GREAT LAKES INITIATIVE FOR HUMAN RIGHTS AND DEVELOPMENT (G.L.I.H.D)

ASSESSMENT ON ENFORCEMENT OF THE LAW DETERMINING OFFENCES AND PENALTIES IN GENERAL (FOCUSING ON SRHR):

Assessing barriers that girls and women face seeking safe abortion services at districts hospitals

December 2020

Table of Contents

List of tables

List of figures

List of Abbreviations

AIDS: Acquired Immune Deficiency Syndrome

ANC: Antenatal Care

DHS: Demographic Health Survey

EC: Emergency Contraception

FP: Family Planning

GBV: Gender Based Violence

GLIHD: Great Lakes Initiative for Human rights and Development

MoH: Ministry of Health

MINEJUST: Ministry of Justice

MVA: Manual Vacuum Aspiration

NGO: Non-governmental Organization

PAC: Post Abortion Care

RBC : Rwanda Biomedical Center

SA : Safe Abortion

STI: Sexually Transmitted Infection

SRH: Sexual and Reproductive Health

WHO: World Health Organization.

1. INTRODUCTION

Rwanda has implemented deliberate policies and reforms to decrease maternal mortality, including the expanding legal exemptions for abortion, yet access to abortion services remains limited for women outside of urban areas where hospitals are more localized. The current guideline for provision of safe abortion services developed following the amendment of the legal grounds of abortion under the Law n° 68/2018 of 30/08/2018 determining offences and penalties in general and the Ministerial Order N°002/MoH/2019 of 08/04/2019 determining conditions to be satisfied by a medical doctor to perform safe abortion; limits the provision of safe abortion protocol to medical doctor in public hospitals and private polyclinics while most of population seek care at the primary level which is the Health center. This has created inequities in service provision, with limited or no access for women who typically use primary health care (public health centers) or the ones living far from district hospitals.

Distance to service delivery points is a known barrier to access and several studies have found that long distances to abortion facilities are associated with increased burden among patients, including higher associated out of pocket costs, greater difficulty getting to the health facility, delayed care, and decreased use of abortion services. Although the degree to which distance is a barrier is not well described, distance may impact different girls/women in different ways(WHO, Geneva 2011 and Basinga Paulin, Rwanda 2012). This assessment examined barriers faced by women when trying to access abortion care at hospital level focusing on the following key elements:

- Current clients' characteristics and attributes,
- Distance,
- Visiting multiple health facilities before obtaining services,
- Delays in obtaining services,
- Days for hospitalization,
- Cost of services.

The findings of this assessment will contribute to the body of evidence on perceived barriers to accessing abortion services in Rwanda and will help different stakeholders

including decision makers and program implementers in revision of current regulations and instructions towards expanding access of abortion services.

2. OBJECTIVES

The purpose of this assessment was to gather information and evidence on problems related to inaccessibility of safe abortion services at public health centers level (primary level); by collecting information on girls and women who received safe abortion services in 8 district hospitals during the period from June 2019 to October 2020 including:

1. General information:
   - The Reasons for provision of safe abortion services.
   - The ages of girls and women receiving safe abortion services.
   - The methods used to terminate the pregnancy
   - The gestational age at the time of provision of safe abortion services.
   - And the methods used for termination of pregnancy.

2. Identifying distance related barriers:
   - Estimate the rate of women & girls who seek safe abortion services in other district/other province than their residence.
   - Determine the number of girls and women who were obliged to present a referral form to receive safe abortion services.
   - Determine the proportion of women who come back for follow up visits.

3. Identify delays in obtaining services:
   - Collecting information on number of days between the dates of transfers and reaching the hospital which provides services.

4. Determine the cost of safe abortion services and the health insurances coverage status for women and girls seeking safe abortion services;
   - Determine the proportion of women & girls with health insurances
   - Classifying girls and women according the total Rwandan francs paid for provision of safe abortion services.
   - Classifying girls and women according to the duration of hospitalization.

3. LIMITATIONS

Due to the method chosen for data collection (collecting data retrospectively from hospital records; patient files, and services delivery registers), the limited time and the limited budget, some information are missing in some hospitals. When planning for remote data collection during the Covid-19 pandemic, it was not possible to collect all information in need due to the limitation of interpersonal contact respecting physical distancing; first we determined what information was still necessary, because data needs may have changed, e.g. if programming has pivoted or needs to pivot due to Covid-19. It was not easy to have the information on time while many health professionals are intervening in Covid-19 preparedness and response.

4. SCOPE OF THE ASSESSMENT

Geographically, this assessment was conducted in eighty (8) hospitals located in seven (7) districts from the 4 provinces and the City of Kigali.

Table (1) shows the location of hospitals sampled to be assessed.

Name of the district hospital	Administrative district	Province
1. Kacyiru Police hospital	Gasabo District	Kigali
2. Nyanza Hospital	Nyanza District	South province
3. Masaka Hospital	Kicukiro District	Kigali
4. Ruhengeli Hospital	Musanze District	Northern province
5. Nyamata hospital	Bugesera District	Eastern province
6. Karongi Hospital	Karongi District	South province
7. Kibagabaga Hospital	Gasabo District	Kigali
8. Nyagatare Hospital	Nyagatare district	Eastern Province

5. METHODOLOGY

To examine the barriers which women and girls face trying to obtain safe abortion services at district hospital, this assessment analyzed retrospectively hospital records (Hospital abortion services registers and patient files) for all women who received safe abortion services at 8 selected district hospitals during the period June 2019 – October 2020 using quantitative approach.

The target population for this assessment included 306 girls and women who received safe abortion services in 8 hospitals; Ruhengeli, Nyamata, Nyanza, Masaka, Kacyiru, Kibagabaga, Kibuye and Nyagatare. In this assessment, we included all women who received safe abortion services in above mentioned district hospitals. And excluded the ones who received safe abortion for therapeutic reasons. We decided to conduct this assessment in above mentioned hospitals, selected from a purposive sampling to represent all provinces and City of Kigali because they were accessible for data collectors and also they were no restriction from their management to perform safe abortion care.

A check list to collect information was introduced to capture information from patient files and hospitals registers, for all women and girls who received safe abortion services. The purpose of this tool was to capture the general information on age, reasons for provision of safe abortion services, age of pregnancy, methods use to provide safe abortion services, number of days of hospitalization, the types of the health insurance and the cost of services. The tool helped to identify the reasons for provision of safe abortion services, the age of safe abortion clients, the age of the pregnancy, the methods used to terminate the pregnancy, the Residence(districts), record if the client come back for a follow up visit, if she visited more than one health facility before having services, number of days between transfer and reaching the destination, the number of days of hospitalization, records if the clients had health insurances and records the cost of safe abortion services.

Descriptive statistics included frequencies and percentages and were conducted to describe clients' characteristics and attributes. The data used in this assessment were anonymously recoded and cannot therefore be traced back to individuals. The checklist

for collecting information from patient files was coded, and did not contain the names of patients. The storage of the collected data was ensured in a safe place.

Anonymity of the participants was maintained at all times and thus the checklist did not require identification of the clients to ensure the anonymity and the confidentiality of responses. Data were organized by clients' codes. The people who conducted the assessment were honest in only reporting the assessment findings.

