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HEALTH CARE COUNSELLORS' PERCEPTIONS AND ATTITUDES TOWARD SAFE ABORTION IN RWANDA

HDI
HEALTH DEVELOPMENT INITIATIVE

EXECUTIVE SUMMARY

It is estimated that 25 million unsafe abortions were performed annually, across the globe, between 2010 and 2014. Africa alone accounted for 29% of all unsafe abortions and 62% of related deaths. Women who live in poverty, especially adolescents, lack information about where and how to access safe abortion services. They often don't have the power to make informed decisions on the subject.

This qualitative study investigates health care counsellors' willingness to perform abortions, their opinions on the relevance of current laws and perceptions of barriers to safe abortion in Rwanda. Data were gathered during focus group discussions and key informant interviews, conducted among a total of 43 health care counsellors from Kigali and the Southern Province of Rwanda.

Counsellors shared their opinions and experience of the consequences of an unmet need for family planning. Topics discussed included: unintended pregnancies, which participants consider reduces the love and affection afforded to the unwanted baby; morbidity and mortality as a consequence of unsafe abortion and hemorrhage; financial hardship because of unexpected expenses associated with unplanned pregnancy; and psychological problems arising from depression and stress. Other related issues discussed included domestic violence, school drop-outs and abortion-related stigma.

Counsellors discussed constraints related to the inefficiencies of health systems. For example, they believe there is a need to decentralize abortion services. Safe abortion services are provided at the district hospital level rather than at health centers, which counsellors feel could make them inaccessible as district hospitals are seen as being removed from the community, geographically as well as socially. Counsellors also raised the subject of negative unintended consequences of improved access to safe abortion services, such as a possible increase in sexually transmitted diseases if people engage in unprotected sex as they no longer fear unwanted pregnancies.

Perceived awareness about and the relevance of laws relating to abortion were also investigated. While some counsellors are in favor of a court process to avoid abuse of safe abortion services, others argued against it. The majority of participants perceive that obtaining a court order prior to an abortion is an obstacle to timely access to safe abortion services. Some believe that the provision of easy access to safe abortion would increase infidelity.

There was a perception among the counsellors surveyed that information about safe abortion services is not readily available, and awareness of the services and the law that governs access needs to be improved. The social stigma still attached to abortion restricts access to and provision of abortion services, and the majority of participants didn't differentiate between access to safe abortion as provided for by the penal code and conducting abortion illegally. Religious and cultural values have a strong influence on the opinions of health care professionals. Therefore, it was not surprising that some counsellors compared abortion to giving up their country to Satan. There was a small but noticeable difference in opinion toward safe abortion between counsellors at health centers and those working at the district hospital level, possibly due to professional experience and exposure and intellectual liberalism of the latter cohort. Professional consensus on safe abortion is vital to reduce barriers and improve access to safe abortion within the legal framework, and to ensure that patients' confidentiality is protected in an atmosphere of stigma around abortion.

ABBREVIATIONS

CMHS IRB	College of Medicine and Health Sciences Institutional Review Board
CSO	Civil society organization
FGD	focus group discussion
FP	family planning
GBV	gender-based violence
HCP	health care professional
HIV	human immunodeficiency virus
KII	key informant interview
RBC	Rwanda Bio-Medical Center
RIB	Rwanda Investigation Bureau
SRHR	sexual and reproductive health and rights
STI	sexually transmitted infection

According to the World Health Organization, unsafe abortion occurs when a pregnancy is terminated either by persons lacking the necessary skills or in an environment that does not conform to minimal medical standards, or both (WHO, 2020).

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1. BACKGROUND

1.1 Introduction

Approximately 25 million unsafe abortions were estimated to have occurred annually, across the globe, between 2010 and 2014 (Ganatra, B., Gerdts, C., Rossier, C., et al., 2017). Africa accounted for 29% of all unsafe abortions and 62% of associated deaths in the same time period (Ganatra, B., Gerdts, C., Rossier, C., et al., 2017). In the same continent, over 9% of maternal deaths are attributed to unsafe abortion and about 1.6 million women annually are treated for related complications (Sedgh, G., Bearak, J., Singh, S., et al., 2016). By 2013, abortion-related deaths had decreased globally, yet significantly increased in Sub-Saharan Africa (Kassebaum, NJ., Bertozzi-Villa, A., Coggeshall, MS., et al., 2014). Studies show that abortion-related stigma affects not only women who have abortions, but also health care professionals (HCPs) in facilities that provide abortion services and people who advocate for safe abortion (Norris, A., Bessett, D., Steinberg, JR., et al., 2011).

