Methods

In February 2012, the Rwanda Ministry of Health launched a comprehensive postabortion care program, with the support of VSI. The program introduced misoprostol for the treatment of incomplete abortion and miscarriage into existing PAC services in Rwanda. The program was set up to capitalize on and strengthen the existing referral system in Rwanda, as well as to ensure that women presenting for treatment of incomplete abortion and miscarriage were able to access postabortion contraception.

3.1 COMPONENTS OF THE POSTABORTION CARE INTERVENTION

The comprehensive PAC program included two components:

- 1) Strengthening of facility-based clinical PAC services, and expansion of services to health centers through integration of medical treatment with misoprostol.
- 2) A community awareness campaign to establish links within the community, develop community capacity for prevention of unwanted pregnancies, and provide information on the availability of postabortion care services.

Facility-based PAC services

In this program, PAC services included:

- ***Treatment of incomplete abortion and miscarriage:*** Providers treated with misoprostol, oxytocin, manual vacuum aspiration (MVA) and dilatation & curettage D&C.
- ***Contraceptive counseling and services:*** All women were to be provided with postabortion family planning counseling and their choice of a modern contraceptive method.
- ***Referral:*** To ensure comprehensive provision of services, all health centers established referral linkages to hospitals.

The pilot program's innovative component was to allow for the treatment of incomplete abortion with misoprostol at health centers among women presenting with incomplete abortion and miscarriage with a uterine size equivalent to 13 weeks and without signs of complications.

PAC service provision took place at health centers and hospitals, which were linked with referral services to ensure continuum of care. All women presenting at health facilities with incomplete abortion were assessed and treated as per the established service guidelines. For complicated cases or where treatment of the patient was beyond the capacity of the facility, referrals followed the appropriate guidelines. At health facilities that offered family planning services, women received contraceptive counseling and were offered the contraceptive method of their choice during their initial visit and the follow-up visit. Many mission facilities did not provide family planning services. When a woman received postabortion care at a facility without family planning services, she was referred to a secondary family planning post, small health posts dedicated solely to the provision of family planning services.

A regimen of 600mcg oral misoprostol was used in the program. This is the regimen included in the WHO guidance for the treatment of incomplete abortion.

Community awareness strategy

A community awareness campaign was also conducted in order to ensure that communities were aware of the available PAC services in the pilot program. VSI and the Rwanda MOH created a PAC brochure in Kinyarwanda containing messages about the dangers of unsafe abortion and the availability of PAC services at health facilities. The messages were targeted to women and key community members (community leaders at different levels, including local government, law enforcement, and health system administrators, etc.) who could facilitate women accessing PAC services and reduce barriers to access. The brochures were field tested during the initial phase through distribution to communities in the pilot program districts and getting feedback at the three district-level community sensitization meetings. In addition, PAC supervisors reviewed and provided feedback on the materials. Changes from testing were integrated, and the Safe Motherhood Technical Working Group validated the PAC brochure. Additional information, education and communication (IEC) materials for use in the participating health facilities such as posters and counseling flip cards were also developed during the pilot program. These materials were not distributed during the pilot program, as they had not yet been validated.

Three of the four pilot program districts conducted one-day community sensitization meetings at the district level. Gisagara and Nyabihu held community sensitization meetings in November of 2012. The community sensitization meeting in Bugesera took place in October of 2012. At the meetings, Ministry

of Health officials and district supervisors presented on the dangers of unsafe abortion and the comprehensive PAC services available through the PAC pilot program. Community leaders returned to their communities to conduct additional sensitization activities using the knowledge they had acquired at the district-level meetings. In addition to holding district-level community sensitization meetings, district supervisors in Gisagara district participated in an “open day,” where organizations working in different areas of development in the district came together to share their work. Each participating organization set up a stand where attendees could come to learn about their programs.

3.2 PILOT PROGRAM DISTRICTS AND PARTICIPATING HEALTH FACILITIES

Four districts participated in the pilot program: Bugesera, Kicukiro, Gisagara and Nyabihu (Figure 1). All of the public health centers and hospitals in the four districts participated in the program. The four districts have a combined estimated population of 1,049,459 (Table 1). Gisagara has two district hospitals, and the other districts have one district hospital each. Doctor to population ratios ranged from 1:5,097 in Kicukiro to 1:99,251 in Nyabihu. However, nurse to population ratios were much higher, ranging from 1:720 in Kicukiro to 1:2,279 in Bugesera.

Although each pilot program district is similar in population size, many other district characteristics, such as urban/rural geography, topography, and accessibility vary. The urban district of Kicukiro is located in Kigali. Bugesera district is close to Kigali, yet it is a less urban district than Kicukiro. Gisagara and Nyabihu are located far from the capital in the south and northwest parts of the country. The mountainous terrain in Nyabihu creates challenges to health care access for many. The facility assessment revealed that fewer cases of incomplete abortion present at health facilities in Nyabihu than in other districts.

More than half of the public facilities in Kicukiro and Gisagara are mission facilities. The proportion of mission facilities is slightly less than one third in Nyabihu (31%). Bugesera has the smallest proportion of mission facilities at 13%, with only two mission health centers in total (Table 1).

Mission health facilities are owned by the MOH and funded by religious institutions. The majority of mission facility staff members are MOH employees. In general, these mission facilities follow public health institution regulations. However, some exceptions are made because of their religious status. Most mission facilities do not provide modern family planning services; instead, they refer women to secondary posts for these services.

Health centers and hospitals are the only facilities that provide primary healthcare in Rwanda. Although smaller health posts exist, their services are specialized or temporary. Secondary family planning posts are an example of a health post that provides only specialized services. There are two types of hospitals in Rwanda: national referral hospitals and district hospitals. National referral hospitals are intended to function primarily as referral centers from district hospitals. All hospitals that participated in this pilot program are district hospitals.

The private medical sector in Rwanda has grown substantially in recent years, and private facilities play a key role in the health system in Rwanda. However, due to funding restrictions private facilities were not included in the pilot program.

Figure 1: Implementation sites in Rwanda

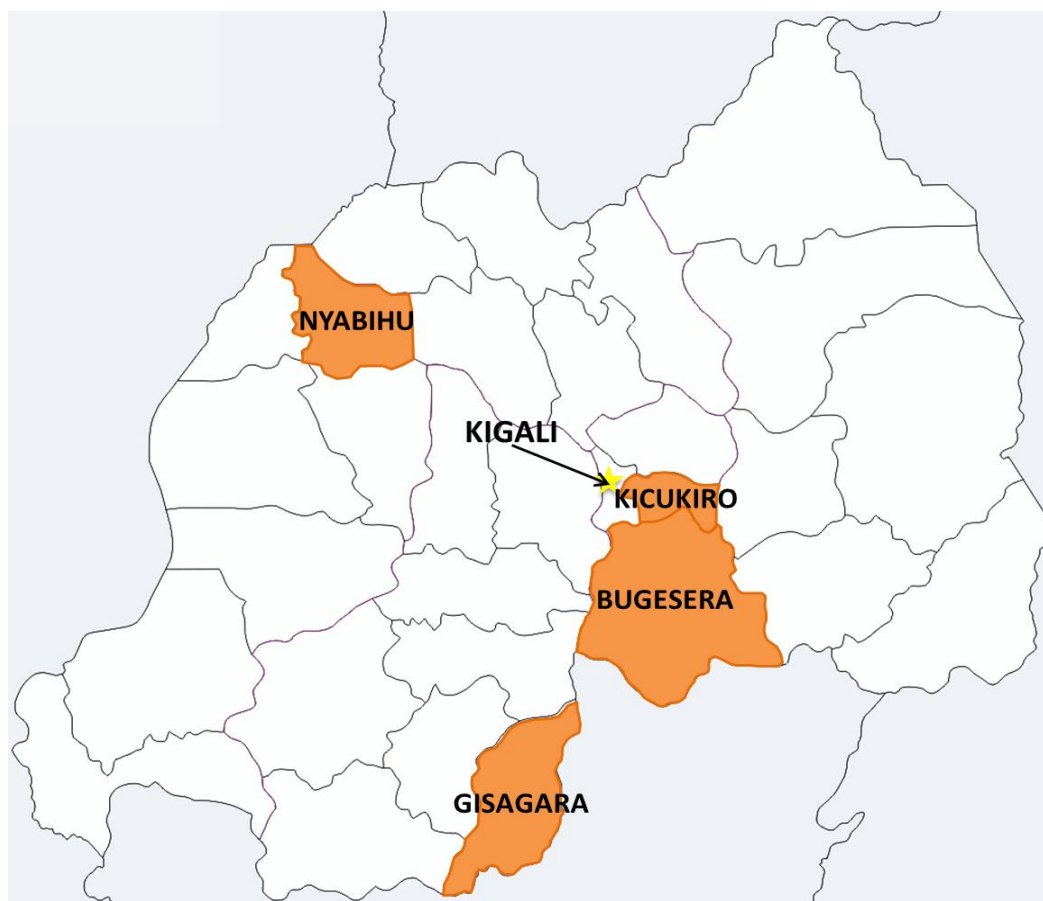


Table 1: Background characteristics of participating districts and health facilities

	Bugesera	Kicukiro	Gisagara	Nyabihu	Total
Population	274,113	214,256	262,426	298,664	1,049,459
Public Health Facilities¹					
Health Center ²	14	8	13	15	50
Hospital	1	1	2	1	5
Total	15	9	15	16	55
Proportion of public mission facilities (%)³	13.3	62.5	69.0	31.3	39
Doctor to population ratio	1: 29,627	1: 5,097	1: 40,157	1: 99,251	
Nurse to population ratio	1: 2,279	1: 720	1: 4,932	1: 1,474	

¹Data in this table were drawn from Rwanda Ministry of Health reports.

