SAFE ABORTION WITHOUT REFERRAL

Overcoming Unnecessary Barriers to Safe Abortion Services for Members of the Community-Based Health Insurance Scheme

Key messages

- By law, abortions can be performed in hospitals and polyclinics without patients requiring a referral letter. However, in practice, members of the Community-Based Health Insurance (CBHI) scheme must first go to a health center to get a transfer note to a hospital or risk not having the procedure reimbursed.
- Victims of gender-based violence (GBV) are exempt from the transfer requirement but subjected to the practice of having to report to Isange One Stop Center (IOSC) before accessing comprehensive abortion care.
- These access barriers encourage women to seek out unsafe alternatives with negative economic, medical and psychosocial consequences.
- To ensure access to comprehensive abortion care without the need for a transfer note and decrease unsafe abortions, it is recommended to abolish the transfer requirement by amending the CBHI Law.

Transfer notes as a barrier to accessing comprehensive abortion care

In Rwanda, abortions may only be performed in public or private hospitals and polyclinics by medical doctors with a bachelor's degree within the first 22 weeks of gestation, and under certain conditions, such as rape, incest, forced marriage or when the mother's life is in danger (Ministerial Order N°002/MoH/2019 determining conditions to be fulfilled for a medical doctor to perform an abortion). This Ministerial Order also stipulates that a person seeking abortion services has the right to access a licensed hospital or polyclinic of their choice without a transfer.[1] Despite this clear legal regulation, members of the Community-Based Health Insurance scheme (CBHI, also called Mutuelle de Santé) must first go to a health center or post, which are not allowed to perform abortions, to obtain a transfer note to a higher-level facility such as a district hospital (Art. 11, CBHI Law). If they access a hospital directly, CBHI does not cover the abortion and patients need to pay for the procedure and all associated costs themselves.

The Rwanda Social Security Board (RSSB), the authority managing the CBHI, has attempted to resolve this problem by issuing a letter mandating hospitals not to require transfer notes for victims of gender-based violence (GBV) who wish to end a pregnancy; the hospitals are instructed to receive them as emergency cases. However, this letter has not completely resolved the issue because of the practice to require CBHI members who are victims of GBV to log a GBV case with the Isange One Stop Center (IOSC)[2] prior to receiving abortion care.[3] Women who are not GBV victims still need to obtain a transfer note. These requirements conflict with the Ministerial Order, which gives women and girls the right to access a clinic of their choice directly without a transfer note nor an IOSC visit.

[1] Note that Art. 9 of the Ministerial Order clearly states in Kinyarwanda that a transfer note is not necessary while the English translation is more ambiguous, "... receive the services without necessarily presenting the medical transfer." When different language versions conflict, the one in Kinyarwanda prevails.

[2] The IOSC consists of centers set up by the Ministries of Health and Justice and the National Police to offer GBV victims psychosocial, legal and health support and to initiate investigations of GBV cases.

[3] It is not defined by law whether using IOSC is a mandatory prerequisite to get an abortion, and if so, for whom (minors, adults, or all). While the Ministry of Health requires referral to IOSC for GBV victims presenting at health centres, health posts or private hospitals for any medical issue (Ministry of Health, 2020), it seems that in practice, different district hospitals and IOSC locations (which are usually within a district hospital) follow varying practices when it comes to abortion services, some requiring an IOSC visit and others not.

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In addition, the requirements to log a GBV case or obtain a transfer note subject patients to delays in getting a safe abortion. Abortion care is time-sensitive with a short window between learning about a pregnancy, deciding whether to keep it, and requesting an abortion. Because of stigma, women do not feel comfortable asking for a transfer note at health centers and posts and may not feel comfortable explaining to their families or community why they need to take time off work or family duties to go to a clinic. Requiring an additional step increases the pressure women are under, causing potentially even more delays, which increase the risk to patients' health and can lead to missing the abortion window and being forced to carry an unintended pregnancy to term. Insisting on a visit to IOSC or a health center also leads to extra expenses for women. This compounds the already difficult access to abortions because 30% of district hospitals in Rwanda refuse to perform the procedure for religious reasons (RBC, 2022). Consequently, women who find the hurdles too high and women who have reasons not to disclose a perpetrator's name have no choice but to seek unsafe abortions because they are prevented from easily accessing an authorized abortion provider.

Lastly, the issue of transfer notes may lead to an increased workload for health centers and posts, which need to issue transfer notes for a service women could directly obtain at hospitals, tying up resources that could be used to treat other patients. The transfer requirement is an unfair and unjust obligation imposed not only on women and girls but also on primary care providers.

