National Protocol for Operationalization of Exemptions for Abortion in the Penal Code of 2012
# Table of Contents

Table of Contents ................................................................. ii  
Acknowledgements .................................................................... iii  
List of Acronyms ....................................................................... iv  
1. Introduction ........................................................................... 5  
  1.1 Reducing Maternal Morbidity and Mortality Through Addressing Unsafe Abortions .............................................. 5  
  1.2 Penal Code of 2012 and Program Services for the Provision of Safe Abortion Services Within the Legal Framework .............................................. 6  
  1.3 Components of Safe Abortion Services within the Legal Framework ................................................................. 7  
2. Diagnosis and Management ................................................... 8  
  2.1 Definitions of Abortion .......................................................... 8  
  2.2 Management of Termination of Pregnancy ................................................. 10  
3. Legal Aspects and Procedures for Termination of Pregnancy .......................................................................................... 13  
  3.1 Legal Definitions of Gender Based Violence, Rape, Incest, and Forced Marriage ................................................................. 13  
  3.2 Victim's Rights to Choice .......................................................... 14  
  3.3 Investigative (Forensic) Interview ........................................... 15  
  3.4 Medico-Legal (Forensic) Examination Procedure .................... 17  
  3.5 Police and Legal Investigative Services ................................... 18  
  3.6 Legal Procedures to Follow Before the Provision of Termination of Pregnancy ................................................................. 19  
4. Service Delivery Overview and Protocols for Health Facilities for Termination of Pregnancy ................................................................. 20  
  4.1 Termination of Pregnancy Service Delivery Overview and Protocols for Hospitals ................................................................. 20  
  4.2 Criteria for the Selection of the Method for Termination of Pregnancy ................................................................. 23  
5. Methods for Uterine Evacuation ................................................ 24  
  5.1 Uterine Evacuation with Manual Vacuum Aspiration .................. 24  
  5.2 Uterine Evacuation with Medical Methods .................................. 33  
6. Postabortion Family Planning .................................................. 38  
7. Pre and Post Abortion Psychosocial Counseling for Women ............ 39  
  7.1 Psychological Management of GBV Survivors ......................................... 40  
  7.2 Assessing the Victim's Risk of Being Severely Wounded, Committing Suicide or Being Killed ................................................................. 41  
  7.3 Rape Trauma Syndrome ......................................................... 43  
  7.4 Provision of Information ......................................................... 45  
  7.5 Developing a Safety Plan ......................................................... 45  
  7.6 Developing a Follow-Up Plan .................................................... 45  
8. Roles and Responsibilities for a Coordinated Service and Multidisciplinary Case Management ................................................................. 47  
9. Monitoring, Evaluation and Supervision of Abortion-Related Services ................................................................. 49  
  9.1 Monitoring, Evaluation and Supervision Overview ......................... 49  
  9.2 Indicators to be Used for Monitoring and Evaluation .................. 50  
  9.3 Monitoring & Reporting Use of Misoprostol and Mifepristone-Misoprostol Combination Pack ................................................................. 52  
10. Appendices ............................................................................ 54  
  10.1 Checklist for Manual Vacuum Aspiration for Uterine Evacuation .................. 54  
  10.2 Checklist for Medical Abortion with Combined Regimen (Mifepristone and Misoprostol) ................................................................. 57  
  10.3 Checklist for Postabortion Family Planning .......................................... 59
ACKNOWLEDGEMENTS

The Ministry of Health would like to thank the following people for their contributions to the development of the National Protocol for Operationalization of Exemptions for Abortion in the Penal Code of 2012.


CHUK/University of Rwanda
BAGAMBIKI Patrick

BAZIGABA Jean Claude Haguruka

BAZIRETE Olive UR/CMHS

BUGINGO Spencer Ministry of Health

DUSHIMEYEZU Evangeline VSI

HAKIZIMANA Xavier RPH

HODOGLUGIL Nuriye VSI

INDOS Noah Partners in Health Kabgayi District

KABILWA Gabriel Hospital

KANYAMANZA Eugene Ministry of Health

KANYAMIKORE William Gisenyi DH

KARIBUSHI Bizimana Jean CHUB

MALIVULA Lee Gisenyi Hospital

MIRIMO Jean Ministry of Health

MIVUMBI Victor Ministry of Health

MUGANDA John King Faisal Hospital

MUHIRE Mathias MUHIMA DH

MUHONGERWA Agnes NPPA

MUKANDEKEZI Deogracias Ruhengeri Hospital

MUKASINE Caroline Ministry of Health

MUNYANGABE Froduard Ministry of Justice Kacyiru Police

MUNYANKINDI Laurent Hospital

NDAGIJIMANA Sylvestre Kibilizi DH

NGOGA Eugene RSOG

NYABIENDA Laurient ARBEF

PACE Lydia Partners in Health

POLEPOLE Marcel GIHUNDWE DH

RWABUKERA Fidele RBC/MPDD

SAYINZOGA Felix Ministry of Health

SEMPABWA Emile Consultant
TRAN Dat  VSI
UMUTONI Natalie  Ministry of Health
UMUZIGA M Providence  UR/CMHS
UWIMANA Chantal  UR/CMHS
              Rwanda National
UWIMANA Daniel  Police
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDS</td>
<td>Acquired immune deficiency syndrome</td>
</tr>
<tr>
<td>CD</td>
<td>Controlled drugs</td>
</tr>
<tr>
<td>CMS</td>
<td>Central Medical Store</td>
</tr>
<tr>
<td>D&amp;C</td>
<td>Dilatation &amp; curettage</td>
</tr>
<tr>
<td>D&amp;E</td>
<td>Dilatation &amp; evacuation</td>
</tr>
<tr>
<td>EVA</td>
<td>Electric vacuum aspiration</td>
</tr>
<tr>
<td>FP</td>
<td>Family planning</td>
</tr>
<tr>
<td>GBV</td>
<td>Gender based violence</td>
</tr>
<tr>
<td>HIV</td>
<td>Human immunodeficiency virus</td>
</tr>
<tr>
<td>HMIS</td>
<td>Health management information systems</td>
</tr>
<tr>
<td>IUD</td>
<td>Intrauterine device</td>
</tr>
<tr>
<td>LMP</td>
<td>Last menstrual period</td>
</tr>
<tr>
<td>MA</td>
<td>Medical abortion</td>
</tr>
<tr>
<td>MDIIT</td>
<td>Multidisciplinary Investigative and Intervention Team</td>
</tr>
<tr>
<td>MMR</td>
<td>Maternal mortality ratio</td>
</tr>
<tr>
<td>MOH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>MTVGBVCAP</td>
<td>Multidisciplinary Treatment of Victims of Gender-based Violence and Child Abuse Protocol</td>
</tr>
<tr>
<td>MVA</td>
<td>Manual vacuum aspiration</td>
</tr>
<tr>
<td>OSC</td>
<td>One stop center</td>
</tr>
<tr>
<td>PAC</td>
<td>Postabortion care</td>
</tr>
<tr>
<td>POC</td>
<td>Products of conception</td>
</tr>
<tr>
<td>PTSD</td>
<td>Post-traumatic stress disorder</td>
</tr>
<tr>
<td>RTS</td>
<td>Rape trauma syndrome</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually transmitted infection</td>
</tr>
<tr>
<td>VA</td>
<td>Vacuum aspiration</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
</tbody>
</table>
1. INTRODUCTION

1.1 Reducing Maternal Morbidity and Mortality Through Addressing Unsafe Abortions

Worldwide, 21.6 million unsafe abortions occurred in 2008, of which approximately 6.2 million, or 29%, were in Africa (WHO 2010). It is also estimated that 47,000 women per year lose their lives due to complications of unsafe abortion, almost all of which could have been prevented (WHO, 2010). The International Conference on Population and Development in Cairo in 1994 encouraged governments to address unsafe abortion as an urgent public health problem and to provide treatment of incomplete abortion (United Nations, 2004).

Complications from unsafe abortion pose a significant public health challenge in Rwanda. Based on results from a national-level study, which includes data from 165 facilities in Rwanda, representative of all facilities providing PAC in 2009, the rate of abortion complications at facilities was estimated at 10.7 per 1,000 women aged 15-44 years old (Basinga et al. 2012).

Since 2000, Rwanda has made significant progress to reduce its maternal mortality ratio (MMR) from 1,071 to 476 per 100,000 live births in 2010 (DHS, 2010). Furthermore, as part of the National Vision 2020 goal, the Rwanda Ministry of Health (MOH) has also committed to reducing the MMR to 200 by the year 2020. Therefore, while progress has been made, the maternal mortality figures remain high, and programs to reduce maternal mortality are still needed. The Rwanda Road Map to Accelerate the Reduction of Maternal and Neonatal Morbidity and Mortality highlights strategic objectives and priority interventions to reach MMR goals, including prevention of unsafe abortion-related morbidity and mortality (MOH, 2013). In addition, the Guidance Document to Operationalize the Exemptions for Abortion in the Penal Code of 2012, provides specific guidance for the implementation of changes brought about in the Penal Code of 2012 to address abortion related mortality (MOH, 2014).

The MOH of Rwanda has launched the Comprehensive Postabortion Care Program in 2012, with the goal to expand access to PAC services by introducing misoprostol tablets for the treatment of incomplete abortion at all levels of facilities with a referral system, as well as vacuum aspiration (to include manual vacuum aspiration-MVA, and electric vacuum aspiration-EVA) for emergency treatment in hospitals and health centers. Major success has been achieved with the Comprehensive PAC Program since 2012, and currently the Program is being scaled-up nationwide with ongoing support from partners. The National Treatment Protocol for Comprehensive Postabortion Care Services and supporting training materials including the Reference Guide, Trainers Guide and Participants Guide were developed as part of the program.

The current protocol was developed to include further information on the provision of safe abortion within the legal framework, as outlined in the Penal Code of 2012 (Republic of Rwanda, Organic Law N° 01/2012/OL of 02/05/2012 Organic law instituting the Penal Code, Official Gazette, special issue, June 14, 2012). The National Protocol for the Operationalization of Exemptions for Abortion in the Penal Code of 2012 includes basic information and guidelines for providing safe abortion services within the legal framework. For comprehensive service provision including safe abortion services and
postabortion care services, this protocol is intended to be used along with the National Treatment Protocol for Comprehensive Postabortion Care Services.
1.2 Penal Code of 2012 and Program Services for the Provision of Safe Abortion Services Within the Legal Framework

While abortion is prohibited in Rwanda, the Penal Code of 2012 published on June 14th provides exemptions for abortion (Republic of Rwanda, Organic Law N° 01/2012/OL of 02/05/2012 Organic law instituting the Penal Code, Official Gazette, special issue, June 14, 2012). In an effort to abide by the Maputo Protocol (Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa, 2003), which Rwanda ratified in 2005, the Penal Code of 2012 provides exemptions from criminal liability for abortion, as specified in articles 162 through 167 of the Penal Code (Section 5: Crime of Abortion): in cases of rape; incest up to the second degree; forced marriage; or when the pregnancy severely jeopardizes the health of the unborn baby or that of the pregnant mother.

The specific articles of Section 5; Crime of Abortion are provided below:

**Article 162: Self-induced abortion**

Any person who carries out self-induced abortion shall be liable to a term of imprisonment of one (1) year to three (3) years and a fine of fifty thousand (50,000) to two hundred thousand (200,000) Rwandan francs.

**Article 163: Causing a woman to abort with or without her consent**

Any person who causes a woman to abort without her consent shall be liable to a term of imprisonment of ten (10) years to fifteen (15) years. In case of mutual consent, a person who causes a woman to abort shall be liable to a term of imprisonment of two (2) years to five (5) years. Any person who, through recklessness or negligence causes a woman to abort shall be liable to a term of imprisonment of six (6) months to one (1) year and a fine of two hundred thousand (200,000) to five hundred thousand (500,000) Rwandan francs or one of these penalties.

**Article 164: Abortion resulting in death**

A person who administers, delivers or orders a substance which he/ she knows the effect, to a woman and causes abortion which results into death shall be liable to a term of imprisonment of fifteen (15) years to twenty (20) years, if the woman had consented to the abortion or to life imprisonment, and a fine of two hundred thousand (200,000) to two million (2,000,000) Rwandan francs, if such a woman had not consented to the abortion.

**Article 165: Exemption from criminal liability for abortion**

There is no criminal liability for a woman who commits abortion and a medical doctor who helps a woman to abort if one of the following conditions is met: 1° when a woman has become pregnant as a result of rape; 2° when a woman has been subjected to forced marriage; 3° when a woman has become pregnant due to incest in the second degree; 4° when the continuation of pregnancy seriously jeopardizes the health of the unborn baby or that of the pregnant woman. The exemption from criminal liability under items 1°, 2° and 3° of Paragraph One of this Article shall be permitted only if the woman who seeks abortion submits to the doctor an order issued by the competent Court recognizing one of the cases under these items, or when this is proven to the Court by a person charged of abortion. The Court where the complaint is filed shall hear and make a decision as a matter of urgency.
Article 166: Requirements for exemption from criminal liability for a medical doctor who performs an abortion or a woman who consents to an abortion

A medical doctor who performs an abortion or a woman who consents to an abortion or her legally recognized representative if she cannot decide for herself whether to abort is not criminally liable in accordance with item 4° of Paragraph One of Article 165 of this Organic Law if the following conditions are met: 1° after the medical doctor finds that continuation of the pregnancy would seriously endanger the health of the woman or that the unborn child cannot survive; 2° the medical doctor has sought advice from another doctor where possible, and: a. the medical doctor makes a written report in three (3) copies signed by him/herself and the doctor he/she consulted; b. one copy is given to the interested party or her legal representative if she cannot decide for herself; c. another copy is kept by the medical doctor who consulted her; d. the third copy is given to the hospital medical director.

Article 167: Self-induced abortion or performing abortion to another person by a medical professional

For offences provided for under Articles 162 and 163 of this Organic Law, if the offender is a medical doctor, a midwife or a pharmacist, he/she shall be liable to an additional penalty of suspension from exercising his/her profession for a period of three (3) years to five (5) years. In case of recidivism, the suspension from exercising the profession shall become definitive. A person, who contravenes the provisions of Paragraphs One and Two of this Article, shall be liable to a term of imprisonment of more than five (5) years to seven (7) years.

Article 168: Advertising means of abortion

Any person who, by any means, advertises drugs, materials and any other substances believed to induce abortion shall be liable to a term of imprisonment of six (6) months to two (2) years and a fine of one million (1,000,000) to three million (3,000,000) Rwandan francs or one of these penalties.

1.3 Components of Safe Abortion Services within the Legal Framework:

The following are the components of safe abortion services within the legal framework:

1. Termination of pregnancy, as specified in the Penal Code of 2012 (rape, incest and forced marriage)
2. Emergency termination of pregnancy ("therapeutic abortion") when the pregnancy severely jeopardizes the health of the unborn baby or that of the pregnant woman
3. Streamlined procedures for the provision of legal support and services for obtaining court orders
4. Psychosocial and gender based violence prevention services to women
5. Family planning counseling and service provision, and where there is prevalence and resources are available, STI evaluation and treatment and HIV counseling and/or referral for testing
6. Community awareness and mobilization on prevention of unsafe abortion and Penal Code of 2012 for the current exemptions for abortion

Overarching principles for provision of safe abortion services:
• All women should be informed about their right to terminate a pregnancy within the legal framework, and they should be supported to make the final decision to keep or terminate the pregnancy
• Abortion should be provided under safe conditions by trained providers to all eligible women with the use of most up-to-date, safe and effective methods
• For legal termination of pregnancy cases (i.e. rape, incest and forced marriage), abortion services should be provided as early as possible to avoid increased risk to women
• Police and judicial components of the service should be expedited to avoid unnecessary and potentially high risk delays
• Confidentiality, prevention of stigma and discrimination against women who may use abortion services should be a key component of services
• High quality services require a multidisciplinary approach with collaboration of all stakeholders involved, as well as generation of community awareness and participation
2. DIAGNOSIS AND MANAGEMENT

2.1 Definitions of Abortion

Threatened abortion
Threatened abortion usually refers to vaginal bleeding during the first 22 weeks of pregnancy (WHO, 2008). Bleeding may be scanty, with or without low backache and cramp-like pains (WHO, 2007). The pain may resemble that experienced during a menstrual period. The cervix remains closed and the uterus is soft with no tenderness when palpated. The size of the uterus corresponds to the dates of gestational age. The symptoms may continue over a period of time.

- Generally, no medical treatment is necessary.
- Advise the patient to avoid activities requiring effort as well as sexual intercourse. It is not necessary that she stay in bed.
- If bleeding resumes, re-examine her for further assessment.
- If bleeding continues, assess fetal viability (or search for an ectopic pregnancy using ultrasound scan. Persistent bleeding, particularly if the uterus is too big for the term of pregnancy, can indicate the presence of twins or a molar pregnancy.

Inevitable abortion
This condition presents with vaginal bleeding that may be heavy, with clots or the gestational sac containing the embryo or fetus. The membranes can rupture at this time, and amniotic fluid will be present. The cervix dilates, and tissue or clots may be seen in the vagina or protruding through the cervical opening. Blood loss may be excessive. The pain during miscarriage may be as intense as during labor. The mother may present in a state of shock that is out of proportion to the revealed blood loss. This is caused by products of conception becoming trapped in the cervix and will resolve with their removal. Therefore, it will result in an incomplete or complete abortion.

- If pregnancy is ≤ 16 weeks, plan to evacuate the contents of the uterus. Misoprostol 400 mcg by mouth (repeated once after four hours if necessary)
- Use other evacuation methods as needed
- If pregnancy is > 16 weeks:
  - Wait for spontaneous expulsion of the products of conception and, if necessary, evacuate the intrauterine products of conception;
  - If necessary, infuse a drip of diluted 20 units of oxytocin in 500 ml of intravenous solution (serum physiologic or Ringer lactate); perfuse at a rate of 40 drops per minute to facilitate the expulsion of the products of conception.

Ensure follow-up of the patient after treatment.

Incomplete abortion
Treatment of incomplete abortion is one of the core elements of PAC (Corbett and Turner, 2003; Curtis, 2007; Postabortion Care Consortium Community Task Force, 2002; USAID PAC Working Group, 2010). It occurs when there are retained products of conception (POC) after induced abortion (whether by unsafe or safe methods) or after spontaneous abortion, also known as miscarriage. If not addressed promptly, an incomplete abortion
may result in excessive bleeding and/or infection and lead to more serious, life-threatening problems (WHO, 1991).