²One new health center opened in Kicukiro during the pilot program period. This new facility participated in all months of pilot program implementation; however, this facility did not participate in the baseline facility assessment.

³Venture Strategies Innovations, 2012. Summary of Facility Assessment Findings in Four Districts of Rwanda.

3.3 PILOT PROGRAM TRAINING

Providers across four districts (Bugesera, Kicukiro, Gisagara and Nyabihu) were trained at a total of five district hospitals and 49 health centers. The MOH and VSI conducted one training of trainers (TOT), after which the trainers conducted one district training in each of the pilot program districts (Table 2). Each district training lasted five days, and a total of 25 master trainers and 121 health providers participated in the trainings.

Table 2: Providers trained in the PAC pilot program during TOT and cascade trainings by district and by level of providers*

Level of providers	Providers trained during TOT	Cascade trainings in the districts				Total
		Bugesera	Gisagara	Kicukiro	Nyabihu	
High-level providers	24	2	2	8	2	38
Mid-level providers	1	100%30	30	13	34	108
Total	25	32	32	21	36	146

* High-level includes (assistant) medical doctors, health center managers, general practitioners, PAC services supervisors, maternal health specialists, gynecologists. Mid-level includes nurses, midwives, and health center managers.

Trainings covered the following topics: diagnosing and assessing women who present with symptoms of incomplete abortion; the different treatment methods used for incomplete abortion; identifying the eligibility of women for misoprostol treatment (600mcg orally); following the clinical protocols for the treatment of incomplete abortion at health center and hospital levels; informing women about treatment methods (i.e., what to expect, warning signs and follow-up schedule); comprehensive counseling on family planning and contraceptives; as well as classroom demonstrations and practice on the use of MVA. Additionally, providers, data managers, and district supervisors were trained in pilot program monitoring and evaluation.

3.4 MONITORING AND EVALUATION

The Ministry of Health, in collaboration with VSI, developed indicators, data collection tools, and a monitoring and reporting system. The pilot program assessed the feasibility and utility of this system, as well as the two types of indicators (See Appendix I: Indicators for more information):

- 1) **Service delivery indicators**, which are to be integrated into the Health Management Information System (HMIS). These include the number of cases of incomplete abortion or miscarriage that presented at the health facility, the number of cases that were treated, treatment method used for each case, and others.
- 2) **Performance indicators**, which were used to assess how well the introduction of misoprostol was carried out. These include provider giving treatment, dose and route of misoprostol, stock of postabortion care supplies, and others.

The pilot program’s monitoring and evaluation (M&E) tools are described in Box 2.

Box 2: Monitoring and evaluation tools used in the Rwanda comprehensive PAC pilot program

Monitoring and Evaluation Tools

Patient File: The Rwanda Ministry of Health provided all health facilities with patient files. A file was created for each woman who came to consult at the health facility with an incomplete abortion or miscarriage. The patient files included: medical and obstetrical history, physical exams, abortion and miscarriage complications, description of treatment, biological data, etc.

PAC Register: Data on all women presenting with incomplete abortion was transcribed from the patient files onto this form, which summarized key PAC information for each woman.

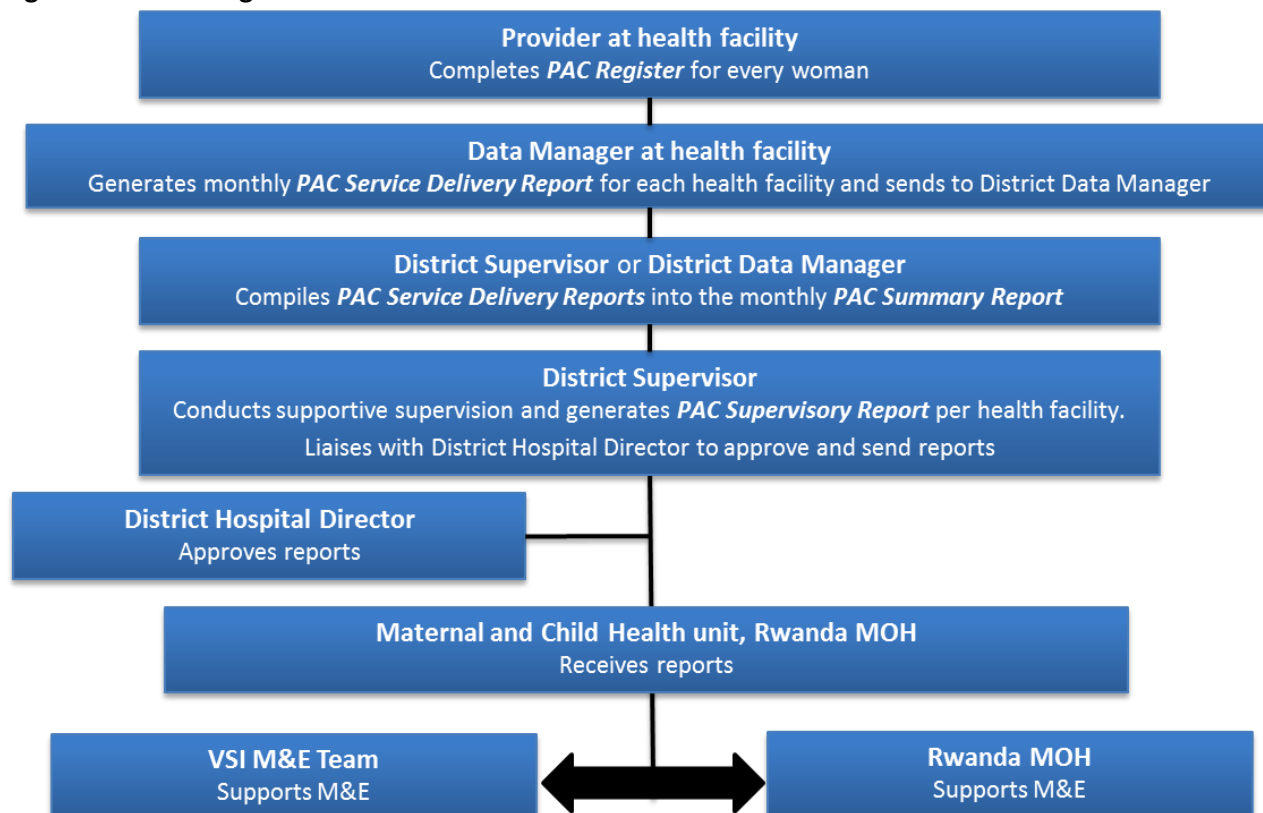
PAC Service Delivery Report: Each month, the data manager for each health facility, with support from the PAC supervisor, produced a monthly summary of the service delivery at that facility, which included caseload, complications, and post-procedure contraceptive uptake at that facility using information from the PAC Register.

PAC Summary Report: For each month, the district data manager or the PAC supervisor compiled the monthly PAC Service Delivery Reports from each facility into a summary for the entire district, the PAC Summary Report.

PAC Supervisory Report: PAC supervisors completed this report to collect information on the performance indicators. In addition, this tool included a short checklist to help the PAC supervisor monitor and provide supportive supervision of the PAC service delivery at the health facility.

The information flow for all data collection tools and reporting systems is presented in Figure 2.

Figure 2: Monitoring and evaluation information flow



In addition to quantitative data collected with the monitoring and evaluation tools, pilot program staff collected qualitative information from providers and district supervisors about the pilot program to monitor the fidelity of implementation and to ensure timely identification of challenges.

District supervisors recorded information about program implementation meetings in reports that were submitted to VSI staff. During regular monitoring visits, VSI staff conducted informal individual and group interviews, documenting the interview information in notes but not audio-recording it. Depending on the availability of the providers, some of these interviews took place individually, while other discussions took place in groups. Each of the four program districts held one program implementation meeting. Program implementation meetings were held in Bugesera and Gisagara in July 2012 and in Nyabihu and Kicukiro in October 2012. Program implementation meetings brought providers together to discuss challenges and share best practices. Qualitative feedback was used to inform pilot program conclusions and recommendations.