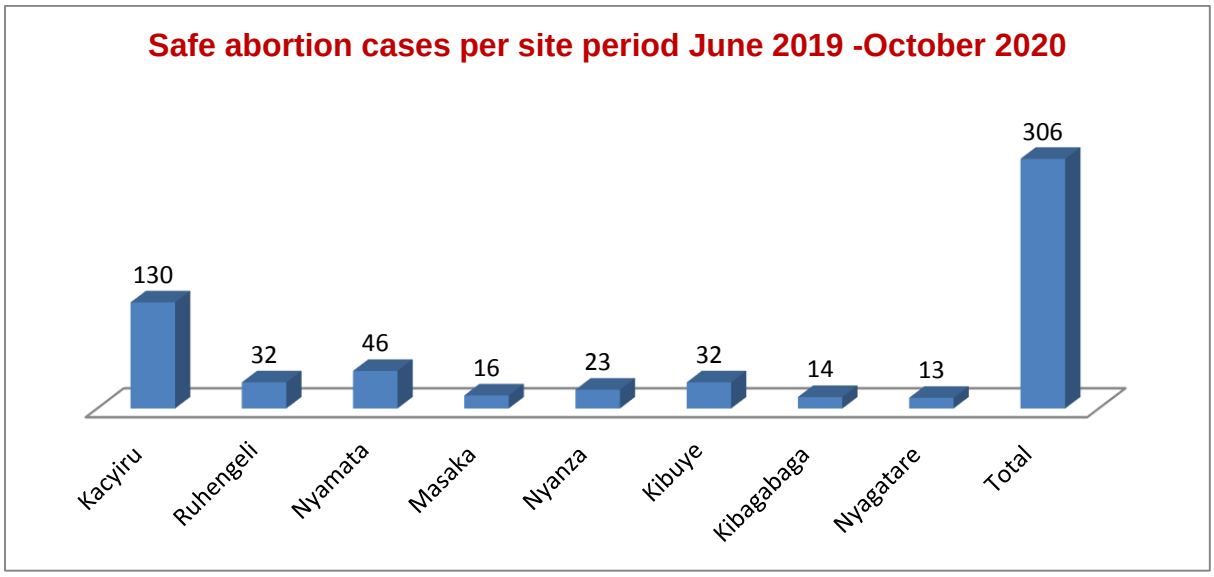
6. FINDINGS

This section presents in details findings on the reasons for provision of safe abortion services, the age of the women, the age of the pregnancy, the methods used to terminate the pregnancy, the residence status, to record if the clients come back for a follow up visit, if girls/women were obliged to present the referral form to be received, number of days between transfer and reaching the destination, the number of days of hospitalization, to record if the clients had health insurance and record the cost of safe abortion services.

6.1. Number of safe abortion cases by District Hospital assessed

Figure (1) Number of safe abortion cases per site

This figure shows the number of all girls and women who obtained termination of pregnancy (safe abortion services) during period from June 2019 to October 2020 (excluding those who received safe abortion services for therapeutic reasons.)



This figure shows that Kacyiru hospital is the one which received a big number compared to other 7 district hospitals; Kacyiru hospital served 42% of all cases.

6.2. Age of girls and women seeking termination of pregnancy services

Table (2) Age of girls and women seeking safe abortion services

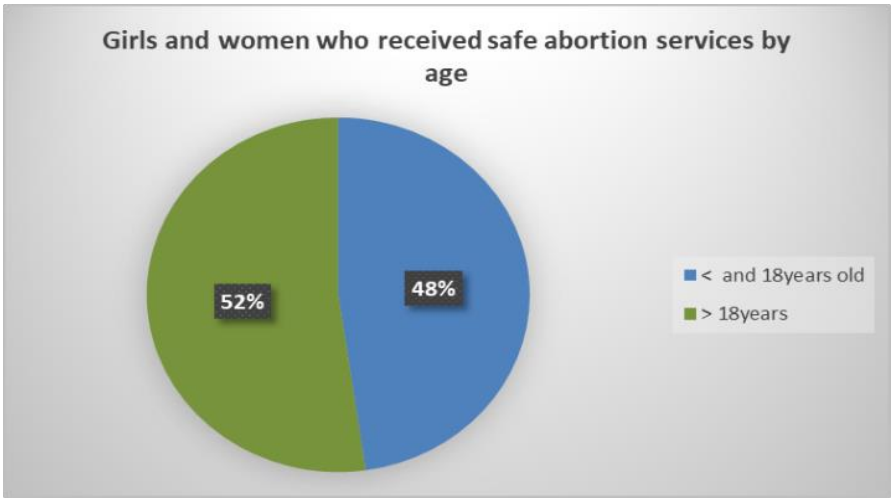
This table classifies girls and women who received safe abortion services by age; this in two groups: < or = 18years old and > 18years old.

Total number received safe abortion by age of women	Kacyiru	Ruhengeri	Nyamata	Masaka	Nyanza	Kibuye	Kibagabaga	Nyagatare	Total
≤18years old	76	9	14	11	6	11	7	12	146
> 18years old	54	23	32	5	17	21	7	1	160
Total	**130**	**32**	**46**	**16**	**23**	**32**	**14**	**13**	**306**

This table indicates that certain hospitals search us Kacyiru police, Masaka, and Nyagatare hospital receive a big proportion of children (≤18 years old) compared to other hospitals.

Figure (2) Classifying all girls and women by age

This figure classifies all girl and women who received safe abortion services at assessed hospitals by age



This figure indicate that, 48% of all girls/women who terminated their pregnancy where under 18 years old or age 18 years and 52% where above 18 years old.

6.3. Reasons for requesting termination of pregnancy

Table (3) Girls and women by reasons for requesting safe abortion services

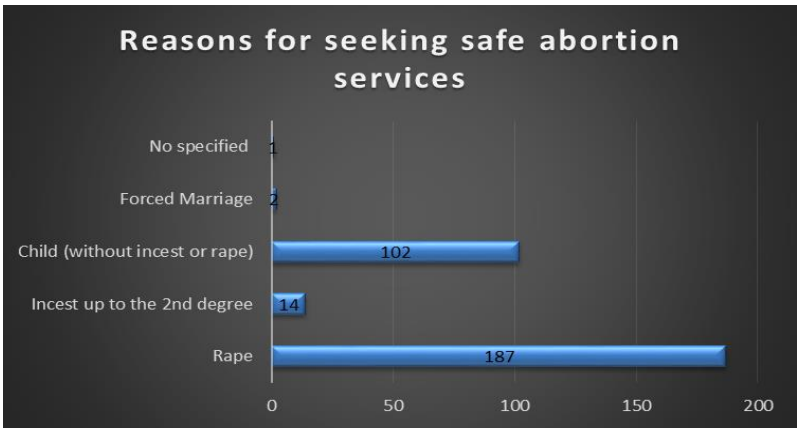
This table classifies all girls and women who received safe abortion services by reasons for requesting termination of pregnancy by district hospitals assessed.

Number by Reasons	Kacyiru	Rutheng eri	Nyamata	Masaka	Nyanza	Kibuye	Kibagabaga	Nyagatare	Total
Rape	61	32	39	6	12	19	7	11	187
Incest up to the 2nd degree	7	0	1	0	2	2	0	2	14
Child (without incest or rape)	61	0	6	10	7	11	7	0	102
Forced marriage	0	0	0	0	2	0	0	0	2
No specified	1	0	0	0	0	0	0	0	1
Total	**130**	**32**	**46**	**16**	**23**	**32**	**14**	**13**	**306**

This table shows that in most cases at all hospitals assessed; girls and women requested abortion services mainly due to rape or child.

Figure (3) Classify all girls and women by reason for seeking safe abortion services.

This figure classifies all girls and women who received safe abortion services by reason for seeking termination of pregnancy



This figure shows girls/ women requested termination of pregnancy because of rape in 61 %, age (child) without rape 33%, and incest 4.6% and that only 0.7% requested safe abortion services due to forced married.

