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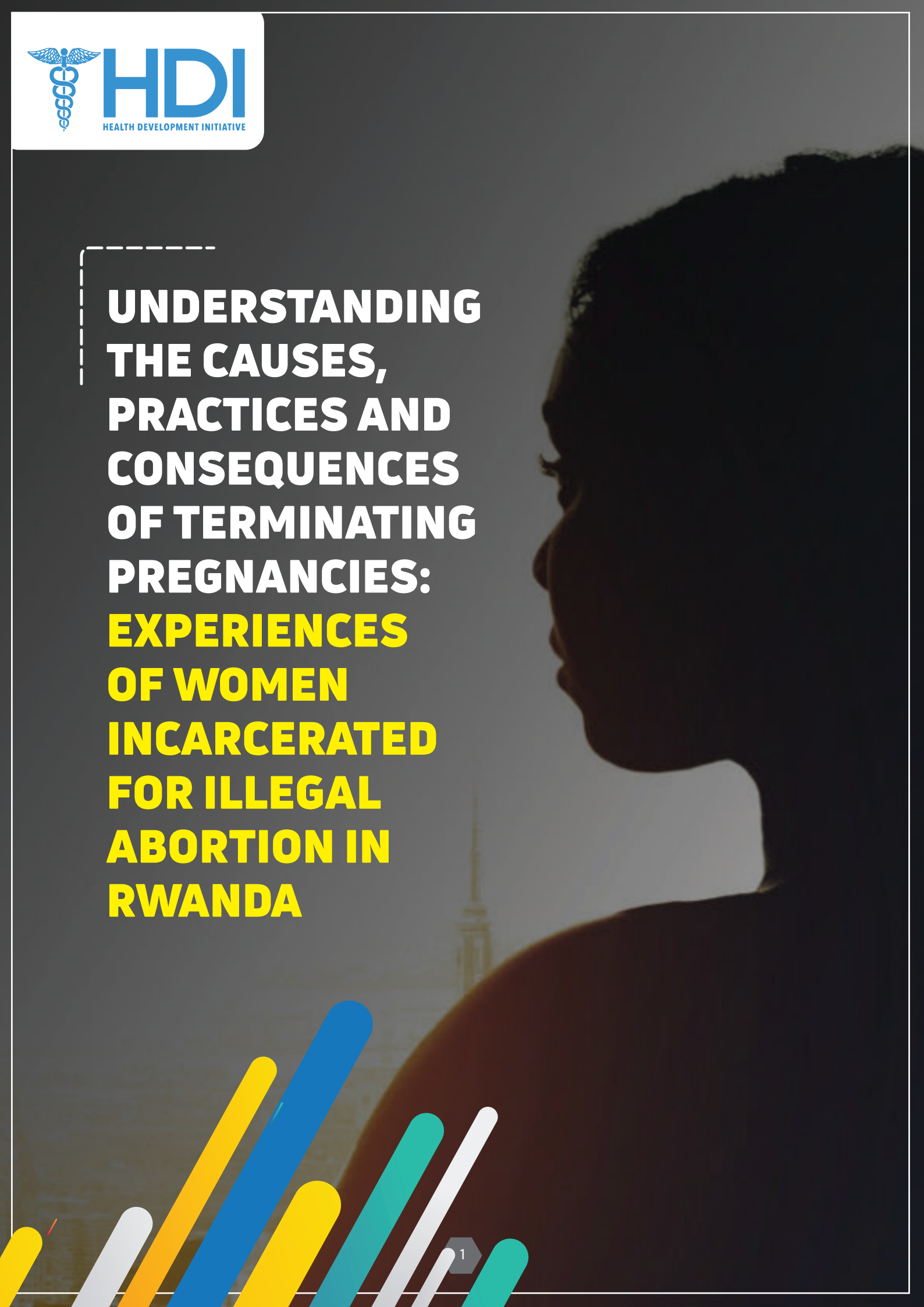
UNDERSTANDING THE CAUSES, PRACTICES AND CONSEQUENCES OF TERMINATING PREGNANCIES: EXPERIENCES OF WOMEN INCARCERATED FOR ILLEGAL ABORTION IN RWANDA



UNDERSTANDING THE CAUSES, PRACTICES AND CONSEQUENCES OF TERMINATING PREGNANCIES: **EXPERIENCES OF WOMEN INCARCERATED FOR ILLEGAL ABORTION IN RWANDA**

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The Co-Investigators Natacha Mugeni and Amy Shipow from the HDI team contributed to the conception and design of this project. They designed the research protocol, conducted the study approval, followed-up with the National Ethics Committee, trained and supervised the research team in data collection, and helped author the final report.

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ABBREVIATIONS AND ACRONYMS

HDI: Health Development Initiative
WHO: World Health Organization
SRHR: Sexual and Reproductive Health and Rights
GBV: Gender-Based Violence

KEY DEFINITIONS (FROM THE WHO)

Unsafe abortion: a procedure for terminating a pregnancy performed by persons without the adequate or required skills or in an environment lacking the minimum required medical standards or both

EXECUTIVE SUMMARY

Globally, there has been an increase in the number of unsafe abortion cases from 20 million cases in 2003 to 22 million cases in 2008, which comprise 47percent of all abortions and 49 percent, respectively.[1]In the past, abortion was performed using crude tools such as sharpened tools, washing detergents and glycerine, and other traditional herbs which caused physical trauma.[2] Through advances in the field of medicine, contemporary methods are now used and involve the use of medication and surgical procedures, such as osmotic dilators, vacuum aspiration, and misoprostol. Abortion accounts for over 70,000 maternal deaths worldwide and an estimated 60,000 induced abortions were performed in Rwanda between 2009 and 2010.[3] Every year in Rwanda, 24,000 women need emergency treatment for medical complications resulting from unsafe abortions, and 30 percent of women do not receive any treatment from complications due to fear of arrest.[4] Approximately 24 percent of all incarcerated women in Rwanda were convicted for obtaining an abortion. With the current penal code restricting access to safe, legal abortion under four circumstances, HDI recognizes the need to learn more about women who have been convicted of terminating their pregnancies. As a result, this study seeks to explore the causes, practices, and consequences of women incarcerated for terminating their pregnancies in Rwanda.

Semi-structured interviews were conducted among 38 women who were convicted of abortion within four Rwandan prisons. They were purposively sampled among a list of women charged with abortion provided by the four prisons.

Results of the study will be utilized to inform advocacy efforts for increased access to safe abortion services and in contributing to the development of national policies and guidelines.

[1] Alan, Guttmacher Institute, and Family Health International, 2015.
[2] When Abortion is a Crime Rwanda <www.ipas.org/~/media/Files/PubsManual/CRMRWD2E15.ashx>
[3] Guttermacher Institute, 2012.2013.
[4] Guttmacher Institute, "Factsheet: Abortion in Rwanda."

BACKGROUND OF THE STUDY

1.1 Introduction

With the Sustainable Development Goals' revitalization in 2015, there remains a renewed effort among the global community to advance women's health and promote safe, legal, and comprehensive abortion services. While unsafe abortions are preventable, they continue to pose unnecessary risks to women's health and lives.[5] The World Health Organization (WHO) in 2008 reported that, each year, throughout the world, approximately 210 million women become pregnant, and over 135 million of them deliver live born infants. The remaining 75 million pregnancies end in stillbirth, or spontaneous or induced abortion.[6] Efficiently focusing on unsafe abortion is essential to guarantee fewer maternal deaths and improved reproductive health, especially for women in developing countries.[7] Moreover, eradicating unsafe abortion is necessary to fulfill the international commitments that many countries have ratified including the International Conference on Population and Development in Cairo[8] and the 1995 Fourth World Conference on Women in Beijing, International Human Rights and other global and regional commitments.

Rwanda is among 13 Southern African Development Community (SADC) countries in which abortion is only legal in limited circumstances including rape, incest, or danger to the mother's life. [9] The history of abortion within Rwanda has long been a restrictive process. Before 1977, Rwanda's Criminal Code stipulated that an abortion could be carried out only of necessity to save pregnant woman. In 1977, the law specified that if a pregnant woman's life is in danger, she would need two medical opinions and to be seen by a State physician in a State-approved hospital.[10] After HDI and other civil society organizations formed a coalition to advocate for expanded abortion access, the penal code was revised in 2012 to include new exemptions for legal abortion. Women were eligible for abortion in cases of rape, incest, forced marriage, or medical grounds. It was likewise specified that if the abortion occurred before 22 weeks of pregnancy, there would be no criminal liability for the woman or doctor who assisted in the procedure.

Nonetheless, in practice, abortion remained largely inaccessible for most women since the exemption from criminal charges under these sanctioned cases only stood if the woman obtained a court order[11] as well as retrieved consent by two doctors for the procedure. Since there is only one doctor for every 15,806 people[12] in Rwanda, gathering this provider consent is challenging.

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[5]Unsafe abortion: the preventable pandemic. Prof. Dr. David A Grimes, Janie Benson, DrPH. Et. Al. The lancet vol 368, No. 9550, Nov. 2006

[6]World Health Organization (2008) Unsafe Abortion: Global and regional estimates of the incidence of unsafe abortion and associated mortality in 2008: Sixth edition, WHO, Geneva

[7]Deciding Women's LivesAre Worth Saving (IPAS) (2001): *Expanding the Role ofMidlevel Providers in Safe Abortion Care*

[8] UNFPA, 2004, Programme of action "Adopted at the International conference on Population and Development, Cairo, 5-13 Sept. 1994,"

[9] Morna and Manteboheleng (2018). "Abortion: SA Must Speak Up." https://mg.co.za/article/2018-09-28-00-abortion-sa-must-speak-up

[10] East African Center for Law and Justice. "Abortion in Rwanda." http://eaclj.org/about-us/13-the-christian-medical-fellowship-abortion-.html

11 N° 01/2012/OL of 02/05/2012 Organic Law instituting the penal code (2012) (Article 165: Exemption from criminal liability for abortion)

[12] National Institute of Statistics of Rwanda (NISR), The Statistical Yearbook, 2014 Edition, November 2014.