Evidence suggests that unsafe abortions are linked to poverty and other social inequity indicators (Bell, SO., et al., 2020). In Sub-Saharan Africa unsafe abortion is a public health issue (Grimes, DA., Benson, J., Singh, S., et al., 2006), and poses a serious physical and mental health risk to women (Dixon-Mueller, R., 1990).

Where access to safe abortion is restricted, women resort to unsafe clandestine methods (Guttmacher Institute, 2016), which are associated with a high incidence of abortion-related complications and deaths (Okonofua, FE., 2008). Countries where abortion is legalized record a relatively low rate of abortion-related deaths (Khan, KS., Wojdyla, D., Say, L., et al., 2006). In South Africa, the revision of the abortion law has seen a dramatic drop in abortion-related maternal death rates. In Ethiopia, a subnational study showed a decline in the incidence of complications arising from unsafe abortion once abortion was legalized (Singh, S., Sedgh, G., Bankole, A., Hussain, R., 2012).

The last two decades have seen several developing countries liberalize their abortion laws to mitigate the impact of unsafe abortions (Gebreselassie, H., Fetters, T., Singh, S., et al., 2010). But despite abortion law revision in 1985, unsafe abortions are still common in Ghana (Sundaram, A., Juarez, F., Bankole, A., Singh, S., 2012), suggesting that factors other than the legal framework affect women's access to safe and professional abortion services. Even in the Sub-Saharan Africa countries where induced abortion is legal, some HCPs consider the practice immoral (Sedgh, G., Henshaw, S., Singh, S., 2007).

The Rwandan Organic Law Instituting the Penal Code N° 01/2012/OL of 02/05/2012 states that abortion is legally sanctioned under five circumstances: if the pregnant person is a child; if the person is pregnant as a result of rape; if the pregnant person was subjected to forced marriage; if the person is pregnant as a result of incest with a second-degree relative; and if the pregnancy puts the health of the mother or the fetus at risk (Ministry of Justice, 2012).

1.2 Study justification

Rwanda's Demographic and Health Survey of 2010 showed that 13% of adolescents are sexually active by the age of 15 (National Institute of Statistics of Rwanda, 2010). This increases the chance of young people resorting to unsafe abortion. Studies conducted in Rwanda confirm that unwanted pregnancy and unsafe abortion are public health concerns for women, often resulting in complications that require expensive treatment (Basinga, P., Moore, AM., Singh, S., et al., 2012a; Hodoglugil, NNS., Ngabo, F., Ortega, J., et al., 2017; Vlassoff, M., Musange, SF., Kalisa IR., et al., 2015).

Women, in particular adolescents, living in poverty often lack access to information about legal safe abortion in their country, as well as to the services themselves. They may also lack the autonomy to choose to seek safe abortion services, or the financial means to do so. Abortion remains a controversial topic in many sectors, including health care, and there are reports of women being discouraged from seeking abortion by the general negative views of HCPs, and a lack of confidentiality and privacy for women who seek abortion services (WHO, 2005).

Rwanda revised its previously strict abortion law in 2012 after several advocacy initiatives by civil society organizations and despite opposition from faith-based organizations (Umuhoza, C., Oosters, B., van Reeuwijk, M., Vanwesenbeeck, I., 2013). The requirement for court approval to seek safe abortion was removed from the penal code, with the intention of improving access to safe abortion services (Ministry of Health, 2019). Significant numbers of fatalities resulting from complications of unsafe abortions prompted the Ministry of Health's quest to reduce Rwanda's maternal death statistic (Ministry of Health, 2012).

Despite the availability of safe abortion services, Rwandan women and girls continue to undergo illegal and unsafe abortions (Basinga, P., Moore, AM., Singh, S., et al. 2012b). In Rwanda, as in many low-income countries, abortion service providers experience discrimination and stigma

in and outside of the workplace, which can cause them to stop providing the services (Harries, J., Cooper, D., Strebel, A., Colvin, CJ., 2014; Botes, A., 2000). Religious and moral objections to the termination of pregnancy also contribute to the reluctance of some HCPs to provide abortion services (Aniteye, P., Mayhew, SH., 2013; Voetagbe G., Yellu N., Mills J., et al., 2010), and a number of studies show that the personal beliefs of abortion providers are often in conflict with what is allowed for under the law (Campbell, O., Cleland, J., Collumbien, M., Southwick, K., 1999). The disconnect between personal values and legislated rights can impede the provider–patient relationship and an HCP's ability to offer timely, thoughtful and supportive safe abortion services. It is important, then, that when changing policies and laws, societal norms and the personal values of HCPs are considered for the important role they play in the successful delivery of abortion services (Rehnström Loi, U., Gemzell-Danielsson, K., Faxelid, E., Klingberg-Allvin, M., 2015).