6.4. Age of pregnancy

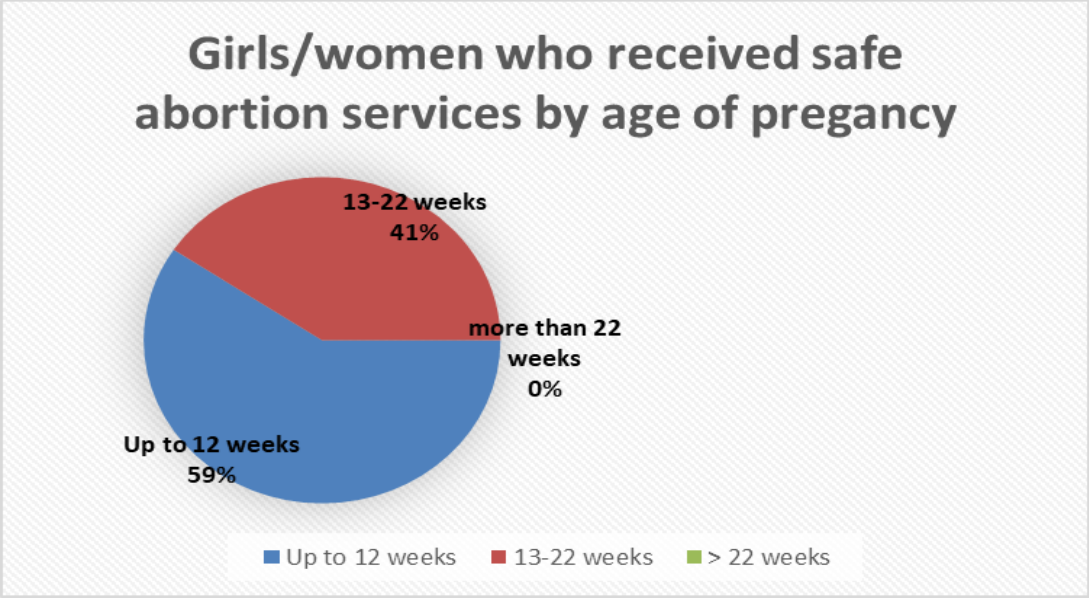
Table (4): Girls and women who received safe abortion services by gestational age

This table shows the age of pregnancy for girls and women, the time for removal of product of conception

Girls and women by gestational age	Kacyiru	Ruhengeri	Nyamata	Masaka	Nyanza	Kibuye	Kibagabaga	Nyagatare	Total
Up to 12 weeks	43	26	19	0	14	20	5	3	130
13-22 weeks	32	6	13	0	9	12	7	10	89
> 22 weeks	0	0	0	0	0	0	0	0	0
No data	55	0	14	16	0	0	2	0	87
Total	**130**	**32**	**46**	**16**	**23**	**32**	**14**	**13**	**306**

The results in this table show that in total 130 terminated pregnancies were less than 13 weeks, and that 89 with age between 13- 22 weeks.

Figure (4) Classifying all girls and women who received safe abortion services by gestational age



For those who documented the gestational age (= 219); The assessment findings shows that 59% (130/219) had a gestational age of the pregnancy less than 13 weeks, and 41%(89/219) had a gestational age between 13-22 weeks.

6.5. Methods used for termination of pregnancy

Table (5) methods used for termination of pregnancy

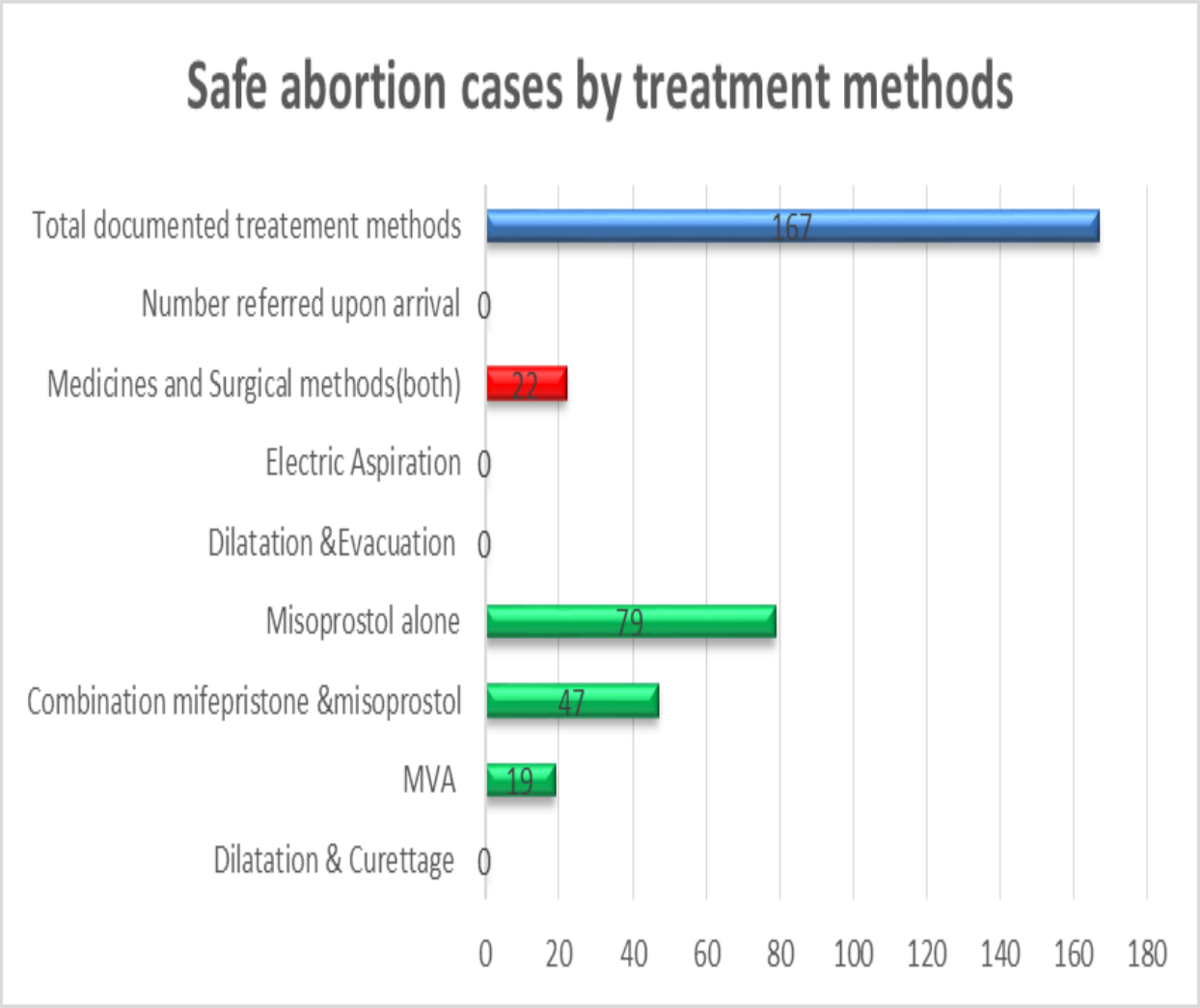
This table shows the methods used to terminate the pregnancy in different hospitals**.**

Safe Abortion cases treated; by treatment method	**Kacyiru**	**Ruhengeri**	**Nyamata**	**Masaka**	**Nyanza**	**Kibuye**	**Kigabagabaga**	**Nyagatare**	**Total**
Number treated with Dilatation & Curettage	ND	0	0	0	0	0	0	0	0
Treated with MVA	ND	1	7	7	0	1	2	1	19
Treated with Combination mifepristone &misoprostol	ND	2	10	1	12	3	7	12	47
Treated with misoprostol alone	ND	29	17	6	5	22	0	0	79
Treated with Dilatation &Evacuation	ND	0	0	0	0	0	0	0	0
Treated with Electric Aspiration	ND	0	0	0	0	0	0	0	0
Medicines and Surgical methods(both)	ND	0	5	0	6	6	5	0	22
Number referred upon arrival(reason in comment column)	ND	0	0	0	0	0	0	0	0
No data	130	0	7	2	0	0	0	0	139
Total	**130**	**32**	**46**	**16**	**23**	**32**	**14**	**13**	**306**

This table shows that a big percentage of medical doctors use Medicines and MVA for pregnancy termination.

Figure (5) Methods used to terminate the pregnancy

This figure shows the methods used by doctors to terminate the pregnancy



This figure shows that, among those who documented the treatment methods (167), 79 (47%) used misoprostol alone, 47(28%) used Combination mifepristone & misoprostol and 19 (11%) used MVA.