3.5 DATA MANAGEMENT AND ANALYSIS

VSI staff entered the data from the *PAC Service Delivery Reports* and the *PAC Supervisory Reports* into a central database in Microsoft Excel and then exported the data into *Stata/SE 12* (StataCorp 2011). Data analysis was conducted in Stata in January 2013.

3.6 PILOT PROGRAM TIMELINE

All of the pilot program activities, including the preparatory phase, implementation, data collection and analysis, took place between 2010 and 2013 (Figure 3). The MOH and VSI were responsible for the ongoing management and oversight of the pilot program activities.

After the approval of a technical green paper submitted by VSI and Jhpiego/MCHIP, which summarized evidence for the use of misoprostol for obstetric indications, a formal, full assessment of the commitment and capacity of stakeholders to introduce misoprostol was conducted in September 2010. During this assessment, VSI staff met with the Ministry of Health, the central medical stores of Rwanda, and various maternal health stakeholders.

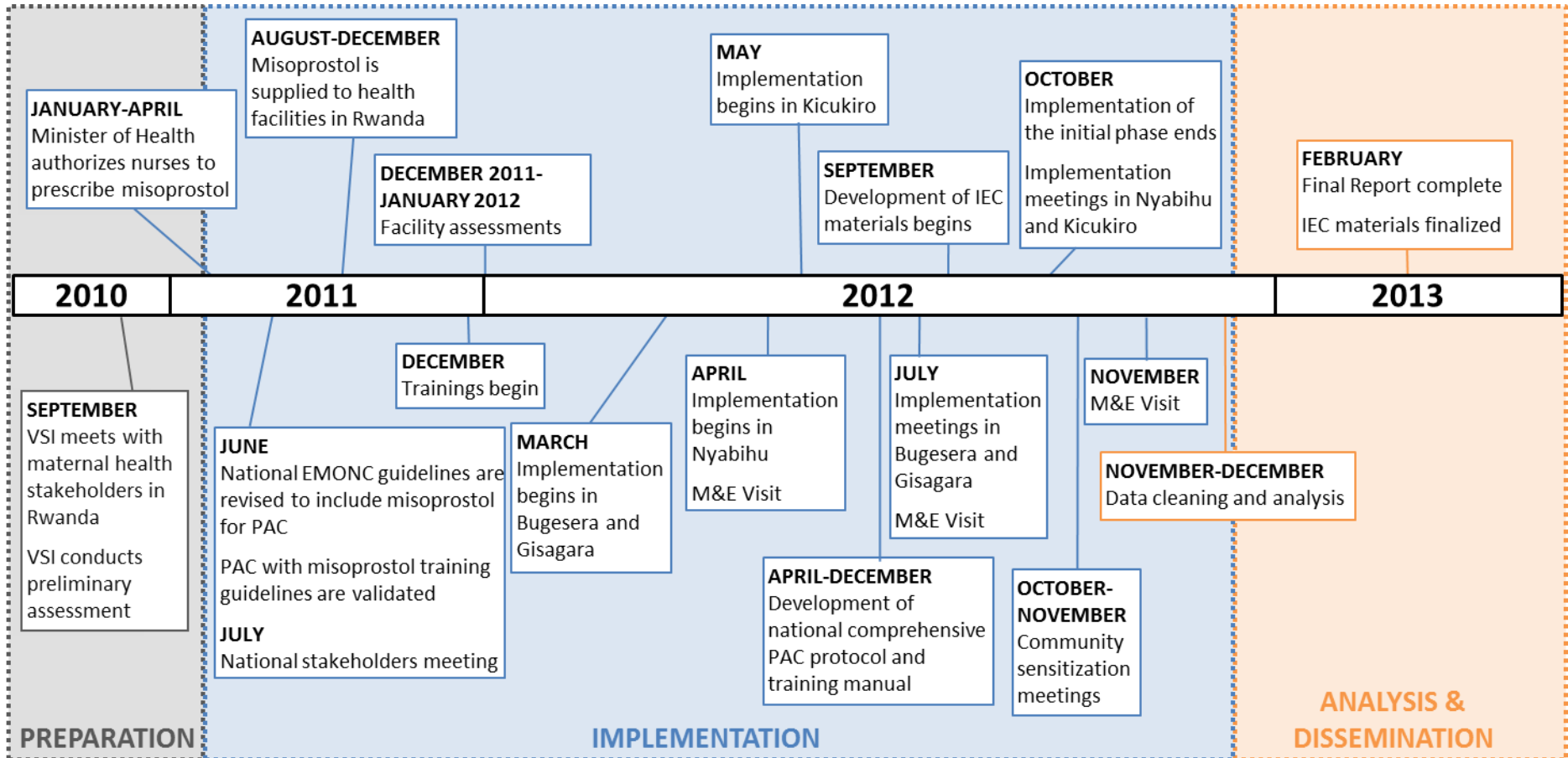
Between August and December of 2011, misoprostol was supplied to health facilities in Rwanda. In December 2011, VSI began the trainings of trainers (TOT), which was then followed by the training of providers. In December 2011 and January 2012, the MOH/VSI staff conducted facility assessments at all facilities in the four pilot program districts to gather baseline information about resources, staffing and PAC service availability, and to address any issues prior to implementation of services.

Provision of PAC services with misoprostol was initiated only after ensuring that all facilities had the required supplies. For this reason, implementation started at different times in the different districts. Implementation began in Bugesera and Gisagara in March 2012, in Nyabihu in April 2012, and in Kicukiro in May 2012.

The national comprehensive PAC protocol and training curriculum were developed between April and December of 2012. The development of the IEC materials occurred between September 2012 and February 2013.

US-based VSI staff conducted M&E visits in April 2012, July 2012 and November 2012. In October 2012, implementation of the initial phase ended. In the following two months, VSI staff cleaned and analyzed pilot program data. The final report was completed in February 2013.

Figure 3: Rwanda comprehensive PAC pilot program timeline (2010 -2013)



4. Results

Data collection at most health facilities coincided with the start of implementation. However, select facilities began collecting data during the preparatory phase before the start of implementation to gather baseline data on the patient caseload and treatment offered. The main analysis in this report uses only data that were collected after the official start of implementation (after ensuring that all of the trainings were complete, supplies were ready, and monitoring and supervision systems were in place). Baseline data from the preparatory phase were only used to show the trend in time (Figure 6), but not included in further analysis of pilot program data. Data from service delivery indicators and performance indicators are presented separately.

Service Delivery Indicators

District supervisors and district data managers compiled information on service delivery indicators using the *PAC Service Delivery Reports*.