In effect, legal abortion under any of the sanctioned circumstances is a rarity, especially in Rwanda where abortion is highly stigmatized even among health and legal professionals. This is evident during the period from August to December 2014, as 16 percent of the 527 women seen at Isange One-Stop Centers/GBV centers were pregnant as a result of rape, incest, or forced marriage; yet, only five percent of these cases were reported to have requested a pregnancy termination, and none of the women received a court order.

To strengthen women's access to reproductive health, reduce the rates of unwanted and early pregnancies, as well as increase women's autonomy over their bodies, HDI helped advocate for further measures toward abortion legality. In 2018, Rwanda's new penal code was passed to include removal of the court order; inclusion of child defilement among exemption criteria; and better link the Ministry of Health guidelines and the penal code. While progress has been and continues to be made, women can still be prosecuted for illegal abortions. These women face a prison sentence of one to three years and a fine equivalent of $300 US Dollars.

1.2 Study Justification

Rwanda has made extraordinary progress to improve access to health services, including enacting a law on sexual and reproductive health of persons, increased healthcare services and reduced maternal mortality in Rwanda.[13] However, a gap remains between women's desired and actual fertility: 47 percent of all pregnancies in Rwanda are unintended. For women of reproductive age 15 to 44 years-old, this rate stands at 114 unintended pregnancies per 1,000 women annually, similar to East Africa as a whole in 2008.[14] Twenty-two percent of these unintended pregnancies result in induced abortion, most of which occur in Kigali City.[3] In Rwanda, approximately half of all abortions are performed by untrained individuals—34 percent by traditional healers plus 17 percent that are self-induced by women. The other half of abortions are provided by physicians (19 percent), nurses or medical assistants (16 percent) and midwives (14 percent). Based on estimates from the Demographic Health Survey, it is estimated that 16,749 women were treated for complications of induced abortion in 2009 out of the 60,000 abortions that occur in Rwanda annually.[15] Furthermore, an estimated 40 percent of clandestine abortions in Rwanda lead to complications requiring treatment in a health facility. According to a May 2014 Guttmacher Institute report, in 2012 the Rwandan government paid an estimated $1.7 million to treat approximately 18,000 women for complications from unsafe abortion; this is equal to approximately 11 percent of the country's total public spending on reproductive health.

Although abortion aligns with the national conversation around women's SRHR, abortion remains taboo and stigmatized in Rwandan society, making it increasingly more challenging to reach women who are considering or performing unsafe abortions in Rwanda. Due to the lack of evidence-based knowledge of women convicted of abortion, these qualitative interviews were implemented to advance policies and guidelines around safeguarding legal abortion under the current penal code and advocating for the inclusion of further exemptions to protect women's SRHR.

[13] Law N° 21/05/2016 OF 20/05/2016 Relating to Human Reproductive Health.
[14] Basinga, P., Moore, A. M., Singh, S., Remez, L., Birungi, F., & Nyirazinyoye, L. (2012). Unintended pregnancy and induced abortion in Rwanda: Causes and consequences. New York, NY: Guttmacher Institute.
[15] Basinga, P. et. al (2012). Abortion incidence and post-abortion care in Rwanda.Rwanda Medical Journal.Vol.69 (2).

1.3 Objectives of the study

- To understand the causes, practices, and consequences of terminating pregnancies among women convicted of abortion in Rwanda;
- To inform advocacy and awareness around unsafe abortions;
- To document stories and incidences of unsafe abortions;
- To recommend to the government and development partners to focus on issues that will reduce unsafe abortion in Rwanda.

METHODOLOGY

2.1 Introduction

To assess the qualitative research, the study used thematic analysis, which emphasizes pointing, examining, and recording patterns (or "themes") within data. Themes are patterns across data sets that are important to the description of a phenomenon and are associated with a specific research question and descriptive research design. The purpose is to describe and provide information on what is prevalent regarding a group of people, a community, a phenomenon or a situation.

2.2 Study sites and selection of the Study Participants

The study occurred in four Rwandan prisons with the following characteristics:
Nyagatare Prison, an institution for convicted minors only, located in the Eastern Province;
Ngoma Prison, an institution for women-only, located in the Eastern Province;
Nyamagabe Prison, an institution for men and women, located in the Southern Province;
Nyarugenge Prison, an institution for both men and women, located in Kigali City (although there were no male prisoners at the time of the study).

2.3 Participant's eligibility

Young girls and women aged 15 to 45, who were charged and convicted of abortion, were eligible for study participation. They were selected for charges both before and after the penal code of 2012.

2.4 Inclusion Criteria

Self-identify as female
Between ages 15 to 45 years-old
Were convicted for abortion
Had ability to verbally communicate
Willing to participate in the study

2.5 Exclusion Criteria

Under 15 years of age or older than 45 years of age
Women who are convicted, but who denied the charge
Unable to communicate
Unwilling to provide required information

2.6 Sampling and Sample Size

Due to a limited pool of eligible participants, researchers decided to include all participants incarcerated for abortion. Across the four prisons, 40 participants were identified, but two women who denied the charge were automatically rejected. Hence, 38 participants met the inclusion criteria and were purposively selected to participate. The prison administrative staff was employed to maintain confidentiality of women interviewed. When the detainee came, the administrative staff gathered all information about the detainee and kept it in the clerk office. The staff helped the three enumerators, all trained with a background in psychology, to understand the circumstances in which participants were imprisoned as well as contextualize the stigma women may face from their fellow inmates during incarceration.

2.7 Procedures at enrolment

During enrolment, a member of the research team explained the purpose of the study, the importance of using audio recording, possible risks, potential benefits to participation, and the ability to discontinue involvement at any time, all of which were detailed in a written consent form to interviewees. Participants were also informed of data management, including HDI's agreement of confidentiality and storing of any identifying information in locked cabinets. If participants agreed to these conditions, they signed the informed consent form and received a copy for their personal records.

2.8 Data Analysis and Presentation

Qualitative data analysis was predominantly used for the study. Through semi-structured interview questions, respondents were free to extend their explanations beyond pre-determined questions. The study sought to gain as much information as possible regarding the process of abortion (from before the procedure to after). The in-depth interviews allowed participants significant freedom to answer questions; and the researcher was attune to inconsistencies, pieces of the story that seemed to be missing, and new angles that might provide additional information. The interviews were recorded to allow the researcher to be more attentive, sensitive, and more present to ask follow-up questions.

Narratives of the interviews were then transcribed and translated. Data from the structured questionnaires were analyzed through SPSS version 22. MAXQDA was also implemented to assess qualitative and quantitative data. Before the analysis, a codebook was prepared for qualitative variables that were based on the numbering system of the questionnaires. In an effort to ensure the correct code was entered for each variable, all the qualitative variables were chronologically arranged using the questionnaire number and the coded variable number. After confirming that all data were correctly entered, descriptive statistics were implemented to facilitate the meaningful distribution of measurements and to also describe, summarize, and organize data.

RESULTS

3.1. Socio-demographic information

The following subsection presents the biographical data of respondents involved in this study. Data presented are age, marital status, District, employment status and education level.

Table 1: Respondents by age

Age	Frequency	Percentage, %
Between 15 -19	7	18.4
Between 20-24	13	34.2
Between 25-30	7	18.4
Between 30-35	7	18.4
Between 35-40	3	7.9
Between 40-45	1	2.6
Total	38	100.0

The table above represents the ages of females, aged 17 to 42 years-old, which were grouped into six distinct categories. The majority of the respondents, 34.2percent, can be classified as young women, aged 20 to 24 years. Adolescents aged 15 to 19 years-old were among the next largest group (18.4 percent), alongside respondents who were 25 to 30 years-old, and 30 to 35 years-old. One young adult between the 20-24 age group was initially incarcerated during her adolescence at age 19. Thus, more than half of those incarcerated (52.6 percent) were young people under the age of 25. There were 7.9 percent of the respondents between 35 to 40 years, while 2.6 percent of women were aged between 40 to 50 years. The average age was 25.45 years-old with a standard deviation of 6.18. Participants spanned from 17 to 42 years-old, with a median age of 24 years-old. The most popular age was 22 years-old.

Time Spent in Jail

Approximately 29 percent of women were remanded (n=11) while 71.1 percent of women (n = 27) received sentences. Sentencing lengths spanned from 5 months to 240 months, with one woman claiming an indefinite sentence length. When assessing the amount of their sentence served, respondents were physically incarcerated between 1 month and 156 months (13 years); however, the majority of women were incarcerated between 1 to 18 months. The three outliers were 60 months (reported an indefinite sentencing length), 66 (sentenced for 120 month) and 156 months (sentenced for 240 months). Excluding these sentencing anomalies, the average and median sentencing lengths were approximately 7 months (SD = 4.4).