6.6. The distance related factor and referral status

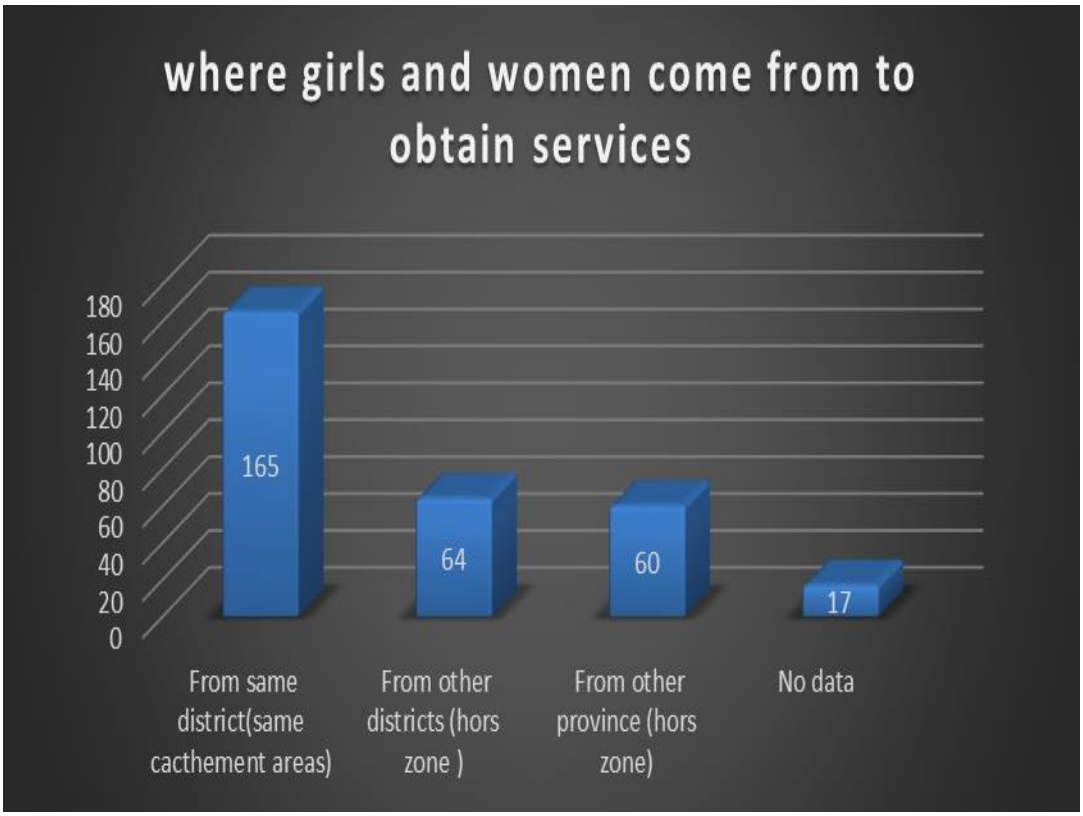
Table (6) distance related factors

This table classifies girls and women according to where they come from to obtain safe abortion services

where girls are coming from or referral status	Kacyiru	Ruhengeri	Nyamata	Masaka	Nyanza	Kibuye	Kigabagaga	Nyagatare	Total
Referred by health centers from the catchment area (same district)	49	21	31	8	15	21	10	10	165
Referred by hospitals or health centers from other districts (hors zone same province)	31	9	0	4	6	8	3	3	64
Referred by health facilities from other province (hors zone)	47	2	1	4	2	3	1	0	60
No data	3	0	12	0	0	0	2	0	17
Total	**130**	**32**	**46**	**16**	**23**	**32**	**14**	**13**	**306**

This table shows that a big number of girls and women who received safe abortion services outside their district of residence (had to travel to obtain safe abortion services in another district, in the same province or in a different province). It shows that Kacyiru police hospital has a big number of women and girls who came from other provinces (47out of 130), and other districts (31 out of 130).

Figure (6) Classifying girls and women according to where they come from



This figure shows that a big proportion of girls and women received services in a different district than the residence; 64 (21%) girls and women were from different districts to the one providing abortion services and 60(19%) were from different province to the one providing abortion services .

6.7. Girls and women were obliged to obtain transfer from another health facility.

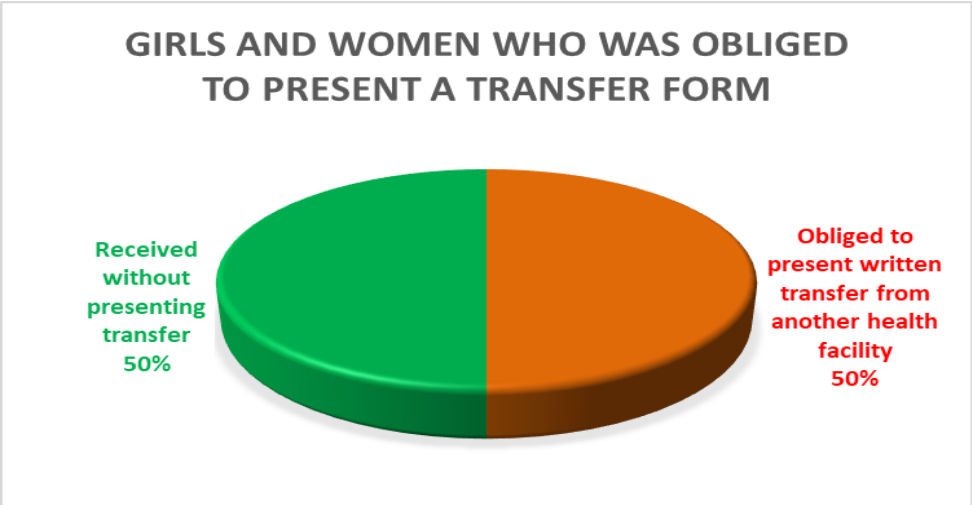
Tables 7. Girls and women who were obliged to present a written transfer form

This table shows the number of women and girls asked a transfer from in order to be served at the hospital which provided safe abortion services.

Classification of beneficiaries by presenting or not presenting transfer form	Kacyiru	Ruhengeri	Nyamata	Masaka	Nyanza	Kibuye	Kibagabaga	Nyagatare	Total
Obliged to present written transfer from another health facility	ND	9	13	13	16	21	7	9	88
Received without presenting transfer	ND	23	33	3	7	11	7	4	88
No data	130	0	0	0	0	0	0	0	130
Total	**130**	**32**	**46**	**16**	**23**	**32**	**14**	**13**	**306**

The results in this table show that in all hospitals some service providers still requesting girls and women to present a transfer form in order to be given safe abortion services. Or girls and women in all districts still take that as a requirement to received safe abortion services.

Figures (7) girls and women who was obliged to present a transfer form from another district



For those who document this information (176), 88 (50%) of women and girls who obtained abortion services had to visit another health facility to obtain a transfer form.

6.8. Girls or Women who went back for the follow up visit in 2 weeks after termination of pregnancy

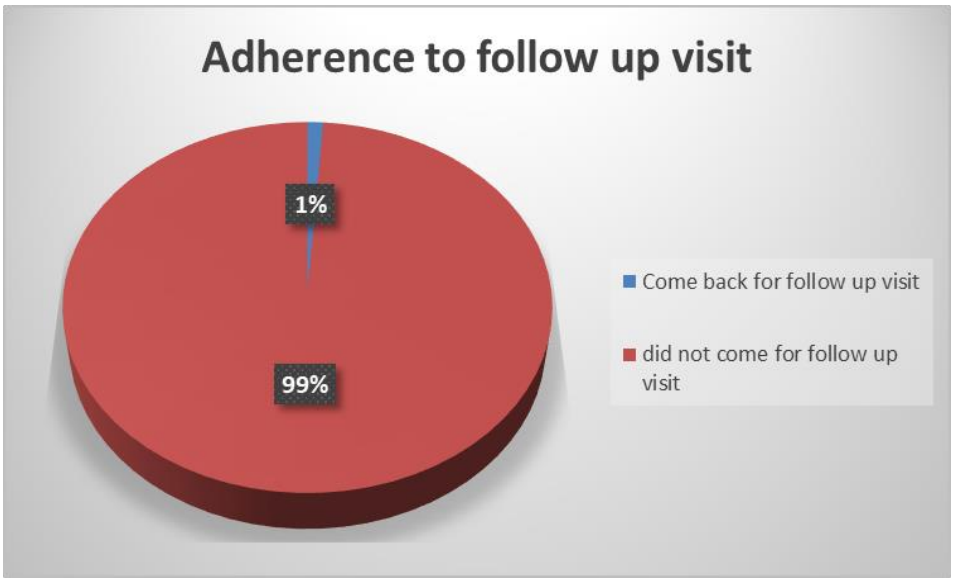
Table (8): Number of girls and women who went back for follow up visit

This table shows the number of girls/women who went back to the hospital for the follow up visit per district hospital assessed.