4.1 PAC SERVICE DELIVERY

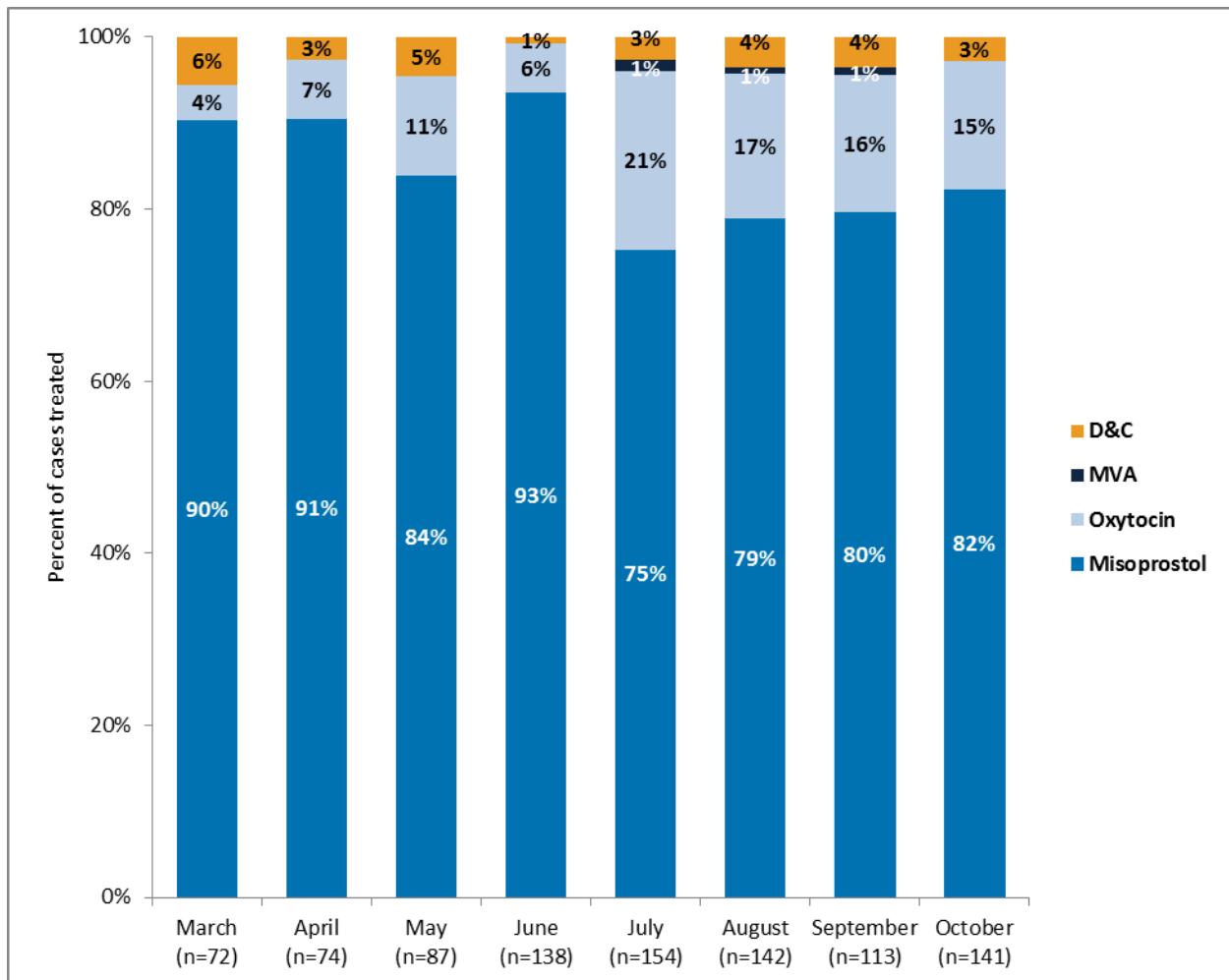
A total of 921 women were treated for incomplete abortion or miscarriage between March 2012 and October 2012 at the pilot program sites in the four districts (Table 3). Overall, misoprostol was used to treat 83% of all women who received postabortion care during the pilot program, making it the most common treatment method. While Nyabihu and Bugesera had relatively higher rates of misoprostol use for treatment with misoprostol (90% and 86%, respectively), in Kicukiro, misoprostol was used to treat a smaller proportion (78%) of the 279 cases. Oxytocin and dilatation and curettage (D&C) were the other methods of treatment. Oxytocin was the second most common treatment method, but the proportion of cases treated with oxytocin fluctuated. Fluctuations in oxytocin treatment may be partially due to underreporting; some health facilities did not record information on oxytocin treatment during March and April 2012. This underreporting was later corrected during monitoring and supervisory activities. D&C use followed oxytocin. MVA use was reported only from Kicukiro, and it remained the least commonly used method. Providers in Kicukiro used MVA to treat 1% of all cases of incomplete abortion or miscarriage.

Table 3: Incomplete abortion and miscarriage cases presenting by district (March-October 2012)

Incomplete abortion and miscarriage cases	Pilot Program Districts				Total number (%)
	Bugesera	Gisagara	Kicukiro	Nyabihu	
Treated with misoprostol	237 (85.6%)	219 (83.9%)	218 (78.1%)	94 (90.4%)	768 (83.4%)
Treated with oxytocin	21 (7.6%)	38 (14.6%)	52 (18.6%)	10 (9.6%)	121 (13.1%)
Treated with D&C	19 (6.9%)	4 (1.5%)	5 (1.8%)	0	28 (3.0%)
Treated with MVA	0	0	4 (1.4%)	0	4 (0.4%)
Total cases treated	277	261	279	104	921

As Figure 4 shows, as soon as misoprostol was introduced with the program, providers began using it extensively to treat cases of incomplete abortion and miscarriage. Within the first month of implementation, providers were already using misoprostol to treat the majority (90%) of cases, and misoprostol remained the predominant treatment method throughout the pilot program.

Figure 4: Distribution of treatment methods used for incomplete abortion or miscarriage cases over the course of the PAC pilot program (n=921)



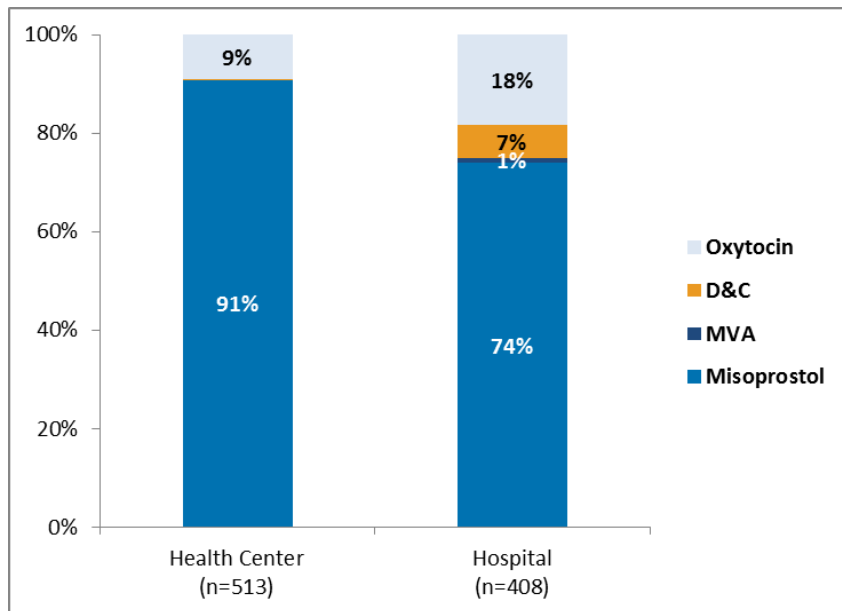
Treatment methods used during the pilot program also varied by facility type. According to the results of the baseline facility assessment, 96% of health centers did not offer any treatment method for incomplete abortion or miscarriage before the initiation of the pilot program. Women who arrived at these health centers seeking treatment were referred to hospitals. During the pilot program, after treatment with misoprostol was made available at health centers, 56% of all cases that were treated received treatment at health centers, and of those, 91% were treated with misoprostol (Figure 5). Although hospitals did not offer treatment with misoprostol prior to pilot program implementation, many (80%) offered other treatment methods (mainly D&C and oxytocin) for incomplete abortion and miscarriage, according to the baseline assessment. During the pilot program, a total of 408 women were treated in hospitals,

“Before we were receiving on average five PAC cases per day. Now, during the PAC program we are receiving only about one case per day. This is because many more cases are being treated at health centers.”

Doctor, Bugesera Hospital, Bugesera District

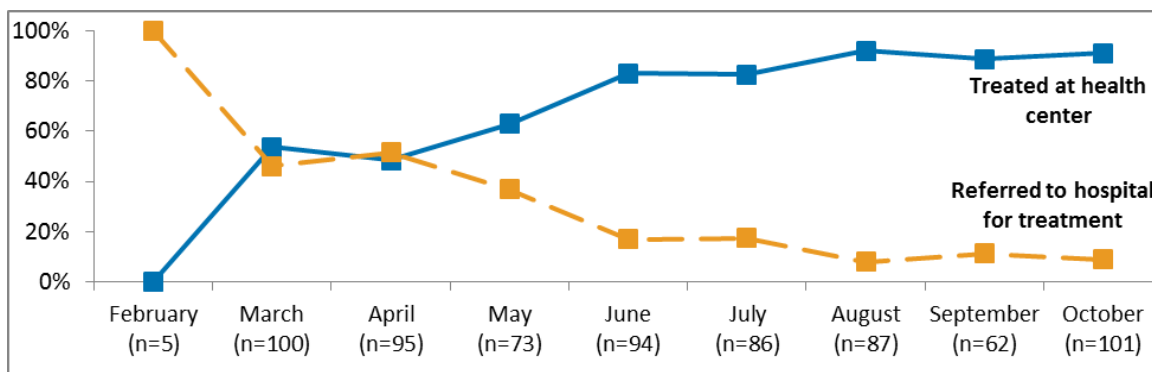
and misoprostol became the primary treatment method in hospitals. Hospitals continued to use other methods to treat complicated cases throughout the pilot program (18% of treated cases with oxytocin; 3% with D&C; and 1% with MVA).

Figure 5: Distribution of treatment methods for incomplete abortion and miscarriage cases according to facility type (n=921)



The referral patterns for incomplete abortion and miscarriage cases also changed significantly after the pilot program began. Only two health centers provided PAC services before the pilot program began. All other health centers referred women to hospitals for treatment. Overall, health centers referred 17% of all cases that presented during the pilot program. The proportion of women who were referred from health centers to hospitals decreased substantially during the pilot program. Upon initiation of the program, health centers immediately began treating cases with misoprostol and the proportion of cases referred began to decrease. The proportion of cases treated at health centers reached 91% by the end of data collection in October 2012 (Figure 6).