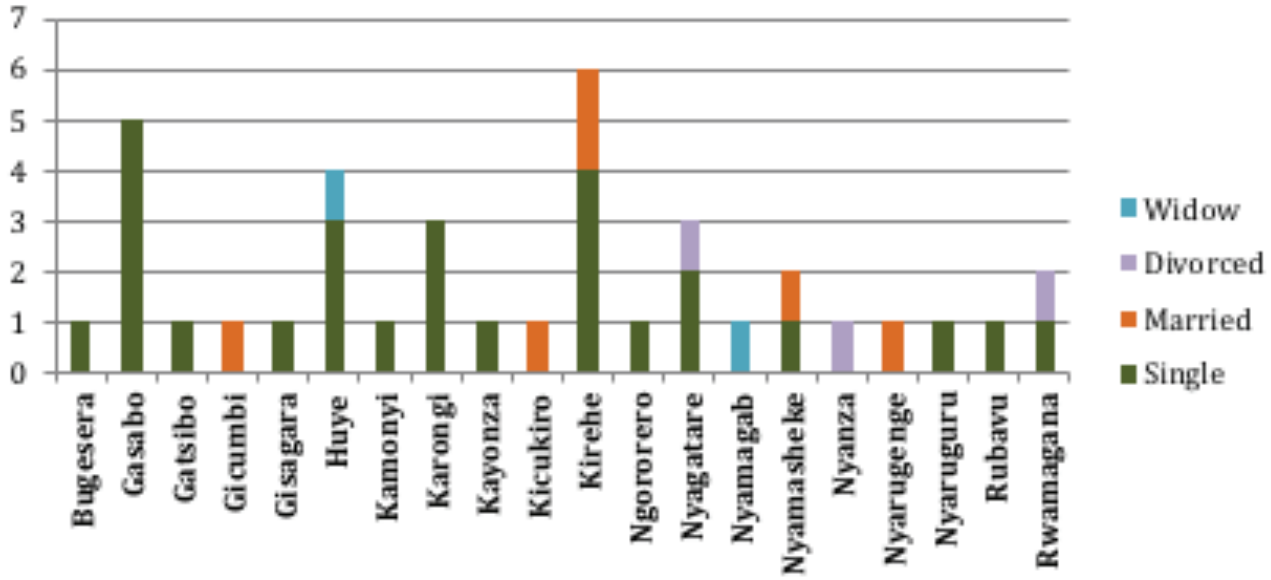
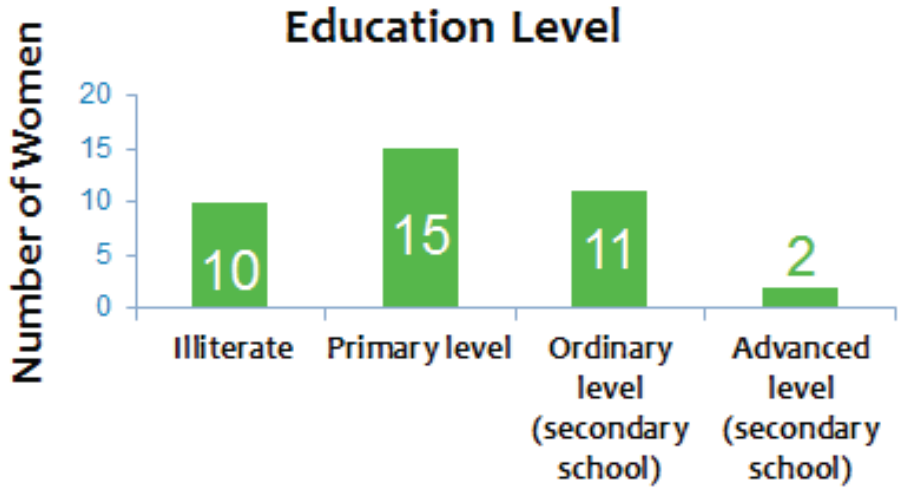


Figure 1: Distribution by district and marital status[16]

Figure1 illustrates that the majority of respondents who committed abortion across different districts were single females. This was followed by married women, divorced women, and widowed women, respectively, who were less likely to perform abortions. The majority of abortions occurred in small, rural villages throughout all the districts. Most of the incarcerated women were from Kirehe (Eastern Province), Gasabo (Kigali City), Huye (Southern Province), Karongi (Western Province), and Nyagatare (Eastern Province). The minority of abortions occurred in Gicumbi District in the Northern Province.

Table 2: Education level



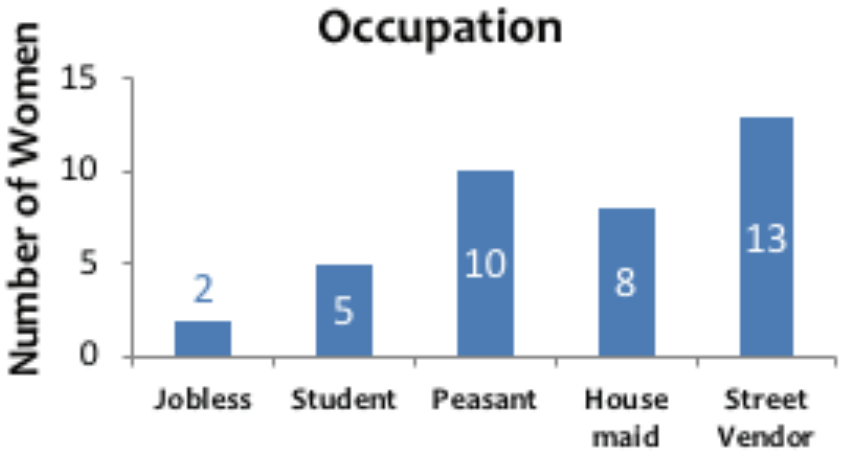
[16]Respondents were from districts within the following provinces: Eastern Province (Bugesera, Gatsibo, Kayonza, Kirehe, Nyagatare, Rwamagana Districts); Southern Province (Gisagara, Huye, Kamonyi, Nyamagabe, Nyanza, Nyaruguru Districts);Western Province (Karongi, Ngororero, Nyamasheke, Rubavu Districts); and Kigali City (Gasabo, Kicukiro, Nyarugenge).

The second factor that contributed to women's vulnerability was education level.[17]More than a quarter of women convicted were illiterate, with almost one-third of women dropping out of school before completing secondary school. Consequently, women's low level of education may correlate to a lack of information on SRHR as well as decreased access to other health services. It was observed that men would approach these vulnerable women with gifts such as phones or lotions; in more severe circumstances, men would rape these women.

Prior Pregnancies

The majority of women prisoners (57.9 percent) were pregnant one time before their abortion, while 21.1 percent of women were pregnant twice before and 21.1 percent were pregnant three or more times previously.

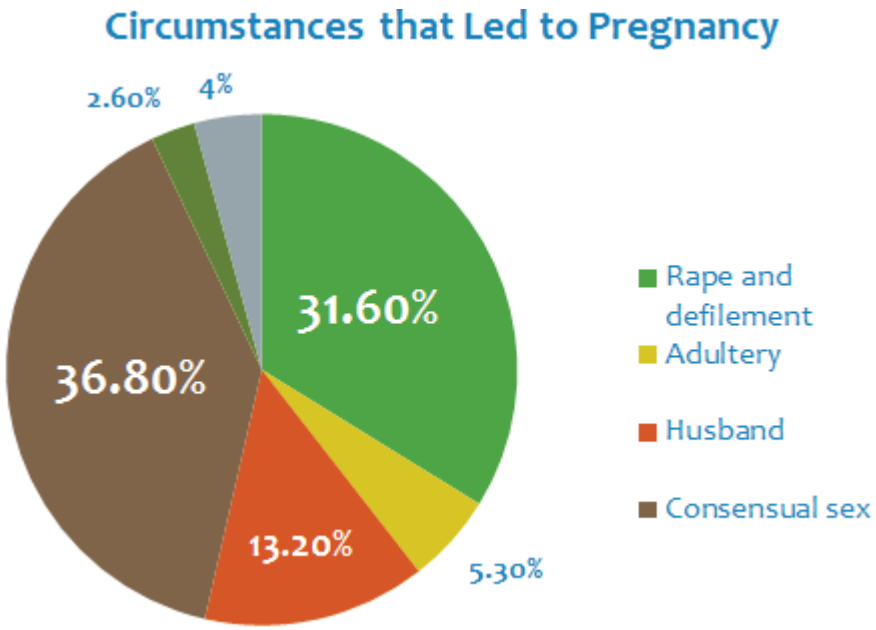
Table 3: Employment status



All participants in this study were living with low wages, as most women were street vendors, selling fruits (gucuruza ku gataro) or second-hand clothes. The following most common professions were peasants and housemaids, respectively. These women all lived in poverty, often having to leave their families in order to look for jobs in more urban areas. Therefore, poverty and low-skilled employment serve as risk factors for unwanted pregnancies. Often, these women attempted to talk to their partners, of whom the majority ran away or denied the act to avoid taking responsibility. Others avoided contact with the women entirely. As a result, these women described feeling panicked and subsequently wanted to terminate their pregnancies.

[17]In Rwanda, primary school is attended by children aged 6 to 12 years-old. Ordinary Level extends from Senior 1 to 3, for adolescents aged 13 to 15 years-old. Students then progress to Advanced Level, which comprises Senior 4 to 6, for adolescents aged 15 to 18 years-old.