Number who comeback for the standard follow up visit in 2 weeks	Kacyiru	Rutheng eri	Nyamat a	Masaka	Nyanza	Kibuye	Kibaga baga	Nyagat are	Total
Come back for follow up visit	ND	0	0	0	1	0	1	0	2
did not come for follow up visit	ND	32	46	16	22	32	13	13	174
No data	ND	0	0	0	0	0	0	0	130
Total	**ND**	**32**	**46**	**16**	**23**	**32**	**14**	**13**	**176**

The result in this table shows that at all hospital there is weakness, women do no go back for follow up visit

Figure (8) Girls and women who went back for follow up visit



This figures shows that only 1% managed to go back to the district hospital for a follow up visit in the 2 weeks.

6.9. Delay in receiving safe abortion services.

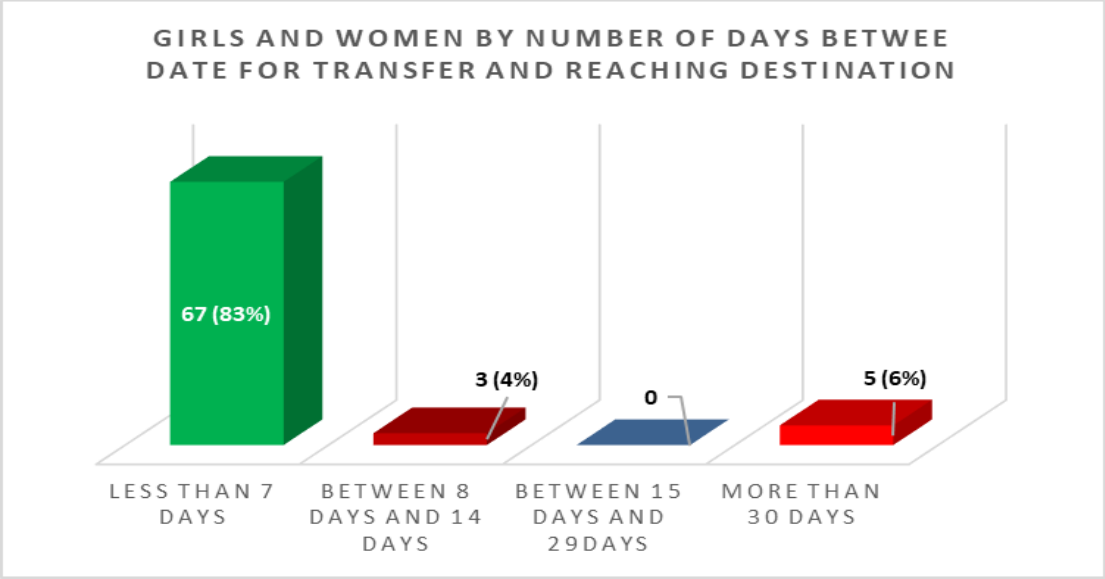
Tables (9): Number of days between transfer and reaching the destination

This table shows the number of days between transfer and reaching the hospital which provided safe abortion services.

Days between transfer and reaching the destination	Kacyiru	Rubengeri	Nyamata	Masaka	Nyanza	Kibuye	Kibagabaga	Nyagatare	Total
Less than 7 days	N/D	9	13	N/D	16	13	7	9	67
Between 8 -14 days	N/D	0	0	N/D	0	3	0	0	3
Between 15 - 29 days	N/D	0	0	N/D	0	0	0	0	0
More than 30 days	N/D	0	0	N/D	0	5	0	0	5
No data	N/D		0	N/D	0	0	0	0	0
Total number transferred	**N/D**	**9**	**13**	**N/D**	**21**	**21**	**7**	**9**	**80**

The assessment results show that for 80 girls and women to who were transferred; it took less than a week for most of them to reach the hospital which provided safe abortion services.

Figures (9) Days between transfer and reaching the destination



This figure shows that for most girls/women it takes less than one week to reach the destination from the date they obtained transfer. However for 10% it takes more than a week (4% sending between 8 - 14 days and 6% spending more than 30days)

6.10. Number of hospitalization days

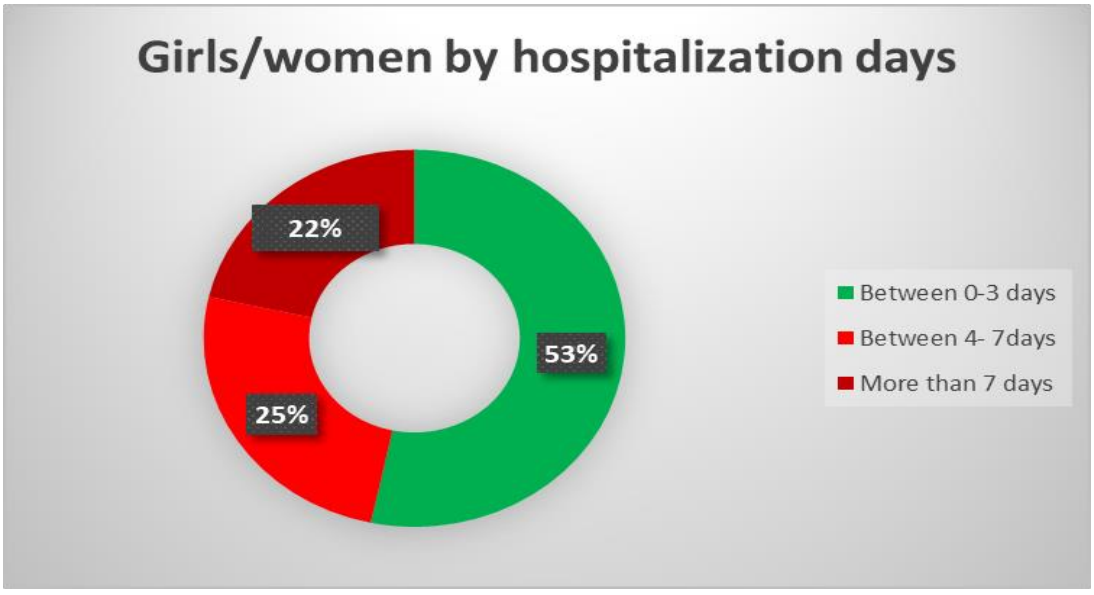
Table (10) Number of days of hospitalization

This table shows the number of days between date of first consultation and date of discharge

Number of hospitalization days	kacyiru	Ruheng eli	Nyamat a	Masaka	Nyanza	Kibuye	Kibagab aga	Nyagata re	Total
Hospitalized between 0-3 days	N/D	15	5	6	14	14	10	8	72
Hospitalized between 4-7days	N/D	5	2	4	6	11	4	2	34
Hospitalized for more than 7 days	N/D	12	1	3	3	7	0	3	29
No data	130	0	38	3	0	0	0	0	171
Total	N/D	**32**	**46**	**16**	**23**	**32**	**14**	**13**	**306**

This table shows the number of hospitalization of girls and women who received safe abortion services by district hospital. for a big number we could not collect that information .

Figures (10) Hospitalization dates



For 135 girls/women; for whom we managed to get information on hospitalization days, 53% were not hospitalized or hospitalized less than 3days, 22% hospitalized for a period between 4-7 days and 25% hospitalized more than 7 days.