Typical presenting signs of incomplete abortion are:
- Vaginal bleeding
- Dilated cervix
- Uterus smaller than indicated by date of last menstrual period

Signs and symptoms that are sometimes present are:
- Cramping or lower abdominal pain
- Partial expulsion of products of conception

For the treatment of incomplete abortion up to 13 weeks gestational size, the recommended methods are misoprostol 600 mcg oral single dose or MVA. Please refer to the National Treatment Protocol for Comprehensive Postabortion Care Services for details of service provision guidelines to treat incomplete abortion.

Complete spontaneous abortion

This occurs when the conceptus, placenta and membranes are expelled spontaneously and completely from the uterus. The pain stops and signs of pregnancy regress. The uterus is firmly contracted on palpation.
- It is not necessary to evacuate the uterine cavity. Make the woman feel at ease about that topic. No further medical intervention is required, although support through the aftermath of pregnancy loss should be available.
- Conduct counseling and ensure the provision of family planning and other health reproductive services.

Septic abortion

Septic abortion is defined as an abortion having infectious complications. If pathogens appear in the lower genital tract as a result of a spontaneous abortion or an abortion performed in unsafe conditions and then spread throughout the body, the infection can turn into sepsis. The risk of sepsis is greater if the products of conception are retained in utero and are slowly evacuated. Sepsis is a common complication of instrumental abortion practiced in unsafe conditions.

In cases of suspected abortion in unsafe conditions, look for signs of infection or traumatic vaginal, uterine or intestinal lesions and thoroughly irrigate the vagina to remove all herbal preparations, local medications or caustic substances that may be present.

Missed Abortion

Missed abortion in the first trimester is characterized by the arrest of embryonic or fetal development. The cervix is closed and there is no or only slight bleeding. Ultrasound examination shows an empty gestational sac or an embryo/fetus without cardiac activity.

A single dose of misoprostol 800 mcg vaginal or 600 mcg sublingual, every 3 hours, maximum 2 doses) may be offered as an effective, safe, and acceptable alternative to the traditional surgical treatment for this indication. After administration of misoprostol, hospitalization is not necessary and the time to expulsion varies considerably. Bleeding may last for more than 14 days with additional days of light bleeding or spotting, and the woman should be advised to contact a provider in case of heavy bleeding or signs of infection. A follow-up is recommended after 1 to 2 weeks.
Termination of Pregnancy per Penal Code of 2012

a) Therapeutic abortion

In Rwanda, a pregnancy can legally be terminated when the pregnancy poses a severe risk to the health of the pregnant mother, or when the fetus has severe health conditions. The medical decision for pregnancy termination when pregnancy poses severe risk to the unborn baby or to pregnant woman is made by the obstetrician and gynecologist, and should follow the procedures outlined in this protocol. A court order is not required for these circumstances, and there is no limitation of gestational age for pregnancy termination.

b) Termination of pregnancy, when the pregnancy is a result of rape; incest up to the second degree; or forced marriage

When the conditions as described in the Penal Code of 2012 are fulfilled, including provision of a court order, pregnancies as a result of rape, incest up to the second degree or forced marriage can be terminated up to 22 weeks of gestational age. Special exceptions can be provided for pregnancies beyond 22 weeks, based on the assessment of the individual situation of the patient. Young women under the age of 18, who become pregnant are also considered as child defilement (according to Article 3 of Law No: 54 of 14/12/2011 Relating to the Rights and the Protection of Children and Article 190 of the Penal Code), and should be treated as rape cases. Section 3 on Legal Aspects of Pregnancy Termination provides further details.

2.2 Management of Termination of Pregnancy

If it is an emergency, the provider should refer to Section 2.2.8

2.2.1 Psychosocial assessment

A. Confirm that the woman was provided psychosocial counseling for her condition
B. Identify if she has other psychosocial needs and link her with available services

2.2.2 Legal assessment

A. Review records to confirm legal procedures have been completed accordingly
B. If legal procedures are not complete: link women immediately with legal support and other services for completion of procedures and provide additional information and support to woman and her family as needed
C. Obtain informed consent from woman and/or her family

2.2.3 Clinical history and examination

A. Obtain history
   1. History of current pregnancy
      a) Last menstrual period (LMP)
      b) Pregnancy symptoms
   2. Bleeding or clotting disorders
   3. Drug allergies
   4. History of previous pregnancies (ectopic pregnancy, miscarriage, live births, fetal deaths)
   5. Acute or chronic illness or conditions (including malaria, HIV/AIDS, other sexually transmitted infections (STIs))
B. Ancillary testing (if indicated and available)
1. Hemoglobin or hematocrit
2. Ultrasound is not routinely needed
3. If pregnancy test is available, it can be used to confirm the diagnosis. However, pregnancy testing is not routinely needed to provide treatment.
4. Blood typing and Rh immunoglobulin can be done, if available
5. Sexually transmitted disease screening: HIV, Hepatitis B, RPR

C. Perform physical exam
   1. Vital signs: blood pressure, temperature, pulse, and respiratory rate
   2. General appearance: pallor, level of energy and alertness, ambulatory, no indication of acute distress
   3. Speculum exam
      a) Discharge from cervical opening
   4. Pelvic exam
      a) Uterine size, tenderness
      b) Cervical motion tenderness
      c) Adnexal mass suggestive of ectopic pregnancy

Note: Determining the gestational age is a critical factor in selecting the most appropriate termination method. History of last menstrual period, bimanual pelvic examination, abdominal examination and recognition of symptoms of pregnancy are usually adequate to establish gestational age. Laboratory or ultrasound testing may also be used, if needed (WHO 2012)

2.2.4 Assessment and diagnosis

   A. Assess whether the woman is in stable condition (See section 2.2.8 for Emergency assessment and care, and refer patient accordingly for emergency cases)

   B. Confirm the diagnosis of pregnancy and gestational age

   A uterus that is smaller than expected may indicate:
   • The woman is not pregnant
   • Inaccurate menstrual dating
   • Ectopic pregnancy or abnormal intrauterine pregnancy, e.g. spontaneous or missed abortion

   A uterus that is larger than expected may indicate:
   • Inaccurate menstrual dating
   • Multiple gestation
   • Uterine anomalies, such as fibroids
   • Molar pregnancy

2.2.5 Treatment

The methods used for termination of pregnancy are:

<table>
<thead>
<tr>
<th>Medical methods</th>
<th>Surgical methods</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Combined regimen</td>
<td>1) Vacuum Aspiration (VA), manual or electric</td>
</tr>
<tr>
<td>(mifepristone and misoprostol)</td>
<td>2) Dilatation &amp; Evacuation (D&amp;E)</td>
</tr>
<tr>
<td>2) Misoprostol alone (where mifepristone is not available)</td>
<td>3) Dilatation &amp; Curettage (D&amp;C)</td>
</tr>
</tbody>
</table>

WHO recommends both vacuum aspiration and medical methods for termination of pregnancy (WHO 2012). Both mifepristone and misoprostol are included in the WHO Essential Drugs List for abortion (WHO 2009). Dilatation and curettage (D&C) is an obsolete method of surgical abortion and should be replaced by vacuum aspiration and/or medical methods (WHO 2012).
2.2.6 Contraception after termination of pregnancy

All patients should be counseled on contraceptive methods and ideally provided a method of their choice before they leave the health facility, as fertility may return as soon as within 10 days of treatment. Contraceptive counseling should also be routinely provided for women who undergo therapeutic abortion. Contraceptive services should be provided at the same site with pregnancy termination services to increase uptake. Postabortion contraceptive method use is the same after treatment of incomplete abortion or therapeutic termination of pregnancy.

A. Hormonal contraception (e.g., oral contraceptive pills, implants and injectables) can be given at the clinic on the day medical treatment is provided for PAC (misoprostol), or for therapeutic abortion, at the same time that the first pill is given, regardless of the regimen used (WHO 2012). Similarly, after surgical treatment with MVA or other medical/surgical procedure, hormonal contraception can be initiated on the same day. Hormonal methods can be started even if infection is present, while at the same time, treating for infection.

B. When medication is used for the treatment of incomplete abortion or for pregnancy termination, an intrauterine device (IUD) can be inserted when successful treatment is confirmed at the follow-up visit. When VA is used for uterine evacuation, an IUD can be inserted on the same day immediately after the procedure. In case of confirmed infection, or if the provider suspects an infection, insertion of the device can be delayed until the follow-up visit to make sure that all traces of infection have disappeared.

C. Condoms can be given the day treatment is provided with any methods.

D. Emergency contraceptive pills may be given in advance as a back-up method.

E. Female or male sterilization can be provided at a follow-up visit.

2.2.7 Follow-up after termination of pregnancy

A. Schedule a follow-up visit one to two weeks following treatment

B. History suggestive of successful treatment:
   1. For women who are treated with medical abortion: they may experience bleeding ranging from lighter than a menstrual period to much heavier than a menstrual period after taking the tablets, usually with passage of clots or tissue.
   2. For women who are treated with vacuum aspiration; they may have slight bleeding or spotting for the next 1-2 weeks after the procedure which gradually subsides.
   3. Pregnancy symptoms have lessened or disappeared; she no longer feels pregnant.

C. Physical exam suggestive of successful treatment:
   1. Minimal or absent bleeding
   2. Normal uterine size (small, firm)
   3. Non-tender uterus and adnexae and no cervical motion tenderness.
4. Closed cervical opening

D. At the follow-up visit, if findings show that abortion may be incomplete and the woman is clinically stable, follow the procedures for treating incomplete abortion as outlined in the National Treatment Protocol for Comprehensive Postabortion Care Services.

E. All women should be given contraceptive counseling and advice at the follow-up visit as well. She should be asked about her current contraceptive method and given any additional information on the use of the method. Those women who are not currently on a method should be offered an effective method before they leave the clinic.

2.2.8 Emergency assessment and care

A. Rapid initial assessment for shock if woman appears to be frankly hemorrhagic, losing consciousness, near collapse, septic, etc.
   1. Check vital signs (blood pressure, pulse, temperature, respiratory rate)
   2. Signs of shock:
      a) Fast, weak pulse (rate > 110 beats per minute)
      b) Low blood pressure (diastolic <60)
      c) Pallor (generally very pale, pallor of palms or around the mouth)
      d) Sweatiness
      e) Rapid breathing (respiration > 30 per minute)
      f) Anxiety, confusion or unconsciousness
      g) Frank, profuse hemorrhage

B. If the woman is in shock or clinically unstable:
   1. If woman is conscious or family member is present, confirm if woman:
      a) Is on current medications
      b) Has any serious health conditions
      c) Has known allergies
   2. Proceed immediately to stabilize the woman:
      a) IV fluid volume replacement with large-bore IV catheter
      b) Oxygen by mask if available
      c) If sepsis is suspected, blood and cervical cultures if possible
      d) Broad-spectrum IV antibiotics if indicated
      e) Uterine evacuation as soon as possible, if indicated
      f) Determine underlying etiology of shock and treat accordingly, e.g. intra-abdominal injury or ruptured ectopic pregnancy.

C. Transfer to a reference hospital
   1. If woman requires transfer to a facility that can provide higher-acuity care, she may need stabilization and volume replacement with IV fluids before/during transport.
   2. Complete the register and the referral form. Notify referral facility that woman is being transported and give report on her diagnosis and condition.
   3. Arrange for the management of other reproductive health problems and conditions according to the local protocols.

3. LEGAL ASPECTS AND PROCEDURES FOR TERMINATION OF PREGNANCY

No one agency or professional alone is fully equipped to prioritize the wellbeing of a victim of violence and balance the demands of justice. With the exception of therapeutic abortion, the legal exemptions for safe abortion in Rwanda (rape, incest and forced marriage) fall under the
category of gender based violence (GBV). Therefore, termination of pregnancy services for those cases will follow the Multidisciplinary Investigative and Intervention Team (MDIIT) Model as outlined in the Protocol for Multidisciplinary Treatment of Victims of Gender-based Violence and Child Abuse Protocol (MTGVBCAP), which adapts the evidence-based, best practice protocols for working with victims of child, domestic and gender-based violence. The MDIIT model was developed to aid police, medical, psychosocial and legal service providers in working together with the highest level of collaboration to respond with the timeliness, objectivity, comprehension and precision required to best serve the physical, mental health, social protection and legal needs of the victim. The methodology described in the MTGVBCAP methodology aims to minimize further traumatization of the victim and includes One Stop Centers, locations where victims can access multiple services. One Stop Centers are important points of entry for victims requesting abortion as they are set up to deliver specialized care from the point of first contact. Research has shown this model to afford the victim the best possible outcome from the investigative and intervention process.

3.1 Legal Definitions of Gender Based Violence, Rape, Incest, and Forced Marriage

Gender Based Violence:

Article 3 of LAW N°59/2008 OF 10/09/2008 ON PREVENTION AND PUNISHMENT OF GENDER- BASED VIOLENCE defines gender based violence as any act that results in a bodily, psychological, sexual and economic harm to somebody just because they are female or male. Such act results in the deprivation of freedom and negative consequences. This violence may be exercised within or outside households.

Rape:

According to Penal Code of 2012, Article 196, rape means causing another person to engage in a non-consensual sexual intercourse by using force, threat or trickery. The perpetrator of rape is liable to a term of imprisonment for 5-15 years, or to life imprisonment if the rape results in the death of the victim. Article 198 defines marital rape as any act of sexual intercourse committed by one spouse on the other by violence, threat or trickery, which is punishable by law by up to 10 years of imprisonment, or to life imprisonment if the rape results in the death of the victim.

Rape of children (women under the age of 18):

According to Article 3 of LAW N°54/2011 OF 14/12/2011 RELATING TO THE RIGHTS AND THE PROTECTION OF CHILDREN, a child is defined as any person under the age of eighteen years. In addition, according to Article 190 of the Penal Code, pregnancies of children (women younger than 18) fall under rape, as per the “child defilement” definition below:

Child Defilement: Any sexual intercourse or any sexual act with a child regardless of the form or means used. Article 191 defines the penalty for child defilement, which is: any person who commits child defilement, shall be liable to life imprisonment with special provisions. According to article 192 (Child defilement by a person having authority over the child), if child defilement is committed by his/her parent or guardian, a representative of the administrative authority, a representative of the religious authority, a security officer, a medical professional, a teacher, a trainee or any person who has abused his/her position or
authority over a child, the offender shall be liable to life imprisonment with special provisions and a fine of one hundred thousand (100,000) to five hundred thousand (500,000) Rwandan francs. It is also noted that actions relating to the protection of a child's rights and the fight against sexual violence shall be exempted from paying court fees.

Article 197: Penalty for rape on a person aged eighteen (18) years or above

Any person who rapes a person aged eighteen (18) years or above shall be liable to a term of imprisonment of more than five (5) years to seven (7) years. If rape is committed on an elderly person, a person with disability or a sick person, the penalty shall be a term of imprisonment of seven (7) years to ten (10) years and a fine of five hundred thousand (500,000) to one million (1,000,000) Rwandan francs. If rape results in an incurable disease for the victim, the offender shall be liable to a term of imprisonment of ten (10) years to fifteen (15) years. If rape results in the death of the victim, the offender shall be liable to life imprisonment.

Marital rape

Per penal code of 198, marital rape is defined any act of sexual intercourse committed by one spouse on the other by violence, threat or trickery. Penal code 199 defines the penalty for marital rape:

Any person who commits marital rape shall be liable to a term of imprisonment of at least two (2) months but less than six (6) months and a fine of one hundred thousand (100,000) to three hundred thousand (300,000) Rwandan francs or one of these penalties. If marital rape results in an ordinary disease, the offender shall be liable to a term of imprisonment of six (6) months to two (2) years. If marital rape results in an incurable illness, the offender shall be liable to a term of imprisonment of more than five (5) years to ten (10) years. If marital rape results in the death of the victim, the offender shall be liable to life imprisonment.

Penal code article 200 defines prosecution of marital rape:

The prosecution of marital rape shall be instituted only upon complaint of the offended spouse. The offended spouse may, at any stage of the procedure, apply for the termination of the prosecution, when he/she withdraws his/her complaint. The offended spouse may also demand that the execution of the judgment be terminated in the best interest of the family.

Incest:

Incest is defined as engaging in sexual intercourse between people having a family relation. Incest in the 1st degree includes sexual intercourse with parents, siblings, or children, who share half of their genes. Incest in the 2nd degree includes sexual intercourse with uncle, aunt, nephew, niece, grandparents, grandchildren, or half sibling, who share around one quarter of their genes. (National Genetics and Genomics Education Center)

Forced marriage

Article 195 of the Penal code defines forced marriage as participating in early or forced marriage of a minor. Any person who plays a role in early or forced marriage of a minor shall be liable to a term of imprisonment of
six (6) months to two (2) years and a fine of one hundred thousand (100,000) to three hundred thousand (300,000) Rwandan francs.

Obligation to denounce violence and mistreatments against the child: According to Article 28 of LAW N°54/2011 OF 14/12/2011 RELATING TO THE RIGHTS AND THE PROTECTION OF THE CHILD, a child victim of the facts mentioned in points 1°, 2°, 3° of paragraph 2 of Article 27 of this Law, has the right to denounce them to the authority in charge of placement. The members of the family or any other person knowing that the child is a victim of violence or mistreatments shall have the obligation to denounce them to the authority in charge of placement or to the nearest organ of Rwanda National Police.

3.2 Victim's Rights to Choice

Dealing with victims who have unwanted pregnancies as a result of rape, incest or forced marriage requires a thorough understanding of victim's rights and provision of additional legal and psychosocial services. Victims share in common a sense of loss of control over their lives, their bodies, personal safety, their internal reactions (mood swings, flashbacks etc.). Even the simplest choice is often taken from them during their experience of violence. Some victims have been disrespected in every way possible. To restore a sense of control, a sense of self-determination and sense of dignity in the victim's life, service providers should respect the victim's choice. That is, at any given time that a victim is received at a hospital, any other health facility, police or legal facility, she has a right to choose which services she will receive. She has a right to choose to receive no services at all. This is true even if there is a police or prosecution order for a forensic medical examination or forensic interview. The experience of respect of and trust in the victim to make good decisions for herself alone may lead that victim to return at a later time to the service providers and authorities to either initiate or resume services. Children with the support of parent or guardian receive or decline services following victim's choice. Victim's choice helps victims to overcome common barriers to disclosing violence, and it is anticipated that more women will feel comfortable to seek GBV related services where the principle of victim's choice is practiced.