3.2. Causes



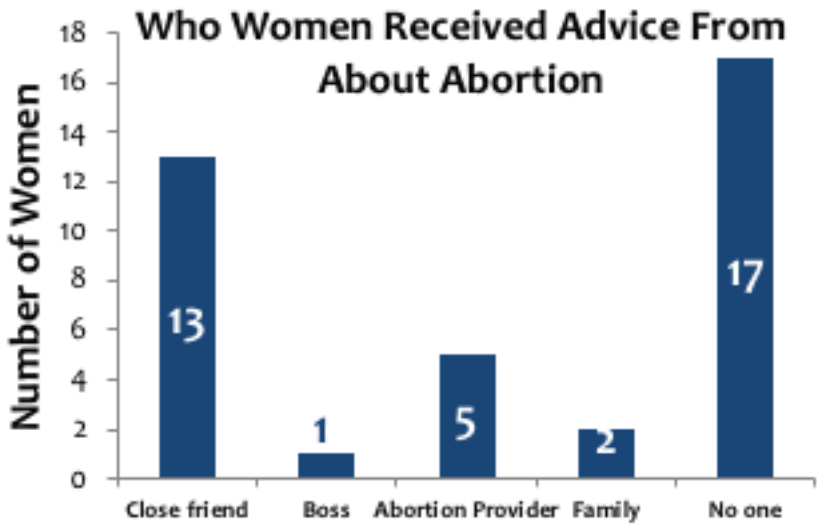
Women predominately sought abortion as a result lovemaking (36.8 percent), which was described as sexual intercourse that was consensual and desired at the time; however, women elaborated that their age, life situations, and lack of affection contributed to their decision to abort. Most of these women were street vendors (n=9) and housemaids (n=5) whose partners refused to help them in their pregnancy or denied impregnating them entirely: ***"I was very poor and the life condition was bad. The man impregnated me refused to give a help. That is why I decided to use traditional plants for abortion."*** Women in the lowest socioeconomic class (Ubudehe 1) and with primary education as their highest level of school did not have the means to support a child, were still pursuing their own education, or were ashamed to tell their families. It is evident that low education levels serve as a detriment to health outcomes as women are less likely to be informed about their reproductive rights, sexual health services (i.e. family planning methods), and legal aid services. Even if they happened to be aware of these rights, many could not have afforded legal representation.

The next highest reason to seek abortion was rape (31.6 percent), which occurred among 12 women who were students (n=3), house-maids (n=3), jobless (n=2), farmers (n=2), and street vendors (n=2). Although rape falls within the four exemptions to women's eligibility to obtain a legal abortion, these women reported that they were unaware of the law. Approximately 13 percent of the women (n=5) aborted because their husband left them while about 10 percent of the women (n=4) were impregnated by another man outside of their primary partner and therefore sought abortion.

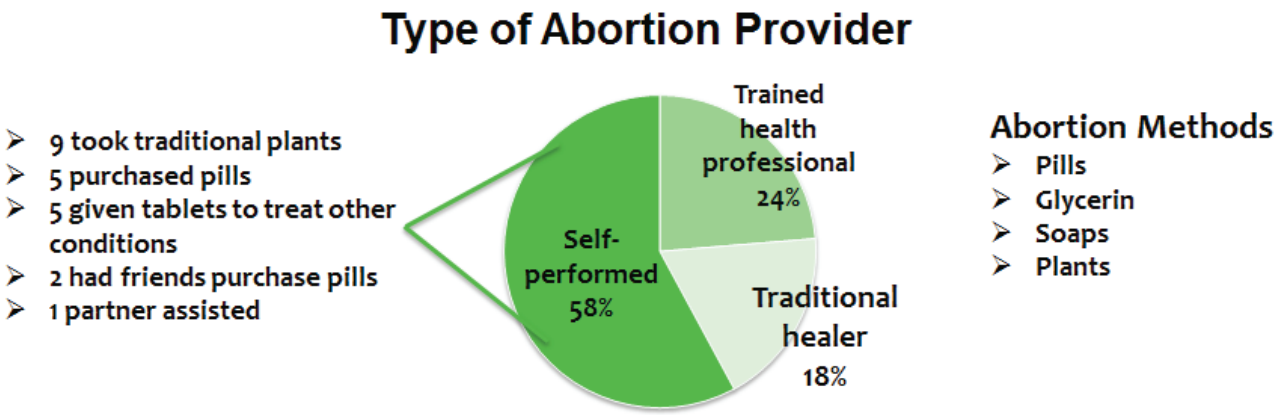
Table 3: Role of the male partner

Role of Male	Frequency	Percentage, %
Denied pregnancy	10	26.3
Supported woman getting an abortion	3	7.9
Left and rejected the woman	11	28.9
Missing	9	23.7
Did not know about pregnancy	4	10.5
Died	1	2.6
Total	**38**	**100.0**

Most women convicted (28.9 percent, n = 11) stated that the man responsible left and hated her; 26.3 percent of women claimed that the man denied the pregnancy (n = 10); and 23.7 percent of women (n = 9) stated that the man went missing after news of the pregnancy.



When making the decision to have an abortion, 44.7 percent made the decision on their own (n =17) whereas 34.2 percent (n = 13) entrusted a close friend. Others (5.3 percent) were advised by a family member and 2.6 percent of women obtained help from a work colleague.



3. 3. Practices

Only 23.7 percent of women (n = 9) convicted obtained an abortion performed by a trained health professional, such as a doctor, nurse, or pharmacist. On the contrary, 18.4 percent of women (n=7) had an abortion by an untrained health professional (i.e. a traditional healer). Almost 60 percent of women (n=22) performed an abortion with the use of traditional medicine or other materials such as medical tablets, soap, glycerin, etc.

When discussing the experience of finding an abortion provider, approximately one-third of women (31.6 percent) stated that they miscarried due to stress, poverty, poor life circumstances, and age. Among the 12 women who self-reported miscarriage, 10 women stated that their abortions were unintentional. Four of these women were given malaria tablets that inadvertently induced the abortion, and an additional woman was given medicine to treat a fever, which subsequently caused her abortion. Moreover, four of the women who miscarried were also raped. Only two of the women who claimed they miscarried later explained that a neighbor provided traditional medicine and another took ownership of her conscious decision to obtain an abortion:
"I did not know that I was pregnant. When my womb became too big, my family said that I was sick and asked the wife neighbor to begin to give traditional medicine in order to be healed. That was what have made me to abort."

Almost a quarter of the women (n = 9) found abortion providers who would use traditional plants and 7.9 percent (n = 3) had friends who took them to a traditional healer:
"I went somewhere with my friend, then I saw medicine. I drank it without asking any precaution."

On the contrary, 13.2 percent of women (n = 5) independently purchased tablets in a pharmacy while 5.3 percent (n =2) had friends purchase such tablets for them. Only 15.8 percent of women (n = 6) obtained a physician's help.

Table 4: Effectiveness of abortion instructions

Instructions on abortion process	**Were the instructions clear?**				
	Yes	**%**	**No**	**%**	**Total**
Pills to reduce pain of another sickness	0	0	1	100.0	1
Doctor assistance	4	80.0	1	20.0	5
Drinking glycerin and soap	0	0	1	100.0	1
Drinking pills	1	7.7	12	92.3	13
Drinking traditional plants	3	27.3	8	72.7	11
Miscarriage	0	0	5	100.0	5
No techniques	0	0	2	100.0	2
Total	**8**	**21.1**	**30**	**78.9**	**38**

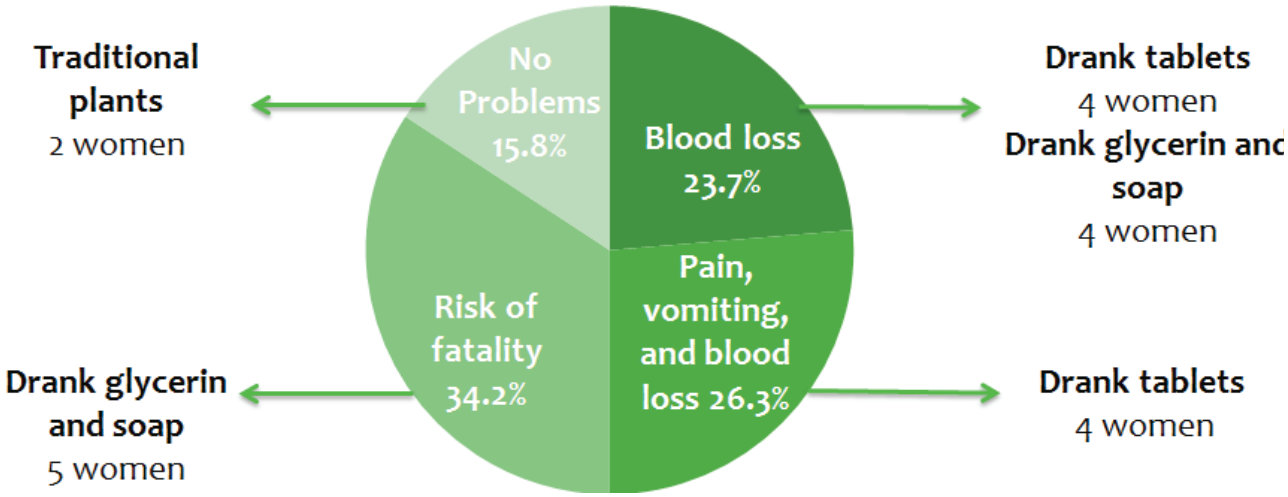
Only 21.1 percent of women (n = 8) received clear instructions on how to terminate the pregnancy while the majority, 78.9 percent of women (n =30) used inappropriate or insufficient instructions. There was significant confusion around how to take pills and traditional plants.