The perceptions and attitudes of HCPs have been surveyed in some regions of Sub-Saharan Africa, such as Ethiopia, Ghana, South Africa and Nigeria (Gebreselassie, H., Fetters, T., Singh, S., et al., 2010; Harries, J., Stinson, K., Orner, P., 2009; Sundaram, A., Juarez, F., Bankole, A., Singh, S., 2012), but few studies have been conducted in Rwanda on this particular subject. One Rwandan research group looking at the implementation of the liberalized abortion law discovered confusion among HCPs about abortion-related rights and their own responsibilities, making some HCPs reluctant to provide safe abortion services for fear of professional stigma (Påfs, J., Rulisa, S., Klingberg-allvin, M., et al., 2020). It should be noted, however, that the study did not specifically target counsellors as participants.

Health care professionals have a strong influence over access to abortion services, regardless of the legal framework they are working within (Rehnström Loi, U., Gemzell-Danielsson, K., Faxelid, E., Klingberg-Allvin, M., 2015). In particular, health care counsellors are at the forefront of providing counselling services to women seeking abortion in Rwanda. This study seeks to assess the perceptions of HCPs relating to safe abortion in Rwanda and their attitudes toward providing these services, in order to better understand their substantial impact on the accessibility, availability and quality of abortion services and their willingness or otherwise to provide them.

1.3 Overall objective

To explore the willingness and/or unwillingness of health care counsellors to support the provision of safe abortion services in Rwanda.

1.3.1 Specific objectives

1. To explore the willingness and/or unwillingness of health care counsellors to support provision of safe abortion services.

2. To explore the perceived relevance/benefit of the amendments to the penal code covering safe abortion in Rwanda.

3. To explore the perceived barriers to the provision of safe abortion in Rwanda.

4. To identify ways to raise awareness about safe abortion services in Rwanda.

2. METHODS

2.1 Research design

This study was conducted using qualitative research methods. Focus group discussions (FGDs) and key informant interviews (KIIs) were conducted to explore the perceptions and attitudes of health care counsellors toward safe abortion.

A literature review was conducted of published and unpublished materials related to both safe and unsafe abortion. The databases PubMed and Google Scholar were used to search for published literature. Reports and surveys from different organizations working within sexual and reproductive health and rights (SRHR) areas were also consulted. The keywords used were: abortion, safe abortion, adolescent, pregnancies, family planning (FP) and SRHR in Rwanda.

2.2 Study description

This was a qualitative study that explored opinions of health care counsellors toward safe abortion as allowed for in Rwanda's 2012 penal code and its 2019 revisions. The study also sought to explore the willingness or unwillingness of health care counsellors to provide safe abortion services, their opinions of the amendments to the penal code and perceived barriers to the provision of safe abortion in Rwanda.

The FGDs were conducted with health care counsellors from Nyanza and Kicukiro districts, while KIIs were conducted with health care counsellors from Nyarugenge, Nyanza, Huye, Nyaruguru, Gasabo and Kicukiro.

2.3 Study site

The study was conducted in the Southern Province and Kigali. However, by the time the KIIs were going to be conducted, the COVID-19 pandemic had already broken out. Hence the KIIs were conducted by telephone interview due to COVID-19 preventive restrictions in place.

2.4 Study population

The study population consisted of both male and female counsellors working in public and private/faith-based health facilities.

2.5 Data collection techniques

The FGDs were conducted with mixed groups comprising male and female counsellors. The KIIs were conducted with hospital-based counsellors/clinical psychologists.

2.6 Sampling procedures

Counsellors were invited for a one-day training session about the 2012 penal code related to safe abortion in Rwanda and its 2019 revisions. Some attendees were then invited to participate in the study and those who accepted were organized into focus groups for interviews. The KII subjects were not part of the training session.