The same principles of victim's choice apply to a woman's decision of terminating her pregnancy, when she becomes pregnant as a result of rape, incest or forced marriage. After being properly informed about her choices, it is the right of the woman to ask for or refuse termination of pregnancy. On the other hand, in the case of therapeutic abortion, it is again the woman to make the final decision for pregnancy termination, but it is important to inform the husband and allow the couple to make a joint decision. In case of disagreement between husband and wife for therapeutic abortion, the decision of the wife is the one to be taken into consideration. Article 10 of the Law No: 49/2012 of 22/01/2013 Establishing Medical Professional Liability Insurance describes a patient's right to refuse treatment and withdraw consent, which should be strictly followed during the provision of abortion related services.

Article 10: Right to refuse treatment and withdraw consent (Law No: 49/2012 of 22/01/2013 Establishing Medical Professional Liability Insurance)
The patient or any other health service user shall have the right to refuse treatment or any medical procedure, to withdraw consent during treatment or to refuse the continuation of the medical procedure performed on him/her. Refusal of treatment or withdrawal of consent shall be made in writing and documented in the patient's medical record. Where in an emergency case uncertainty exists about the existence or nonexistence of prior consent of the patient or his/her representative, any necessary intervention may only be performed, in the interests of the patient, after favorable opinion from another competent health professional or from the management of the health facility where health care services are being provided. All information on this intervention must be entered into the patient's medical record by the physician receiving him/her.

For children under 18 years old, or for victims who lack the capacity, consent from parents, guardians or other representatives should be sought, but the opinion of children shall prevail, and Article 11 of the Law No: 49/2012 of 22/01/2013 Establishing Medical Professional Liability Insurance describes how to get consent for minors or other incapable persons.

**Article 11: Consent of minors or other incapable persons (Law No: 49/2012 of 22/01/2013 Establishing Medical Professional Liability Insurance)**

The health professional who intends to provide healthcare services to a minor or an incapable person must endeavor to inform his/her parents or his/her representative or his/her guardian and obtain their prior consent.

In case of emergency and in the absence of his/her parents, legal representative or guardian for their consent, the opinion of another competent health professional shall be required before making a decision

**3.3 Investigative (Forensic) Interview**

In the case of rape, incest or forced marriage, investigative interviews will have to be conducted to uncover detailed information about the alleged event(s) of interpersonal violence from the victim. A victim's statements about an event become an important component of the "body of evidence" used to convict an alleged perpetrator. The information obtained from the investigative interview can also be used as evidence of the assault to support a victim's court case for a court order to terminate a pregnancy. A brief overview of the interview procedures are provided below. A standardized protocol for interview and further details can be found in the MTVGBVCAP.

Personnel conducting investigative interviews of adult and child victims of violence should be trained in specialized skills training. This training should include knowledge of:

- Psychological principles and symptoms of trauma and how to identify, minimize and respond to them in the course of the interview
- The requirements of evidence for criminal prosecution and minimum skill level in standardized interview protocol, such as the Narrative Format, for conducting investigative interviews

**3.3.1 Goals for initial investigative interview**

- A brief description of injuries, if any, to the victim.
- A brief description of what happened.
• How the incident began.
• Where the assault took place (e.g., residence, open area, vehicle, etc.)
• The identity (name) and/or description of the assailant(s), if known, or of other persons who may be able to identify the assailant.
• A brief description of injuries, if any, to the assailant (e.g., whether the assailant may have been scratched or hit by the victim).
• Where the assailant(s) lives and/or works, or areas frequented, if known.
• The direction in which the assailant(s) left and a description of the means by which the assailant(s) left (e.g., if the assailant left by vehicle, a description of the vehicle should be obtained).
• Whether or not a weapon was involved.
• Items taken from or left at the scene by the victim or the assailant(s).
• Items used by the assailant to conceal identity or biological evidence (e.g., condom, mask, gloves, items used to wash).
• In cases of attempted sexual assault, inquire if the client could identify the assailant.

The Investigative Interview(s) report should include victim statements of the above to the greatest detail. A transcript in part or whole of the investigative interviews may be made from the disc as requested by the prosecution for court cases.

The details of the pre and post interview procedures for One Stop Centers is outlined in detail in the MTVGVBVCAP, and briefly summarized below. The same interview procedures and principles apply to interviewing women at any facility, where she may be received first, including hospitals and police stations.

3.3.2 Pre-Interview Procedures
1. Unless there is an acute medical and/or an acute psychological need of the victim, the investigative interview is conducted after initial reception at the facility.
2. Orient the victim/guardian to the purpose and format of the investigative interview.
3. Explain that the victim will not be accompanied and why.
4. Obtain written consent to conduct the interview.
5. The Multidisciplinary team assigned to the case meets with the interviewer in the observation room to plan the interview strategy. Any information obtained regarding the alleged violent event(s) or regarding the victim, is presented to the interviewer (e.g. the judiciary presents the police report, the social worker presents the intake information, the physician presents results of any medical exam or acute medical care delivered, the psychologist presents on the psychological state of the victim or any information presented during crisis counseling). If there is any caution against the victim participating in investigative interview at that particular time, the advantages and disadvantages are weighed. The team makes a joint decision in the best interest of the victim.
6. The victim is accompanied by the social worker and escorted and introduced to the investigative interviewer.

3.3.3 Post Interview Procedures

Following the investigative interview, the Multidisciplinary team conducts a brief Case Review. They meet privately (usually in observation room) to
discuss their impressions and information gathered in the interview in reference to all sources up to the moment. Out of this discussion, they jointly begin to formulate an initial unified case plan that consists of the plan to guide the initial (immediate) investigation and intervention services. The case plan may include:

- Identification of the evidence that remains to be gathered by the Multidisciplinary team, including evidence at crime scene or from witnesses
- Reporting evidence critical to apprehending the suspect, to protecting the victim and others, and to guiding the criminal investigator evidence gathering (crime scene evidence collection, witness interview)
- Formulation of initial recommendations for a comprehensive safety plan (e.g. safe room/ house stay)
- Discussion of the best way for each service provider to work in the short term with the victim, given his/ her current condition, vulnerabilities, strengths and needs

3.3.4 Key Points to Remember for Investigative Interviews

- The end goal of an investigative interview is to uncover the truth about what occurred or did not occur. It is not the end goal to obtain a disclosure of violence.
- Multiple interviews may be conducted but multiple interviewers must be avoided.
- Strictly follow wording of questions and prompts and the sequence of conducting the interview. This is especially important with a child.
- All staff members, regardless of discipline and role, adhere to the guidelines for non-suggestive questioning (see Principles for Investigative Interviewing in the MTVGBVCAP) to avoid tainting the victim's statement and memory.
- The Multidisciplinary Team live/ recorded, joint observation of the investigative interview is designed to spare the victim from system-induced traumatization and spare professionals time, effort and secondary traumatic stress.

3.4 Medico-Legal (Forensic) Examination Procedure

In the case of rape, incest or forced marriage, as with other GBV cases, a medical examination should be done only with the victim's consent. It should be compassionate, confidential, and complete.

3.4.1 Steps to Prepare the Victim

1. Introduce yourself
2. Ensure that a trained support person or trained health care provider preferably, and where possible, of the same sex accompanies the victim throughout the examination.
3. Explain what is going to happen during each step of the examination, why it is important, what it will tell you, and how it will influence the care you are going to give.
4. Reassure the victim that she is in control of the pace, timing and components of the examination. Ensure her that she can choose to stop the examination at any time.
5. Reassure the victim that the examination findings will be kept confidential and even if the victim decides to press charges the information necessary in court will only be passed on to the police and to the court.
6. Ask her if she has any questions.
7. Ask if she wants to have a specific person present for support. *Always try to ask her this when she is alone.*
8. Review the consent form with the victim. Make sure she understands everything in it, and explain that she can refuse any aspect of the examination she does not wish to undergo. Explain to her that she can delete references to these aspects on the consent form. Once you are sure she understands the form completely, ask her to sign it. If she cannot write, obtain a thumb print together with the signature of a witness.
9. Limit the number of people allowed in the room during the examination to the minimum necessary, and explain the roles and responsibilities of all of the individuals involved to the victim.
10. Perform the examination as soon as possible.
11. Do not force or pressure the victim to do anything against her will. Explain that she can refuse steps of the examination at any time as it progresses. Even if the victim has signed a consent form the victim can at all times withdraw her consent.

3.4.2 Steps for Taking the History
1. If the interview is conducted in the treatment room, cover the medical instruments until they are needed.
2. Before taking the history, review with the team any services they have provided, for example the details of the investigative interview, and any documents or paperwork brought by the victim to the facility so that you do not duplicate questioning.
3. Use a calm tone of voice and maintain eye contact if culturally appropriate. Let the victim tell the story the way she wants to. Questioning should be done gently and at the victim's own pace. Avoid questions that suggest blame, such as "what were you doing there alone?"
4. Avoid asking suggestible questions.
5. Take sufficient time to collect all needed information, without rushing. Do not ask questions that have already been asked in the Multidisciplinary Team Investigative Interview or documented by other people involved in the case.
6. Avoid any distraction or interruption during the process of taking the victim's history. Lock office door from inside and place a sign, "Exam in Session" on outside of door and turn off cell phone.
7. Prepare the victim by explaining what you are going to do at the outset of exam and announce at every step throughout exam.
8. For sample history and examination form see *Protocol for Multidisciplinary Treatment of Victims of Gender-based Violence and Child Abuse*

Evaluate victim for possible pregnancy; ask for details of contraceptive use and date of last menstrual period. Explore the possibility of a pre-existing pregnancy in women of reproductive age by a pregnancy test or by history and examination. The following checklist suggests useful questions to ask the victim if a pregnancy test is not possible.

3.4.3 Useful questions for previous and preexisting pregnancy

* When was the first day of your last menstrual period?
* Have you had sexual intercourse prior to this event and when was the last?
Have you been pregnant before? How many times and what was the outcome of the pregnancies?
Do you use contraception? What type?
Do you have a current sexual partner?

If pregnancy cannot be ruled out or confirmed provide her with information on emergency contraception to help her arrive at an informed choice.

3.5 Police and Legal Investigative Services

The Judicial Police Officer and the Legal Support Professional request from outside agencies, gather and organize all police statements and reports (including timely information on evidence gathered to aid in apprehension of the suspect). They utilize this information to assist the team in conducting all investigative and intervention services (including but not limited to medical exam, investigative interview, prosecution/court preparation support) with the victim. The Legal Officer aids the team in best practices in collecting evidence needed for the strongest prosecution. From the evidence gathered at the One Stop Center, the Judicial Police Officer provides timely ongoing reports to aid those conducting criminal investigation. From the evidence gathered, the Legal Officer reports to the prosecutor's office. These Judicial Police Officer and Legal Officer reports usually includes, but is not limited to, all relevant and necessary information gathered from:

- Statements from all attending medical personnel
- Any forensic evidence collected by medical personnel
- Statements from the first contact to whom the victim reported the incident (could be the police officer who referred the case or the receptionist who met the victim at the center)
- Copy of completed Victim Assessment and Medical Report Forms
- Copy of the Investigative Interview on disc and report form

The multidisciplinary investigative and intervention team jointly decides which sensitive information is shared beyond the team and which sensitive information is held in confidence within the team following the Multidisciplinary Team protocol, the ethical standards of the professions and the laws of Rwanda.

The Judicial Police Officer and Legal Officer follow principles including:

- Calm the victim
- Pace so as not to traumatize
- Ensure privacy (lock office door and post “In Session” sign outside door) and safety
- Treat the victim with respect and courtesy
- Explain the limits of confidentiality
- Inform victim of his/her legal and protection rights
- Instruct the victim that he/she has the right to refuse to answer any or all questions
- Emphasize that all information the victim provides may be vital to the apprehension of the alleged perpetrator
- Inform the victim of police and judicial procedures as per law
- Never blame or judge the victim
- Follow Principles of Investigative Interviewing
- Coordinate investigative services with Multidisciplinary Team members assigned to the victim's case
- When victim declines services, assist social worker with appropriate support services offered by the state and in his/her Umudugudu

3.6 Legal Procedures to Follow Before the Provision of Termination of Pregnancy
• Record review to confirm the eligibility of women for one of the exceptions provided in the Penal Code of 2012
• Confirmation of court approval
• Confirmation of signature from another provider, where possible
4. SERVICE DELIVERY OVERVIEW AND PROTOCOLS FOR HEALTH FACILITIES FOR TERMINATION OF PREGNANCY

4.1 Termination of Pregnancy Service Delivery Overview and Protocols for Hospitals

The Guidance Document to Operationalize the Exemptions for Abortion in the Penal Code of 2012 (Guidance Document) provides detailed information on the key priorities, strategies and activities for implementation. Based on the Guidance Document, Figure 1 below lays out major components of program services for the provision of safe abortion services within the legal framework. Figure 2 and Figure 3, Service Delivery Diagrams for Termination of Pregnancy at the hospital level highlights the key steps to follow for the initial and follow-up visits during pregnancy termination services.

Figure 1. Program services for the provision of safe abortion services within the legal framework

Women who are eligible for safe abortion services under the Penal Code are the “beneficiaries in need” (i.e. women who become pregnant as a result of rape, incest, forced marriage, or whose pregnancy severely jeopardizes the health of the unborn baby or that of the pregnant woman). In order to prove their case and obtain a court order in case of rape, incest or forced marriage, women will report to the police, who will collect their statement and any evidence. The police may then refer the alleged victim to GBV related services, including counseling offered by health facilities, NGOs or CBOs. In other cases, women may access services through other entities, such as GBV services, judiciary, faith based institutions and health facilities providing counseling. These women will have to be linked with health care services, as well as with the police and judicial system. With regard to therapeutic abortions, women do not
need a court order and they will directly be sent to seek medical attention from the health system.
Figure 2: Service Delivery Diagram for Termination of Pregnancy – Initial Visit

**Termination of Pregnancy Service Delivery Diagram – INITIAL VISIT**

- **Hospital Admission**
- **Therapeutic abortion**
- **Danger to maternal & fetal health?**
- **Court order?**
  - **Yes**
  - **Advise accordingly to get a court order**
  - **≥ 13 weeks**
  - **Gestational age?**
  - **≤ 12 weeks**
  - **Doctor-Patient consultation**
  - **Out-patient management**
- **In-patient management**
  - **MA**
  - **MVA**
  - **D&E**
  - **Follow MA protocol**
  - **Follow MVA protocol**
  - **Manage Accordingly**
  - **Monitor at the facility**
  - **Book follow-up visit in 1-2 weeks**
  - **Explain to women what to expect and warning signs**
- **Contraceptive service**
- **Discharge**

---

1. Pregnancy severely jeopardizes the health of the unborn baby or that of pregnant woman
2. The doctor, in consultation with the woman and her family makes the decision for inpatient or outpatient treatment
3. Where mifepristone is not available, misoprostol alone regimen can be used
4. Provider can determine if further monitoring is necessary based on the conditions of the individual patient
Figure 3: Service Delivery Diagram for Termination of Pregnancy - Follow-up Visit

Termination of Pregnancy Service Delivery Diagram - FOLLOW UP VISIT

Women returns to hospital 1-2 weeks after initial visit

Medical History, Psychosocial assessment, Lab test
Physical & Pelvic Exam
May use ultrasound for treatment confirmation

Little or no bleeding
Normal size uterus
No signs of infection
Empty uterus with U/S

Same/smaller uterine size
Bleeding and/or pain
No sign of other complications
U/S diagnosis of incomplete abortion

Treatment options for incomplete abortion:
Misoprostol OR
MVA OR Other Surgical Methods

Treatment successful

Misoprostol 600 mcg oral, single dose
(uterine size up to 13 weeks gestation)

Monitor for 1 hour

Book follow-up visit in 1-2 weeks
Explain what to expect and warning signs

Contraceptive services before discharge

Contraceptive services before discharge

Same/smaller uterine size
Bleeding and/or pain
No sign of other complications
U/S diagnosis of incomplete abortion

Treat with MVA or other surgical methods as indicated

Monitor for 1 hour

Book follow-up visit in 1 week
Explain what to expect and warning signs

Contraceptive services before discharge

Follow the National Comprehensive Treatment Protocol for Postabortion Care Services

Provider can determine if further monitoring is necessary based on the conditions of the individual patient
### 4.2 Criteria for the Selection of the Method for Termination of Pregnancy

**Table 1. Criteria for the selection of the method for termination of pregnancy**

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Medical Abortion</th>
<th>Vacuum aspiration (MVA or EVA)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intrauterine pregnancy &lt;14 weeks*</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>Intrauterine pregnancy, uterine size 14-22 weeks</td>
<td>YES</td>
<td>NO (Dilatation and Evacuation)</td>
</tr>
<tr>
<td>Women with:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>慢性腺体功能不全</td>
<td>Mifepristone contraindicated; misoprostol alone regimen can be considered</td>
<td>YES</td>
</tr>
<tr>
<td>相关长期皮质激素治疗</td>
<td></td>
<td></td>
</tr>
<tr>
<td>继发多形性红细胞生成障碍</td>
<td></td>
<td></td>
</tr>
<tr>
<td>妇女对米非司酮、米索前列醇或其他前列腺素过敏</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td>确诊或疑似异位妊娠</td>
<td>NO</td>
<td>NO</td>
</tr>
<tr>
<td>哺乳的妇女</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>妇女有严重/不稳定问题:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>溢血性出血</td>
<td>YES, Monitor closely</td>
<td>YES, Monitor closely</td>
</tr>
<tr>
<td>心脏疾病</td>
<td></td>
<td></td>
</tr>
<tr>
<td>严重贫血</td>
<td></td>
<td></td>
</tr>
<tr>
<td>妇女有HIV</td>
<td>YES</td>
<td>YES</td>
</tr>
</tbody>
</table>

*Both medical abortion and vacuum aspiration (VA) are the recommended methods for pregnancy termination by the WHO (WHO, 2012). Medical abortion can be used during the first and second trimester with specific regimens according to the week of gestation. VA is the recommended technique of surgical abortion for pregnancies up to 14 weeks of gestation.*
5. METHODS FOR UTERINE EVACUATION

5.1 Uterine Evacuation with Manual Vacuum Aspiration (MVA)

5.1.1 Introduction to Manual Vacuum Aspiration (MVA)

Vacuum aspiration is the recommended surgical method for uterine evacuation by the WHO (WHO 2012) and it involves evacuation of the contents of the uterus through a plastic or metal cannula, attached to a vacuum source (Frankel & Abernathy, 2007; Ipas, 2009). Electric vacuum aspiration (EVA) employs an electric vacuum pump. Manual vacuum aspiration (MVA) uses a hand-held vacuum syringe and flexible plastic cannulae. MVA is a safe and effective technique for uterine evacuation; its low cost, simplicity and portability make it an especially valuable reproductive health technology. More than 25 years of clinical research in over 100 countries has shown vacuum aspiration for uterine evacuation to be safer than, and as effective as D&C. Further, MVA offered in outpatient settings has been shown to reduce the cost and length of stay related to the procedure, when compared to sharp curettage performed in an operating theater. MVA is also an excellent alternative to electric suction, producing an equivalent vacuum (Greenslade et al., 1993; Baird & Flynn, 2001). MVA is associated with less bleeding than sharp curettage.

