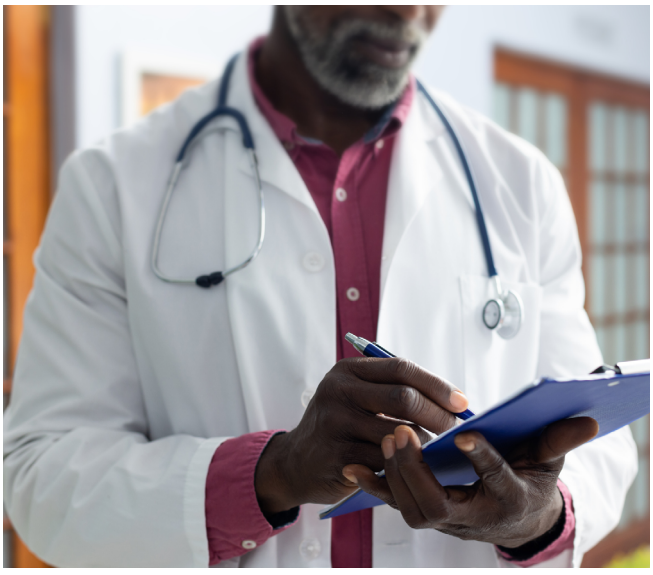
KUTEMERANYA N' IBWIRIZA RYA MINISITERI Y' UBUZIMA RYOROHEREREZA ABEMEREWE GUKURAMO INDA

Conscientious Objection to the Ministerial Order That Facilitates Access to Safe Abortion

Key messages

- To ensure access to safe abortions regardless of the patient's wealth or location, the government should strictly regulate the conditions under which medical doctors may refuse to provide timely and appropriate care.
- Conscientious objection is not currently regulated by law in Rwanda. If conscientious objection continues without limit, women and girls will face an increased risk of death and severe complications from delayed and unsafe abortions or will be forced to carry an unwanted child to full term, including pregnancies resulting from rape, incest, forced marriage or child defilement.
- While entirely banning conscientious objections is preferable from a public health standpoint, the medical community and the general public may be more amenable to balancing providers' personal beliefs against patients' right to receive appropriate medical services. Lifesaving provisions could be added to the Ministerial Order N°002/MoH/2019 on abortion conditions.



Conscientious objection is not regulated

Conscientious objection is the refusal to discharge a responsibility, such as providing a medical procedure, based on personal, religious or moral beliefs. Rwandan law does not regulate conscientious objection by medical doctors (nor health care facilities) which means that there are no rules governing if and how they can legally object to providing care. There are also no rules or guidelines on how to proceed if a patient is refused health care based on conscientious objection, such as referring the patient to another provider.

Based on the Rwanda's Law on Human Reproductive Health, medical doctors and other staff of public health facilities are required to provide good patient care and fast and high-quality service without discrimination. The Ministerial Order N°002/MoH/2019 on abortion conditions permits abortions under certain conditions and grants patients the right to access an accredited hospital of their choice to receive comprehensive abortion care.

The unregulated practice of conscientious objection denies patients these rights and violates the law. When a patient is refused abortion services, she has limited options and no recourse against the decision. Only medical doctors are permitted to perform abortions; trained nurses and midwives are not permitted to provide comprehensive abortion care. If the hospital does not have other medical doctors on duty to perform an abortion, the patient must find and travel to another of the 52 authorized hospitals in the country (RBC, 2022). This imposes an additional burden on the patient's time and finances and may expose her to additional scrutiny from her family and community. Even if she can travel to another hospital, another conscientious objector may turn her away yet again. These delays may cause a woman to miss the abortion deadline of 22-week gestation age. If these burdens are overwhelming, a patient must choose between carrying an unwanted pregnancy to term or enduring unsafe abortion methods provided outside a safe, authorized health care setting.

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Figure 1: Proportion of health facilities in Rwanda that provide safe abortions (*Rwanda Ministry of Health—Fourth Health Sector Strategic Plan July 2018—June 2024, p. 76, Annex 1*)

A. Evidence

Because the prevalence and consequences of conscientious objection have not been studied in Rwanda, it is unclear how many of the estimated yearly 60,000 unsafe abortions performed in Rwanda (*Guttmacher*, 2013) are a result of this practice. It is only known that 12 of 45 district hospitals (30%) are faith-based and do not perform abortions for religious reasons (*RBC*, 2022). It is unknown where and how often women are being denied abortions. However, it is widely known that Rwandan women are directly or indirectly denied safe abortion care at unacceptable rates.