2.6.1 Inclusion criteria

- All HCPs such as nurses who provided health care counselling
- Over 18 years old
- Agreed to sign a consent form
- Based at any health care facility

2.6.2 Exclusion criteria

- Health care counsellor but not practicing in any health care facility
- Under 18 years old

2.7 Recruitment of study participants

Five FGDs were participants who attended the training and come from one of the selected districts of the Southern Province or Kigali. Three KII participants were selected from urban-based hospitals (Muhima, Masaka and Kibagabaga), while three more KII participants were selected from rural-based hospitals (Munini, Nyanza and Kabutare). In total, six FGDs and six KIIs were conducted, with participants from different locations and settings.

Overall, two FGDs comprised participants recruited from the Southern Province and three with participants from Kigali. The rationale for recruiting more participants from urban-based districts was because, according to literature, more abortions are performed in urban areas than in rural, thus urban-based counsellors see more clients seeking abortion than those based elsewhere in Rwanda.

2.8 Data collection procedures

Qualitative data collection was performed with participants drawn from six districts, which were purposefully selected. Counsellors were identified based on their role of

counselling and on their presumed knowledge of the existing legal framework within which safe abortion services are provided in Rwanda. It should be noted that many of the counsellors are also trained nurses.

The FGDs were moderated by highly experienced, qualified and well-trained researchers. Interviews were conducted face-to-face. Before data collection could begin, participants were introduced to the purpose and aim of the study and invited to take part. If they agreed to continue, participants filled out a consent form in accordance with ethical principles.

The data collectors started by filling out a sociodemographic information sheet. The FGD participants sat in a semi-circle to facilitate discussion, and were assigned numbers to enable the moderator/notetaker to note participants by number rather than name during the discussion.

All FGDs and KIIs were conducted in Kinyarwanda. Two voice recorders were used to capture the conversations. Field notes were taken to supplement the recordings. Where necessary, field notes were expanded on by the note-taker, with assistance from the moderator, to create a daily summary of the collected data.

2.9 Data management and analysis

After the completion of data collection, audio recordings were reviewed for completeness and quality control. Later these were transcribed. All Kinyarwanda transcripts from the FGDs and KIIs were read (as Microsoft Word documents) and re-read for a deep understanding of the collected information. Verbatim transcripts of recordings were translated into English.

A codebook was developed covering key themes, the research-specific objectives were noted, and all transcripts were coded. Labels were attached to fragments of text to facilitate the comparison of similar or related pieces of information when analyzing the qualitative data. ATLAS.ti v.7.5.18 software was used for data analysis.

Finally, key information and quotations were extracted and concurrence tables were produced to evaluate the saturation of the information. All five steps of qualitative data analysis (reading, interpreting, coding, reducing and displaying) were performed to ensure consistency within the data. The extracted quotations are included in this report.

2.10 Ethical considerations

Ethical issues of this study were reviewed and approved by the College of Medicine and Health Sciences Institutional Review Board (CMHS IRB). In addition, written informed consent was obtained from each participant of the FGDs and KIIs before any discussion commenced. Confidentiality of participants was respected during and after data collection. All individual identifiers were anonymized.

3. FINDINGS

3.1 Sociodemographic characteristics of the study participants

In total, 43 counsellors participated in this study. Five FGDs were conducted, each consisting of between six and nine participants. In addition, six KIIs were conducted. Of the 43 participants, 15 were from the Southern Province while 28 were from Kigali. Participants' ages range from 25 to 60 years. Further sociodemographic characteristics of the study participants are presented in Table 1 below.

Table 1: Sociodemographic characteristics of study participants

Site	*Districts*	*# of FGDs (N=5) # of KIIs (N=6)*	*# of participants (N=43)*	*Average age (range)*	*Marital status*	*Occupation*	*Education level*
Nyanza	Nyanza	FGD 1	6	39 (26–46)	Married (6)	Doctor (1) Nurses/counsellors (3) Midwives (1) Psychologist (1)	Bachelor (3) Diploma (2) Secondary (1)
	Nyanza	FGD 2	6	41 (36–60)	Married (6)	Nurses/counsellors (3) Midwives (2) Admin (1)	Diploma (4) Secondary (2)
Kigali	Kicukiro	FGD 3	9	35 (26–39)	Married (6) Single (3)	Nurses/Counsellors (8) Counsellors (1)	Bachelor (4) Diploma (3) Secondary (2)
	Kicukiro	FGD 4	7	38 (25–45)	Married (3) Single (4)	Nurses/Counsellors (7)	Bachelor (3) Diploma (4)
	Kicukiro	FGD 5	9	34 (27–40)	Married (8) Single (1)	Nurses/Counsellor (5) Psychologists (4)	Bachelor (7) Diploma (2)
Telephone	Kicukiro	KII 1	1	38	Married	Clinical Psychologist	Bachelor (1)
	Gasabo	KII 2	1	31	Married	Clinical Psychologist	Bachelor (1)
	Nyanza	KII 3	1	35	Married	Clinical Psychologist	Bachelor (1)
	Huye	KII 4	1	34	Single	Clinical Psychologist	Bachelor (1)
	Nyaruguru	KII 5	1	37	Married	Clinical Psychologist	Bachelor (1)
	Nyarugenge	KII 6	1	40	Married	Clinical Psychologist	Bachelor (1)