Table 5: Female perceptions of abortion cost

	What did you think of the price?				
Abortion Process	**Appropriate**	**Too expensive**	**Inexpensive**	**No cost paid**	**Total**
Purchase of pills in pharmacy (self)	1	4	0	2	7
Friends purchased pills	0	3	0	0	3
Friends took woman to traditional healer	1	0	0	0	1
Help from male who impregnated woman	2	4	2	1	9
Traditional plants (self)	0	1	2	9	12
Miscarried	0	6	0	0	6
Total	4	18	4	12	38

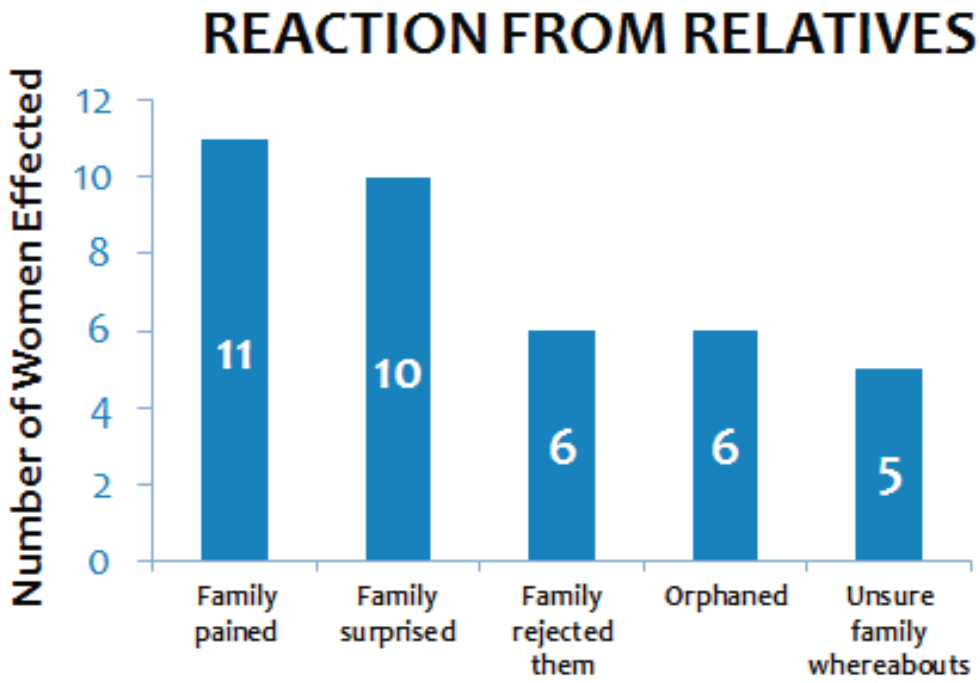
From the above table, the majority (n = 18, 47.4%) confirmed that cost paid was too expensive, followed by 12 women who paid nothing (31.6%).

3. 4. Consequences



After terminating their pregnancies, 34.2 percent of women experienced high risk conditions that they thought precluded them to death. The technique that caused the greatest risk of death was drinking glycerin and soap, followed by drinking tablets and traditional plants. Drinking glycerin and soap as well as drinking tablets also caused a significant loss of blood. Furthermore, 26.3 percent of women (n =10) reported pain, loss of blood and vomiting in addition to 23.7 percent of women (n = 9) who reported losing a significant amount of blood. Only 15.8 percent of women (n = 6) experienced no problems.

After terminating their pregnancies, the majority of women (28.9 percent) who used drinking glycerin and soap felt they were at a high risk of fatality, and 26.3 percent of women (n=10) responded that they experienced pain, loss of blood and vomiting. Only 15.79 percent of women (n = 6) responded to having no problems after their abortions.



Family, friends and loved ones expressed strong reactions to these abortions. Most women, 28.9 percent (n = 11), reported that the terminated pregnancies caused their families pain whereas 26.3 percent of women (n = 10) claimed their families were surprised; and 15.8 percent of women (n =6) were rejected by their relatives. The remaining women were either orphaned (15.8 percent) or did not know what happened to their loved ones after (13.2 percent).

DISCUSSION

Unsafe abortion is one of the leading causes of maternal mortality and morbidity in Rwanda and in the world at large. The WHO published an estimation that in 2003 approximately 42 million pregnancies were voluntarily terminated, of which 20 million were unsafe. This study intended to understand different causes, consequences and practices of unsafe abortion among Rwandan women who terminated their pregnancies, and as result were sentenced and imprisoned.
The objectives of the study were to identify risk factors related to unsafe abortions, as well as understand the socio-demographic, cultural aspects, and motivations of these convicted women. The study focused on the actual practices of these abortions and their consequences on the lives of these women and their relatives. This study equally assessed what the women knew about abortion before terminating their pregnancies, as well as the role of the men throughout this process.

Causes of Unsafe Abortion
In sum, leading factors that pushed young women and girls to terminate pregnancies were poverty, rape, adultery, and unplanned motherhood. These factors were aggravated by the denial or refusal to take responsibility from the male who impregnated them. Predominantly, these women were poor and had lower education levels: of the 38 women who participated, all of them fall within Categories 1 and 2 of Rwanda's Participatory Poverty Assessment, "Ubudehe" which is based on land ownership and employment titles. Category 1 is designated for the most impoverished families who do not own a home and can barely afford basic needs, and Category 2 is for those who have a dwelling but rarely get full-time employment. Moreover, almost all participants were unaware of the law regarding abortion, and rarely sought advice from parents, professionals, or authority figures.

Practices of Unsafe Abortion
Most women used pharmaceutical tablets, traditional plants, and traditional healers when conducting abortion. Only 23.7 percent of women (n=9) obtained an abortion performed by a trained health provider (i.e. a doctor, nurse, or pharmacist) while 76.3 percent of women (n=29) had an abortion by a traditional healthcare provider. Nine women (23.7 percent) bought traditional plants and 13.2 percent of women (n=5) independently purchased tablets in a pharmacy. Almost all women (89.5 percent) confirmed that techniques used to terminate the pregnancy were neither appropriate nor effective. Ultimately, however, all women who evaded the law were discovered by a neighbor, friend, or local leader.

Approximately 26 percent of women (n=10) stated that their abortions were unintentional. One young woman who was raped said, ***"I had miscarriage. I did not perform abortion, and I am in jail instead of being to school.»*** Often these women, who experienced severe health consequences after their miscarriage, went to a neighbor or friend for medical advice or support; however, these trusted sources turned them in to local authorities. One woman stated: ***"My relatives could not believe that a pregnancy of four moths could be miscarried. So they informed the police and accused me of deliberately terminating the pregnancy."***

Consequences of Unsafe Abortion
Research demonstrates that the health risks to unsafe abortion include infections, hemorrhage, organ damage, abdominal pain, vaginal infections, and stress on the circulatory system. Women

reported bleeding, vomiting, and pain as the primary outcomes of their abortions. One participant commented on the traumatic nature of this event: ***"Now, I realize that I am a survivor. If my mother did not find me in my room, I must pass the way today. I will never forget she saves me."*** Thus, participants felt the high risk of fatality, but were willing to risk their lives in order to avoid unwanted and unplanned motherhood.

Psychologically, women also suffered from mental distress. Across the interviews, women were observed to have low self-esteem, anxiety, social isolation, post-traumatic stress, and symptoms of depression such as anhedonia (i.e. loss of interest in activities that were formerly enjoyable). Many felt they were living in their own "internal world" since they faced judgment and hostility from their communities. One woman stated: ***"My life is not the same, has changed completely. It is hard to me to speak, I always think too bad things happened and I have big problem of trauma."*** Another woman commented on the anguish she experiences in prison: ***"I always think to my children who are alone, no family care and no one look after me. All the problem I meet it is on my head."*** Another woman remarked: ***"I constantly feel guilty of what I did and that results in me not sleeping well and having a lot of nightmares. I was the provider of my family and I don't know what they will do now. I feel like I let them down."***

Such ostracism, suspicion, and anger were magnified among parents and other relatives. Participants stated that their parents not only failed to understand their choice, but also projected hatred and shame onto the women. In order to punish the women for bringing shame to their family, relatives would excommunicate the affected girl, either at the hospital or in jail. Although the women are imprisoned for one to three years, community members and families view these women as permanently guilty and stigmatize them for not conforming to societal and cultural standards. Hence, the consequences of abortion are not merely physical, but also they impact the women throughout their daily life: perpetual poverty, stifling social connections, and creating internal distress related to the unsafe procedure and lack of both emotional and social support.

To respond to the consequences of abortion, Rwanda's Ministry of Health published a national Post-Abortion Care Guideline, which includes comprehensive mental health support. Nevertheless, enumerators observed that while the prisons had social workers, they were not providing psychological services to the women. Further enquiries need to be conducted to ascertain if the social workers need more sensitizations, training, time, supervision, or other resources to start providing this counseling.

3.6 Strengths and Limitations

A primary strength of the study was that it successfully covered the entire Kigali population who were eligible to participate: 38 girls and women convicted and incarcerated in Rwandan prisons. The study illustrated the circumstances and suffering of victims and how these social determinants (i.e. poverty, low education levels, low literacy, lack of knowledge on the law, interpersonal violence, etc.) influenced their decision to terminate their pregnancies. As a result of these factors, women faced an increased risk for unintended pregnancy, ultimately contributing to higher rates of unsafe abortion.

The study also provides further evidence for informed advocacy. The study encourages community organizing and civil society to reduce the stigma against illegal abortions. Moreover, the study will help facilitate the Ministry of Health to establish policies and strategies for reducing maternal morbidity and mortality that result from unsafe abortion. These include obstetrics and gynecology

problems, stigma, psychological distress, health complications in general, and in some cases untimely deaths.