Clinical indications for MVA:

- Treatment of incomplete abortion for uterine size up to 13 weeks from the last menstrual period (LMP)
- Termination of pregnancy up to gestational age 12-14 weeks, as permitted by law
- Endometrial biopsy; it should not be performed in case of suspected pregnancy

Contraindications for MVA:

- Patients with acute cervicitis or pelvic infection, except in an emergency
- Patients with large fibroids unless emergency back-up is available

Precautions for MVA use:

In the following cases, MVA should be used with caution and only in facilities with full emergency back-up:

Patients with:

- History of bleeding disorders: Risk of excessive bleeding or hemorrhage
- History or suspicion of uterine perforation: Risk of injuring the bowel
- Severe anemia: Risk of severe shock and death
- Hemodynamic instability due to cardiac disease, hemorrhage or septic shock: Risk of severe shock and death
- Uterine fibroids that make it impossible to assess the duration of gestation: Risk of perforation

In the presence of infection, proceed only with antibiotic coverage (antibiotic therapy should be started prior to the procedure): the patient may require referral to a higher level of care.

5.1.2 Pre-procedure care
Before beginning the evacuation procedure, review what has been done up to this point. The following list can be used as a guide or checklist before starting the procedure:

- Perform a rapid assessment: complications either ruled out or treated and patient is stable.
- Obtain patient history.
- Conduct a physical exam.
- Perform a speculum exam.
- Conduct a pelvic exam to assess uterine size.
- Rule out contraindications to MVA.
- Review precautions, where appropriate.
- Tell the patient what is happening (and what to expect) during the procedure.
- Discuss pain management with the patient.
- Discuss family planning options— including if the patient chooses a method and meets the medical eligibility criteria. The IUD can be placed immediately after the uterus has been evacuated. Implants can be inserted prior to discharge from the facility.
- Obtain any required consents:
  - Informed consent including counseling and information on the procedure, pain control and what to expect.
  - Consent for IUD if postabortion IUD is desired and the patient meets the medical eligibility criteria.
- Provide counseling as appropriate: Counseling before, during and after uterine evacuation.
- Have the patient empty her bladder.
- Position and drape the patient in lithotomy position.
- Administer pain control 15-30 minutes before the procedure, depending on type of pain medication being used.
- Ensure that:
  - All emergency drugs/equipment are available.
  - Emergency back-up is available.
  - Sterilized/high-level disinfected instruments are ready.
  - Family planning/birth spacing methods are available in the treatment room.
- Implement infection prevention measures.
- If possible, have a support person available to provide emotional support during the procedure.

Refer to Appendix 10.1 for Checklist for MVA for Uterine Evacuation

5.1.3 Preparing MVA instrument

Be sure to follow these steps to prepare vacuum aspiration instrument for the procedure:

A. Select cannulae:
   1. Inspect cannulae for cracks or other defects; discard if there are any visible signs of weakness or wear.
   2. Select cannulae according to the assessment of uterine size (weeks from LMP). It is a good idea to prepare several cannulae of different sizes for the procedure. The cannula needs to be large enough to allow passage of tissue expected (according to gestation) and fit snugly through the cervix.

B. Select syringes:
   1. Select syringes and adapters, if needed.
   2. It may be useful to prepare two syringes because the amount of blood and tissue in the uterus is difficult to predict.
3. Note that the colored dots on the cannula match the color of the appropriate adapter, if applicable.

C. Inspect syringes:
   ● The syringe must be able to hold a vacuum. Discard syringes with any visible cracks or defects or those that do not hold a vacuum.

D. Attach the adapter (if required):
   ● Attach to the end of the syringe or cannula. The MVA Plus syringe does not require an adapter.

E. Check the plunger and valve on the syringe:
   ● The plunger should be positioned all the way into the barrel, and the pinch valve open, with the valve button out.

F. Close the pinch valve:
   ● Push the button down and forward until you hear it lock into place.

G. Prepare the syringe:
   1. Grasp the barrel and pull back on the plunger until the arms of the plunger snap outward.
   2. Plunger arms must be fully secured over the edge of the barrel, so the plunger cannot move forward involuntarily. Incorrect positioning of the arms could allow them to slip back inside the barrel.
   3. Never grasp the syringe by the plunger arms.

H. Check the syringe for vacuum tightness before use:
   1. Leave the syringe for several minutes with the vacuum established. Open the pinch valve–you should hear a rush of air into the syringe, indicating that there was a vacuum in the syringe.
   2. Re-establish the vacuum in the syringe for use during the procedure.

5.1.4 Performing the vacuum aspiration procedure

STEP 1: Before you start
Before beginning the procedure, the following steps must have already been completed:
   ● Drape the patient in lithotomy position.
   ● Ensure that:
     - All emergency drugs/equipment are available.
     - Emergency back-up is available, as needed.
     - Sterilized/high-level disinfected instruments are ready.
     - Family planning/birth spacing methods are available in the treatment room.
     - Pre-procedure medication is administered:
       - IV medication: 15-30 minutes before the procedure
       - Oral medication: 30-60 minutes before the procedure
   ● Start antibiotic prophylaxis by giving 100 mg doxycycline orally (ACOG practice bulletin 104, May 2009)
   ● Hands are washed and gloves are on.
   ● Do bimanual exam to determine uterine size, position and cervical dilatation. If using MVA, ensure that the uterine size is less than or equal to 13 weeks.
   ● Disinfect the vulva and vagina
   ● Insert a vaginal speculum and visualize the cervix.
   ● Using the no-touch technique, apply antiseptic solution two to three times to the cervix (especially the cervical opening) and vagina using a sterile ring forceps and a cotton or gauze swab.
   ● Check the cervix for tears or protruding POC. If POC are present in the vagina or cervix, remove them using ring (or sponge) forceps.
   ● Gently apply a vulsellum or single-toothed tenaculum to the anterior lip of the cervix. Ring forceps are preferable as they are less
likely than the tenaculum to tear the cervix and do not require the use of lignocaine for placement.

**STEP 2: Dilate the cervix if indicated**

When induced abortion has occurred, the cervix is usually dilated. Cervical dilatation is usually necessary when a missed abortion has occurred or when the cervical canal will not allow passage of a cannula appropriate to the uterine size. When needed, cervical dilatation should be done gently with cannulae of increasing size, taking care not to traumatize the cervix:

- If cervical dilatation is needed, assess the need for additional pain management before proceeding. If a paracervical block is used, then give paracervical block before proceeding.
- If dilatation of the cervix is needed, begin with the smallest dilator and end with the largest dilator that ensures adequate dilatation (usually 10-12 mm). Be extremely careful not to tear the cervix or create a false opening.

**STEP 3: Insert the cannula**

Gently introduce the appropriate suction cannula according to uterine sizing (use the largest available for that uterine size):

- While gently applying traction to the cervix, with the vulsellum (or tenaculum), use the no-touch procedure to insert the cannula through the cervix into the uterine cavity, just past the internal cervical opening. Rotating the cannula with gentle pressure often helps ease insertion.

**STEP 4: Measure the size of the uterus**

Slowly push the cannula into the uterine cavity until it touches the fundus, but not more than 10cm. Note the uterine depth by dots visible on the cannula. Next, withdraw the cannula slightly.

**STEP 5: Evacuate the uterus**

- Hold the vulsellum (or tenaculum) and the end of the cannula in one hand and the syringe in the other.
- Attach the prepared syringe to the cannula.
- Make sure not to push the cannula further into the uterus as you attach the syringe.
- Release the pinch valve(s) on the syringe to transfer the vacuum through the cannula to the uterine cavity.
- Evacuate remaining contents by gently rotating the syringe from side to side (i.e., 10 o'clock to 12 o'clock) and then slowly moving the cannula back and forth within the uterine cavity. Bloody tissue and bubbles should begin to flow through the cannula into the syringe.
- Check for signs of completion that include red or pink foam; a gritty sensation as the cannula passes over the surface of the evacuated uterus; and the uterus contracting (gripping) around the cannula.
- To avoid losing vacuum, be careful not to withdraw the cannula opening beyond the cervical opening. If the vacuum is lost or if the syringe is more than half full, empty it and then re-establish the vacuum. Also, avoid grasping the syringe by the plunger arms while the vacuum is established and the cannula is still in place.
- Once evacuation is completed, detach the syringe (MVA) and remove the tenaculum and speculum, and place contents into a container. Withdraw the cannula and place cannula in decontamination solution.
- With the valve open, empty the contents of the MVA syringe into a strainer by pushing on the plunger. Place the empty syringe on a
high-level disinfected tray or container until you are certain that
the procedure is complete.
- Perform a bimanual exam to check the size and firmness of the
uterus. If needed, do cervical tear repair. If patient has provided
prior voluntary consent to IUD insertion, insert the IUD.

**STEP 6: Tissue inspection**
- Inspect the tissue removed from the uterus:
  - For quantity and presence of POC;
  - To assure complete evacuation; and
  - To check for a molar pregnancy (rare).
- If necessary, strain and rinse the tissue to
remove excess blood clots, then place in a
container of clean water, saline or weak acetic
acid (vinegar) to examine. If sending tissue
specimens for pathology, prepare tissue according to local
laboratory requirements.
- If no POC are seen:
  - All of the POC may have been passed
before vacuum aspiration was performed
(complete abortion).
  - The uterine cavity may appear to be
empty, but may have not been emptied
completely.
  - Repeat the evacuation to ensure the
procedure was done correctly/the
equipment functioned properly.
  - The vaginal bleeding may have been due to something other than
an incomplete abortion (such as bleeding from fibroids).
  - The uterus may be abnormal, such as in a double uterus (rare).
- Gently insert a speculum into the vagina and examine for bleeding.
  If the uterus is still soft and not smaller or if there is
persistent, brisk bleeding, repeat the evacuation.

**STEP 7: Process instruments (Infection Prevention)**
- Place contaminated, disposable objects in a properly marked and leak-
proof container.
- Place sharp instruments in a separate puncture-proof container.
- Decontaminate all instruments (cannulae, syringes, adapters,
tenaculum, speculum, etc.) in 0.5% chlorine solution for at least 10
minutes.
- Immerse both gloved hands in decontaminated solution and remove them
by turning them inside out.
- Wash hands thoroughly with soap and water.

5.1.5 Post-procedure care
- Observe the patient for one (1) to three (3) hours. Have the woman
rest in a comfortable position.
- Use the pain management scale to determine the level of
pain/discomfort.
- Give paracetamol 500 mg by mouth or another pain medicine if needed.
- Give doxycycline 200 mg orally after the procedure (ACOG practice
bulletin 104, May 2009)
- Take vital signs before moving the patient from the procedure area.
  Monitor her until pulse and blood pressure are normal.
- Encourage the woman to eat, drink and walk as she wishes if there
are no problems.

*Reminder*
Postabortion and
abortion care
is not
complete
without family
planning
services!
*The absence of
products of
conception in a
woman with
symptoms of
pregnancy may
strongly
indicate the
possibility of
ectopic
pregnancy.*
- Explore the patient's feelings and concerns and provide explanation and support to her emotional state as needed.
- Check bleeding at least once before discharge and check to see that cramping has reduced. Inform the woman that prolonged cramping is not normal.
- Before the patient leaves the facility:
  - Include the husband/partner in counseling if the patient agrees.
  - Remind patient and her partner that fertility can return as early as 10 days post procedure.
  - Explain the benefits of birth spacing for maternal and child health.
  - Provide family planning counseling and assist the patient in deciding on a method before she is discharged. If the patient chooses, provide a family planning method.
  - Refer the woman for HIV and other STI services as indicated

Refer to Section 6 and Appendix 10.5 for more detail on postabortion family planning.

- Discharge the patient as soon as she is stable, can walk without assistance, and has received post-procedure counseling and family planning information and services, including when she can safely resume intercourse. In most instances, uncomplicated cases can be discharged in one (1) to two (2) hours.
  - Provide instructions for taking medications, routine hygiene and resuming sexual activity.
  - Advise about care at home and signs of complications that require immediate attention:
    o Prolonged cramping (more than a few days)
    o Prolonged/heavy bleeding
    o Bleeding more than a normal menstrual period
    o Delay in resumption of menstrual period by more than eight (8) weeks
    o Severe or increased pain or distention of the abdomen
    o Foul-smelling vaginal discharge
    o Fever, chills, nausea or vomiting for more than 24 hours
    o Fainting
  - Provide other health services as needed (if available) such as tetanus prophylaxis or Rh immune globulin if patient is Rh-negative.
  - Record information: Record complete information on patient chart and other forms as needed.
  - Include appropriate counseling topics in the patient encounter if needed:
    - Information on the pain management options available to the patient
    - Information on normal complications that can be expected
    - Information on follow-up care at home and when to return to the facility
  - Address any other reproductive health needs of the patient and refer as appropriate (HIV, other sexually transmitted diseases, domestic violence, etc.)

5.1.6 Follow-up visit
- Assess if the treatment was successful. Take clinical history and conduct a pelvic examination to confirm complete evacuation of the uterus. Ask each woman about side effects she experienced and bleeding patterns. Bimanual exam will help the provider assess
whether the uterus is firm, involuted and pre-pregnancy size. A speculum exam will confirm a normal cervix and rule out infection. Ultrasound may be useful if available, but it is not necessary for the diagnosis of incomplete abortion or its treatment. Complete evacuation can be confirmed with clinical history and pelvic exam.

- Based on history and exams, if uterine evacuation is not complete and a woman does not have complications or a medical condition requiring MVA at the hospital level, another MVA can be performed or a dose of misoprostol (600 mcg orally) can be given for the treatment of incomplete abortion to complete the evacuation of uterus. For any woman requiring an MVA, treat or refer according to service guidelines.

At the follow-up visit after MVA treatment:

- Provide contraceptive counseling education again
- Help each woman choose an appropriate contraceptive method
- Ensure that those who are not planning to get pregnant soon leave the clinic with a contraceptive method.

**ALL** contraceptive methods can be offered without any restrictions at the follow-up visit.

5.1.7 Managing problems during the MVA procedure

Several types of problems (technical and procedural) and medical complications can occur during and after completing a vacuum aspiration procedure. Most are not serious, and if recognized immediately and corrected or treated, the patient’s recovery will not be affected.

Technical Problems

In most MVA procedures, the syringe vacuum remains constant until the syringe is approximately 90% full. However, a decrease in vacuum may occur before the procedure is complete if the cannula is blocked or withdrawn prematurely.

A. Full Syringe

If the syringe is full:

- Close the pinch valve of the syringe.
- Disconnect the syringe from the cannula, leaving the tip of the cannula in place inside the uterus.
  (Do not push the plunger when disconnecting the syringe.)
- Empty the syringe into a container for inspection by opening the pinch valve and pushing the plunger into the barrel. (Be careful not to splash the contents of the syringe into your eyes.)
- Re-establish a vacuum in the syringe, reconnect it to the cannula, and resume the aspiration.
  (You can keep a second prepared syringe on hand during the aspiration and switch syringes if one becomes full.)

B. Cannula withdrawn prematurely

If the opening of the cannula is pulled into the vaginal canal with the valve still open, the vacuum will be lost.

- Remove the syringe and cannula, taking care not to contaminate the cannula through contact with the vaginal walls or other non-sterile surfaces.
- Close the pinch valve of the syringe.
- Detach the syringe from the cannula, empty the syringe, and then re-establish the vacuum in the syringe (See above: Full Syringe).
• Reinsert the cannula if it has not been contaminated. (If contamination has occurred, insert another sterile or high-level disinfected cannula.)
• Reconnect the syringe, release the valve, and continue aspiration.

C. Cannula Clogged
If no tissue or bubbles are flowing into the MVA syringe, the cannula may be clogged.
If using MVA:
• Close the pinch valve of the syringe.
• Remove the syringe and the cannula, taking care not to contaminate the cannula through contact with the vaginal walls or other non-sterile surfaces.
• Remove the material from the opening in the cannula using a sterile or high-level disinfected forceps or sponge, without contaminating the cannula. If contamination occurs, use another sterile or high-level disinfected cannula.
• Reinsert the cannula, attach a prepared syringe and release the pinch valve.

D. MVA syringe does not hold vacuum
If the MVA syringe does not seem to hold a vacuum:
• Try lubricating the plunger and barrel with a drop of silicone.
• If this does not work, replace the O-ring.
• If the syringe still does not hold a vacuum, discard it and use another syringe.

Procedural Problems

Procedural problems occurring during an MVA procedure are infrequent. Most are not serious, are related to the inexperience of the provider, and are easily corrected.

A. Less than expected tissue
The most common procedural problem is obtaining less than expected tissue. Tissue that is inadequate in quantity or contains no definite POC may indicate:
• All POC passed before the vacuum aspiration.
• The vaginal bleeding was not due to pregnancy.
• A possible ectopic pregnancy (see below).
• Inadequate technique

B. Incomplete evacuation
Using a cannula that is too small or stopping the aspiration too soon can result in retained tissue, subsequent hemorrhage, infection, and continued pain and cramping.
• Careful observation for the signs of completion and tissue examination to identify the POC are the best ways to ensure complete evacuation. Other signs of complete evacuation are feeling the gritty sensation and frothy blood (crist metalitique, le sang mousseux) are other signs of complete evacuation.
• Incomplete evacuation is treated by repeating the evacuation.

C. All POC passed before the vacuum aspiration
• Further evacuation is not necessary unless the clinical findings suggest that the evacuation is still incomplete (e.g., persistent vaginal bleeding, fever, etc.).