6.11. Number of girls/women with health insurance

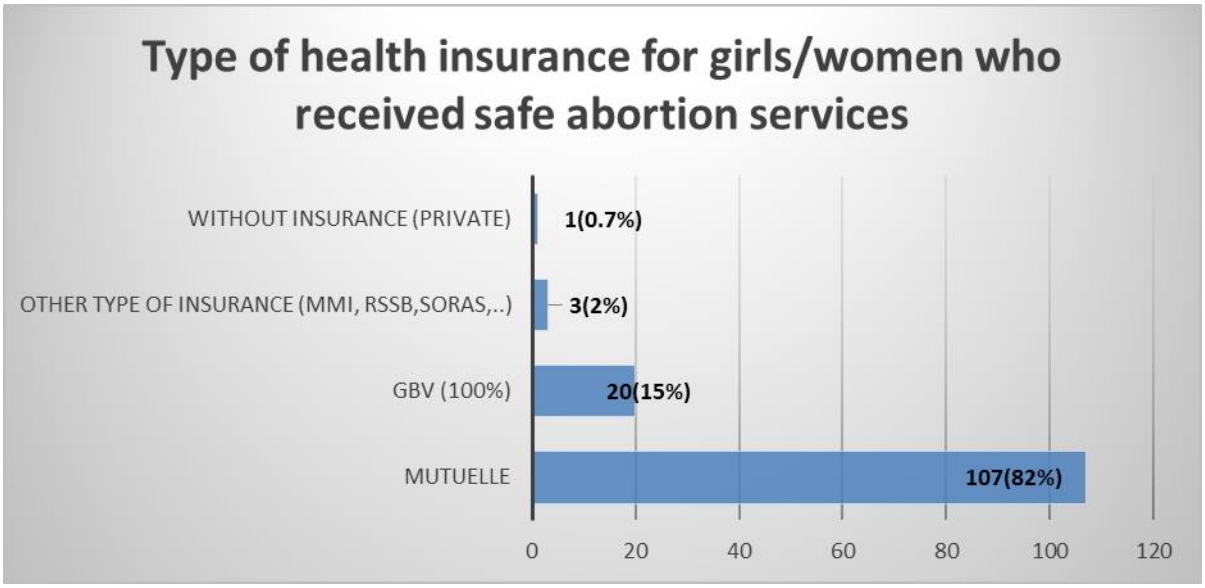
Table (11) Number of girls/women with Health insurance

This table shows the number of women and girls who had health insurance and the type of health insurance they used at the time they received safe abortion services.

Type of Health insurance which clients had	Kacyiru	Rukheng eri	Nyamat a	Masaka	Nyanza	Kibuye	Kibaga baga	Nyagat are	Total
Mutuelle de santé	N/D	32	31	9	14	21	N/D	11	107
GBV (100%)	N/D	0	0	3	7	10	N/D	1	20
Other insurances (MMI, RSSB, SORAS,..)	N/D	0	0	0	2	1	N/D	0	3
Without insurance	N/D	0	1	0	0	0	N/D	1	1
No data	N/D	0	14	4	0	0	N/D	0	18
Total	**N/D**	**32**	**46**	**16**	**23**	**32**	**N/D**	**13**	**149**

The results in this tables show that most of girls and women who received safe abortion services have health insurance.

Figures (11): The type of health insurance for women who received safe abortion services



This figure shows that in most cases safe abortion services are covered by the community health insurance (80%) and GBV funds (15%). Meaning that most of clients are not employed or don't have a contract of work (job in formal sector).

6.12. Cost of services and payment for Mutuelle de santé (CBHI) and fees paid by the client

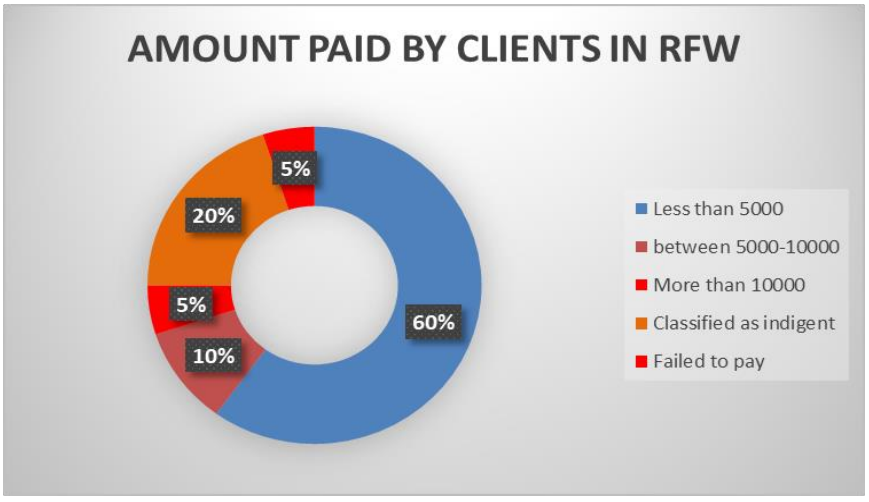
Tables (12) Cost of safe abortion services; fees paid by girls/women

This table shows the cost of services for girls and women and the amount paid by clients to receive safe abortion services.

Amount paid by the clients in RwF	Kacyiru	Rukeneri	Nyamata	Masaka	Nyanza	Kibuye	Kibagabaga	Nyagatare	Total
Less than 5,000	N/D	ND	N/D	5	12	7	N/D	N/D	24
between 5,000-10,000	N/D	ND	N/D	2	1	1	N/D	N/D	4
More than 10,000	N/D	ND	N/D	0	1	1	N/D	N/D	2
Classified as social cases(unable to pay)	N/D	ND	N/D	2	0	6	N/D	N/D	8
Failed to pay	N/D	ND	N/D	0	0	2	N/D	N/D	2
Total	**N/D**	**ND**	**N/D**	**9**	**14**	**17**	**N/D**	**N/D**	**40**

It was difficult to get this information from hospital records. For women we managed to obtain information; this table shows that in most cases women and girls had to pay less than 5000 Rwf for safe abortion services received.

Figure (12): Amount paid by clients in Rwf



This figure shows that 60% of girls/women paid less than 5000 Rfw (as ticket Moderateur), 10 % paid between 5000-10000Rfr, 20% paid more than 10.000Frw and 5 % failed to pay the ticket moderateur.

6.13. Cost of services to the health system

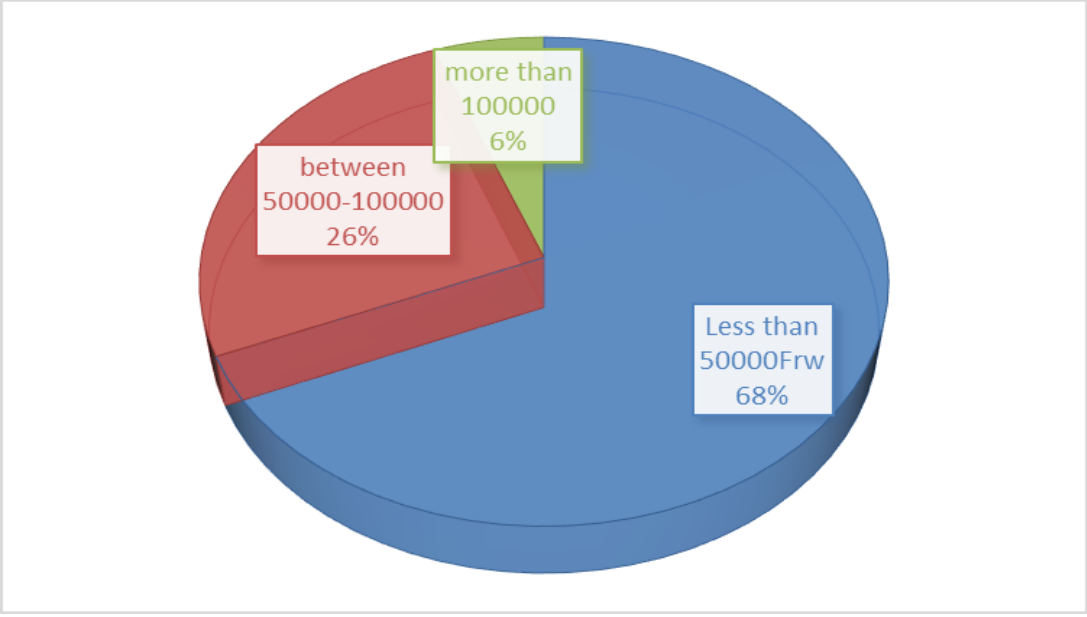
Table (13) Total fees paid for provision of safe abortion services

This table shows the total fees paid for provision of safe abortion services; including the part paid by the health insurance and the part paid by the clients (hospital total bill).