Possible Solutions

A range of solutions could address unregulated conscientious objection to abortions:

- The Ministry of Health could ban medical doctors from conscientious objection entirely;
- The Ministry of Health could issue mandatory rules on conscientious objection that:
  - require conscientious objectors to apply,
  - track conscientious objectors in a register,
  - define situations in which conscientious objection is not permitted, such as post-abortion care or an abortion needed to save the life of the mother;
- The Ministry of Health could issue medical guidelines on conscientious objection;
- The Rwanda Medical and Dental Council (RMDC) and other medical professional regulatory bodies could issue ethical guidelines on conscientious objection;
- Learning materials and curricula for pre-service training in medicine and health sciences could be updated to include information on conscientious objection and value clarification and attitudes transformation;
- Access to comprehensive abortion care could be expanded from hospitals and polyclinics to health centers;
- Trained nurses and midwives could be allowed to perform abortions on their own or following a tele-consultation with a medical doctor given that they are already allowed to provide post-abortion care services (an existing ministerial order prohibits nurses and midwives from raising conscientious objections, i.e., they are compelled to provide service irrespective of their beliefs);
- A free, anonymous complaint line for patients could be established to report non-compliance of health care providers;
- More research and better monitoring could be conducted on abortion and conscientious objection to abortion in Rwanda.

Recommendation

Conscientious objection prioritizes the personal belief of a doctor over a patient's right to health, well-being and essential services. From a public health perspective, the clearest way to eliminate the issues caused by conscientious objection is to ban the practice entirely as a matter of law. However, a ban may not be politically feasible, as it is likely to face strong opposition from the public, medical community and faith-based health care providers. In addition, a ban would require a medical doctor to perform a sensitive procedure that the doctor does not want to perform, which places patients in an uncomfortable and potentially unsafe position. Therefore, if banning conscientious objection is not feasible, it should be regulated, but only if the system guarantees that all abortion patients will be transferred to an authorized abortion provider without undue barriers, cost or delay.

Over the long term, the government should consider expanding access to safe abortions by allowing health centers, nurses and midwives to perform abortions. The feasibility and safety of medical abortions performed by nurses and midwives under the supervision of medical doctors via telemedicine has already been demonstrated (*RSOG, 2023*). This policy step would drastically improve access to safe abortions and should reduce mortality and morbidity resulting from unsafe abortions.

A. Strongest solution: Total ban of conscientious objection

Various countries, such as Ethiopia, Sweden and Finland, do not allow conscientious objection in health care (*Centre for Reproductive Rights*). A ban on conscientious objection would close a legal gap that has been an obstacle to the full implementation of the Ministerial Order on abortion conditions and has multiple advantages over allowing conscientious objection:

- **Access to comprehensive abortion care will be more widely and easily accessible** when abortion care cannot be refused since all medical doctors in Rwanda, approximately 2,800 including 100 obstetrician/gynecologists,[1] would need to comply with the Ministerial Order on abortion services and the Law on Human Reproductive Health. If conscientious objection is permitted, such a high number of doctors may refuse the procedure (either out of sincere reasons or to avoid having to perform a routine procedure in favor of more high-profile services) that access could remain limited. The more doctors register as conscientious objectors, the higher the abortion workload for the remaining doctors—a tipping point may be reached where they decide to refuse abortions to avoid having to spend much of their time performing one procedure. In Italy, for example, 71% of gynecologists are registered as conscientious objectors and 40% of reproductive health clinics do not offer safe abortions, forcing women to travel to other locations or countries and even resulting in an increase of clandestine abortions (*Autorini et al., 2020; Center for Reproductive Rights*).

- **All medical doctors will receive equal treatment and conditions** under a ban while women would have recourse against any doctor refusing to provide abortion care. Conversely, if conscientious objection is allowed, doctors who prioritize their duty of care and choose to provide abortions may be subject to stigma which may harm their career progression, workload and task distribution compared to conscientious objectors (*Autorini et al., 2020*).

- **No additional mechanisms or regulations, such as a transfer system, need to be established.** Where conscientious objection is permitted, countries are obliged to provide the necessary infrastructure and referral system to ensure patients have timely access to other health care providers so as not to undermine their right to legally enshrined essential care based on human rights law (*Maputo Protocol*) and global standards set by the World Health Organization and the International Federation of Gynecology and Obstetrics. Establishing such an infrastructure is a logistical and economic burden on the government that can be avoided by banning conscientious objection.

B. Partial ban: Regulation of conscientious objection and creation of a transfer system

If it is not politically feasible to ban conscientious objection despite the practical and ethical reasons supporting a ban, conscientious objection must be tightly regulated. There must be limits on when care may be denied. The law should prohibit all physicians, including conscientious objectors, from:

- refusing to save a patient's life in an emergency;
- refusing medically necessary post-abortion care;
- refusing to provide abortions where this results in undue barriers;
- counseling patients against seeking an abortion based on their own beliefs;
- intimidating or harassing patients based on their pregnancy or decision to seek abortion services;
- breaking confidentiality;
- failing to issue transfers to a provider who performs timely and appropriate abortion service.