D. Uterine Perforation
Uterine perforation is rare with MVA. However, when a woman who has received PAC treatment complains of severe pain, consider intra-abdominal injury (i.e., injury to the abdominal organs such as the uterus, cervix, vagina or even bowel). Other signs include abdominal distension, cervical motion tenderness, shoulder pain and rigid abdomen. For intra-abdominal injury, refer to high levels if needed.
E. Other Problems

Vaginal bleeding not due to pregnancy

Women of reproductive age may have irregular periods (i.e., missed or skipped periods) followed by vaginal bleeding due to:

- Progesterone-breakthrough bleeding with use of progestin-only contraceptive methods (i.e., injectables, implants)
- Uterine fibroids (i.e., benign, smooth muscle tumors that grow in the wall of the uterus)
- Estrogen-breakthrough bleeding (i.e., anovulation)
- Ectopic Pregnancy

Ectopic pregnancy

Delay in treatment of an ectopic pregnancy is particularly dangerous. The risk of an ectopic pregnancy is greater if the patient has a history of any of the following:

- Previous ectopic pregnancy
- Pelvic infection
- IUD or progestin-only contraceptive use

If ectopic pregnancy is suspected, check again for signs of an ectopic pregnancy, and quickly prepare the woman for referral if surgery (minilaparotomy or laparoscopy) is not available. Rupture of an ectopic pregnancy is a real and life-threatening possibility. If this happens, death can be prevented only by stopping the hemorrhage through immediate surgical removal of the ectopic pregnancy, stopping bleeding, and replacing blood loss, if required.
5.2 Uterine Evacuation with Medical Methods

Use of medication for termination of pregnancy is a globally endorsed method, and has been increasingly used worldwide. The WHO added mifepristone with misoprostol and misoprostol only medical abortion in its Model List of Essential Medicines (WHO, 2005). The combination of mifepristone plus misoprostol is more effective in achieving complete abortion than either drug used alone (Ngoc 2011, Kulier 2011). In the first trimester, the combination of mifepristone and misoprostol results in successful abortion with no need for further aspiration evacuation in over 95% of cases. The risk of ongoing pregnancy for pregnancies <9 weeks is less than 1% with the combined regimen.

Mifepristone, developed in France and originally known as RU-486, was first approved for clinical use in 1988. Mifepristone blocks progesterone activity in the uterus, leading to detachment of the pregnancy. Mifepristone increases uterine sensitivity to prostaglandins (like misoprostol) and softens the cervix. Misoprostol, a synthetic prostaglandin, stimulates cervical ripening and uterine contractions, causing uterine evacuation.

Where mifepristone is not available, medical abortion using misoprostol alone is an important option. In the first trimester, the rate of successful abortion with misoprostol alone regimen, without need for further intervention is approximately 85% (Carbonell 2001, von Hertzen 2007). The rate of ongoing pregnancy after misoprostol-only medical abortion is approximately 5% (von Hertzen 2007).

5.2.1 Administering Medical Abortion

Eligibility criteria for medical abortion:

Most women can use mifepristone-misoprostol for medical abortion. Both drugs used for medical abortion have been shown to be safe and effective. Uterine rupture is a rare complication associated with later gestational age and prior uterine surgery, and each case should be assessed individually.

Table 2. Contraindications and precautions for medical abortion

<table>
<thead>
<tr>
<th>Contraindications for medical abortion</th>
<th>Precautions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suspected or confirmed ectopic pregnancy</td>
<td>Severe uncontrolled asthma or long-term corticosteroid therapy</td>
</tr>
<tr>
<td>Intrauterine device (must be removed prior to termination)</td>
<td>Severe/unstable health problems including:</td>
</tr>
<tr>
<td>Gestational trophoblastic disease</td>
<td>- Hemorrhagic disorders</td>
</tr>
<tr>
<td>Known hypersensitivity or allergy to mifepristone</td>
<td>- Heart disease</td>
</tr>
<tr>
<td>Chronic adrenal failure</td>
<td>- Severe anemia</td>
</tr>
<tr>
<td>Concurrent long term corticosteroid therapy</td>
<td></td>
</tr>
<tr>
<td>Inherited porphyria</td>
<td></td>
</tr>
</tbody>
</table>

Where mifepristone is not available, medical abortion using misoprostol alone is an important option. In the first trimester, the rate of successful abortion with misoprostol alone regimen, without need for further intervention is approximately 85% (Carbonell 2001, von Hertzen 2007). The rate of ongoing pregnancy after misoprostol-only medical abortion is approximately 5% (von Hertzen 2007).

Mifepristone and misoprostol are included in the WHO Essential Medicines List for medical termination of pregnancy (WHO 2011).
Table 3. Mifepristone and misoprostol combined regimen for medical abortion (WHO 2012)

<table>
<thead>
<tr>
<th>Gestational age</th>
<th>Dose and route</th>
</tr>
</thead>
<tbody>
<tr>
<td>≤ 9 weeks (63 days)</td>
<td>200 mg oral mifepristone followed 24 hours later by 800 mcg vaginal, sublingual or buccal misoprostol</td>
</tr>
<tr>
<td>&gt;9 weeks to ≤12 weeks (63 to 84 days)</td>
<td>200 mg oral mifepristone followed 36 hours later by 800 mcg vaginal misoprostol. Subsequent misoprostol doses should be 400 µg, administered either vaginally or sublingually, every 3 hours up to 5 doses</td>
</tr>
<tr>
<td>&gt;12 weeks to ≤22 weeks (84 days to 154 days)</td>
<td>200 mg oral mifepristone followed 36 hours later by repeated doses of misoprostol. For 12-22 weeks, the initial dose of misoprostol may be either 800 mcg vaginally or 400 mcg orally. Subsequent misoprostol doses should be 400 µg, administered either vaginally or sublingually, every 3 hours up to 5 doses</td>
</tr>
</tbody>
</table>

Table 4. Where mifepristone is not available, misoprostol alone regimen for medical abortion (WHO 2012)

<table>
<thead>
<tr>
<th>Gestational age</th>
<th>Dose and route</th>
</tr>
</thead>
<tbody>
<tr>
<td>≤ 12 weeks (84 days)</td>
<td>800 mcg vaginal or sublingual. Repeat every 3 hours for a maximum of 3 doses in 12 hours.</td>
</tr>
<tr>
<td>&gt;12 weeks to ≤22 weeks (84 to168 days)</td>
<td>400 mcg vaginal or sublingual. Repeat every 3 hours for a maximum of 5 doses</td>
</tr>
</tbody>
</table>

For therapeutic abortion beyond 22 weeks:
The same MA regimen for 12-22 weeks can be used for 22-24 weeks (WHO 2012). For pregnancies beyond 24 weeks, the dose of misoprostol should be reduced, owing to the greater sensitivity of the uterus to prostaglandins. For pregnancies beyond 30 weeks, misoprostol 50 mcg orally every 4 hours up to 6 times (Rwanda National Protocol for Labor Induction).

Place of administration for medical abortion:
For pregnancies with gestational age up to 12 weeks, after taking mifepristone at the facility, women may be given misoprostol tablets to take home. The doctor will instruct her how to take the tablets correctly, and set up a follow-up visit. The doctor, in consultation with the woman and her family will make the final decision on whether women with pregnancies up to 12 weeks should be hospitalized or not. This decision will take into consideration of factors such as socio-economic status, transportation, and other relevant factors. All of the women with pregnancies of gestational age 13 weeks or above will be hospitalized for medical termination of pregnancy.

Administration of mifepristone and misoprostol regimen (gestational age up to 12 weeks; outpatient):
For a woman in stable condition who does not require MVA or other treatment, give one (1) tablet of 200 mg mifepristone orally. Explain the following to the woman:
• **Procedure:** She will be given 4 more tablets (misoprostol 800 mcg) to take home with her. After 24 hours, she will put 4 tablets under her tongue, and keep them there for 20-30 minutes, and swallow the remaining pieces. She will attend a follow-up visit one to two weeks after the treatment. The four tablets of misoprostol can also be administered buccally or vaginally; and explain to the woman how to use the tablets accordingly.

• **What to expect:** Bleeding similar to a menstrual period may continue up to two (2) weeks, and spotting can persist until the next menstrual period.

• **Possible side effects:** She may experience pain/cramping; chills/fever; nausea/vomiting; diarrhea. Let her know that most women will experience lower abdominal pain and cramping during medical abortion. Cramping usually begins one to three hours after taking misoprostol, and diminishes soon after passing pregnancy. The woman can take painkillers if necessary. Chills and fever are transient, and usually do not require any treatment. Reassure the woman that they are common side effects and will go away spontaneously. Antipyretics may be used for fever, if needed.

• **Family planning provision:** Before the woman leaves the clinic, provide contraceptive counseling. All of the methods, with the exception of IUD can be provided with the first dose of medical abortion, and provide her method of choice.

Administration of mifepristone and misoprostol regimen (gestational age ≤12 weeks as inpatient or gestational age ≥13 weeks as outpatient):

• For women with gestational age up to 12 weeks, but for whom the doctor confirmed the decision to be treated as inpatient, the administration of mifepristone and misoprostol tablets will be the same, with the only exception of women being observed in the hospital.

• For women with gestational age 13 weeks or above, use the appropriate WHO regimen as provided in this Protocol; and use other methods of uterine evacuation as indicated by woman’s gestational age or clinical status.

> Refer to Section 6 and Appendix 10.3 for more postabortion family planning.

**Post-administration**

• After administering mifepristone or misoprostol observe and monitor the woman in the facility for amount of vaginal bleeding and manage side effects accordingly. Also inquire about any other symptoms experienced by the woman.

• Provide contraceptive counseling about all methods before discharge; learn about her reproductive goals; and ensure that each woman leaves the facility with a contraceptive method or referral for her method of choice. Explain to the woman that she can get pregnant before having menses. At the time of treatment, the woman can be offered condoms, oral contraceptives, injectables and implants. She can also be scheduled for IUD or sterilization at the follow-up visit. While waiting for the long acting method of choice, a woman should be advised to use a temporary method such as male or female condoms.

• Before the patient leaves the facility:
  - Include the husband/partner in counseling if the patient agrees.

*Reminder* Abortion service is not complete without family planning services!
- Remind patient and her partner that fertility can return as early as 10 days post procedure.
- Explain the benefits of birth spacing for maternal and child health.
- Provide family planning counseling and assist the patient in deciding on a method before she is discharged. If the patient chooses, provide a family planning method.
- Provide instructions for taking medications, routine hygiene and resuming sexual activity. She can resume sexual activity when the bleeding stops.
- Inform the woman about danger signs to look for after being discharged and when to contact a medical provider immediately if the following occurs:
  - **Heavy bleeding:**
    - Soaking more than two (2) extra-large sanitary pads (or local equivalent) per hour for more than two (2) consecutive hours;
    - Sudden heavy bleeding after bleeding has slowed or stopped for several days; or
    - Continuous bleeding for several days with feelings of dizziness and light-headedness.
  - **Signs of infection:** Foul smelling vaginal discharge; persistent abdominal pain that does not get better with medication, rest or heating pad; fever which lasts more than a day or develops within one (1) day after taking misoprostol.
  - **Feeling very sick** (Fever, chills, fainting, nausea or vomiting for more than 24 hours)
- Provide other health services as needed (if available) such as tetanus prophylaxis or Rh immune globulin if patient is Rh-negative.
- Record information: record complete information on patient chart and other forms as needed.
- Include appropriate counseling topics in the patient encounter if needed:
  - Information on the pain management options available to the patient
  - Information on what to expect during treatment and the warning signs
  - Information on follow-up care at home and when to return to the facility
- Address any other reproductive health needs of the patient and refer as appropriate (HIV, other STIs, domestic violence, etc.)
- Set up a follow-up appointment within one (1) to two (2) weeks after treatment.
- Discharge when a woman feels comfortable after taking misoprostol and side effects are managed, with the instructions about danger signs.

**Follow-up visit**
- Assess if the treatment was successful. Take clinical history and conduct a pelvic examination to confirm complete evacuation of the uterus. Ask each woman about side effects she experienced and bleeding patterns. Bimanual exam will help the provider assess whether the uterus is firm, involuted and pre-pregnancy size. A speculum exam will confirm a normal cervix and rule out infection. Ultrasound may be useful if available, but it is not necessary for
the diagnosis of incomplete abortion or its treatment. Complete evacuation can be confirmed with clinical history and pelvic exam.

- Based on history and exams, if uterine evacuation is not complete and a woman does not have complications or a medical condition requiring MVA at the hospital level, misoprostol (600 mcg orally) can be given for the treatment of incomplete abortion. For further details, refer to the section on treatment of incomplete abortion in this protocol.

Follow-up care
- A follow-up visit should be scheduled between 7 and 14 days. Assess for a completed abortion.
- The use of clinical signs and symptoms with bimanual examination, human chorionic gonadotrophin (hCG) levels or ultrasonography (if available) can confirm abortion completion.
- When a woman reports ongoing symptoms of pregnancy and/or has only minimal bleeding after taking medical abortion medications as directed:
  - Ongoing pregnancy should be suspected and further evaluation could include pelvic examination, demonstrating a growing uterus, or an ultrasound scan, demonstrating an ongoing pregnancy;
  - Offer vacuum aspiration or repeat administration of misoprostol to complete her abortion;
- When a woman reports prolonged or excessive bleeding and cramping, and ongoing intrauterine pregnancy is not suspected:
  - Consider a diagnosis of ectopic pregnancy and manage appropriately;
  - Repeat misoprostol or vacuum aspiration to complete the abortion;
- When a woman reports lighter than expected bleeding or no bleeding, and ongoing intrauterine pregnancy is not suspected:
  - Consider a diagnosis of ectopic pregnancy and manage appropriately.
<table>
<thead>
<tr>
<th>Description</th>
<th>Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pain</td>
<td>• Respectful, nonjudgmental communication</td>
</tr>
<tr>
<td></td>
<td>• Verbal support and reassurance through explanation of what to expect</td>
</tr>
<tr>
<td></td>
<td>• The presence of a supportive person who can remain with her during the process (only if she desires it)</td>
</tr>
<tr>
<td></td>
<td>• Hot water bottle or heating pad</td>
</tr>
<tr>
<td></td>
<td>• NSAIDs, such as ibuprofen</td>
</tr>
<tr>
<td>Bleeding</td>
<td>• Explain woman that bleeding (similar to menstrual bleeding) is a natural part of process and create reasonable expectations about the amount and duration of bleeding</td>
</tr>
<tr>
<td>Fever (repeated does of misoprostol may cause temperature elevation)</td>
<td>• Antipyretic drugs, such as paracetamol</td>
</tr>
<tr>
<td></td>
<td>• If fever persists for more than 24 hours after misoprostol, further assessment is warranted</td>
</tr>
<tr>
<td>Nausea and vomiting</td>
<td>• Self-limiting. Reassure, provide anti-emetics if desired</td>
</tr>
<tr>
<td>Diarrhea</td>
<td>• Self-limiting. Reassure, provide antidiarrheal medication if desired</td>
</tr>
<tr>
<td></td>
<td>• Encourage oral hydration</td>
</tr>
</tbody>
</table>

At the follow-up visit after medical abortion treatment:

• Provide contraceptive counseling education again
• Help each woman choose an appropriate contraceptive method
• Ensure that those who are not planning to get pregnant soon leave the clinic with a contraceptive method.

**ALL** contraceptive methods can be offered without any restrictions at the follow-up visit.
6. POSTABORTION FAMILY PLANNING

Postabortion family planning is one of several high-impact practices (HIPs) in family planning identified by a technical advisory group of international experts (USAID 2011). Postabortion family planning counseling and services should be offered at the same place and time as treatment as a key component of PAC, after any treatment method. It is very important that women who are treated leave the facility with an effective contraceptive method to avoid unplanned pregnancies.

When counseling a woman who has been treated for an incomplete abortion or miscarriage on family planning, two important pieces of information should be communicated to her:

• She can again be pregnant 10 days after treatment of an incomplete abortion or miscarriage.

**Refer to Appendix 10.3 for further detail on providing postabortion family planning services**

• To enable her to recover well, it is better to wait at least six months before another pregnancy.

Most contraceptive methods can be initiated on the day of the treatment, regardless of the treatment method used. The following table shows various contraceptives and when they can be initiated after providing treatment services based on the method used.

Table 6. Contraceptive methods and when they can be initiated during the postabortion period based on the treatment method

<table>
<thead>
<tr>
<th>Type of contraception</th>
<th>When using medical methods</th>
<th>When using MVA or other surgical methods</th>
</tr>
</thead>
</table>
| Intrauterine device (IUD) | • Can be inserted at the follow-up visit, after making sure that the treatment is complete  
  • In case of confirmed infection or if the provider suspects infection, insertion of the device can be delayed until all traces of infection have disappeared  
  • If the hemoglobin rate is less than 7 g/dL, postpone the insertion until anemia is treated  
  • Provide a temporary contraception method (e.g. hormonal contraception or condoms) | • Can be inserted immediately (on the day of uterine evacuation)  
  • In case of confirmed infection, or if the provider suspects infection, insertion of the device can be delayed until all traces of infection had disappeared  
  • If the hemoglobin rate is less than 7 g/dL, postpone the insertion until anemia is treated  
  • Provide a temporary contraception method (e.g. hormonal contraception or condoms) |
<p>| Oral contraceptive pills (combined or progestin only)* | These methods can be initiated immediately (on the day of treatment) after both treatment methods. All of the hormonal methods can be used even if infection is present. *Misoprostol (add mifepristone) does not interact with hormonal contraception, and the hormonal methods can be administered at the same time the first pills are given to women. | |</p>
<table>
<thead>
<tr>
<th>Method</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male and female condoms</td>
<td>Condoms can be initiated immediately (on the day of treatment). They can be used as an interim method for women who cannot decide on a contraceptive, or who cannot be offered their method of choice immediately after treatment of incomplete abortion.</td>
</tr>
</tbody>
</table>
| Tubal ligation         | • Can be done at a follow-up visit  
• Provide a temporary contraception (e.g. hormonal contraception or condoms) |
Abortion can be a traumatic event for any woman terminating her pregnancy, regardless of the cause. Therefore it is very important that all women who undergo termination of pregnancy be provided appropriate psychosocial counseling, both before and after the procedure; in addition to medical and legal services.