Total Cost of services	Kacyiru	Ruhengeri	Nyamata	Masaka	Nyanza	Kibuye	Kibagabaga	Nyagatare	Total
Less than 50000Frw	N/D	ND	ND	5	12	7	ND	ND	24
between 50000-100000	N/D	ND	ND	2	1	6	ND	ND	9
more than 100000	N/D	ND	ND	0	1	1	ND	ND	2
TOTAL	**N/D**	**ND**	**ND**	**9**	**14**	**17**	**ND**	**ND**	**35**

For the information we had from some hospitals, this tables shows that in most cases the bill was less than 50,000frw

Figures (13): Total hospital bill



This figure shows that the hospital bill representing the total cost of services was less than 50,000frw for 60%, between 50,000 and 100,000 for 23% and more than 100,000 Rwf for 13%.

7. DISCUSSION

During this assessment the data were collected in 8 district hospitals; 3 hospitals in Kigali, 2 in Eastern province, 1 in South province, one in Northern province and 1 in Western province(Table 1). The results show that in all those hospitals they were 306 girls and women who received safe abortion services. We considered all women who received safe abortion services during period from June 2019 to October 2020 at each hospital included; excluding clients who received abortion services for therapeutic reasons. The data show that Kacyiru police hospital received a big proportion of clients with 42% of all cases since it is a national referral GBV center (Figure 1).

The results from the assessment show that 146 out of 306 (48%) who seek safe abortion services in district hospitals during the period June 2019 to October 2020 were children (figure2), this mean that all of those children have to be accompanied by their parents/ or caregivers, who had to drop off they daily work for some days . This is definitely a big burden to families, and this might have a big social economic impact at family level. If services were available at the health centers level this burden would have been reduced.

The findings show that the main reason for seeking safe abortion services is rape and under age for child under 18 years old (Table 3). Since it is known that low social economic status search us poverty, hunger, orphans,… increases the risk of sexual violence(WHO, 2008). We can assume that most of girls and women seeking safe abortion services came from families with low social economic conditions, with low income and without caregivers. It will be difficult for vulnerable groups to be able to receive services at district hospital, which are usually localized far from home, getting safe abortion services near their communities will make things easier and shipper.

The assessment results show that most of girls/women 130/219 (59%), had a pregnancy age less than 12 weeks (figure 4), which explain that the process for termination of pregnancy were easier; According to national services guidelines and from experience,

the earlier the pregnancy is terminated, the easier is the process. This means that for a big proportion of women (more than half), termination of pregnancy is an easy process. This is in favor of expanding the provision of safe abortion services to midlevel health care providers, nurses and midwives at health center level.

The results of the assessment show that the common used methods for termination of pregnancy are medical methods (Misoprostol alone + Combination mifepristone and misoprostol at 75%), and 11% used Manual vacuum aspiration (figure 5). It is known that the use of medicine and the Manual vacuum aspiration are methods which does not require a medical doctors to be delivered; they are methods which could be performed by midlevel health providers (nurses and midwives) at the primary level (health center) especially if the pregnancy is less than 12 weeks. We can conclude that if the current Law was favorable, nurses and midwives could manage a big number of cases seeking safe abortion services. Currently there is big number of nurses and midwives trained and administering successfully misoprostol alone and who do manual vacuum aspiration for post abortion care services at the health center level (MoH PAC guidelines).

Findings from the assessment also show that there a big proportion of girls and women who seek safe abortion services far from their residence (figure 6) in different districts at (21%), and in different provinces (19%). This explains the non-accessibility of safe abortion services in some district hospitals either because the district hospital is managed by faith-based organizations (religious), or because the health providers at nearby district hospital is not willing to providers safe abortion services. This explains the burden to beneficiaries, their families and community members. Receiving services far from residence areas; involve also supplementary cost for transportation, accommodation of caregivers, and etc. The adoption of the provision of safe abortion services by mid-health level providers and widening the range of health facilities allowed to provide safe abortion services will address this barrier and will release the burden to beneficiaries and their families.

The result of this assessment found that (figure7) half (50%) of women who received safe abortion services were obliged to obtain a transfer form another health facility. May be because they was obliged to present the transfer form in order to be considered for the for community health insurance; as this a normal requirement for other services and the normal flow of the health system or because women thought it is a requirements. In any case this explains complications imposed to girls and women when trying to obtain safe abortion services at the hospital level, this also can cause delay in obtaining services.

According the national protocol for safe abortion care; women should go back to the hospital in two weeks for a follow up visit. At that moment, the health providers examine and confirm the success of the method of treatment, manage any complications and provide post abortion contraception. Looking at the results of this assessment only 1% are documented that they went for follow up visit at hospital level (figure 8). This explains among other reasons that there is a difficult for girls and women to go back for a follow up visit at the district hospital level. This is due to many factors including geographical accessibility; the long distance and the transport from home to the hospital. Expanding the provision of safe abortion services at health center level will improve the adherence to post abortion follow up visit, and will improve the quality of care for girls and women specifically those living in remote rural areas and from poor families.

This assessment shows that there is no big delay due to transfer in most cases (83%), it take less than a week to reach the destination (figures 9). which is a good and acceptable time, however for 10% of women and girls it take more than a week (4% sending between 8-14 days and 6% spending more than 30days). The delay in 10% of the case is very important and could lead to an advanced age of pregnancy which might result into refusal of abortion services and expose women to complications due to rate termination of pregnancy. Allowing midlevel providers (nurses and midwives) at primary health care to provide safe abortion services will stop in most cases different kinds of delay, since the woman will be able to receive safe abortion services near home, during first days of her consultation.

The results from this assessment show that for more than half of girls and women receiving safe abortion services, the process to remove the product of conception was easy, that women were not hospitalized or had to be hospitalized less than 3 days (figure 10). This demonstrates that in most cases safe abortion is any easy process which can be handled at the health center level by mid-level health providers. The same figure 10 demonstrates that 25% spend more than 7 days which is a long time; and we cannot confirm that this was only due to the complicated process as also this might due to the delay related to the availability of the medical doctor to induce abortion; since often physician in hospital have many responsibilities, and other do not feel comfortable to provide abortion services due to their religious beliefs.

The figure 12 shows that in most of cases women and girls had to pay less than 5,000 Rwf as ticket moderateur for safe abortion services received. Even if this amount is not very high, there is other additional cost related to care which are not included in the hospital bill such as meals for the beneficiary and the caregivers, the accommodation for the caregivers and the transport to and from the hospital, which really explains a big burden to girls and women receiving safe abortion services. It was also observed that some women and girls (5%) failed completely to pay the hospital bill (ticket moderator) and other 5% were considered as indigents (not able to pay the ticket moderator).

The result of the assessment also shows that the hospital bill were less than 50,000 Rwf for 60%, and more than 50,000 in about 40% of cases. This shows a big burden to the health system and to health insurances covering health services. The adoption of the provision of safe abortion services by mid-health level providers, will allow the provision of safe abortion care services at a broader range of health facilities; including public health centers. Which will cause a reduce costs of service provision, and contribute to the financial sustainability of health system.

8. RECOMMENDATIONS AND CONCLUSION

The purpose of this assessment was to gather information and evidence on problems faced by girls and women seeking safe abortion services at district hospital level and then gaps related to inaccessibility of safe abortion services at public health center level. During the assessment, data were collected in 8 district hospitals located in different districts and provinces. We analyzed retrospectively hospital records including the hospital abortion services registers and patient files for all women who received safe abortion services at 8 selected districts hospitals during the period June 2019-October 2020.