The Ministry of Health should also maintain a register to track which medical doctors are conscientious objectors to ensure there is sufficient coverage in all regions of Rwanda. The Ministry should also consider requiring objectors to attend trainings and attest that they will follow all regulations. It will also need to establish a system to ensure easy transfer to non-objecting doctors.

Regulating conscientious objection in such a way would clarify the legal situation and provide the Ministry of Health with a clear overview of the number and geographic distribution of conscientious objectors. This knowledge could help the ministry develop measures to improve access in areas where the provision of comprehensive abortion care is restricted due to the number of conscientious objectors.

[1] Human Resources for Health Program Rwanda (https://www.hrhconsortium.moh.gov.rw/; unpublished data 2023) and Rwanda Society of Obstetricians and Gynecologists (RSOG), 2023.

C. Impact

Improved access to safe abortions would result in a decrease in delayed and unsafe abortions, maternal morbidity and mortality and associated costs, including costs for post-abortion care. Unintended pregnancies would be reduced, improving the mental health, quality of life and future prospects of affected women. Better access to safe abortions would also increase health system capacity due to a drop in patients seeking post-abortion care.

D. Policy pathway

To regulate conscientious objection to abortion care, the Ministry of Health needs to amend the Ministerial Order N°002/MoH/2019 of 8 April 2019 determining conditions to be satisfied for a medical doctor to perform an abortion.[2]

Suggested wording

Ban on refusal of abortion services

When a patient who satisfies the legal and medical requirements for abortion requests an abortion, a medical doctor may not refuse and must provide abortion care.

In case of refusal, the penalty is Rwf [amount][3] and in repeat cases, the fine doubles.[4]

Partial ban of conscientious objection (refusal) to provide abortion services

A medical doctor may refuse the provision of medical or surgical abortions based on personal beliefs (right to conscientious objection) if the conscientious objection has been registered with the employing health care facility and the medical doctor complies with any additional requirements set by the Ministry of Health.

A medical doctor refusing to perform an abortion must issue a transfer note to another authorized, easily accessible health care provider or medical doctor willing to provide comprehensive abortion care if the patient meets the legal requirements for an abortion.

A medical doctor may not invoke the right to conscientious objection:

- in emergency situations where the patient's life or health is at risk;
- where referral is not possible or timely or where this results in undue barriers;
- for post-abortion care.

A medical doctor may not:

- counsel patients against seeking an abortion based on their own beliefs;
- intimidate or harass patients based on their pregnancy or decision to seek abortion services;
- break confidentiality;
- fail to issue transfers to a provider who performs timely and appropriate abortion service.

Health care staff other than medical doctors do not have the right to invoke the right to conscientious objection to abortion.

The Ministry of Health shall establish a register of conscientious objectors based on information received from health care facilities and issue guidance on the implementation of this Article.

If a medical doctor refuses abortion care without having registered as conscientious objector, or refuses to issue a transfer note for a legally eligible patient in a timely manner, or refuses to perform an abortion pursuant to para. 3, the penalty is Rwf [amount] and in repeat cases, the fine doubles.

If health care staff other than medical doctors refuse to participate in abortion services, the penalty is Rwf [amount] and in repeat cases, the fine doubles.

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[2] Alternatively, conscientious objection could be regulated via the draft Law regulating Health Services (e.g., in Art. 51) but it would be a more complex, lengthy legal pathway.

[3] Imposing financial penalties on medical doctors is not current practice in Rwanda at this time. To operationalize this system as part of an overall or partial ban of conscientious objections for medical doctors would require a thorough and detailed plan. The penalty amounts in this suggested wording should be set high enough to deter non-compliance while being realistic given the salary levels of Rwandan medical doctors and other medical staff.

[4] Note that the RMDC could take disciplinary action against a doctor not complying with the M.O., resulting in a temporary suspension of the medical license.

The implementation guidance to regulate conscientious objection by the Ministry of Health should contain:

- procedure to register conscientious objection to provide medical and/or surgical abortions;
- procedure for keeping the register up-to-date;
- requirement for conscientious objectors to sign a declaration that they will continue to provide the services to which they object in emergencies, where referral is not possible, where service denial it would cause an undue burden to the patient, or for post-abortion care;
- requirement for conscientious objectors to undergo mandatory training on legal and ethical requirements of a medical doctor, including value clarification and attitudes transformation and sensitivity training;
- exclusion of conscientious objectors from counselling sessions on safe abortion;
- exclusion of conscientious objectors from leadership roles and the RMDC mentorship program, including stepping down if currently in leadership or currently participating in mentorship;
- explicit guidance on how to implement suspensions or penalties of conscientious objectors, such as removal from leadership, disqualification from programs, etc.;
- guidance for health care providers on referral management for comprehensive abortion care;
- requirement for health care providers to develop a strategy to ensure patients get access to comprehensive abortion care in a timely, safe and respectful manner with a non-objecting medical doctor, to be approved by the Ministry of Health;
- requirement for the Ministry of Health to regularly review the geographic dispersal and number of willing providers in public and private health facilities, and if such review shows that access to comprehensive abortion care cannot be guaranteed anymore, take appropriate steps to remedy the situation.