** FGD: focus group discussion, KII: key informant interview*

3.2 Consequences of unmet family planning needs

The domain of SRHR covers a number of aspects including access to FP and safe abortion, and the unmet need of these elements can usually be associated with several consequences. Participants were interviewed about their perceptions of the consequences of the unmet need for FP that exists among their clients.

Their responses were categorized under unwanted pregnancy, psychological problems (depression), death/mortality and potential spread of the human immunodeficiency virus (HIV) and AIDS, poverty, school drop-outs, and excommunication of adolescents or misunderstandings/conflicts in families. The standout consequences as perceived by counsellors are cited below.

Unwanted pregnancy

According to participants, unwanted pregnancy negatively affects love and affection toward the unwanted child. This can begin while the baby is still in the womb and can continue as a child grows into adulthood. Other perceived consequences of unwanted pregnancies are illustrated with the following quotations.

"When a woman becomes pregnant and it is not wanted, she is always thinking bad … [she] thinks of terminating the pregnancy." (FGD 2, Counsellors, Respondent 1)

"An unwanted pregnancy can cause the husband to cheat on the woman and brings in more conflicts." (FGD 2, Counsellors, Respondent 3)

Psychological problems

Counsellors said that unwanted pregnancies affect the mental state of the mother, leading to depression and stress. Terminating a pregnancy has far-reaching psychological effects on both older and young mothers. Unwanted pregnancies lead to a deterioration of the mother's overall health, as depression and stress leave her vulnerable to other illnesses. Unintended pregnancies result in children who in adulthood may not know their fathers, which poses serious psychological impacts.

"Psychological problems are much more likely … for she is always judging herself." (FGD 3, Counsellors, Kicukiro, Respondent 3)

"Due to depression, she won't be able to make money for herself and her family." (FGD 4, Counsellors, Kicukiro, Respondent 3)

Morbidity and mortality

Counsellors described loss of life as a potential consequence of unsafe abortion. Excessive bleeding brought on by the procedure can cause serious illness and sometimes death, especially in adolescents. The participants said that this age group is exposed to many complications related to early pregnancy and/or the potential death. According to participants, adolescents involved in these situations sometimes end up taking their own lives.

In addition, counsellors said that approximately 70% of sexually transmitted diseases among school students are a result of unmet needs of FP. They mentioned this could lead to serious consequences, such as the contraction of HIV. Below are some quotations to illustrate their views.

"There is loss of life due to unsafe abortion – girls easily die from the act or their life deteriorates." (FGD 2, Counsellors, Kigali, Respondent 3)

"We have five schools in our health center's catchment area, but the majority of female students who seek treatment at our health center do so because of sexually transmitted diseases." (FGD 2, Nyanza, Respondent 5)

Adolescents usually give birth at home; quite often they bleed heavily. Some of them present at the health facility severely anemic. This is usually due to either unsafe abortion or miscarriage.

"At the CHUK [University Teaching Hospital of Kigali] in the Pavilion ward, HCPs experience stinking smells. You find young beautiful girls who used toothbrushes and pierced their uterus." (FGD 2, Nyanza, Respondent 2)

Poverty

Participants feel that unplanned spending on unwanted pregnancies could spill over and impact the country's whole economy and its economic growth. They see unwanted pregnancies as potentially impacting an individual's ability to save. According to participants, the children who result from these circumstances sometimes become street kids and are unable to attend school. A depressed teen mother is viewed as somebody who may not be able to financially support herself and her child/children.