All GBV victims, as well as women whose pregnancy will be terminated due to medical reasons need to undergo counseling, with specific objectives outlined in Table 7. While the goal of the pre-abortion counseling is to reduce the distress in relation to termination of pregnancy, post-abortion counseling should focus on reducing negative emotions (such as culpability, feelings of guilt, internalized stigma, etc.), as well as to manage post-traumatic stress disorder (PTSD) and other psychological problems. The counseling strategies and information outlined here should be provided to women who will undergo therapeutic abortion as well as for women who decide to terminate a pregnancy as a result of rape, incest or forced marriage.

Table 7. Types of counseling, target group and objectives of counseling for abortion related services

<table>
<thead>
<tr>
<th>Type of Counseling</th>
<th>Target group</th>
<th>When</th>
<th>Objectives of counseling</th>
</tr>
</thead>
</table>
| 1. Counseling for GBV victims | Women who have been victims of GBV | At their first admission to a facility | • Respond to the woman's emotional needs (safety, care, etc.)  
• Identify means of psychosocial support including social services, family members, etc.  
• Identify means of physical, financial and legal support (safe houses, fee waivers, legal support personnel)  
• Awareness of services for emergency family planning, pregnancy termination, etc.  
• Provide information on other related topic (STI/HIV counseling; re-integration into society, etc.) |
| 2. Counseling for pregnant GBV victims | Women who have become pregnant as a result of rape, incest or forced marriage | When the victim comes back after initial counseling with a pregnancy; or for a victim who admits to a facility when she is pregnant | • Respond to the woman's emotional needs (safety, care, etc.)  
• Discuss her options with pregnancy  
• Discuss and identify the support she will need to keep the pregnancy (financial, social, child care, adoption options, etc.)  
• Discuss and identify the support she will need to terminate the pregnancy (court order; access to a hospital, etc.)  
• Follow-up with other needs and services as appropriate |
### 3. Counseling before termination of pregnancy

| All women who will have their pregnancy terminated (including GBV victims and therapeutic abortion patients) | Before the procedure of termination of pregnancy | • Respond to the woman's emotional needs  
• Discuss her options for pregnancy termination (medical, surgical)  
• Discuss the expected side effects and warning signs of each method  
• Discuss efficacy and safety of each method  
• Help women choose a pregnancy termination method  
• Respond to her questions and concerns |

### 4. Counseling after termination of pregnancy

| All women who will have their pregnancy terminated (including GBV victims and therapeutic abortion patients) | After the procedure of termination of pregnancy | • Respond to the woman's emotional needs  
• Provide family planning counseling  
• Provide follow-up information (including treatment confirmation, HIV testing, and mental health) |

Further information on the details of the psychosocial management of women who have been victims of gender based violence is provided in the Reference Manual for the Clinical Management of Gender-Based Violence Survivors, by the Ministry of Health, 2009. Please refer to the manual for further details in relation to providing counseling, as well as for other key information on Clinical Management of GBV Survivors.

The MOH decree #20/13 from 3/31/2006 regarding the medical management of sexual violence against women determined six areas that should be covered by health facilities, including services that should be provided to the victim at no charge, in conditions that ensure patient confidentiality, quality of care and the timely provision of HIV post-exposure prophylaxis. It also states that the medical examination of the perpetrator should be done free of charge (so that sexual violence could be evidenced) and that a medical report should be drafted right away.

According to the statistics compiled by the police force from 2005 to 2008, it appears that out of over 6,000 rapes reported to the Rwandan police force, more than ¾ of victims were under 18 years old. This report also shows that the children and teenagers that were interviewed identified three main forms of violence: physical violence, sexual violence and psychological violence. The report also showed that most cases of violence occurred at home, within the community and in the woods/fields (Clinical Management of GBV Survivors, 2009).

It is important to note that the overall level of violence being experienced (including rape, incest and forced marriage) is significantly higher than the violence being reported. Many times these acts of violence are repeated in various ways against the
same individuals, thus developing a cycle of violence instead of yielding any improvements.

7.1 Psychological Management of GBV Survivors

The management of GBV survivors is crucial as violence can impact the life of individuals in various ways: physically, psychologically, socially, spiritually and economically.

The management of victims helps identify problems related to violence, ensure the safety of GBV survivors, improve access to care and prevention services, and facilitate the victim's reintegration process in the community. Information, education and communication in the community through health workers will allow participants to have access to information, understand the extent of the problems at hand, and develop management and prevention measures.

7.1.1. Counseling

Effective counseling through effective communication techniques is key to helping the victim express her feelings in order to understand what she went through and adequately manage her case. Counseling sessions should help the survivor and the provider develop a relation of trust, so that the victim can share her story and explain what she went through without feeling any shame or any guilt. The objectives of counseling are as follows:

- Reduce the negative emotions weighing on the victim's conscience
- Help understand the extent of the problem by being objective
- Empower GBV survivors without making them feel guilty
- Help GBV survivors build new values and convictions that will have a long-lasting impact on their lives
- Help GBV survivors understand their role in life
- Support GBV survivors and facilitate their reintegration in society.

7.1.2. Assessing the risk of GBV

Various types of wounds, health conditions and behaviors should give the providers reasons to believe that the patient is experiencing domestic violence or sexual abuse. The following are “red flags” for sexual abuse, and the providers need to assess the victim's safety before she can leave the facility (risk of committing suicide, risk of committing a homicide or risk of sustaining serious injuries).

<table>
<thead>
<tr>
<th>Red flags for sexual abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Teen pregnancy (less than 18 years old)</td>
</tr>
<tr>
<td>• Sexually transmitted infections (among children and young girls)</td>
</tr>
<tr>
<td>• Vaginal itching or bleeding</td>
</tr>
<tr>
<td>• Painful defecation or urination</td>
</tr>
<tr>
<td>• Pain in the lower abdomen or pelvis</td>
</tr>
<tr>
<td>• Sexual problems, lack of pleasure</td>
</tr>
<tr>
<td>• Vaginismus (vaginal tightness causing discomfort)</td>
</tr>
</tbody>
</table>
• Anxiety, depression, self-destructive behavior
• Previous unexplained chronic physical symptoms
• Alcohol and drug abuse
• Sexual simulation (sexual excess or disgust for sexual intercourse)
• Extreme obesity.

Principles for Counselling Child and Adult Victims

• Be calm because the crisis may overwhelm you the counsellor
• Assess the stage of the crisis quickly (Denial, Anger, Bargaining, Resignation or Acceptance stage) in order for you to give appropriate counsel
• Apply active listening
• Begin where the victim is
• Accept the client's definition of the crisis
• Ask for what has already been done
• Explore all the issues involved
• Ask what new thing could be done to solve the problems
• Use silence to give an opportunity for the victim to think through what is discussed
• Ask about activities or routines which provide support in time of stress
• Agree on a timetable of implementation of a plan made to resolve the crisis
• Arrange follow-up

7.2 Assessing the Victim's Risk of Being Severely Wounded, Committing Suicide or Being Killed

Any individual experiencing physical abuse should be assessed in order to determine if s/he is at risk of sustaining additional injuries or being killed before being sent back home. The following factors are related to such risks:

• Violence outside of the person's home
• Violence against children
• Homicide threats targeting the victim, the children or threats of committing suicide if the victim decides to leave
• Increased threats
• Drug use by the perpetrator
• Physical abuse during pregnancy
• In cases when the victim has tried to leave her partner, if divorce proceedings are underway, if the victim tried to seek help to end violence in the past
• Sexual abuse
• The perpetrator is obsessed by the victim and claims he cannot live without her.
• Harassment
• Severe wounds were inflicted to the victim in the past
• Weapons can be found at the victim's home
- The perpetrator has threatened the victim's family and friends
- The victim feels in danger.

After looking at these risk factors with the victim, ask her if she feels that she's at risk. If she says "yes", her answer should be taken very seriously. If she says "no" but you still think that she is in danger, you should have a completely open discussion with her. Explain to her that she is likely to be abused again or even be killed. If she has already been thinking about leaving her partner, tell her that she should consider leaving him without saying anything. Make sure that she can find a place that is safe for her and her children.

Abuse seems to be a factor leading GBV survivors to commit suicide. Therefore, all the individuals who have experienced physical abuse should be asked if they have had suicidal thoughts. They should be asked frankly if they intend to hurt themselves and if they have a plan.

Ask the following questions:
- Have you ever felt so belittled that you thought about dying?
- Have you ever thought about taking your own life?
- Have you thought of the way you could do it?
- Do you own any weapons? Do you have a significant amount of pills and tablets at home? (Depending on the answer to the previous question.)
- Do you think there is someone you can count on to take revenge on the perpetrator?
- Have you ever thought about committing suicide in the past?

If it appears that the GBV survivor is very likely to commit suicide, she should be urgently referred for a psychological evaluation or be sent to a safe house. Homicidal thoughts also call for a psychiatric evaluation. In most cases, people killing their partner have been abused for a long period of time and cannot think of any other way out. They usually kill their partner in an act of self-defense, or to prevent that person from seriously injuring or killing them or their children. If the GBV survivor has had homicidal thoughts, please ask her if she's planning on killing or injuring her partner. Does she have a plan or does she own a weapon? If she does, you may have to breach the confidence and warn the competent authorities. It is important for the provider to distinguish words like "I want him to die" (that are usually said in a highly emotional state) from the actual intention of killing somebody. Ask the survivor if she thinks she could put her thoughts into action. This will clarify the immediate risk level.

- Explain to the GBV survivor that she needs to be referred to psychological support services as part of the follow-up procedure
- Explain to her that survivors sometime think about committing a homicide when they think they do not have any other options. However, resources are available to support her and you can help her access them.
- If she refuses to consult the psychological support services or the protection center (safe house), or if she's planning to kill her husband, contact the authorities.
7.3 Rape Trauma Syndrome (RTS)

The rape trauma syndrome (RTS) was defined in 1974 by Ann Burgess and Lylte Holmstrom. It encompasses various emotional reactions expressed by most victims of sexual violence. It can be divided into three stages:
- The acute stage
- The renormalization stage.
- Long term phase

7.3.1 Acute stage

The acute stage occurs immediately after the rape and usually lasts a few days or a few weeks. The victim's reactions depend on internal factors (personality) and external factors (culture, type and circumstances of the abuse...). Clinical signs of this trauma include both psychotic decompensation and reversible disorders. In the hours following the assault, victims are in a state of shock and react according to two patterns:
- The expressed response: the victim expresses her fears, anxiety and anger in a loud manner (crying spells, laughs, agitation, etc.)
- The controlled response: the survivor remains calm, appears to be without emotion and hides her feelings.

A survivor may alternate these two responses. She may be angry and then be thankful she is still alive before feeling sad again.

The immediate phase starts a few days after the assault and lasts a few weeks. The survivor may display a wide range of physical, behavioral and emotional responses. For example, if this individual was abused while alone, she may want to be accompanied everywhere she goes. If she was raped by several people, she may withdraw into herself and isolate herself.

Behavioral symptoms
- Crying spells, shouts, nervous laugh, logorrhea
- Permanently alert, extremely vigilant, unable to sleep or relax (insomnia, nightmares, awoken in the middle of the night)
- Highly concerned about hygiene (obsession to wash or clean herself), interminable prayer rituals
- Refusing physical contact
- Avoiding everything that might remind her of the assault (location, people, discussion topics, sexual intercourse, etc.)
- Distrust and excessive suspicion toward other people, especially men (both for male and female survivors)
- Difficulties concentrating
- Eating disorders
- Consumption or increased consumption of drugs and alcohol
- Isolation (loss of interest in others, in routine activities and in sexual activity)
- Emotional dependency (inability to stay alone)
- Stuttering
- Mood swings, anger and aggressiveness toward friends and family for mundane things
Acts of revenge
- Intensification of preexisting behavioral disorders.

Psychological symptoms
- Fear: Survivors are afraid that people will not believe them, that they will be abused again, that their family and friends will blame them, or that they contracted an STD (especially HIV/AIDS). They may also be afraid of strangers.
- Paralyzing anxiety, panic attacks, terror (confusion and crying)
- Helplessness
- Feeling humiliated, embarrassed, ashamed and dishonored
- Feeling soiled; lack of self esteem; self-depreciation
- Feeling that the body has endured irreversible damages
- Ashamed of her own behavior; feeling of guilt (wondering how she could have protected herself better; worried about dishonoring her entire family)
- Isolation; fear of not being understood
- Anger, aggressiveness toward the perpetrator
- Euphoria; feeling of relief after avoiding death
- Absence of any emotions, silence, withdrawal (the survivor needs to protect herself psychologically and reflect on what happened to her)
- Denial of the assault and of its severe consequences
- Depression symptoms, suicidal thoughts/attempts
- Acute stress disorder (dissociative symptoms, persistent neurovegetative state, tendency to relive the event)
- Psychotic decompensation
- Intensification of preexisting psychological disorders
- Flashback

7.3.2 Renormalization stage

This stage can last several months or several years. The renormalization process starts when the survivor is ready to come to terms with the abuse she experienced. The duration of this stage may vary from one individual to the next and depends on factors related to the abuse itself (circumstances, intensity, duration, etc.), to the individual (age, personality, ability to cope, etc), and to the survivor's environment (support or rejection from family and friends).

The post immediate stage occurs several weeks or several months after the assault. The following symptoms can be observed throughout this stage:
- Persistent or exacerbated symptoms
- Fear of retaliation, anxiety regarding the GBV management process and the lifelong impact of the abuse
- Pseudo-phobia: fear of men, crowds, strangers, sexual intercourse, physical contact, being alone
- Intensified feeling of being threatened and physically unsafe
- Depressive disorders
- Chronic fatigue
- Loss of identity: feeling of being dead or broken inside; fear of being a different person; fear of being inexistent
- Resignation, helplessness, lack of hope
- Denying the assault and its various consequences is a common reaction during the post-immediate phase
- Post-traumatic Stress Disorder (PTSD)

### 7.3.3 Long-term phase

Clinical signs of the trauma can remain in the long-term or even throughout the victim's entire life.
- Persistent symptoms (see previous section)
- Anger guided toward the perpetrator
- Losing the will to live
- Extreme awareness of danger (for instance fear of new or unexpected situations)
- Sexual disorder (significant decrease or excess in sexual activity, reminiscent trauma during sexual intercourse).

### 7.4 Provision of Information

- Please let the patient know about the availability of support and protection services
- Provide information regarding the services available at the facility level (test and curative/preventive treatment) and possible referrals to other medical, legal, psychological and socio-economic services
- Provide the survivor (and the people who came with her) with information regarding next steps and available support services.

### 7.5 Developing a Safety Plan

GBV survivors may have difficulties making decisions, especially when they are traumatized. Counseling best practices should be used to assist the survivors and help them identify their needs. The following elements should be considered:
- The survivor's thoughts regarding her safety plan
- The accessibility of services
- The coverage of GBV services by a mutual insurance society or a regular insurance program
- The safe house used to protect the victim (for instance the Isange Center located at the Kacyiru Hospital)
- The education of the community in GBV.

### 7.6 Developing a Follow-Up Plan

In the context of GBV, counseling is used in order to help the survivors express their needs, identify possible solutions and make free and informed decisions. In order to be efficient, counseling sessions should be based on trust and mutual respect between the patient and the provider.

Most GBV survivors refuse to tell anyone about their problem. If a survivor tells you what happened, it means that person trusts you.

Throughout the counseling sessions, health workers need to come up with a monitoring system in order to ensure that the survivor remains psychologically and socially stable. This monitoring process should occur through particular interview sessions with very specific goals.
Please tell the survivor that she can come back to the facility at any time if she has any questions or health-related issues. Throughout the counseling sessions, the counselor should work with the survivor in order to facilitate her social and professional reintegration. The counselor will also encourage her to maintain her professional activity in order to keep feeling useful and not be isolated. In order for the monitoring process to be efficient, the social workers can organize home visits in order to:

- Intensify the counseling sessions
- Assess the survivor’s economic and social situation
- Facilitate the family’s participation in the survivor’s reintegration process
- Break the survivor’s isolation

Assist the survivor in case that individual cannot perform daily activities due to the trauma; ensure the well-being and safety of the survivors placed under the provider's responsibility.
8. ROLES AND RESPONSIBILITIES FOR A COORDINATED SERVICE AND MULTIDISCIPLINARY CASE MANAGEMENT

The provision of high quality services requires a multidisciplinary approach with collaboration of all stakeholders involved, including but not limited to agents in the judicial, police, and social services and the health system. Specifically, understanding how one’s individual role in case management connects to others’ roles, as well as collaborating with these stakeholders will provide a better experience for the victim, and ensure that services are timely, accessible, high-quality and not duplicative. Noted below are the specific roles for each stakeholder in multidisciplinary case management.

Roles and Responsibilities for Prosecutor

- Immediately guide the victim to refer the request of abortion to judge
- Attend the hearing when so is requested by the judge

Roles and Responsibilities for Judge

- Hear, consider, analyze the request
- Make a decision (order)
- Issue the order as a matter of urgency (article 165 penal code)

Roles and Responsibilities for Police Officers

- Receive, inform and orient the victim
- Mobilize and sensitize the community (law enforcement)
- Assist and support the victim to get required services (health facility, prosecution, court)
- Conduct a comprehensive investigation

Roles and Responsibilities for Doctors

- Conduct clinical examination of the patient (history, physical examination, other special procedures and tests, etc.)
- Confirm the diagnosis
- Treat any associated medical condition (STI, genital injury, etc.)
- Make a report to the requesting authority (judge, prosecutor, police)
- Obtain informed consent to perform abortion
- Perform abortion when ordered by court, or qualifies for therapeutic abortion
- Complete hospital records accordingly
- Give a follow-up date for an HIV test in 3 months

Roles and Responsibilities Social Workers

- Receive the patient
- Assist the patient in her orientation for different components of care (medical, mental health, police and legal services)
- Assess the socioeconomic status of the patient
• Conduct follow-up with the victim including home visits, and support victim's social re-integration
• Keep patient records for traceability
• Counseling

Roles and Responsibilities for Mental Health Providers (Psychologists, Counselors, Mental Health Nurses)

• Conduct psychological assessment of the patient
• Provide psychological support and counseling to the patient
• Provide psychotherapy where needed and additional follow-up
• Refer to psychiatrist as needed
• Guide parents, in case of minors

Roles and Responsibilities for Nurses and Midwives

• Provide counseling to women
• Prepare the patient for the clinical exam (take vital signs, weigh the patient, show the changing room, etc.)
• Assist the doctor during the examination of patient and procedures
• Support and observe the patient after procedure
• Conduct postabortion family planning counseling
• Provide a family planning method
• Record the findings

Roles and Responsibilities for Local Administration

• Generate community awareness
• Provide social protection and assistance (financial assistance, rehabilitation, orientation, fight stigma and discrimination)

Roles and Responsibilities for Churches, Civil Society and CHW

• Generate community awareness (Good understanding of the provision of the penal code)
• Prevent and fight stigma
• Advocate for access to affordable services and financial assistance
9. MONITORING, EVALUATION AND SUPERVISION OF ABORTION RELATED SERVICES

9.1 Monitoring, Evaluation and Supervision Overview

Service delivery monitoring will take place at hospitals and One Stop Centers (OSCs)/Gender-Based Violence (GBV) Centers. At hospitals, providers will complete one Service Delivery form for each woman who seeks pregnancy termination services. The Service Delivery form will be used to monitor provision of pregnancy termination services, including information on the exemption the woman applied for, gestational age at the time of admission, method used for pregnancy termination, and return for follow up, among other indicators. See Section 10.6 for a draft of the Service Delivery form.