While the study contributes soundly to the evidence-base for safe abortion access and services in Rwanda, the small sample size serves as a limitation to the generalizability of the study. However, the semi-structured interviews and recording allowed this study to gather more comprehensive data that helped bolster the validity and reliability of data. The semi-structured could have provided further probes on the type of traditional plants and medicines that women took, as well as how they approached pharmacists for these requests. Additionally, it would have been interesting to learn more about how the women met the traditional healers, and how the healers responded to abortion complications.

Future studies can enhance the sample size by interviewing women who were fined for abortion but not incarcerated. Lastly, even though women's age at incarceration was asked on the survey, participants failed to respond; therefore, further triangulation of women's records and increased probing would have been helpful to garner missing data.

3.7 Future Directions

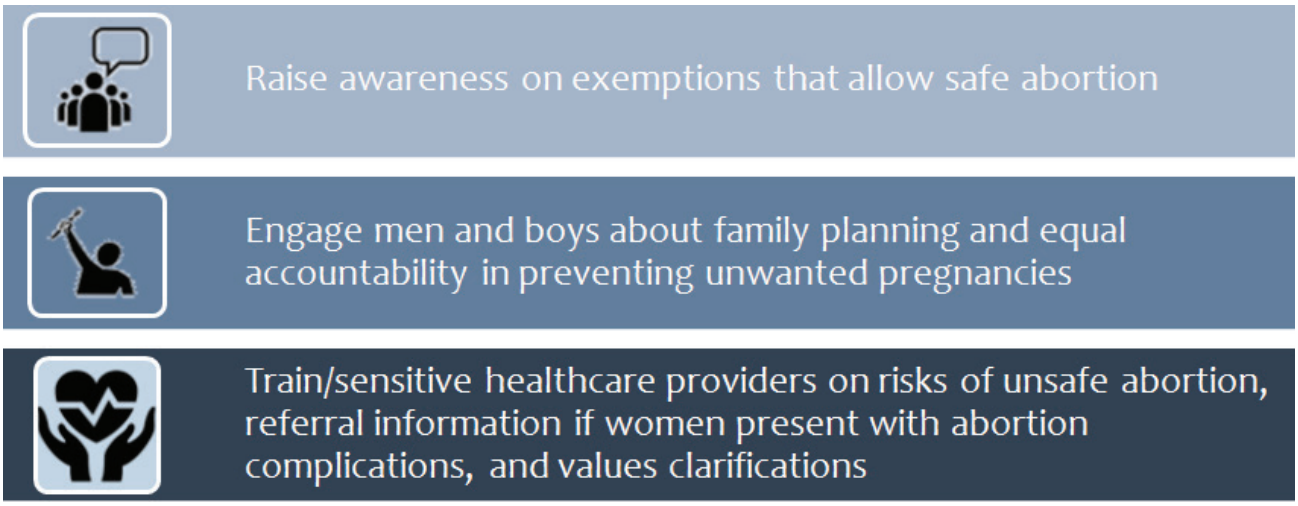
Although it is commonly known in Rwanda that wealthier young girls and women are likewise having unwanted pregnancies and seeking abortion services, this discussion did not arise among the semi-structured interviews. As a result, future studies could interview women who are open, have the means to travel outside the country to obtain an abortion, and have more family support. By interviewing women who from different financial backgrounds, researchers can learn how the social determinants of health contribute to differential causes, practices, and consequences of abortion. Moreover, future studies could examine the physical health outcomes, psychological well-being, and community re-integration of women after their incarceration period.

Future exploration should also be conducted into how sentencing lengths are determined and how they differ among judges. Since more than one-quarter of the women incarcerated for abortion explained that they unintentionally miscarried, legal aid should likewise follow-up with these cases to investigate the veracity of such claims in order to obtain subsequent remediation, if appropriate.

CONCLUSIONS AND RECOMMENDATIONS

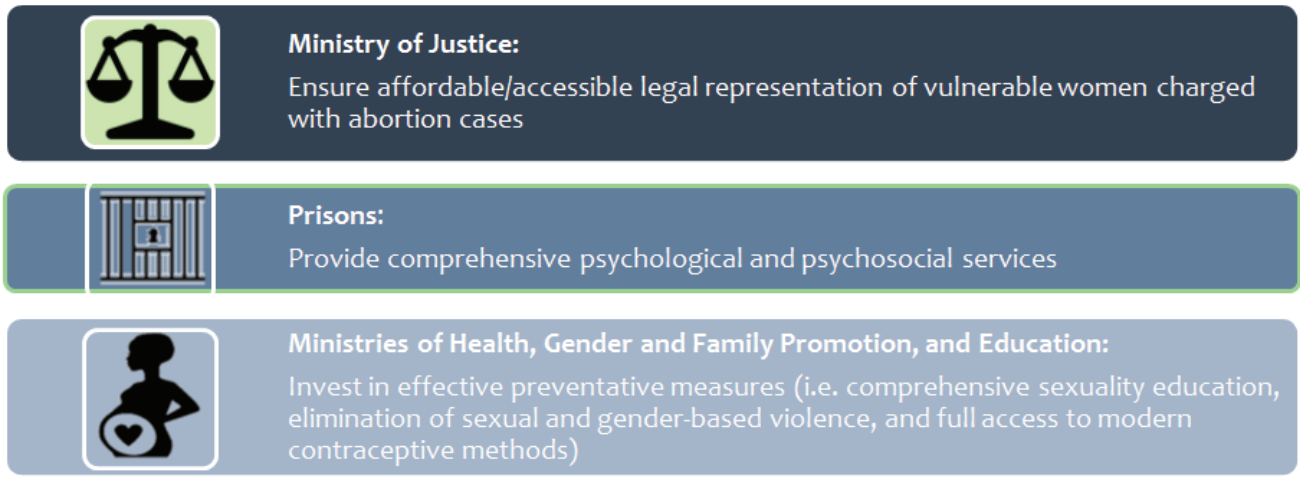
The phenomenon of unsafe abortions not only occurs in Rwanda. According to a recent study in The Lancet (n.d), from 2010 to 2014, nearly 55 million pregnancies were terminated early and of those terminations, nearly half (25.5 million), were deemed unsafe. This study aimed to analyze and understand the complications of unsafe abortion in the Rwandan context among female participants who were incarcerated for performing illegal abortions. Findings address the lack of knowledge regarding the causes, practices, and consequences of terminated pregnancies for convicted women. HDI learned that even when women are eligible for abortion, obtaining a written report by two medical doctors and receiving a court order pose insurmountable challenges. The near impossibility of accessing legal and safe abortions disproportionately affects vulnerable and poor women, often under the age of 25, who lack any legal representation during their court cases. Furthermore, before incarceration, most participants were unaware of the law and their rights. To prevent maternal mortality and morbidity caused by unsafe abortions, it is imperative that the public is educated on the law, especially women of lower education levels, lower socioeconomic status, and minors. All participants expressed their concerns related to the lack of male responsibility: for most, the men who got these women pregnant denied parental responsibilities and broke contact with the victim. Participants' testimonies further revealed that all of them did not plan their pregnancies. Once they learned of their pregnancies, most were filled with panic and sought advice from trusted friends or from their partners who did not help them. As a result, they opted to conductillegal and unsafe abortions which jeopardized both their physical and psychological health. Due to the clandestine and taboo nature of abortion, women were forced to bear the shame and internalized distress alone and behind bars, long after the abortion itself.

Recommendations for Civil Society Organizations, Government Institutions, and Other Key Stakeholders:



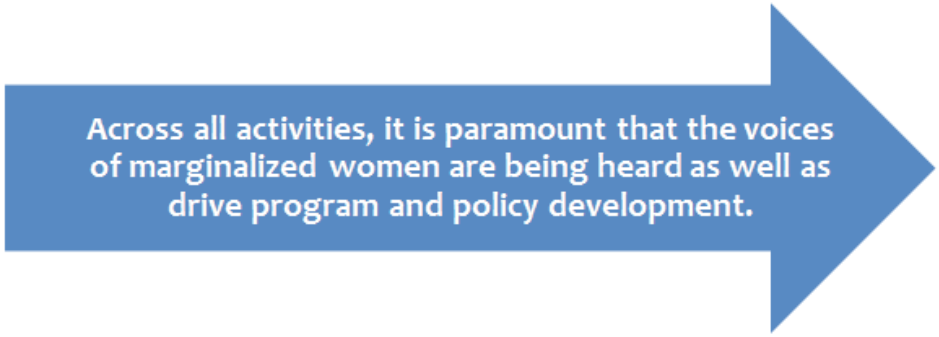
Awareness-raising activities should target women of reproductive age and other stakeholders working in SRHR. Follow-up meetings should investigate barriers to family planning usage (i.e. cost, distance to facility, misconceptions, partner refusal, etc.). Furthermore, trainings should specifically target districts with the highest rates of unsafe abortion and teenage pregnancies. By engaging men and boys, CSOs, can increase awareness of responsible fatherhood, consent, and positive masculinity.

Healthcare providers need further trainings and sensitizations according to their practice. For example, pharmacists will be sensitized on the risks of unsafe abortion, be given referral information if a woman presents with abortion complications, and participate in values clarification workshops. Traditional healers and healthcare providers need to either be trained or undergo refresher trainings on safe abortion and post-abortion care policies and procedures.



Since incarcerated women experience a higher prevalence of depression, suicidal ideation, low self-esteem, and familial marginalization, prisons need to provide comprehensive psychological and psychosocial services, including screenings, diagnosis, accompaniment and treatment. CSOs specifically have a further responsibility to monitor this post-abortion counseling and care within prisons, as well as be involved in prison programming more broadly.