According to participants, unwanted pregnancies lead to unplanned population growth, affecting the country's economic growth. They feel that parents are often unable to afford school fees for unwanted children. Participants consider that these

situations compromise the general wellbeing of the whole family in which the unwanted pregnancy occurs, thereby negatively impacting the country's development.

Unplanned baby expenses can cause poverty among teen mothers. This can lead to them dropping out of school and they may end up being unable to put their child in school as well, so the cycle continues.

"Such a person may be depressed; the family gets affected economically and so does the country's economy at large. Providing food to children becomes difficult. Generally, when family planning services are not accessed the entire family is affected." (KII, Clinical Psychologist, Hospital 1)

"We have witnessed poverty among families; they complain that the lack of family planning can cause poverty in families." (FGD 2, Counsellors, Nyanza, Respondent 1)

3.3 Perceived willingness to support safe abortion

Under this category, the overall opinions of counsellors were sought to identify how they feel about the current environment within which safe abortion is provided.

While there are some counsellors who are in favor of having the court approval process in place to avoid abuse of safe abortion services, others argued against the idea by giving the example of the period when FP had just been introduced to the community. They said that some members were skeptical during that period and thought that the availability of contraception was going to increase rates of adultery and infidelity. However, this turned out to not be the case, and safe abortion skeptics will similarly be proved wrong. Participants' willingness and readiness to support the uptake of safe abortion services is illustrated by the following comments.

"Some years back, people said introducing family planning would increase adultery. But even before family planning, nothing stopped infidelity." (FGD 2, Nyanza, Respondent 2)

Many participants support the current abortion arrangement – they argue that courts take a lot of time, and that this is further complicated by fear, illiteracy and a lack of confidence among most women. Without this requirement as a barrier, people can go directly to the health facility and the problem is addressed right away.

"I think the current situation is better – they no longer have to pay court fees, which were a challenge for poor people. It is going be done without any delay." (FGD 3, Kicukiro, Respondent 1)

"For me, I think the best way is the current one, because it saves the women from going through a lengthy court process that might deliver a result after the specified period of time within which the abortion is allowed to be conducted has passed." (FGD 2, Nyanza, Respondent 5).

"It is better today … The new system is easier. Before, the court would approve abortion after the pregnancy had matured and was no longer suitable for abortion." (FGD 1, Nyanza, Respondent 6)

"Changing the law has brought positive things; it will reduce the number of women who were accessing unsafe abortion, which was associated with bad outcomes." (FGD 1, Nyanza, Respondent 2)

"This new law will protect people from putting their life in danger. The services will take place at the health facilities and any other issues will be managed accordingly." (FGD 1, Nyanza, Respondent 5)

"Going through courts of law was associated with a lot of waiting ... when you look at the population we have today, the courts of law cannot solve all the problems on time." (FGD 1, Nyanza, Respondent 1)

3.4 Perceived relevancy/benefit of amendments to safe abortion law

Counsellors' opinions were sought on the significance of the amendments made to the penal code in 2019. These changes saw the removal of the need for a court order to be able to access safe abortion services in a health care facility.

To illustrate the impact of changing the law, participants talked about a shorter waiting time for women and adolescents seeking safe abortion. They also mentioned a reduction in the death rate among women who have easy access to safe abortion.

One of the participant's hypothesis was that waiting for a court order delayed access to abortion services. The delay could make eligible individuals resort to unsafe abortion instead, which could result in health problems, including death.

Some of the counsellors believe that the current arrangement (under the revised law) is helping people to feel comfortable to attend hospitals. However, counsellors are mindful that where they support the change of the law to allow easy access to safe abortion, others such as politicians see it leading to an increase in unsafe sex and its consequences. The following quotes illustrate the views of participants.

"I would rather choose not to go through the court. For me, going through court involves a lot of bureaucracy … you can be caught up for the 22 weeks and then the abortion can't be carried out." (FGD 3, Kicukiro, Respondent 1).

"Today people can quickly access the service, unlike when they had to seek a court order – there is a restriction of 22 weeks [after which you cannot access safe abortion services] that could be up before a court decision is made, so there would be no access to an abortion. Secondly, the number of people seeking abortion increased considerably. I think this, in turn, reduced the number that previously sought unsafe abortion." (KII, Clinical Psychologist, Gasabo, Hospital 2).