Figure 6: Treatment vs. referral of incomplete abortion and miscarriage cases presenting at health centers during the PAC pilot program (n=703)*

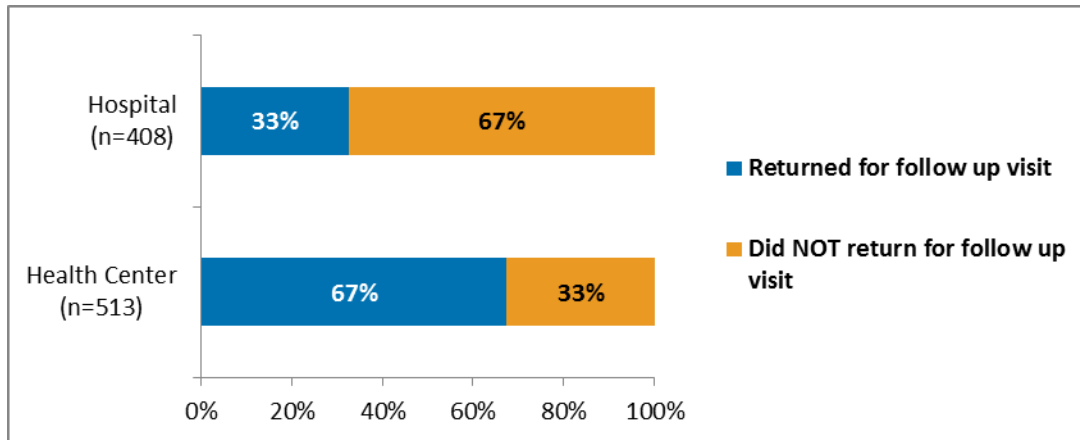


*Preparatory phase baseline data that were collected prior to the start of implementation has been included in this figure in order to show the shift in treatment and referrals that occurred upon implementation. Because districts began the pilot program at different times, preparatory phase data is included in the months of February, March, and April, yet March and April also contain data from the pilot phase.

4.2 RATE OF FOLLOW-UP

All women were informed to return for follow-up within 1-2 weeks of treatment, as per protocol, yet follow-up rates remained low with only about half of all women (52%) returning for a follow-up visit after treatment. The rate of follow-up was higher at health centers (67%) than at hospitals (33%) (Figure 7).

Figure 7: Proportion of women who returned for follow-up by facility type (n=921)



4.3 COMPLICATIONS DUE TO TREATMENT AND REFERRALS DUE TO TREATMENT FAILURE

Information on referrals due to treatment failure comes from follow-up data, which were available for approximately half (52%) of all women who were treated. Among women who returned for follow-up, only 45 (9%) were referred for completion of uterine evacuation (Figure 8).

Figure 8: Total number of cases treated, women who returned for follow-up, and cases referred to hospitals due to treatment failure



The rate of follow-up was highest among women treated with misoprostol (55%), and only 10% of these women were referred due to treatment failure. Referrals due to treatment failure varied by treatment method received. All referrals were made from health centers to hospitals. No women were referred due to treatment failure after treatment with MVA or D&C because these treatment methods were only

used in hospitals. Among women who were treated with oxytocin and returned for follow-up, approximately 5% were referred due to treatment failure.

Providers recorded information about complications during the initial PAC visit. Complications due to treatment with misoprostol were minimal. Among the 768 women who were treated with misoprostol, only 2% experienced some minor complications due to treatment. Providers did not report any complications due to other treatment methods.

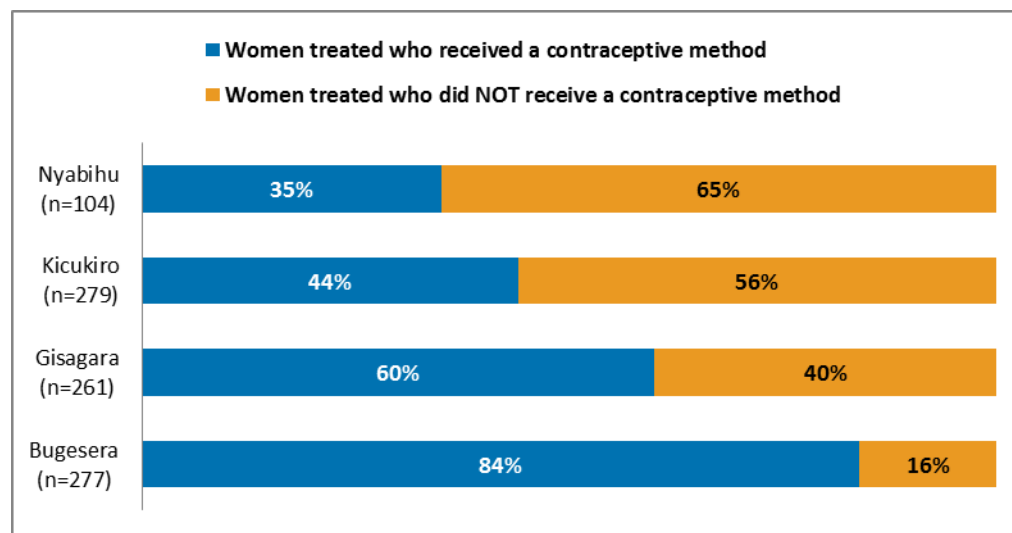
4.4 DEATHS RELATED TO COMPLICATIONS OF UNSAFE ABORTION

There were no abortion-related deaths during the pilot period.

4.5 CONTRACEPTIVE METHOD PROVISION

Overall, 59% of women received a contraceptive method. Slightly more women obtained a contraceptive method at health centers (64%) than at hospitals (54%). Contraceptive uptake varied by district. Bugesera had the highest proportion of women who received a contraceptive method (84%), and Nyabihu had the lowest rate of contraceptive uptake at 35% (Figure 9).

Figure 9: Percentage of women who received a contraceptive method at the initial visit or at follow-up by district (n=921)



Performance Indicators

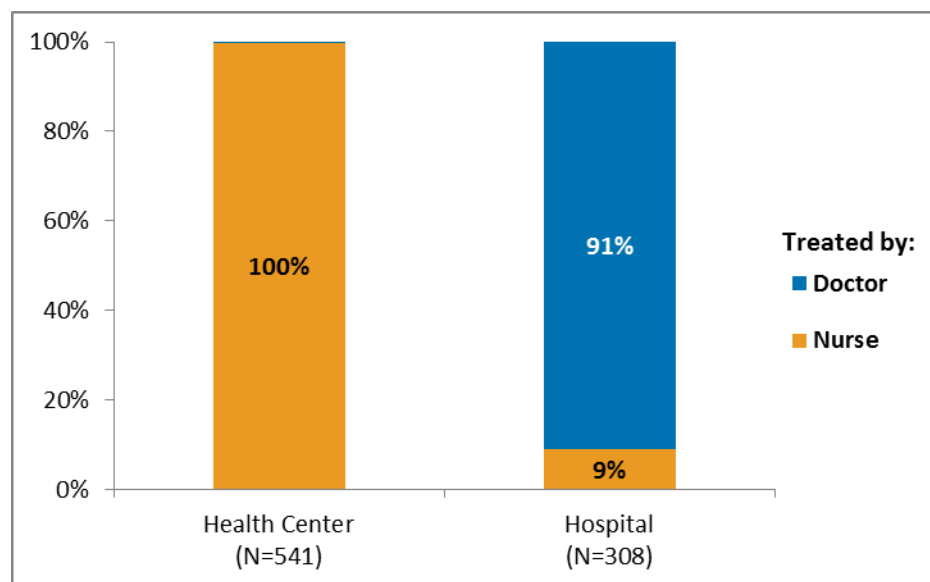
District supervisors collected data on performance indicators using the ***PAC Supervisory Reports***. Because performance indicators and service delivery indicators were collected using different tools, there are some minor differences between data gathered using the ***PAC Service Delivery Reports*** compared to data gathered using the ***PAC Supervisory Reports***.

4.6 TREATMENT BY HEALTH PROVIDER TYPE

The introduction of misoprostol stimulated task-shifting and task-sharing during the pilot program, as all of the cases at the health centers were treated by nurses (with misoprostol or oxytocin). At hospitals, doctors treated 91% of cases (Figure 10). Overall, nurses treated twice as many cases (67%) as doctors

(33%). Due to the fact that doctors oversee all treatment at hospitals, it is possible that some nurses treated cases at hospitals that were recorded as being treated by doctors.

Figure 10: Treatment of incomplete abortion and miscarriage cases by provider level and facility type (n=849)



4.7 DOSE AND ROUTE OF MISOPROSTOL FOR THE TREATMENT OF INCOMPLETE ABORTION AND MISCARRIAGE

All providers (100%) reported that they gave the correct dose of misoprostol (a single dose of 600mcg) via the correct route (oral).

4.8 WOMEN PRESENTING WITH SERIOUS COMPLICATIONS DUE TO UNSAFE ABORTION

Overall, few women (6%) presented with serious complications due to unsafe abortion, and most of these cases were admitted to hospitals. Of the 58 women who had a complication, 47 (12%) presented at hospitals (Table 4). The most common complication was severe hemorrhage. However, it is important to note even this complication was infrequent. Among the total number of cases of incomplete abortion and miscarriage, only 4% of women experienced severe hemorrhage.