This research has significant implications for civil society advocacy work to expand access to safe and legal abortion services, family planning and contraception. CSOs have an obligation to advocate for friendly policies and programs that address family planning, contraception, and safe-abortion services. Programs that strengthen reproductive rights, decision-making, and service delivery need to target women who have low levels of education and income, and who have repeatedly experienced marginalization.



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APPENDICES

Appendix A:

Questionnaire

A.	Demographic Characteristics of the study participant	
1.	Cell	
2.	Sector	
3.	District	
4.	Sex	
5.	Current Age	
6.	Age imprisoned	
7.	Marital status	
8.	What is the highest level of education you have attained?	
9.	Employment status: What was your job before terminating pregnancy? How many years were you doing that job?	

B. Causes	
Question	Comments
1) Can you please tell me how you ended up here? Probe: Could you tell me more about the circumstances that made you consider obtaining an abortion?	
2) What did you know about the law before trying to get an abortion?	Depending on answer continue with question 3
3) Did you try to obtain a court order?	If yes, continue with question 3a. If no, continue with question 3b
3a) Please describe the process.	
3b) What barriers prevented you from engaging with the courts?	
4) Did you have any contact with GBV officers?	If yes, continue with question 4a. If no, continue with question 4b
4a) What was that interaction like?	
4b) What barriers prevented you from interacting with a GBV officer?	

5) Did you tell anyone you were going to get an abortion?	If yes, continue with question 5a. If no, continue with question 5b.
5a) Who did you feel comfortable going to for advice? Probe: What were you told?	
5b) What were some of your fears or hesitations in approaching people about the abortion?	
6) What was the role of the male who impregnated you in the process of terminating your pregnancy?	
7) Have you had any pregnancies before having an abortion? If so, how many?	

C. Practices	
Question	Comments
1) Can you please tell me about the experience of finding a provider who would perform abortion?	
2) How long did it take from the time you wanted an abortion to the time you received one?	
3) Was your abortion performed by a trained health professional, such as a doctor, nurse, or pharmacist?	If no, continue with question 4
4) Was your abortion performed by a traditional healer?	Only ask if question 3 was answered as "no"
5) What techniques were used to terminate the pregnancy? Probe: What tools were used? Probe: How long did the procedure take?	
6) What medical advice were you given following the termination of the pregnancy? Probe: Were these instructions clear? Probe: Was this advice appropriate and effective?	
7) How much did the procedure cost? Probe: What did you think of the price (appropriate, too expensive, or inexpensive)?	

D. Consequences	
Question	Comments
1) What happened after you terminated your pregnancy? Probe: How long after the termination were you imprisoned?	
2) How did your family, friends and loved ones react to you terminating your pregnancy?	

3a) How has terminating your pregnancy affected you?	
3b) How has terminating your pregnancy affected your household?	
4) Can you tell us what your daily life is like in prison?	
Do you have any final thoughts or comments that you would like us to know?	

Appendix B

Questionnaire-Kinyarwanda

Ikiganiro cyihariye/ Ibibazo by'ikiganiro mbonankubone.

A. Demographic Characteristics of the study participant			
1.	Akagari		
2.	Umurenge		
3.	Akarere		
4.	Igitsina		
5.	Imyaka afite ubu		
6.	Imyaka amaze afunze		
7.	Irangamimerere		
8.	Ni uruhe rwego rwo hejuru rw'amashuri wize?		
9.	Imiterere y'akazi: Ni uwuhe murimo wakoraga mbere y'uko ukuramo inda? Uyu murimo wari umaze imyaka ingahe uwukora?		

B. Impamvu	
Ikibazo	Ibisobanuro
1) Ese wambwira uko wageze hano? Cukumbura: Wambwira bisumbyeho ibyaba byaraguteye guhitamo gukuramo inda? Could you tell me more about the circumstances that made you consider obtaining an abortion?	
2) Ni iki wari uzi ku itegeko mbere yo kugerageza gukuramo inda? What did you know about the law before trying to get an abortion?	Bitewe n'igisubizo komereza ku kubazo cya 3
3) Wagerageje kubona icyemezo cy'urukiko?	Niba ari yego, komereza ku kibazo cya 3a. Niba ari oya, komereza ku kibazo cya 3b.
3a) Ngaho nsobanurira uko wabikoze.	
3b) Ni izihe nzitizi zatumye utajya mu nkiko?	
4) Wigeze uvugana n'abakozi bashinzwe kurwanya ihohoterwa rishingiye ku kitsina?	Niba ari yego, komereza ku kibazo cya 4a. Niba ari oya, komereza ku kibazo cya 4b.

4a) kiganiro mwagiranye cyari kimeze gute?	
4b) Ni izihe nzitizi zatumye utavugana n'umukozi ushinzwe kurwanya ihohoterwa rishingiye ku gitsina?	
5) Hari umuntu wigeze ubwira ko wari ugiye gukuramo inda?	Niba ari yego, komereza ku kibazo cya 5a. Niba ar oya, komereza ku kibazo cya 5b.
5a) Ninde/bande wumvise wisanzuye kujya kumugisha inama? Cukumbura: Ni iki wabwiwe?	
5b) Ni ibihe bintu mu byo watinyaga cyangwa washidikanyagaho mu kubwira abantu ku bijyanye no gukuramo inda?	
6) Umugabo/umusore waguteye inda yagize uruhe ruhare mu gukuramo inda yawe?	
7) Wigeze utwita izindi nda mbere yo gukuramo inda? Niba ari yego, ni zingahe?	

C. Imigenzereze

Ikibazo	Ibisobanuro
1) Ese wambwira ibyerekeranye n'iko wabonye umuganga wari gukuramo inda?	
2) Byagufashe igihe kingana gute guhera igihe washakaga gukuramo inda kugeza ivuyemo?	
3) Inda yawe yaba yarakuwemo n'umuntu wize iby'ubuvuzi, nk'urugero umudogiteri, cyangwa umuhanga mu by'imiti?	Niba ari oya, komereza ku kibazo cya 4.
4) Inda yawe yaba yarakuwemo n'umuvuzi wa gihanga?	Kibaze gusa niba ikibazo cya 3 cyasubijwe "oya"
5) Ni ubuhe buryo bwakoreshejwe mu gukuramo inda? Cukumbura: Ni ibihe bikoresho byakoreshejwe? Cukumbura: Icyo gikorwa cyafashe igihe kingana iki?	
6) Ni izihe nama za muganga wahawe nyuma y'uko indaikuwemo? Cukumbura: Ayo mabwiriza yari asobanutse? Cukumbura: Iyi nama yari ikwiye kandi ari ingirakamaro?	
7) Icyo gikorwa cyagutwaye amafranga angahe? Cukumbura: Ni iki watekereje kuri icyo giciro (cyarigikwiriye, kinini cyane, cyangwa ntibyari bihenze)?	

D. Ingaruka	
Ikibazo	Ibisobanuro
1) Byagenze gute nyuma y'uko ukuyemo inda? Cukumbura: Wafunzwe hashize igihe kingana gute ukuyemo inda?	
2) Ni gute umuryango wawe, inshuti n'abo ukunda bakira bate kuba warakuyemo inda yawe?	
3a) Ni gute gukuramo inda yawe byakugizeho ingaruka?	
3b) Ni gute gukuramo inda yawe byagize ingaruka ku rugo rwawe?	
4) Ese watubwira uko ubuzima bwawe bwa buri munsi bumeze muri iyi gereza?	
Hari ibitekerezo cyangwa ibyo waba ushaka kongeraho byanyuma ushaka ko tumenya?	

Murakoze cyane ku bw'umwanya wawe no kuba wemeye kugira uruhare muri ubu bushakashatsi. Turizera ko, ibyo wadusangije uyu munsi bizafasha mu gukora ubuvugizi ku guhindura politiki zirebana no gukuramo inda. Twishimiye amakuru uduhaye.

Appendix c
Informed consent form

Thank you so much for your willingness to take part in this interview. My name is [NAME.....]/. I am from the Health Development Initiative (HDI), a Rwandan organization that is advocating for health and human rights for all. We are doing a research study to understand the causes, practices, and consequences of an induced abortion among young girls/ women who are convicted for abortion in the Rwandan prisons.

First we would like to know if you are interested in taking part in this study. If so, we would like you to first sign a form developed to meet the human subject research requirements. Briefly, the consent form states that: (i) all information provided by you during this conversation will be held confidential, (ii) your participation in this study will be voluntary and you have the right to stop the interview at any time if you feel uncomfortable (iii) there is no harm of any kind that will be inflicted on you as a result of taking part in this study.

We are interested in hearing aboutyour experience, practices and consequences after receiving an abortion.–I have some guiding questions, but you are free to talk about anything you think is important for us to know. We will be recording our discussion on tape and taking notes to enable us capture all that we shall be discussing to be sure we don't miss anything. If you do not want to be recorded, you can still be involved in the study.

Before we start, I just want to emphasize that everything we talk about today is confidential. No one will have access to the tape or notes that I am taking except for those of us working on the project. You should know that no answer is right or wrong. What we are actually interested in is your ownexperience related to obtaining an abortion. When we write up our report, we will not use the names of any interviewees so that no one can be identified. Also, if at any point during the interview you would like to stop, or if there are any questions you would rather not answer, just let me know -- that's fine. You can take a break at any time.