A. Critical root causes

The main cause of the barriers to access safe abortions is the CBHI Law's outdated transfer requirement, which conflicts with the more recent Ministerial Order on abortion conditions. Because a ministerial order is lower in the legal hierarchy, the CBHI Law prevails. The RSSB letter does not remedy the issue because it only applies to GBV victims, who are usually required to visit IOSC, which is an impediment to the right of women and girls to directly access a hospital of their choice.

B. Evidence

In 2020, 64% of the 3,445,665 Rwandan women of reproductive age (15-49 years of age) were members of the CBHI, totaling 2,202,125 (RDHS 2019-20). Therefore, a significant proportion of Rwandan women are affected by the referral requirement and the practice of visiting the IOSC before accessing abortion care.

For the years 2019-2022, records show that 2,525 adult women sought a safe abortion (109 due to incest, 2,147 due to rape and the rest due to other reasons) (HMIS). It is unknown, however, how many women resorted to unsafe abortions instead of getting a transfer or logging a GBV case with the IOSC, or how many unwanted pregnancies were carried to term due to these access barriers.

The impact of these access barriers and the consequences of delayed and unsafe abortions and unintended pregnancies have not been studied; these may include illness and deaths, emotional harm, out-of-pocket expenses for travel or self-funded abortions (safe or unsafe), incarceration for getting an unsafe abortion, and cost to insurance schemes to treat complications from unsafe abortions.[4]

Possible Solutions

The following solutions are available to address the root causes and solve the transfer issue:

- An RSSB letter could be immediately issued as a temporary solution to clarify that women and girls can directly go to a hospital or polyclinic to receive abortion care without the need to first obtain a transfer note at a health center or report to the IOSC. The IOSC visit should be recommended for women and girls seeking justice but not mandated for those merely wanting a safe abortion. This would constitute a victim-centered approach to health care and law enforcement, ensuring prompt medical care while still allowing GBV victims to report to IOSC when they are ready.
- The CBHI Law could be amended to remove the transfer requirement for abortion services to enshrine the change into law, eliminate the conflict between the CBHI Law and the Ministerial Order on abortion conditions, and simplify the process for CBHI members. This solution would simplify access to comprehensive abortion care for all women, whether they are victims of GBV or not. GBV would no longer need to be demonstrated, making an IOSC visit a recommended but voluntary practice.
- Women and girls could be informed of their rights and what help is available to them (e.g., IOSC).

Over the long term, the government should consider expanding access to safe abortions by allowing health centers, nurses and midwives to perform abortions. This policy step would drastically improve access to safe abortions and reduce mortality and morbidity resulting from unsafe abortions.

[4] Post-abortion care has steadily increased from 4,752 cases in 2018 to 9,181 cases in 2022 (HMIS) but it is not known how many of these are due to unsafe abortions, and how many resulting from the issues discussed here.

Recommendation

It is recommended to remove the transfer requirement from the CBHI Law because it would address both the legal conflict and IOSC reporting practice while not extending abortion services beyond their current scope. Only ending the practice of requiring an IOSC visit would neither address the legal conflict between the CBHI Law and the Ministerial Order, nor the fact that some situations eligible for abortion are not necessarily GBV cases (e.g., child pregnancy, incest). It might also be resisted by law enforcement authorities.

A. Recommended approach

Article 11 of the CBHI Law should be amended to abolish the referral requirement by law. It is possible that other procedures or services will be exempt from referral requirements in future; therefore, the following wording is proposed to encompass all legal exemptions to the transfer requirement:

> **Article 11: Health facilities opened to community-based health insurance scheme affiliated members**
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> ... With exception of emergency cases and any other service legally required to be provided by a superior health facility without transfer note, a patient benefits from medical care of health facilities of superior category if he or she has a transfer note.

The amendment of the CBHI Law is a legally strong but long-term solution because of the duration of the legislative process. In the meantime (or if the suggested amendment is politically not feasible), the RSSB should issue another letter to clarify the legal situation, instructing hospitals and polyclinics to not require transfer notes for abortion services for any CBHI member independent of GBV status.

Alternatively, the legal conflict could be clarified by including a provision on transfer notes in the Law Regulating Health Services, currently being drafted by the Ministry of Health.

B. Impact

Both the recommended amendment of the CBHI Law and the interim solution of an RSSB letter would have a high public health impact because they would remove a significant barrier to safe abortion, increasing access and reducing unsafe abortions and related illness and death.

Both solutions would have an overall benefit to the economy and society because of a number of effects: the bureaucracy surrounding abortion care would decrease; patients would save time and out-of-pocket expenses, being able to access hospitals directly; health centers could free up time, resources and money because they would not need to issue transfer notes and would see fewer cases of costly post-abortion care due to a decrease in unsafe abortions; and women and society would not face the psychosocial and economic consequences of delayed and unsafe abortions and unintended pregnancies carried to term.