Table 4: Women presenting with serious complications due to unsafe abortion by complication and facility type during the PAC pilot program (March-October 2012)

	Health Center (n=615)	Hospital (n=409)	Total (n=1,024)
Sepsis	0	5 (1.2%)	5 (0.5%)
Shock	2 (0.3%)	11 (2.7%)	13 (1.3%)
Uterine perforation	0	0	0
Severe hemorrhage	9 (1.5%)	31 (7.6%)	40 (3.9%)
Total complications	11 (1.8%)	47 (11.5%)	58 (5.7%)

4.9 STOCK OF POSTABORTION CARE SUPPLIES

District supervisors collected information about stock of the following postabortion care commodities: misoprostol, supplies for MVA and D&C, and family planning methods (oral contraceptive pills, condoms, intrauterine devices, and injectable contraceptives). Only two health facilities experienced stockouts of misoprostol during the pilot phase. These stockouts were temporary and did not significantly affect the comprehensive PAC program at the facilities where they occurred. No facilities reported stockouts of supplies for MVA or D&C. Supplies of condoms and oral contraceptive pills were constant at all health facilities.

5. Discussion

The comprehensive postabortion care (PAC) pilot program provided data and insights about providing PAC services at health centers and hospitals through an integrated approach that incorporated misoprostol for the treatment of incomplete abortion along with other treatment methods in Rwanda.

By training providers and integrating misoprostol into a well-defined referral system, the pilot program extended PAC services to health centers. Additionally, the program expanded the range of treatment options available at hospitals. Overall, the pilot program's system of data collection, reporting and supervision operated efficiently and accurately. Data from the pilot phase also helped to identify areas for program improvement that can be addressed during scale-up, such as family planning uptake, patient follow-up, training and community sensitization, among others.

Service Delivery

PAC SERVICES AT HEALTH CENTERS

Integrating misoprostol into comprehensive PAC services enabled providers at health centers in pilot districts to offer PAC services for the first time. Prior to the pilot program, health centers referred all PAC cases for treatment at a hospital. The number of health facilities able to provide PAC services increased from seven to 55 as a result of the program, and the program brought services closer to women in their communities. At the end of this initial pilot phase, 91% of cases were being treated at health centers and only 9% were being referred to hospitals for treatment. Bringing services closer to women and allowing treatment to occur in a more timely manner is expected to decrease the likelihood of further complications and morbidity due to incomplete abortion and miscarriage.

“The PAC program came at the right time. Before all PAC cases were referred to the Hospital. It is good for everyone that they can now receive care at the health centers. It is good for the women, it is good for families, it is good for the health system.”

PAC District Supervisor, Gisagara District

By allowing treatment of incomplete abortion and miscarriage to occur at health centers, the pilot program provided increased opportunities for task-sharing among different levels of providers. Additionally, the introduction of misoprostol increased the treatment options available at hospitals and provided a method that could be carried out by mid-level providers at hospitals instead of only by physicians. Although all of these changes are expected to generate significant cost savings for women

using PAC services and for the health system (through decreasing the total cost of treatment, hospital stays, service provider training, physician's time, etc.), costs were not analyzed as part of the pilot program. It is advisable to identify these and other cost-benefits for planning of scale-up of services and long-term sustainability of the program in Rwanda.

TREATMENT METHOD MIX

Prior to the implementation of the pilot program, in the seven facilities that provided any treatment of incomplete abortion and miscarriage, the only available method was dilatation and curettage (D&C). D&C is not a method recommended by the World Health Organization (WHO). Misoprostol, one of the WHO-recommended methods for the treatment of incomplete abortion and miscarriage, became the predominant treatment method as soon as it became available in the pilot program, and was used to treat 83% of cases. The proportion of cases treated with misoprostol remained relatively constant throughout the pilot phase.

It is important to note that D&C continued to play an important role for treatment of incomplete abortion and miscarriage, especially in hospitals. In hospitals, 3% of women who received treatment were treated with D&C, compared to 1% who were treated with MVA. Most facilities in the pilot districts did not have MVA supplies, and few providers had been trained on MVA. MVA is a safer procedure than D&C, and the MOH has already put in plans to strengthen provider skills in MVA provision and provide MVA kits. Once these plans are implemented, it is expected that MVA will be widely available as a surgical method and D&C will be phased out.

MISOPROSTOL SAFETY

Of the 768 women who were treated with misoprostol for incomplete abortion and miscarriage during the pilot program, only 2% experienced complications due to treatment. Among women who were treated with misoprostol and returned for follow-up at a health center, only 13% were referred to a hospital due to treatment failure, indicating that most providers at health centers were able to treat successfully with misoprostol and refer as required for further treatment.

FAMILY PLANNING

Overall, 59% of women received a contraceptive method but family planning uptake varied substantially by district. Several barriers to family planning uptake emerged during the course of the program. Many mission health centers did not offer modern family planning services so women who came for PAC services at these facilities were referred to secondary family planning posts. These posts are often far away from the facility where treatment was administered, making it challenging for women to access services.

In addition, some health providers at secondary family planning posts were unaware that the PAC program was being conducted in their district and may have been unprepared to provide services to women who had been treated at another facility. This highlights the need for further logistical planning in the scale-up phase to strengthen the linkages between the treatment services within PAC and family planning services.

Interviews with providers revealed that religious and cultural beliefs and misinformation about family planning also contribute to low family planning uptake. Providers who were interviewed at health

centers and hospitals recognized the need for additional training on effective family planning counseling to improve their ability to address these barriers.

FOLLOW-UP

In the pilot program, about half (52%) of all women who were treated returned for follow-up. It is plausible to assume that if a woman was feeling well after the procedure, she may not have felt it necessary to return to the health facility for a follow-up visit, and that the distance to the health facility could also have been a contributing factor for women not to go back. Similarly, providers and district supervisors in the pilot program suspected that women who experienced complications or had an incomplete procedure and required further care were more likely to return to a health facility for a follow-up visit. Still, follow-up is an important component of postabortion care services because it helps assure that women's family planning needs are met. Therefore, further efforts should be undertaken to increase the follow-up rate in the scale-up phase.

The finding that follow-up rates were higher at health centers (67%) than at hospitals (33%) highlights another benefit of this program. When PAC services are closer to women's homes, it is easier for them to return for follow-up. Women often have to travel further to reach a hospital than a health center, making it more challenging for them to return for follow-up when they have been treated at a hospital compared to a health center. Increasing follow-up rates improves overall service quality by assuring that PAC services are comprehensive.

Monitoring and Evaluation

DATA COLLECTION

Service delivery indicators provided data that were essential to monitoring the components of the PAC program, and during this pilot phase, they were tested to identify their use in providing effective monitoring and evaluation data. The service delivery indicators are intended to be included in the Health Management Information System (HMIS) during the scale-up phase.

Performance indicators provided useful information during the initial phase. These indicators focused mostly on the introduction of misoprostol, and asked about correct use of misoprostol and stockouts of postabortion care supplies, among others questions. Performance indicators will not need to be included in the HMIS for scale-up. However, it is important to keep track of some of the performance indicators at the health facility level for routine monitoring, such as the supply of PAC treatment methods and the supply of contraceptives, as well as to develop additional indicators to help identify barriers to family planning uptake. Performance monitoring will be an important part of the scale-up process, yet indicators on performance can be collected separately from national-level HMIS service delivery indicators and further refined.

Some providers and supervisors had minor challenges completing the data collection tools during the first few months of implementation. However, the majority of these issues were quickly resolved. The ***Patient File*** was especially challenging, and providers requested more training on this tool and on patient assessment. In some cases, untrained providers completed data collection tools inaccurately, highlighting to the need to train more providers on data collection at each facility.

Language caused some initial challenges and many providers had difficulty completing data collection tools that were in English. District supervisors helped providers to understand these tools. However, some data collection errors occurred during the initial months of implementation as a result of language barriers. Once providers were more familiar with data collection tools, errors were minimal.

PROVIDER TRAINING

During M&E visits and implementation meetings, trained providers expressed a need for refresher trainings. During the first few months of implementation, some providers deviated from the protocol. Supervisors corrected these deviations during supervisory visits. In addition to reinforcement of the protocol and reporting system, providers voiced a need for more training on PAC counseling, family planning counseling, and how to manage complicated cases.

Only two providers from each health facility were trained during the pilot program. Trained providers may be absent from facilities because they are attending a training, they have left for a new job or higher education, or they are occupied with other patients, making services unavailable at times. District supervisors and providers highlighted the need to train additional providers in comprehensive postabortion care. Although trained providers did share some knowledge they attained during the PAC training with other providers at their facilities, this level of knowledge sharing did not ensure that untrained providers could provide PAC services. In most cases, if a woman arrived at a health center for treatment when a trained health provider was not present and attempts by health facility staff to locate a trained provider were unsuccessful, the woman was referred to a hospital. Given that there are an average of 15 maternal health service providers at each hospital and an average of five maternal health service providers at each health center, the consistency of service delivery would increase if all were formally trained to provide PAC services.