A monitoring and enforcement mechanism needs to be developed to ensure that the regulation of conscientious objection to abortion services is implemented and enforced. To facilitate enforcement, a free, anonymous complaint line should be established allowing patients to report non-compliance.

Compliance monitoring could be facilitated by updating the safe abortion indicators dataset to include a section on referrals to capture how many referrals are due to conscientious objection. It would also be possible to integrate monitoring and oversight supervision within existing educational and training programs, which could also serve to train conscientious objectors on issues such as legal and transfer requirements, sensitivity, and situations not allowing conscientious objection.

Finally, the current learning materials and curricula for pre-service training in medicine and health sciences should be reviewed so that they reflect and contextualize safe abortion practices and address a broad range of topics, including value clarification and attitudes transformation. More research on abortion in Rwanda and the collection and effective use of monitoring data on abortion care, conscientious objection and abortion referrals are necessary.

E. Feasibility

Amending the Ministerial Order on abortion conditions is legally feasible and not complex but would not be a fast fix as it takes time to draft, enact and implement an amendment to a ministerial order.

Even though these policy options do not change the scope of legally permitted abortions, some opposition from churches, faith-based institutions and health care and administrative staff is to be expected. Opposition is likely stronger against a ban but also likely if conscientious objection is only partially restricted given the requirements imposed on conscientious objectors. Opposition does not override the compelling reasons for necessary policy change and can be addressed with advocacy at all levels (government, private sector, civil society), social mobilization, enhanced collaboration with and outreach to faith-based organizations, and capacity building with health care providers to increase understanding of the importance of abortion care and the potentially severe consequences for a patient faced with a provider who has a conscientious objection to abortion.

The ban on conscientious objection would be operationally complex to implement since monitoring, oversight and enforcement mechanisms for health care providers would need to be developed and implemented

by the Ministry of Health. Alternatively, the Ministry would need to authorize an appropriate body to monitor and enforce regulation on conscientious objection. Nevertheless, there are also promising signs that telemedicine for medical abortion in the first trimester, managed by nurses and midwives at health centers, is safe, effective and acceptable in the Rwandan context (RSOG, 2023) and may play a critical role in mitigating the impact of conscientious objections on abortion access.

F. Cost considerations

A ban on conscientious objection would not incur costs besides regular costs related to policy development, implementation and enforcement. A partial ban on conscientious objection would require setting up and maintaining a register of conscientious objectors, the annual cost of which is expected to be negligible, particularly if reporting can be streamlined with existing reporting mechanisms between district hospitals and the Ministry of Health. A partial ban would also require setting up a referral system, which is not expected to incur significant costs.

While the magnitude of costs of the health impact of conscientious objectors' refusal of services has not yet been fully evaluated, it may be assumed that increasing access to safe abortions would save out-of-pocket costs for women. They pay around US$15-30 for a safe abortion covered by CBHI whereas without insurance, they pay around US$30-70 at public hospitals and US$100-300 at private clinics. An abortion using (mostly ineffective) traditional medicine costs US$10-30 and mifepristone or misoprostol (abortion pill) bought at a pharmacy US$ 10-20. Additional costs may include US$5-10 for transport and US$2-5 for materials. Clandestine abortions have a high risk of complications which may require post-abortion care, which is only covered by CBHI if a woman receives the services at a health center or health post or receives a transfer note to a hospital. Due to stigma, women often access hospitals directly, in which case they need to pay the full cost of post-abortion care (approximately US$100-300).

Better access to safe abortions will also reduce indirect costs associated with the negative impact of complications for women and their families (time off work and care-giving duties) and lower societal costs associated with mortality and morbidity because of unsafe abortions. Post-abortion care cost the Rwandan health system an estimated US$1.7 million[5] in 2012, 49% of which were non-medical costs (overhead and infrastructure). Responding to the demand for post-abortion care would raise the annual cost to US$2.5 million which would likely be reduced if more resources were invested in safe abortion and contraceptive services (*Vlassoff et al., 2015*).

Until an updated, comprehensive cost-benefit analysis is conducted again, the government can reduce unfair barriers to seeking safe abortions by banning or closely regulating conscientious objections to this legal and lifesaving service.

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