At OSCs/GBV Centers, providers will complete a Client Information form for each woman who reports a case of GBV (rape, incest or forced marriage) to the OSC/GBV center. This form will capture information on each woman, date and reason for admission to the OSC/GBV center, if the woman is pregnant, if the woman desires an abortion, if the woman requests a court order, the exemption of the court order, if the court order is approved, and length of time of court order approval, among other indicators. See Section 9.2, Indicators to be used for monitoring and evaluation, for a list of monitoring indicators to be collected at hospitals and OSCs/GBV centers. See Section 10.7 for a draft of the Client Information form.

One Clinical Focal Point at each hospital will oversee service delivery data collection. The Clinical Focal Point and healthcare providers will be trained on hospital and OSC/GBV Center data collection. The MOH will conduct ongoing monitoring of supplies needed for abortion service provision including Manual Vacuum Aspiration (MVA) kits and medical abortion products.
9.2 Indicators to be used for monitoring and evaluation

9.2.1 Health Services Related Indicators

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Definition</th>
</tr>
</thead>
</table>
| Abortion cases presenting, by legal exemption                             | Total number of abortion cases presenting by legal exemption:  
  - Rape  
  - Incest up to second degree  
  - Forced marriage  
  - Pregnancy severely jeopardizes the health of the mother  
  - Pregnancy severely jeopardizes the health of the unborn baby                                                                                                                                       |
| Abortion cases presenting, by age                                         | Total number of abortion cases presenting:  
  - <18 years old  
  - 18-25 years old  
  - 25-35 years old  
  - >35 years old                                                                                                                                   |
| Abortion cases treated, by treatment method (including referral upon arrival) | Total number of cases of abortion presenting:  
  - Number treated with D&C  
  - Number treated with MVA  
  - Number treated with MA (mifepristone & misoprostol; and misoprostol alone)  
  - Number treated with D&E  
  - Number treated with Electric Aspiration  
  - Number referred upon arrival                                                                                                                                                                           |
| Abortion cases presenting, by gestational age                             | Total number of abortion cases presenting:  
  - Up to 12 weeks  
  - 13-22 weeks  
  - >23 weeks                                                   |
| Dose, route, and timing of mifepristone-misoprostol regimen administration |  
  - Dose, route, and timing for mifepristone-misoprostol regimen administration  
  - Use of correct regimen                                                                                                                   |
| Place of administration of MA (for pregnancies of gestational age <13)     |  
  - Number of woman provided MA inpatient  
  - Number of women provided MA outpatient                                                                               |
| Psychosocial counseling provided                                          | Total number of women who were provided psychosocial counseling                                                                                                                                    |
| Time taken to get abortion service                                       | Time (in days) from when court order was approved and abortion was provided                                                                                                                     |
| Rate of follow-up                                                        | Number of women who return for a follow-up visit by treatment method                                                                                                                                     |
| Complete abortion rate                                                   | Among women who return for a follow-up visit, the number who have a complete abortion                                                                                                                  |
| Women requiring additional treatment                                     | Number of women requiring addition treatment due to treatment failure                                                                                                                                     |
| 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                                                                                       |
| Complications before discharge                                           | Number of women who experience any serious complication before being discharged from the facility                                                                                                           |
| Referrals due to complication of procedure                               | Number of women referred due to complications of the procedure received at the health facility                                                                                                             |
### 9.2.2. Abortion Services Supplies Related Indicators

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>MVA kit supply</td>
<td>Number of days of stockout of MVA kits during the month</td>
</tr>
<tr>
<td>Mifepristone-misoprostol combination pack supply</td>
<td>Number of days of stockout of combination pack during the month</td>
</tr>
<tr>
<td></td>
<td>Number of tablets used during the month and currently in stock</td>
</tr>
<tr>
<td>Contraceptive supply by method</td>
<td>Number of days stockout of contraceptive method, by method</td>
</tr>
<tr>
<td></td>
<td>(oral contraceptive pills, condoms, intrauterine device, injectable)</td>
</tr>
<tr>
<td></td>
<td>Number of units stock of contraceptive methods</td>
</tr>
</tbody>
</table>

### 9.2.3. Legal Services Related Indicators

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>GBV cases presenting</td>
<td>Total number of GBV cases presenting (rape, incest, forced marriage) in all possible venues:</td>
</tr>
<tr>
<td></td>
<td>• GBV (One-Stop) Centers</td>
</tr>
<tr>
<td></td>
<td>• Court</td>
</tr>
<tr>
<td></td>
<td>• Judiciary</td>
</tr>
<tr>
<td></td>
<td>• Police</td>
</tr>
<tr>
<td>Submission of requests for abortion to judiciary</td>
<td>Number of abortion applications submitted to judiciary, by exemption</td>
</tr>
<tr>
<td>Judiciary submission to court</td>
<td>Number of applications (among all applications made to judiciary) that were taken to court</td>
</tr>
<tr>
<td>Approval of court order for abortion</td>
<td>Among applications of request for abortion; cases granted court approval</td>
</tr>
<tr>
<td>Court order decision time</td>
<td>• Amount of time taken by the court to make the decision on approving or denying the request</td>
</tr>
<tr>
<td></td>
<td>• Time taken from when application was first made</td>
</tr>
<tr>
<td></td>
<td>• Time taken from when all related investigation and documentation was completed</td>
</tr>
<tr>
<td>Abortion approval rate</td>
<td>Proportion of court orders issued for abortion among all court cases, by exemption</td>
</tr>
</tbody>
</table>

See Appendix 10.6 for monitoring and supervision tools.
9.3 Monitoring & Reporting Use of Misoprostol and Mifepristone-Misoprostol Combination Pack

9.3.1 Use of misoprostol and mifepristone-misoprostol combination pack

Misoprostol and mifepristone-misoprostol combination pack, used for post abortion care and the management of exemptions for abortion according to the penal code of 2012, are procured from the Central Medical Store (CMS). From there, these products are distributed to lower health levels to reach patients according to the scheme below:

- **Flow of commodities**
- **Flow of information/Feedback**
Monitoring process
Misoprostol and mifepristone-misoprostol combination pack will be monitored according to the procedures outlined in the Ministerial Order to include instructions for the handling and monitoring of Controlled Drugs (CD) to ensure safe and rational use. This class of drugs requires, among others, the following:

Required Materials and Equipment
- Lockable cupboard
- Stock Cards (or Drugs Management Software)
- Registry (CD consumption recording book)

Secured storage
All misoprostol and mifepristone-misoprostol combination products should be kept in a lockable cupboard separately from other non-controlled drugs. The keys should be kept by the health facility's pharmacist or nurse in charge of the pharmacy. Access to these products should be authorized by the pharmacist or nurse in charge of the pharmacy, with appropriate medical prescription signed by a doctor in a District Hospital or a nurse in a Health Center.

Inventory
All misoprostol and mifepristone-misoprostol combination products should have respective stock cards that record all transactions according to the guidelines of the Ministry Health regarding the management of health commodities in Health Facilities (DPs, HDs and HCs). If management software is available, all stock transactions for PAC drugs should be properly recorded to comply with the physical stock.

Registry (CD consumption recording book)
Each health facility should have an appropriate registry to record all distributions of misoprostol and mifepristone-misoprostol combination products. They should only be distributed under presentation of a medical prescription signed and stamped by a medical doctor in a District Hospital or by a nurse in a Health Center. After distribution, the pharmacist or nurse in charge should file a carbon copy of the medical prescription for records and record in the registry the following information:
- Date of the dispensing
- Names of the patient
- Identity card number and phone number of the client (if applicable)
- Name of drugs dispensed
- Amount of drugs dispensed
- Remaining stock
- ID Number of prescription
- Date of the prescription
- Names of prescribing Doctor
- Names of the dispenser
- Signature of the dispenser
- Observation

Reporting
The reporting and requisition of all misoprostol and mifepristone-
imisoprostol combination products should be done through ordinary
flow of information according to the national Logistics Management
Information System (LMIS).
10. APPENDICES

10.1 Checklist for Manual Vacuum Aspiration (MVA) for Uterine Evacuation

Instructions: Rate the performance of the service provider for each step or task using the following scale. The checklist can be used for five (5) cases.

1. Needs Improvement: Step or task not performed correctly or is omitted
2. Competently Performed: Step or task performed correctly but learner does not progress from step to step efficiently
3. Proficiently Performed: Step or task efficiently and precisely performed in the correct order

NA Not Applicable

<table>
<thead>
<tr>
<th>STEP/TASK</th>
<th>OBSERVATION</th>
<th>Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Getting ready</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Greet the woman respectfully and with kind</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Assure the necessary privacy and confidentiality</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Initial assessment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Assess the patient for shock and other life-threatening conditions.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. If any complications are identified, stabilize the patient and transfer if necessary.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical evaluation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Take medical history.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Perform physical (heart, lungs and abdomen) and pelvic examinations.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Give the patient information about her condition and treatment plan.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Discuss her reproductive goals, as appropriate.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. If she is considering an IUD:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• She should be fully counseled regarding IUD use</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• The decision to insert the IUD following the MVA procedure will be dependent on the clinical situation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Before the MVA procedure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Tell the patient what is going to be done and encourages her to ask questions.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Tell the patient she may feel discomfort during some of the steps and that s/he will tell her in advance.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Ask the patient about allergies to antiseptics and anesthetics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Check that the patient has thoroughly washed her perineal area.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Additional pain management options: verbal reassurance and relaxation; medications) can be provided as needed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Check the patient has recently emptied her bladder.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. Determine that required sterile or high-level disinfected instruments and cannulae are present.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
15. Check MVA syringe and charges it (establishes vacuum).

16. Put on apron, wash hands thoroughly with soap and water and dry with clean cloth or air dry.

17. Put sterile gloves on both hands.

18. Arrange sterile instruments on sterile tray.

**MVA procedure**

19. Explain important steps of the procedure prior to performing it.

20. Perform bimanual pelvic examination to confirm uterine size, position and degree of cervical dilation.

21. Check the vagina and cervix for tissue fragments with a speculum exam and removes them.

22. Start antibiotic prophylaxis by giving 100 mg doxycycline orally.

23. Apply antiseptic solution two times to the cervix (particularly the opening) and vagina.

24. Put tenaculum or vulsellum forceps on posterior lip of cervix.

25. Correctly administer paracervical block and wait 2-4 minutes for anesthetic to have maximum effect.

26. Dilate the cervix (if needed) using progressively larger cannulae.

27. Gently apply traction on the cervix to straighten the cervical canal and uterine cavity and insert the cannula gently through the cervix into the uterine cavity.

28. Attach the prepared syringe to the cannula by holding the end of the cannula in one hand and the syringe in the other.

29. Evacuate contents of the uterus by rotating the cannula and syringe clockwise and moving the cannula gently and slowly back and forth within the uterine cavity.

30. Inspect tissue removed from uterus for quantity and presence of POC and to assure complete evacuation.

31. When the signs of a complete procedure are present, withdraw the cannula and MVA syringe and remove forceps or tenaculum and speculum.

32. Perform bimanual examination to check size and firmness of uterus.

33. Insert speculum and check for bleeding.

34. If uterus is still soft or bleeding persists, repeat vacuum aspiration.

**Post-MVA tasks**

35. Before removing gloves, dispose of waste materials and MVA items in 0.5% chlorine solution for 10 minutes for decontamination.

36. Dispose of gloves by placing in leakproof container or plastic bag.

37. Wash hands thoroughly with soap and water and dry with clean, dry cloth or air dry.

38. Check for amount of bleeding and if cramping has decreased at least once before discharge.

39. Instruct patient regarding postabortion care (e.g. when patient should return to clinic).
<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>40.</td>
<td>Give 200 mg doxycycline as post-procedure prophylactic antibiotic</td>
</tr>
<tr>
<td>41.</td>
<td>Provide pain killers (NSAID drugs, such as 800 mg of ibuprofen)</td>
</tr>
<tr>
<td><strong>Counseling and family planning service provision</strong></td>
<td></td>
</tr>
<tr>
<td>42.</td>
<td>Discuss reproductive goals and, as appropriate, provides family planning. <em>(Note: Refer to Appendix 10.5 to use the Checklist for Postabortion Family Planning.)</em></td>
</tr>
</tbody>
</table>

**Comments**
## 10.2 Checklist for Medical Abortion with Combined Regimen (Mifepristone and Misoprostol)

Instructions: Rate the performance of the service provider for each step or task using the following scale. The checklist can be used for five (5) cases.

1. **Needs Improvement**: Step or task not performed correctly or is omitted
2. **Competently Performed**: Step or task performed correctly but learner does not progress from step to step efficiently
3. **Proficiently Performed**: Step or task efficiently and precisely performed in the correct order

**NA** Not Applicable

<table>
<thead>
<tr>
<th>STEP/TASK</th>
<th>Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Getting ready</strong></td>
<td></td>
</tr>
<tr>
<td>1. Greet the woman respectfully and with kindness</td>
<td></td>
</tr>
<tr>
<td>2. Assure the necessary privacy and confidentiality</td>
<td></td>
</tr>
<tr>
<td>3. Review the patient assessment and treatment plan</td>
<td></td>
</tr>
<tr>
<td>4. Confirm the gestational age: ____ weeks</td>
<td></td>
</tr>
<tr>
<td>5. Confirm that the woman is eligible for medical abortion: ____</td>
<td></td>
</tr>
<tr>
<td><strong>Pre-procedure counseling</strong></td>
<td></td>
</tr>
<tr>
<td>6. If other abortion methods are also available at your facility (such as MVA), confirm that the patient was provided counseling and informed on all available methods appropriate for her clinical situation</td>
<td></td>
</tr>
<tr>
<td>7. Confirm that the patient understands the most common transient side effects, and how to manage them, if necessary:</td>
<td></td>
</tr>
<tr>
<td>- Pain</td>
<td></td>
</tr>
<tr>
<td>- Bleeding</td>
<td></td>
</tr>
<tr>
<td>- Fever and/or chills</td>
<td></td>
</tr>
<tr>
<td>- Nausea and/or vomiting</td>
<td></td>
</tr>
<tr>
<td>- Diarrhea</td>
<td></td>
</tr>
<tr>
<td>- Headache/faintness/dizziness</td>
<td></td>
</tr>
<tr>
<td>8. Inform the patient that 2-8% of women may require additional intervention. If the drugs fail, the woman should be prepared to complete the abortion medically or surgically</td>
<td></td>
</tr>
<tr>
<td>9. Inform the patient about warning signs, and tell her to consult a health facility if she experiences any of the following:</td>
<td></td>
</tr>
<tr>
<td>- Severe intractable pain and cramping, which does not respond to pain killers</td>
<td></td>
</tr>
<tr>
<td>- Heavy bleeding</td>
<td></td>
</tr>
<tr>
<td>- Fever which starts a day after treatment, or lasts more than 4 hours after misoprostol administration</td>
<td></td>
</tr>
<tr>
<td>- Vaginal discharge with foul smell</td>
<td></td>
</tr>
<tr>
<td>- No change or no bleeding after administration of drugs on the 7th day since the start of treatment (continuation of pregnancy)</td>
<td></td>
</tr>
<tr>
<td>10. Explain the dosage and administration of</td>
<td></td>
</tr>
</tbody>
</table>
mifepristone and misoprostol* to the patient

11. Explain that the majority of women expel within 24 hours of misoprostol administration but the process may take up to 2 weeks to complete, during which there may be light bleeding.

12. Ask the patient if she has any questions, and address her questions and concerns appropriately.

MA with mifepristone and misoprostol procedure

13. For Pregnancies up to 12 weeks: Confirm, in consultation with woman and her family, whether she will be treated as inpatient or outpatient.

For outpatients (up to 12 weeks):

14. Give 200 mg oral mifepristone to the patient, and ask her to swallow with water.

15. Give the patient the "how to take misoprostol at home after mifepristone" leaflet prepared for combined regimen medical abortion and provide the 4 misoprostol tablets she will be taking at home (Refer to Table 3 for the regimens according to gestational age).

16. Ask the patient to repeat the information on how and when to take the misoprostol tablets at home.

17. Write the date of the follow-up (1-2 weeks from the day of the procedure) and give the patient a follow-up card.

18. Confirm with the patient that she understands the warning signs, and knows when to come back immediately, if required.

19. Inform the patient about the referral facility, in case of emergency.

For inpatients:

20. Follow the regimens in Table 3, based on gestational age.

21. Monitor as needed, and discharge accordingly.

For therapeutic abortion inpatients (>22 weeks):

22. MA regimen for 12-22 weeks can be used for 22-24 weeks (See Table 3), and for pregnancies beyond 24 weeks, the dose of misoprostol should be reduced, owing to the greater sensitivity of the uterus to prostaglandins. For pregnancies beyond 30 weeks, provide misoprostol 50 mcg orally every 4 hours up to 6 times.

23. Before the patient leaves the facility, conduct contraceptive counseling and services as described in Checklist: Contraceptive Counseling and Method Provision.

Comments

*The regimens provided in this protocol are based on the World Health Organization's 2012 Safe Abortion Technical and Policy Guidance for Health
*Systems* (WHO, 2012b). Please check Table 3 in this protocol for correct regimens. Where mifepristone is not available, use the regimens in Table 4 for medical abortion with only misoprostol.
10.3 Checklist for Postabortion Family Planning

Instructions: Rate the performance of the service provider for each step or task using the following scale. The checklist can be used for five (5) cases.