Legally clarifying that transfer notes are not necessary would not change the fact that the IOSC is a voluntary service that GBV victims can continue to use. Women and girls willingness to report to the IOSC or not report would be independent of the legal situation on transfer notes. However, doing away with the transfer requirement would allow them to end their pregnancy safely with an authorized provider. It would constitute a victim-centered approach that prioritizes the rights, choices and needs of GBV victims, enabling prompt medical care while still offering IOSC support as and when women are ready.

C. Policy pathway

The CBHI Law[5] would need to be amended by the Parliament on the initiative of the Ministry of Finance and Economic Planning (MINECOFIN) as the supervising body of the RSSB, in collaboration with the Ministry of Health as the responsible authority for health care. For the interim solution, the RSSB would issue a letter to all hospitals, polyclinics and health centers and posts.

D. Feasibility

Amending the CBHI Law is politically feasible because the current practice already requires hospitals to accept GBV victims for abortion care without a transfer note. The amendment would legally clarify and strengthen the precedent set by the RSSB letter in 2020 without increasing the eligibility for abortion care pursuant to the Ministerial Order on abortion conditions. The only real change would be that children, or women who had consensual sex with a relative of first or second degree, could access safe abortions without a transfer note. Legally, the amendment would require a parliamentary discussion and vote—a more complex and lengthy process than issuing an RSSB letter, but legally entirely feasible.

The interim recommendation of an RSSB letter would be an affordable and easy-to-implement solution because it would not require a lengthy regulatory or legislative

[5] Law N°03/2015 of 2 March 2015 governing the organization of the community-based health insurance scheme.

process. As with an amendment of the CBHI Law, it should be politically feasible since it would continue a current practice and only extend abortion access without a transfer note to children and a small number of eligible women.

Both options are operationally easy to implement as they remove a bureaucratic step in abortion care. It would be necessary to inform all medical doctors and health facilities that transfer notes are not required and should not be requested from patients. This could be done through trainings and letters via the Rwandan Medical Association, the Rwanda Society of Obstetricians and Gynecologists, and Medical Doctors for Choice. In addition, women and girls should be informed about their rights, options and what kind of help is accessible to them (e.g., the right to use IOSC) through community outreach and with information displayed in health facilities.

E. Cost considerations

Costs can be considered from several perspectives. From an individual (pregnant woman/girl) perspective, increasing access to safe abortions would reduce out-of-pocket costs. Women currently pay around US$15-30 for a safe abortion covered by CBHI and about US$30-70 if they access a public hospital without a transfer note or using IOSC first. At a private clinic, women pay US$100-300 for an abortion; US$10-30 for (mostly ineffective) traditional medicine; and US$10-20 for an abortion pill such as mifepristone. Additional costs may include US$5-10 for transport and US$2-5 for materials. Furthermore, clandestine or unsafe abortions using traditional medicine, a self-bought abortion pill or other methods have higher risk of complications which may require post-abortion care. As stated previously, post-abortion care is only covered by CBHI if a woman receives it at a health center or health post or receives a transfer note to a hospital, in which case she pays US$10-30. Due to stigma, women often prefer to access hospitals directly, in which case they must pay the full cost of approximately US$100-300 (or more if complications are severe).

From a health systems perspective, a cost inventory and analysis must be conducted in order to understand the true value of resources associated with safe and unsafe abortions, e.g. the annual cost of safe abortions, the annual costs of post-abortion care, the cost to health centers to see women and then issue transfers notes to other facilities, the potential opportunity costs associated with this practice of transfer for health centers (time/attention diverted from other care). The oft-cited Vlassoff et al. study, which investigated costs to the Rwandan health system, estimated that treatment costs for complications of unsafe abortions were US$1.7 million in 2012[6], 49% of which were non-medical costs (overhead, infrastructure). In addition, they reported that satisfying all demands for post-abortion care would raise the cost to US$2.5 million and ultimately, indicated that lowering barriers to safe abortions would decrease overall costs given that a safe abortion only costs a third of the post-abortion care costs. It would be extremely useful to update this study and, if feasible, conduct an analysis exploring if there is a relationship between a potential increased number of safe abortions due to the removal of barriers to access such as transfer notes, with a potential decrease in number of post-abortion care cases.

From a societal perspective, other evidence would be useful, such as an investigation of the association between increased access to safe abortions and decreased out-of-pocket expenses for Rwandan women and families (collective economic impact), decreased maternal mortality and morbidity and unintended pregnancies, and any other effects on the entire society at large.

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[6] Given the current inflation rate in Rwanda, US$ 1.7M was estimated to be US$ 2.72M in 2022.