8.1. Recommendations

The recommendations go to the decision makers including the Ministries of justice and Health and their affiliate structures and professional associations. Other recommendations go to the technical implementers and Civil Society Organizations working on Reproductive Health and Rights(SRH), Women Empowerment(WE) and Gender Equality(GE). The assessment produced the following recommendations:

8.1.1. Ministry of Justice:

Key policymakers from the MINIJUST should support and take collaborative action in advocating for amendment of the current regulations including the Ministerial order on safe abortion, to enable and regulate the task shifting practice up to midlevel health care providers. The adoption of the provision of safe abortion services by mid-health level providers should be done by revising the current regulations which permit only doctors to do the termination of pregnancy and prohibit qualified nurses and midwives from carrying out this task.

This will allow:

- The provision of safe abortion services at a broader range of health facilities; including public health centers.
- To decrease the number of referrals for safe abortion services.

- To bring services near the community, to women and girls leaving in remote areas and allow them to receive services in a timely manner.
- To reduce the cost of service provision and maximizing benefit to women and girls.
- To address the shortage of medical doctors authorized to provide abortion care.
- To improve the patient outcomes by decreasing the time to definitive care.
- To improve the clinical management of women and girls, and allow doing post abortion care (PAC) follow up.
- To contribute to the financial sustainability of health system.

The amendment of the current Law and regulations will also comply with to the World Health Organization's (WHO, 2015), safe abortion guidance recommendation, that abortion services be provided at the lowest appropriate level of the health-care system, including medical abortion up to 12 weeks completed weeks of pregnancy. The guidelines state that mid-level health workers, including midwives, nurse practitioners, clinical officers, physician assistants, and others, can be trained to provide safe, early abortion without compromising safety.

8.1.2. Ministry of Health:

- The MoH should include task shifting for safe abortion service provision into national policies to allow mid-level health providers, nurses and midwives, to offer services at health center level.
- Develop supporting structure, mentorship, supervision and training for nurses and midwives at primary health care level, required to enable nurses and midwives to provide new additional services and maintain the quality and safety of services.
- The MOH should also offer adequate resources for training and supervision for effectiveness and safety of provision of safe abortion services at primary level.
- Revise, adapt and update protocols and tools in order to support the relevant cadre's new scope of practice.
- There is a need to include in policy mechanisms that will enable continuous support in commodity supplies to enable uninterrupted delivery of these services: Ensure the supply of drugs, MVAs kits and other commodities at primary health facility level/health centers and clinics.

- Integration of safe abortion care into pre-service curricula for nurses and midwives, and in-service training strategies.

8.1.3. Implementers: Service providers, CSOs, Professional associations, and other Stakeholders

- Support initiatives, campaigns, and other advocacy interventions aimed to expand access by decentralizing safe abortion services at primary health care.
- Organize meeting to advocate for acceptability of the rationale of task shifting.
- Develop mechanisms that involve awareness creation on the provision of safe abortion services at primary health care.
- Revise the nurses and midwives task-specific competency to include Safe abortion and develop school-based training.
- Professional associations, health providers should be sensitize in order to not oppose changes in responsibilities.
- Develop mechanisms to motivate nurse and midwives to change and adopt new responsibilities.
- Conduct assessment on attitudes regarding acceptability, appropriateness and credibility and organizational implications.
- Conduct assessment to understand how women and girls perceive the use of services from mid-level health providers; assess client satisfaction through level of trusting, confidentiality and privacy.

8.2. Conclusion

The results from this assessment show that;

- About a half of girls/women who seek safe abortion services in district hospitals during the period June 2019 to October 2020 were children.
- The main reason for seeking safe abortion services is rape and the under age of 18 years old.
- Most of girls/women had a pregnancy age less than 12 weeks.

- The common used methods for termination of pregnancy are medical methods (Misoprostol alone + Combination mifepristone and misoprostol), and Manual vacuum aspiration (MVA).
- There a big proportion of girls and women who seek safe abortion services far from their residence areas; in different districts and in different provinces.
- A half of women and girls who received safe abortion services were obliged to obtain a transfer form from another health facility.
- Almost all girls and women who received safe abortion services could not go for follow up visit at hospital level.
- There is a certain level delay in receiving safe abortion services related to the fact of visiting multiple health facilities.
- For more than a half of girls and women receiving safe abortion services the process for removal of the product for conception was easy, that women were not hospitalized or had to be hospitalized less than 3 days.
- Even if in most cases women and girls had to pay less that 5,000 Rwf as ticket moderateur, it was not possible for some girls/women to pay that cost.
- The hospital bill for provision of safe abortion services is high and there is a burden to the health system.

Above findings confirm that limiting the provision of abortion care services to doctors in district hospitals result into unequal access among Rwanda girls and women. Revising the current Law and regulation which permit only doctors to do the termination of pregnancy and prohibit qualified mid-level health providers; nurses and midwives is possible and needed. The revision will allow the provision of safe abortion care services at a broader range of health facilities, a reduce cost of services, reduced burden to the health system, maximizing benefit to women and girls and an increased availability of abortion services.

REFERENCES

1. Basinga Paulin et all. 2012. Abortion Incidence and Postabortion Care in Rwanda, 2012
2. World Health Organization (WHO). 2003. Managing Complications in Pregnancy and Childbirth: A Guide for Midwives and Doctors. Geneva.
3. Department of Reproductive Health and Research World Health Organization, Health worker role in providing safe abortion care and post abortion contraception. 2015, Geneva: World Health Organization.
4. Kanyesigye, Frank. 2011. “Clinic closed over abortion.” The New Times, 23 July.
5. Kwizera, Charles. 2011. “Long sentences for abortion counterproductive—Karugarama.” The New Times, 4 May.
6. Levandowski, Brooke, Edgar Kuchingale, Linda Kalilani-Phiri, et al. 2011. “The estimated incidence of abortion in Malawi.” Paper presented at the Annual Meeting of the Population Association of America, Washington, DC, 31 March.
7. Rwanda Penal Code 2012 and 2018
8. Ministry of Health/Rwanda, National Guideline on Safe Abortion. 2019, Ministry of Health: Kigali.
9. World Bank, 2016. https://data.worldbank.org/country/Rwanda. Accessed on 21/05/2018
10. International Human Development Indicators. United Nations Development Programme, Human Development Reports, 2016. http://hdr.undp.org/en/countries/profiles/RWA. Accessed on 21/05/2018
11. Social Progress Index, 2017. https://www.socialprogressindex.com. Accessed on 21/05/2018.
12. Health Sector Policy, 2015. http://www.moh.gov.rw/fileadmin/templates/policies/Health_Sector_Policy___19th_January_2015.pdf
13. NISR, MOH , Demographic Health Survey (2005-2015)
14. Rwanda Ministry of Health. Health Sector Policy, July 2014.
15. Tilahun, Marelign, and Gistane Ayele. "Factors associated with age at first sexual initiation among youths in Gamo Gofa, south west Ethiopia: a cross sectional study." *BMC Public Health* 13.1 (2013): 1.
16. Behavioral Surveillance Survey Among Youth Aged 15 - 24 Years in Rwanda
17. Morris, Jessica L., and Hamid Rushwan. "Adolescent sexual and reproductive health: The global challenges." *International Journal of Gynecology & Obstetrics* 131 (2015): S40-S42.

18. Rapid Assessment of Adolescent Sexual Reproductive Health Programs, Services And Policy Issues in Rwanda, December 2011.
19. RMNCAH Policy 2018
20. Family Planning Policy 2012
21. ASRH&R Policy 2011
22. ASRH manual 2011
23. Rwanda National Strategy for Transformation
24. The Law on medical professional liability insurance, 28/04/2013.
25. Human Reproductive Health Law, 20/05/ 2016
26. Reproductive, Maternal, Newborn, Child and Adolescent Health Policy 2018
27. Ministerial Order determining conditions to be satisfied for a medical doctor to perform an abortion, 08 April 2019.
28. www.moh.gov.rw