1 Needs Improvement: Step or task not performed correctly or is omitted
2 Competently Performed: Step or task performed correctly but learner does not progress from step to step efficiently
3 Proficiently Performed: Step or task efficiently and precisely performed in the correct order
NA Not Applicable

<table>
<thead>
<tr>
<th>STEP/TASK</th>
<th>Clients</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Initial interview</strong></td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>1. Greet the woman respectfully and with kindness.</td>
<td></td>
</tr>
<tr>
<td>2. Ensure privacy and make her feel comfortable.</td>
<td></td>
</tr>
<tr>
<td>3. Use effective interpersonal communication:</td>
<td></td>
</tr>
<tr>
<td>Use two-way communication</td>
<td></td>
</tr>
<tr>
<td>Use appropriate language</td>
<td></td>
</tr>
<tr>
<td>Listening</td>
<td></td>
</tr>
<tr>
<td>Non-verbal communication</td>
<td></td>
</tr>
<tr>
<td>4. Encourage patient to talk (e.g., ask questions, express feelings)</td>
<td></td>
</tr>
<tr>
<td>5. Obtain brief reproductive history.</td>
<td></td>
</tr>
<tr>
<td>6. Ask if she was using contraception before she became pregnant. If she was, find out if she:</td>
<td></td>
</tr>
<tr>
<td>Used the method correctly</td>
<td></td>
</tr>
<tr>
<td>Discontinued use, and why</td>
<td></td>
</tr>
<tr>
<td>Had any trouble using the method</td>
<td></td>
</tr>
<tr>
<td>Has any concerns or questions about the method</td>
<td></td>
</tr>
<tr>
<td>7. Identify reproductive goals and individual needs.</td>
<td></td>
</tr>
<tr>
<td><strong>Contraceptive counseling</strong></td>
<td></td>
</tr>
<tr>
<td>8. Follow the steps to give the woman information about contraceptive choices available (use a family planning counseling flipchart or brochure if available).</td>
<td></td>
</tr>
<tr>
<td>9. Injectable contraceptives:</td>
<td></td>
</tr>
<tr>
<td>Show the injectable and describe how it is used</td>
<td></td>
</tr>
<tr>
<td>Explain how the method works and its effectiveness</td>
<td></td>
</tr>
<tr>
<td>Explain common side effects</td>
<td></td>
</tr>
<tr>
<td>Address any question or concern the woman may have about the method</td>
<td></td>
</tr>
<tr>
<td>10. Oral contraceptive pills:</td>
<td></td>
</tr>
<tr>
<td>Show the pills and describe how it is used</td>
<td></td>
</tr>
<tr>
<td>Explain how the method works and its effectiveness</td>
<td></td>
</tr>
<tr>
<td>Explain common side effects</td>
<td></td>
</tr>
<tr>
<td>Address any question or concern the woman may have about the method</td>
<td></td>
</tr>
<tr>
<td>11. Condoms:</td>
<td></td>
</tr>
<tr>
<td>Show the item and describe how it is used</td>
<td></td>
</tr>
<tr>
<td>Explain how the method works and its effectiveness</td>
<td></td>
</tr>
<tr>
<td>Explain common side effects</td>
<td></td>
</tr>
<tr>
<td>Address any question or concern the woman may have about the method</td>
<td></td>
</tr>
<tr>
<td>12. Implants:</td>
<td></td>
</tr>
<tr>
<td>Show the implants and describe how it is used</td>
<td></td>
</tr>
<tr>
<td>Explain how the method works and its effectiveness</td>
<td></td>
</tr>
<tr>
<td>Explain common side effects</td>
<td></td>
</tr>
</tbody>
</table>

1xxii
• Address any question or concern the woman may have about the method

13. Intrauterine device (IUD):
   • Show the IUD and describe how it is used
   • Explain how the method works and its effectiveness
   • Explain common side effects
   • Address any question or concern the woman may have about the method

14. Permanent methods (female and male sterilization):
   • Describe how the procedure is performed
   • Explain how the method works and its effectiveness
   • Explain common side effects
   • Address any question or concern the woman may have about the method

15. Emergency contraception
   • Describe how the method is used
   • Explain how the method works and its effectiveness
   • Explain common side effects
   • Address any question or concern the woman may have about the method

16. Discuss the use of intravaginal methods (diaphragms, vaginal ring, contraceptive jellies, foams, tablets or films), if available

17. Help the patient to choose an appropriate method.

<table>
<thead>
<tr>
<th>Contraceptive Method Provision</th>
</tr>
</thead>
<tbody>
<tr>
<td>18. Explain to patient that she can get pregnant again, as soon as in the next 10 days, so she should start using a method immediately.</td>
</tr>
<tr>
<td>19. Provide the patient her method of choice if available at the facility: (The following methods can be given to women at the time of the treatment of incomplete abortion with misoprostol):</td>
</tr>
<tr>
<td>• Injectables</td>
</tr>
<tr>
<td>• Condoms</td>
</tr>
<tr>
<td>• Oral contraceptives</td>
</tr>
<tr>
<td>• Implants</td>
</tr>
<tr>
<td>• Intravaginal methods</td>
</tr>
<tr>
<td>20. Refer patients to the appropriate facility if the method she has chosen is not available at your facility.</td>
</tr>
<tr>
<td>21. If the method is not immediately available, the patient does not reach a decision at the time, or needs to be referred to another facility for her method of choice, provide a temporary method (e.g., condoms).</td>
</tr>
<tr>
<td>22. Mark the method chosen on Patient Chart</td>
</tr>
<tr>
<td>23. Confirm that the woman understands what to do if she experiences any side effects or problems with the method she has chosen.</td>
</tr>
<tr>
<td>24. Provide follow-up visit instructions if needed.</td>
</tr>
<tr>
<td>25. Address other reproductive health needs (e.g., STIs, HIV) as appropriate.</td>
</tr>
</tbody>
</table>

Comments
10.4 Consent Form for Surgical and Medical Procedures

CONSENT FOR SURGICAL / MEDICAL PROCEDURES

You have been given information about your condition and the recommended surgical, medical or diagnostic procedure(s) to be performed. This consent form is designed to provide a written confirmation of such discussions by recording some of the more significant medical information given to you. It is intended to make you better informed so that you may give or withhold your consent to the proposed procedure(s).

I, _____________________________, ______ after the doctor's discussion, hereby consent to the following surgical/medical procedure:

________________________________________________

to be performed on

(Myself or name of patient)

I understand and agree that the doctors and other members of the Medical Staff of the hospital, may perform, or assist with the surgery/medical procedure. The reasons for the surgery/medical procedure, as well as the anticipated effects, nature and risks associated with it, have been explained to me by Dr. _____________________________

(Name of doctor explaining procedure)

I also consent to such additional or alternative diagnostic, operative or treatment procedures as are immediately necessary in the opinion of the physician performing the procedure. I certify that I am fully aware of and understand the contents of this consent.

Signature (Patient or Authorized Person) _______________________ Date: ___/___/____ Time: ______

If Authorized Person then record relationship with the patient:

________________________________________________

Signature of the Dr: _______________________ Date: ___/___/_____ Time: ______

Names of Witness:
Signature of Witness: ___________________ Date: ___/___/_____ Time: __________
### 10.5 Therapeutic Abortion Record Form Template

**Instructions:** Complete this form for every case of therapeutic abortion. Make three copies, one for hospital records, one for primary doctor’s reports, and one to give to the patient.

<table>
<thead>
<tr>
<th>Hospital name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>District:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient and Service Delivery Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of patient:</td>
</tr>
<tr>
<td>Patient ID number:</td>
</tr>
</tbody>
</table>

**Reason for pregnancy termination:**

- **Fetal malformation**
  Specify:_______________________________________________________
- **Maternal severe condition**
  Specify:_______________________________________________________

**Is the consent form signed by the patient or her legal guardian?**

- * Yes
- * No

<table>
<thead>
<tr>
<th>Consulting Doctor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:____________________________________</td>
</tr>
<tr>
<td>Signature_______________________________</td>
</tr>
<tr>
<td>Date:__________________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Primary Doctor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:____________________________________</td>
</tr>
<tr>
<td>Signature_______________________________</td>
</tr>
<tr>
<td>Date:__________________________</td>
</tr>
</tbody>
</table>
10.6 Monitoring and Evaluation Forms

10.6.1 Service Delivery Form

**SERVICE DELIVERY FORM**

*Complete one form for each woman who comes seeking pregnancy termination services*

<table>
<thead>
<tr>
<th>Health Facility:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>District:</td>
<td></td>
</tr>
<tr>
<td>Completed by:</td>
<td></td>
</tr>
<tr>
<td>Name of provider:</td>
<td></td>
</tr>
</tbody>
</table>

**Date the woman presented at the health facility** *(dd/mm/yyyy):* _______________________________________________________________________

*If the woman came to the facility multiple times, list the dates of each visit:*

*Visit #1 date* *(dd/mm/yyyy):* _______________________________________________________________________

*Visit #2 date* *(dd/mm/yyyy):* _______________________________________________________________________

*Visit #3 date* *(dd/mm/yyyy):* _______________________________________________________________________

**Patient Background Information**

<table>
<thead>
<tr>
<th>Patient number:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>District:</td>
<td>Sector:</td>
</tr>
<tr>
<td>Age:</td>
<td>Marital Status:</td>
</tr>
</tbody>
</table>

**Legal Information**

<table>
<thead>
<tr>
<th>Did the woman have a court order when she presented at the health facility?</th>
<th>* Yes</th>
<th>* No</th>
</tr>
</thead>
</table>

**Date the woman presented the court order to the health facility** *(dd/mm/yyyy):* _______________________________________________________________________

**Number of court order:** | **Length of time for court order approval:** *(time between when woman applied for court order and was granted court order)*

**Name of court granting court order:** _______________________________________________________________________

**Exemption under which woman qualifies for abortion:**

* Rape
* Incest
* Forced Marriage
* Pregnancy severely jeopardizes the health of the mother
* Pregnancy severely jeopardizes the health of the unborn baby

**Obstetric History**
<table>
<thead>
<tr>
<th>Gravida:</th>
<th>Parity:</th>
<th>Number of living children:</th>
<th>Number of previous abortions:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Was the woman given a pregnancy test?  
* Yes  
* No

Pregnancy test results:  
* Positive  
* Negative

Date *(dd/mm/yyyy)*:

Gestational Age

According to LMP:  
Bimanual Exam:

Vital Signs at Arrival

Temperature:  
Blood Pressure:  
Pulse:  
Respiration:

Incoming Referrals

Where was this woman referred from? (check all that apply)

* No referral  
* Hotline  
* Police  
* Community leader  
* Health facility  
* CHW  
* NGO  
* NGO

Other____________________

Treatment

Method of pregnancy termination:

* MVA  
* Mifepristone-Misoprostol  
* Misoprostol  
* D&C  
* Electric Aspiration  
* D&E  
* Other

Other____________________

Pain Medications:

* Analgesics  
* General anesthesia  
* Paracervical block  
* Other:

Other____________________

Contraceptive counseling given?  
* Yes  
* No

Contraceptive method chosen:

* Injectable  
* Pills  
* Implant  
* Condom  
* IUD  
* Ligature  
* Other:

Other____________________
**Additional Services**
*(include women who did not receive pregnancy termination services)*

<table>
<thead>
<tr>
<th>What additional services did the woman receive at this facility?</th>
<th>* Psychosocial services</th>
<th>* Emergency contraception services</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>* Legal services</td>
<td>* Family planning counseling</td>
</tr>
<tr>
<td></td>
<td>* STI testing/treatment</td>
<td>* PEP</td>
</tr>
<tr>
<td></td>
<td></td>
<td>* Other __________________________</td>
</tr>
</tbody>
</table>

**Outgoing Referrals**

Was this woman referred after coming to the health facility?  
* Yes  * No

If so: Date of referral *(dd/mm/yyyy)*:  
_____________________________________________________

Where was she referred to?  
_____________________________________________________

What was the reason for referral?  
_____________________________________________________

**Patients treated with Mifepristone–Misoprostol**

<table>
<thead>
<tr>
<th>Dose of Mifepristone:</th>
<th>Route of administration:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Dose of Misoprostol:</th>
<th>Route of administration:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Time between administration of misoprostol and mifepristone:

**Complications BEFORE Discharge**

Complications before discharge:  
* Severe bleeding  * Infection
  * Severe abdominal pain  * Suspected perforation
  * Other________________________

If the woman experienced complications, explain here:

---

**Follow up**
Date of follow-up visit: 

Name of follow-up visit provider: 

Treatment complete at follow up? * Yes * No

If additional treatment was given at follow up, explain here:

Side effects experienced from treatment:

* Severe abdominal pain and cramping
* Vaginal bleeding requiring treatment
* Fever
* Nausea/vomiting
* Diarrhea
* Severe allergic reaction

Comments/Observations:

10.6.2 Client Information form

CLIENT INFORMATION FORM

Complete one form for each GBV client (rape, incest, or forced marriage) who comes to the OSC/GBV Center

Name of OSC/GBV Center:
District:
Completed by:

Client background information

Client number:

District: Sector: Cell: Village:

Age: Marital Status:

Type of violence:

* Rape * Incest * Forced marriage

Date of violence: dd/mm/yyyy

Was the violence ongoing? * Yes * No

How long has the violence gone on for?

Please describe the violence:
**FIRST VISIT**

### Intake

**Date of first visit (dd/mm/yyyy):**

**Where was this woman referred from? (check all that apply):**

- No referral
- Police
- Health facility
- Court
- Hotline
- Community leader
- CHW
- NGO
- Other
- Please specify__________________________

**Did the woman apply for a court order?**

- Yes
- No

*If the woman applied for a court order complete the section of this form for women who applied for a court order.*

**Did the woman have an approved court order when she came to the first visit?**

- Yes
- No

### Service provision

**Was the woman given a pregnancy test?**

- Yes
- No

**Pregnancy test results:**

- Positive
- Negative

*If the woman is pregnant, complete the section of this form for pregnant women.*

**What services did the woman receive at the OSC/GBV Center at the first visit?**

(check all that apply)

- Medical consultation
- Psychosocial services
- Legal services
- STI testing/treatment
- Safe room
- PEP
- Family planning counseling
- Emergency contraception
- Other________________

**Exit**
Upon leaving the OSC/GBV Center, where was this woman instructed to go?

* Home
* Hospital
* Court/judiciary
* Other, please specify __________________________

Was the woman sent to apply for a court order?  * Yes  * No

Did anyone accompany the woman when she left?  * Yes  * No

If so, who accompanied her?

Please describe any follow-up or outreach that was done after the woman left the OSC/GBV Center:

First visit comments/observations:

Complete this section if the woman returned for a second visit

<table>
<thead>
<tr>
<th>Intake</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of second visit (dd/mm/yyyy):</td>
</tr>
<tr>
<td>Did the woman apply for a court order?  * Yes  * No</td>
</tr>
<tr>
<td>If the woman applied for a court order complete the of this form for women who applied for a court order</td>
</tr>
<tr>
<td>Did the woman have an approved court order when she came to the second visit?  * Yes  * No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service provision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Was the woman given a pregnancy test?  * Yes  * No</td>
</tr>
<tr>
<td>Pregnancy test results:  * Positive  * Negative</td>
</tr>
<tr>
<td>If the woman is pregnant, complete the section of this form for pregnant women</td>
</tr>
</tbody>
</table>
What services did the woman receive at the OSC/GBV Center at the second visit? (check all that apply)

- Medical consultation
- Psychosocial services
- Legal services
- STI testing/treatment
- Safe room
- PEP
- Emergency contraception
- Family planning counseling
- Other________________

Exit

Date of discharge: dd/mm/yyyy

Upon leaving the OSC/GBV Center, where was this woman instructed to go?

- Home
- Hospital
- Court/judiciary
- Other, please specify __________________________

Was the woman sent to apply for a court order? * Yes * No

Did anyone accompany the woman when she left? * Yes * No

If so, who accompanied her? __________________________

Please describe any follow-up or outreach that was done after the woman left the OSC/GBV Center:

Second visit comments/observations:

COMPLETE THIS SECTION FOR PREGNANT WOMEN ONLY

<table>
<thead>
<tr>
<th>Pregnancy information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Was the woman pregnant before the violence? * Yes * No</td>
</tr>
<tr>
<td>Was the woman pregnant during violence? * Yes * No</td>
</tr>
<tr>
<td>Gestational age (in weeks) at time of positive pregnancy test:</td>
</tr>
<tr>
<td>------------------------------------------------------------</td>
</tr>
</tbody>
</table>

**COMPLETE THIS SECTION FOR WOMEN WHO APPLY FOR A COURT ORDER**

<table>
<thead>
<tr>
<th>Abortion court order information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Status of court order:</strong></td>
</tr>
<tr>
<td>* Approved</td>
</tr>
<tr>
<td>* Other_________________________</td>
</tr>
<tr>
<td><strong>Date the woman presented the court order to the OSC/GBV Center (dd/mm/yyyy):</strong></td>
</tr>
<tr>
<td><strong>Number of court order:</strong></td>
</tr>
<tr>
<td><strong>Length of time for court order approval:</strong></td>
</tr>
<tr>
<td><em>(time between when woman applied for court order and was granted court order)</em></td>
</tr>
<tr>
<td><strong>Name of court granting court order:</strong></td>
</tr>
<tr>
<td><strong>Exemption under which woman applied for abortion:</strong></td>
</tr>
<tr>
<td>* Rape</td>
</tr>
<tr>
<td><strong>If court order was denied, please explain reason for denial:</strong></td>
</tr>
<tr>
<td><strong>Did the woman receive an abortion?</strong></td>
</tr>
<tr>
<td>* Yes</td>
</tr>
<tr>
<td><strong>Where did the woman receive the abortion?</strong></td>
</tr>
<tr>
<td>* OSC/GBV Center</td>
</tr>
<tr>
<td>* Referred If referred, please explain ________________________________ ________________________________ _______</td>
</tr>
</tbody>
</table>
11. REFERENCES


Curtis C. Meeting Health Care Needs of Women Experiencing Complications of Miscarriage and Unsafe Abortion: USAID’s Postabortion Care Program. Journal of Midwifery and Woman’s Health, 52(4); 2007.


National Genetics and Genomics Education Center, UK. http://www.geneticseducation.nhs.uk


Republic of Rwanda, Organic Law N° 01/2012/OL of 02/05/2012 Organic law instituting the Penal Code, Official Gazette, special issue, June 14, 2012)


In collaboration with:

Venture Strategies Innovations