COMMUNITY AWARENESS OF UNSAFE ABORTION AND PAC SERVICES

Although community sensitization activities were an important component of the pilot program, providers and supervisors expressed concern that communities lacked awareness about the PAC program. This lack of awareness may have prevented some women who have experienced incomplete abortion or miscarriage from seeking PAC services. Additionally, some women may have bypassed health centers and gone directly to hospitals for services, at greater expense and time.

6. Conclusions

Enabling health centers to provide postabortion (PAC) services through the integration of misoprostol as a treatment method increased the availability of PAC services and brought PAC services closer to women.

Mid-level providers at health centers successfully provided PAC services.

Comprehensive PAC treatment was safe and effective for women. Complication rates were low, and only a small proportion of women required referral for completion of the procedure.

Misoprostol quickly became the primary treatment method for incomplete abortion and miscarriage.

Contraceptive method uptake was moderate. Some mission facilities do not provide modern family planning services, and some providers requested more education on family planning counseling.

Follow-up rates were higher among women who received treatment at health centers compared to hospitals. Providers explained that this was due to women having a shorter distance to travel to reach health centers.

The use of manual vacuum aspiration (MVA) was minimal, and dilatation and curettage (D&C) remained the most commonly used surgical method.

PAC services were not always available at health facilities because there were times when neither of the two trained providers at each facility was present.

The system of data collection and monitoring was successfully implemented, and key service delivery indicators are suitable for integration into the Health Management Information System.

There was minimal awareness among communities and women about the availability of PAC services. Opportunities exist for increased community awareness of PAC service availability.

7. Recommendations

EXPAND POSTABORTION CARE (PAC) SERVICES TO ALL HEALTH CENTERS AND HOSPITALS BY TRAINING ALL PROVIDERS OF REPRODUCTIVE HEALTH SERVICES IN COMPREHENSIVE PAC

Training providers at all health centers and hospitals in Rwanda and ensuring the availability of commodities required to provide comprehensive PAC at all facilities can expand access to PAC services to all districts. Training additional providers at each facility in pilot districts can help reduce gaps in PAC service availability and increase access to services.

STRENGTHEN THE FAMILY PLANNING PROVISION AND REFERRAL SYSTEM AT ALL LEVELS, INCLUDING COMMUNITY HEALTH WORKERS, MISSION FACILITIES, HEALTH CENTERS AND HOSPITALS

Where family planning services cannot be provided on site, linkages between health facilities and secondary family planning posts need to be strengthened to assure that women who are referred for family planning services receive them, especially in the catchment areas of mission facilities. Community health workers (CHWs) should also be trained to sensitize women to the importance of family planning to increase uptake. In addition, at the health center and hospital level, providers need to ensure consistent and on-site provision of family planning counseling and services. Furthermore, to improve the quality of family planning counseling, providers need additional training.

INCREASE COMMUNITY AWARENESS ABOUT PREVENTION OF UNWANTED PREGNANCY, DANGERS OF UNSAFE ABORTION, AVAILABILITY OF PAC SERVICES, AND THE IMPORTANCE OF FOLLOW-UP

Engage providers, CHWs, district health staff, and local administrations in additional community sensitization activities to raise awareness of unwanted pregnancy, the consequences of unsafe abortion, availability of PAC services, and the importance of follow-up. Increasing awareness of PAC services can connect more women to these services when they need them, and community sensitization around the importance of follow-up can increase follow-up rates.

IN ADDITION TO TRAINING ON MISOPROSTOL, TRAIN PROVIDERS ON THE USE OF MANUAL VACUUM ASPIRATION (MVA)

Providers should be trained to provide MVA and equipped with MVA supplies. Although some facilities have MVA equipment, few providers have the training and experience necessary to provide MVA. To be truly comprehensive, a PAC program should include all methods of uterine evacuation.

PROVIDE REFRESHER TRAININGS AND REFERENCE MATERIALS FOR TRAINED PROVIDERS

It is important to keep service providers' skills and knowledge up to date, and certain components of providers' training need to be reinforced to assure that the protocol and reporting system are followed correctly. Providers also need additional support with PAC counseling, family planning counseling, and how to manage complicated cases. Supplying providers with additional job aids and reference materials at health facilities could also improve the quality of PAC services.

INTEGRATE ALL SERVICE DELIVERY INDICATORS INTO THE HMIS, AND INCLUDE PAC INDICATORS ON ALL MATERNAL AND CHILD HEALTH DATA COLLECTION TOOLS

Service delivery indicators provided data that were essential to monitoring the components of the PAC program. Incorporation of these indicators into the Health Management Information System after final refinement, as well as the revision of data collection tools, registers, and other reporting formats based on the final indicators, will allow for effective PAC monitoring at the national level. Additionally, including PAC indicators in all national maternal and child health data collection tools can assure comprehensive collection of PAC data.

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Appendices

APPENDIX A: INDICATORS

To meet the initial phase objectives, two levels of indicators were collected: service delivery indicators (future Health Management Information System (HMIS) indicators that are being field tested during the initial phase) and performance indicators (used during the initial phase only to assess the introduction of misoprostol).

Service Delivery Indicators

These indicators were tested for potential inclusion in the HMIS in the future to monitor service delivery of PAC services. During the pilot phase, they were being collected and assessed in terms of their feasibility and utility.

Indicator	Definition	Data Source	Notes
Incomplete abortion cases presenting, by treatment method (including referral upon arrival)	Total number of cases of incomplete abortion presenting Sub-indicators: <ul style="list-style-type: none"> • Number treated with D&C • Number treated with MVA • Number treated with misoprostol • Number referred upon arrival 	PAC Register	The sub-indicators added together are 100% of the total cases presenting, as women will either be treated or referred after assessment
Rate of follow-up	Number of women who return for a follow-up visit divided by the total number of cases (above)	PAC Register	Calculated overall and by treatment method; calculated as a number at the facility and district levels and as a rate at the central level
Contraceptive method provision	Number of women who take a method of contraception home with them at either the first visit or the follow-up visit, divided by the total number of cases	PAC Register	Calculated overall and by treatment method; calculated as a number at the facility and district levels and as a rate at the central level
Women presenting with serious complications due to unsafe abortion	Number of women presenting with any serious complication due to unsafe abortion (only include shock, sepsis, uterine perforation, or hemorrhage)	PAC Register	Calculated as a number at the facility and district levels and as a rate at the central level
Deaths related to abortion complications	Number of deaths due to abortion complications during the time period	PAC Register	
Referrals for completion	Number of women referred for completion of procedure	PAC Register	Calculated overall and by treatment method; calculated as a number at the facility and district levels and as a rate at the central level
Referrals due to complication of procedure	Number of women referred due to complications of the procedure received at the health facility	PAC Register	Calculated as a number at the facility and district levels and as a rate at the central level

Performance Indicators

These indicators were to be collected as part of the pilot phase only as part of the supportive supervision activities.

Indicator	Definition	Data Source	Notes
Dose and route of misoprostol	Number of women who were treated with misoprostol who received both the correct dose and route of misoprostol, per the clinical protocol, divided by the total number of women treated with misoprostol	PAC Register	Calculated by the supervisor during the supervisory visit
Misoprostol stock	Number of days of stockout of misoprostol during the month Number of tablets used during the month and currently in stock	Stocks Forms and Drug Consummation Registers	Compiled by the supervisor during the supervisory visit
Treatment by provider level	For each treatment method (D&C, MVA, and misoprostol), the proportion of women treated by medical doctors, nurses, etc.	PAC Register	Calculated by the supervisor during the supervisory visit
Number of women presenting with complications, by complication	Number of women presenting with: Sepsis Shock Uterine perforation Severe hemorrhage	PAC Register	Note that this is the total number of complications, not the number of women with complications, since women can have more than one complication. During the supervisory visit, the supervisor will review the complicated cases and provide a summary.
Contraceptive supply by method	Number of days stockout of contraceptive method, by method (oral contraceptive pills, condoms, intrauterine device, injectable) Number of units stock of contraceptive methods	Pharmacy Register or Family Planning Services Register	Compiled by the supervisor during the supervisory visit

APPENDIX B: COMMUNITY AWARENESS BROCHURE

NI BANDE BATANGA SERIVISI ZO KWITA KU BAGORE N'ABAKOBWA BAHUYE N'IKIBAZO CYO GUKURAMO INDA?

Abaganga, abaforomo/kazi n'ababyaza bakora ku bigo nderabuzima no ku bitaro bahawe amahugurwa yerekeye uko bagomba guha abagore n'abakobwa izo serivisi.

IZO SERIVISI ZITANGIRWA HE? Ku bigo nderabuzima, ku bitaro by'uturere no ku bitaro bikuru.