Before we continue, do you have any questions for me?
Voluntary consent
You are free to choose whether or not to partake in the study. You should feel free to ask any questions before, during, and after the interview. If you would like to withdraw from the study, you can do so at any point by contacting Prof. Eugene Rutembesa on 0788426866 or Natacha Mugeni on 0788352277/0788309262 or emailus on :info@hdirwanda.org.
The Rwanda National Ethics Committee has reviewed and approved this project. If you have any concerns about your rights in this project, please contact Dr. Mazarati Jean Baptiste the Chairperson of Rwanda National Ethics Committee 0788309807 or Dr. David Tumusiime the secretary of Rwanda national committee on 0788749398.
Statement of informed consent

- The study has been explained to me in a language that I easily understand. All the questions I had about the study have been clearly answered. I understand what will happen during the interview and what is expected of me.
- I have been informed that it is my right to refuse to take part in the interview today and that if I choose to refuse I do not have to give a reason, and that it will not prejudice the care that I can expect to receive now, or in the future.

- I have been informed that anything I say during the interview today will remain completely confidential: my name will not be used nor any other information that could be used to identify me unless I choose to be mentioned in the study.
- It has been explained that sometimes the researchers find it helpful to use my own words when writing up the findings of this research. I understand that any use of my words would be completely anonymous (without my name unless I want my work to be mentioned). I have been told that I can decide whether I permit my words to be used in this way.
- I do here by voluntarily agree to participate in this study.

Respondent's signature/thumb print.....
Date:.....

Appendix D

Informed consent form-Kinyarwanda

Imyemezabushake

Intangiriro
Urakoze cyane kuba wemeye kugira uruhare muri iki kiganiro. Nitwa [IZINA……]. Ntururtse mu muryango witwa Health Development Initiative (HDI), umuryango nyarwanda ukora ubuvugizi ku buzima n'uburenganzira bwa muntu kuri bose. Turiho turakora ubushakashatsi kugirango dusobanukirwe impamvu, imigenzereze, n'ingaruka zo gukuramo inda ku bushake mu bakobwa/ abagore bahamwe n'icyaha cyo gukuramo inda mu ma gereza yo mu Rwanda.

Twifuzaga kubanza kukubaza niba wumva ushaka kugira uruhare muri ubu bushakashatsi, niba ubishaka, twifuzaga ko wabanza gusinya inyandiko twategwe mu rwego rwo kubahiriza ibisabwa mu bushakashatsi bukorerwa ku bantu. Muri make, iyi nyandiko ivuga ko: (i) amakuru yose uza gutanga muri iki kiganiro azagirwa ibanga, (ii) kugira uruhare muri ubu bushakashatsi ni ubushake kandi ufite uburenganzira bwo guhagarika ikiganiro igihe ushakiye mu gihe wakumva utakibyishimiye, (iii) nta ngaruka mbi nimwe izakubaho iturutse ku kuba wagize uruhare muri ubu bushakashatsi

Dushishikajwe no kumva ibyakubayeho, uko wabigenje n'ingaruka nyuma yo gukuramo inda. Mfite ibibazo bimwe by'inyoborakiganiro, ariko ushobora kuvuga ku kintu icyo aricyo cyose wumva ko byaba ari ingenzi ko tukimenya. Turaza gufata amajwi y'ikiganiro ndetse tunandike ibivugwa kugirango dushobore gufata ibyo tuza kuganira byose mu rwego rwo kwizera ko nta kiducuka. Niba udashaka ko dufata amajwi yawe, ntibyakubuza kugira kugira uruhare mu bushakashatsi.
Mbere y'uko dutangira, nagirango nshimangire ko ibyo turi buganire byose ari ibanga. Nta muntu numwe uzagera ku majwi ndiho nfata cyangwa ibyo ndiho nandika ureste twe turiho dukora muri ubu bushakashatsi. Wakagombye kumenya ko nta gisubizo kiri cyiza cyangwa kibi. Mu kwandika ibyavuye mu bushakashatsi, ntabwo tuzakoresha amazina y'abo twaganiriye kugirango hatagira ubamenya. Ikindi, ni wumva ushaka guhagarika ikiganiro igihe icyo ari cyo cyose, cyangwa niba hari ibibazo uza kumva udashaka gusubiza, uze kubimwira --nta cyo bitwaye. Ushobora gufata akaruhuko igihe cyose ushakiye.

Mbere y'uko dukomeza, hari ibibazo wumva wambaza?

Kwemera ku bushake
Ufite uburenganzira bwo guhitamo kugira uruhare muri ubu bushakashatsi cyangwa kubyanga. Wakagombye kumva wisanzuye kubaza ibibazo byose ushaka mbere, hagati, cyangwa nyuma y'ikiganiro. Uramutse wifuje kuva mu bushakakashatsi, wabikora igihe cyose ushakiye mu kudutelefona muri Health Development Initiative (HDI): Tel: +250788306047/ +250788309262, kandi/cyangwa ukatwandikira kuri imeyili: info@hdirwanda.org.

Komite y'igihugu ishinzwe kurengera abakorerwaho ubushakashatsi yasuzumye kandi yemeza ubu bushakashatsi. Uramutse ugize impungenge/ibibazo byerekeranye n'uburenganzira bwawe muri ubu bushakashatsi, uzaterefone Dr. Mazarati Jean Baptiste umuyobozi wa komire y'igihugu

ishinzwe kurengera abakorerwaho ubushakashatsi kuri 0788309807 cyangwa Dr. Laetitia Nyirazinyoye umunyamabanga w'iyo komite kuri 0738683209.

Inyemezabushake
Nasobanuriwe ubushakashatsi mu rurimi numva neza. Ibibazo byose nari nfite birebana n'ubushakashatsi byasubijwe mu buryo bwumvikana. Nsobanukiwe uko ikiganiro kiri bugende n'uruhare rwanjye.

Namenyeshejwe ko ari uburenganzira bwanjye kwanga kugira uruhare muri iki kiganiro uyu munsi kandi ko niba mpisemo kwanga ntagomba gutanga impamvu, kandi ko bitazahungabanya buryo nakagombye kwitabwaho ubu cyangwa mu gihe kizaza.

Namenyeshejwe ko ikintu cose nza kuvugira mu kiganiro kizagirwa ibanga rikomeye: izina ryanjye ntirizakoreshwa cyangwa amakuru yose ashobora gukoreshwa mu kumenya keretse mpisemo ko bamvuga mu bushakashatsi.

Byasobanuwe ko rimwe na rimwe abashakashatsi basanga bifasha gukoresha amagambo yanjye bwite mu kwandika ibyavuye muri ubu bushakashatsi. Nsobanukiwe ko mu ikoreshwa ry'amagambo yanjye umwirondoro wanjye utazamenyekana (izina ryanjye rizakurwamo keretse nshatse ko uruhare rwanjye rugaragazwa).Nabwiwe ko nshobora gufata icyemezo cyo kuba natanga uburenganzira bwo gukoresha amagambo yanjye muri ubu buryo.
Ubu nkaba nemeye ku bushake kugira uruhare muri ubu bushakashatsi.

Umukono w'ubazwa/igikumwe .....
Italiki:.....

Appendix E

Informed consent form for collecting stories

HDI is involved in advancing the sexual health and reproductive rights of women and girls. Results of the study will be utilized to inform advocacy efforts for increased access to safe abortion services and in contributing to the development of national policies and guidelines.

HDI would like to use testimonies gathered from this research to improve advocacy and public understanding of the consequences of restrictive abortion access.

Will you provide your permission for HDI to distribute your testimonies among stakeholders and relevant partners? If you do not agree to HDI publishing your testimony, you are still able to partake in the study without any penalties.

If you do agree, HDI will not disclose your name and your information will remain completely anonymous.

Please sign below with your consent to HDI anonymously publishing your testimony:

_____ _____

Signature Date

If you would like to withdraw your consent from publishing, you can do so at any point by contacting us at Health Development Initiative (HDI): Tel: +250788352277/ +250788309262, and/or email: info@hdirwanda.org.

Appendix F

Informed consent form for collecting stories Kinyarwanda

HDI ikora ibikorwa byo guteza imbere uburenganzira ku ubuzima bw' imibonano mpuzabitsina n'imyororokere bw'abagore n'abakobwa. Ibizava mu bushakashatsi bizakoreshwa mu guha amakuru abakora ibikorwa by'ubuvugizi kugirango serivisi zo gukurirwamo inda mu buryo bwizewe zizamurwe no mu kugira uruhare mu gukora amategeko n'amabwiriza by'igihugu.

HDI yifuzaga kuzakoresha ubuhamya buzegeranywa muri ubu bushakashatsi mu kuzamura ubuvugizi n'imyumvire y'abantu ku ngaruka ziterwa ninzitizi zo gukuramo inda.

Uzaha uruhushya HDI rwo guha ubuhamya bwawe abafatanyabikorwa n'abandi baterankunga? Nutemera ko HDI itangaza ubuhamya bwawe, nta kibazo ushobora kugira uruhare mu bushakashatsi kandi nta bihano uzahabwa.

Niba wemeye, HDI ntabwo izatangaza izina ryawe kandi amakuru yawe azaguma ari ibanga risesuye.

Ngaho sinya hano munsi wemeza ko HDI izatangaza ubuhamya bwawe ariko bitamenyekanye ko ari ubwawe:

_____ _____

Umukono Italiki

Nuramuka wisubiyeho ukanga ko ubuhamya bwawe butangazwa, ushobora kubikora igihe icyo ari cyo cyose udutelefona kuri Health Development Initiative (HDI): Tel: +250788306047/ +250788309262, kandi/cyangwa utwandikire imeyili kuri :info@hdirwanda.org.

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