ZITANGWA KU KIGUZI KINGANA IKI? Serivisi z'ubuvuzi zirahendutse cyane cyane iyo ufite ubwishingizi bwo kwivuza. Gutanga uburyo bwo kuboneza urubyaro byo bitangwa k'ubuntu.

Amabwiriza asaba abaganga, abaforomo n'ababyaza gutanga serivisi nziza ku bagore n'abakobwa bahuye n'ikibazo cyo gukuramo inda bakimara kugera ku bigo nderabuzima cyangwa ku bitaro ndetse akabasaba kubohereza ku zindi nzego z'ubuvuzi bwisumbuyeho igihe bibaye ngombwa

NI BURYO KI ABATURAGE BAGIRA INYUNGU MURI IZO SERIVISI?

- Muri iki gihe serivisi zo kwita ku bagore n'abakobwa bagize ikibazo cyo gukuramo inda ziboneka ku bigo nderabuzima byegereye abaturage. Ibyo bigabanywa imirimo n'imvune mu byerekeye gahunda y'ubuzima kandi bikorohereza imiryango n'abaturage muri rusange,
- Byagabanijwe ibibazo byo kohereza abagore n'abakobwa ku bitaro by'akarere. Abagore n'abakobwa benshi bakuyemo inda bashobora kwitabwaho bari ku bigo nderabuzima mu buryo butarhanijwe. Gahunda yo kohereza abagore n'abakobwa bakuyemo inda ku bitaro by'akarere yagenewe gusa abafite ingorane zirenze ubushobozi bw'ikigo nderabuzima,
- Bikiza abagore n'abakobwa benshi kandi bigabanywa n'ubumuga butari ngombwa. Ibyo bikorwa byose bizafasha u Rwanda kugera ku ntego yo kugabanywa impfu z'ababyeyi, no guteza imbere ubuzima bwiza bw'umuryango nyarwanda.

UBUTUMWA BW'INGENZI

- Dukumire ingaruka z'uwahuye n'ikibazo cyo gukuramo inda kuko bihungabanyaga ubuzima bikaba byavamo n'urupfu
- Abagore n'abakobwa bahuye n'ikibazo cyo gukuramo inda bafite uburenganzira bwo kwitabwaho no kuvurwa nk'abandi barwayi
- Ikibazo cy'uwakuyemo inda n'ikibazo gikwiye kwitabwaho n'inzego zose na buri wese
- Ibimenyetso mpuruzi: Kuvira kunda bidahagarara cyangwa kuva bikabije, kuribwa mu kiziba cy'inda no kubabara mu mugongo
- Ubufasha buhabwaga uwahuye n'ikibazo cyo gukuramo inda bugizwe n'ubuvuzi, ubujyanama n'uburyo bwo kuboneza urubyaro
- Serivisi z'uwahuye n'ikibazo cyo gukuramo inda zitangwa n'abaganga, abaforomo n'ababyaza bakazitangira kubigoye nderabuzima no ku bitaro
- Serivisi zihabwaga uwahuye n'ikibazo cyo gukuramo inda zirahendutse.
- Ningombwa ko uwahuye n'ikibazo cyo gukuramo inda yitabira uburyo bwo kuboneza urubyaro kandi agakomeza gukurikiranwa na muganga kugira ngo ingaruka zose zikumirwe.

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KWITA KUBAHUYE N'IKIBAZO CYO GUKURAMO INDA NI INSHINGANO YACU TWESE



DUFATANYE GUKUMIRA INGARUKA ZITERWA NO GUKURAMO INDA

ISOBANURAMPAMVU

Gukuramo inda ni ikibazo kibangamiye ubuzima bw'ababyeyi

UKO IKIBAZO GITEYE:

KU RWEGO MPUZAMAHANGA

Raporo yatanze n' Ishami ry' Umuryango w'Abibumbye ryita ku Buzima mu mwaka wa 2008 yerekana ko ku isi yose abagore n'abakobwa bakuyemo inda muri uriya mwaka bageraga kuri miliyoni 21 n'ibihumbi 600 (21.600.000). Muri bo abagera kuri 29% (6.264. 000) ni abo muri Afurika. Iyo raporo yerekana kandi ko ku mwaka hapfa abagore n'abakobwa bitewe no gukuramo inda bagera ku bihumbi 47 000. Kandi abenshi muri bo bakazira ingorane abantu bashobora gukumira cyangwa se kuburizamo.

MU RWANDA

Ubushakashatsi bwakozwe mu Rwanda muri 2009 na Minisiteri y'ubuzima bwerekanye ko nibura buri mwaka abagore n'abakobwa 60 000 bahura n'ikibazo cyo gukuramo inda. Ku ijana, umubare w'abagore n'abakobwa bari mu kigero cy'imyaka 15 na 44, byagaragaye ko abagera kuri 25/1000 bahura n'ikibazo cyo gukuramo inda. Ibi bikaba byerekana ko n'urubyiruko rwugarijwe n'icyo kibazo.

Biragaragara rero ko ingorane ziterwa no gukuramo inda ari ikibazo cy'ingutu cyihutirwa kandi kireba buri wese kugira ngo gukumirwe hakiri kare.

IBIMENYETSO MPURUZA

- Kuvira kunda bidahagarara cyangwa kuva bikabije
- Kuribwa mu kiziba cy'inda
- kubabara mu mugongo



1

INGAMBA ZAFASHWE

Guverinoma y'u Rwanda ibinyujije muri minisiteri y'ubuzima yiyemeje gukumira impfu zihitana abagore n'abakobwa bahuye n'ikibazo cyo gukuramo inda. Ni muri urwo rwego minisiteri y'ubuzima ikomeje gukwirakwiza hose mu gihugu serivisi z'ubuzima bw'imyorokere zitandukanye ariko zuzuzanya kugirango Abagore n'abakobwa bahuye n'ikibazo cyo gukuramo inda bajye baziya mbaza.

SERIVISI ZAGENWE GUTABARA ABAGORE N'ABAKOBWA BAHUYE NIKIBAZO CYO GUKURAMO INDA, ZIKUBIYE MURI IZI ESHATU.

UBUVUZI: Umugore cyangwa umukobwa wahuye n'ikibazo cyo gukuramo inda, bamwakira byihutirwa ; Bakamusuzuma; bakamuvura hakoreshejwe imiti cyangwa ubundi buryo bwabugenewe nko koza munda.

UBUJYANAMA: Umugore cyangwa umukobwa wahuye n'ikibazo cyo gukuramo inda arihangashyamba.

Nyuma yo kuvurwa, agirwa inama agomba gukurikiza mu gihe atarakira . Zimwe muri zo: kwirinda imirimo ivunanye, kwirinda gukora imibonano mpuzabitsina no gukora urugendo rururere . Ahabwa kandi inama zerekanye imirire kugira ngo yiyongerere amaraso yatakaje ndetse n'inama zerekanye kuboneza urubyaro. Ahabwa gahunda yo kugaruka kubonana na muganga. Ahabwa inama kandi kuberekeye serivisi zipima zikanatanga inama ku cyorezo cya SIDA.

UBURYO BWO KUBONEZA URUBYARO: Mbere yo gutaha ahabwa uburyo bwo kuboneza urubyaro yihitiyemo kugira ngo bimurinde gusama inda itateganyijwe no gusama imburagije.



2

URUHARE RWA BURI WESE

■ **GUFASHA ABAGORE N'ABAKOBWA KUBONA UBUVUZI:** Twese tugomba gutera inkunga abagore n'abakobwa bagize ikibazo cyo gukuramo inda kugira ngo bitabweho bwangu. Gutinda kubavura bafite icyo kibazo bishobora kubavutsa ubuzima bwabo.

■ **KURWANYA IMYUMVIRE MIBI:** Uwagize ikibazo cyo gukuramo inda ni umurwayi nkabandi ; ntibikwiye gutera ipfunwe cyangwa ngo byitirirwe amarazi. Nibyiza kwihutira kujya kwa muganga. Abagore n'abakobwa bahuye n'ikibazo cyo gukuramo inda bafite uburenganzira bwo kuvurwa nk'uko bikwiye. Gutinda kubaha serivisi bishobora kubaviramo ingaruka zo gutakaza ubuzima bwabo.

■ **GUHWITURIRA ABAGORE N'ABAKOBWA KUJYA KWA MUGANGA:** Abagize umuryango bafite inshingano yo kwita ku mugore n'umukobwa wagize ikibazo cyo gukuramo inda bamufasha mu byo akeneye byose kandi bakamuhutirira kujya kwa muganga no gukurikiza inama zabavuzi.

■ **URUHARE RW'ABAJYANAMA B'UBUZIMA BW'UMUBYEYI:** Bafite inshingano yo gukangurira abagore n'abakobwa bakuyemo inda kujya kwa muganga. Iyo abagore n'abakobwa bageze mu miryango yabo bavuye ku ivuriro, abajyanama b'ubuzima bw'umubyeyi barabakurikirana, bagira ikibazo bakabagira inama yo gusubira kwa muganga bwangu.



3