"The advantage is not having to seek a court order to access services; they get quick service, which was not the case before." (FGD 1, Nyanza, Respondent 3)

"It's advantageous … because there are reports of babies who were born while their cases were still pending in court." (FGD 3, Kicukiro, Respondent 8)

"The current law that replaced the old one, of course it is helping. The former was delaying the safe abortion process – it was making people turn to unsafe abortions which caused health problems, including death." (FGD 3, Kicukiro, Respondent 4)

3.5 Perceived reluctance to support safe abortion

Skepticism of participants

While participants appreciate the effects of the change to the abortion penal code, they are not without doubts. They are concerned with the possibility of abuse of the service by some sectors; proposing a situation where a woman just walks into a health facility with an unwanted pregnancy and the law supports her, so the pregnancy is terminated without involving the Rwanda Investigation Bureau (RIB) at all. The RIB is the agency tasked with gathering evidence for the court to approve or disapprove the client's claims.

Participants are concerned that it would be easy to terminate pregnancies that don't necessarily fall within the categories provided for by the abortion law.

Participants also reason that the number of people seeking abortion services and contraception will increase, and expressed concern about the increased need for human resources in the already overloaded health sectors delivering these services. They commented that there is no guarantee that even safe abortions won't result in complications.

Some clinical psychologists described a tendency for clients to delay seeking abortion services and then blaming hospitals for not being able to provide these services after the recommended maximum number of weeks' gestation have passed.

"There are health workers who don't believe such a service should be available to their clients … the challenge has been the negative perceptions and beliefs of [health care] workers." (KII, Clinical Psychologist, Hospital 3).

"Once it is easy to go to the health center to end a pregnancy, it will be turned into an easy game that doesn't give it [the pregnancy] any value." (FGD 4, Kicukiro, Respondent 3)

"At least in court they ask for tangible evidence, it's harder to lie about the cause of a pregnancy. A woman who before would have been prepared to give birth because she was not raped, now she might think it is easy to abort and children's rights will be abused." (FGD 4, Kicukiro, Respondent 6)

"There is no way of verifying or confirming if those seeking abortion are telling the truth, and if you find out they're not after the abortion has happened, the unborn baby is dead." (FGD 1, Nyanza, Respondent 4)

Some participants wondered how long it takes to produce evidence of the justification for abortion that is presented to HCPs. They reiterated that they needed to think on behalf of Rwandan society. Participants think the law is not very clear about verifying the information provided by clients at the health facility.

One participant went as far as proposing the placement of a RIB agent at health facilities to interrogate and confirm if those seeking abortion services are telling the truth.

"The old law protected the culture and avoided dishonesty … with the new law, sexually active people are allowed to engage in sex, get pregnant and lie about it to get abortion services." (FGD 3, Kicukiro, Respondent 5).

"Seeking a court order was good, although it could take time to make a decision, but despite a long process, it was protecting somebody." (FGD 1, Nyanza, Respondent 5)

In addition, participants said that during the revision, the law was relaxed in order to give the community easy access to services. Participants claim that adultery could increase if patients can seek an abortion by claiming they were raped or impregnated by a relative. A doctor would have no way of knowing the truth, which encourages dishonesty.

"Adultery will increase because it has been simplified for the community. For example: I meet a boy, he gets me pregnant … if I am not comfortable with it, I run to the health center and say that I was raped." (FGD 3, Kicukiro, Respondent 3)

Participants are concerned that while there is justified support for safe abortion, too much effort is being put into improving access to safe abortion and less into preventing unwanted pregnancies in the first place. To them, an embryo in the womb is already a living child and has a right to live. They explained their reluctance in the following ways.

"We have surrendered the country to Satan by killing children who would be the future Rwandans." (FGD 3, Kicukiro, Respondent 1)

"Why are we committed to performing abortions instead of taking preventive measures against unwanted pregnancies?" (FGD 3, Kicukiro, Respondent 1)

"Let us give birth to children we are capable of raising instead of killing those children who are living already." (FGD 4, Kicukiro, Respondent 1)

Participants questioned the logic behind improving access to safe abortion – they wondered if maybe these measures were not effective as many young girls still die as a result of unsafe abortion. Periodic evaluation of current practices is crucial, participants said, and they are not convinced this is being done. They drew a comparison with methods being used in Rwanda to reduce the prevalence of HIV, such as carrying out home visits and educating communities. As a result of such interventions, the country's HIV/AIDS prevalence has been constant at 3% in the general population.

"We have to implement and reinforce interventions just like we have committed ourselves to not go beyond 3% HIV/AIDS prevalence in the general population of Rwanda." (FGD 4, Kicukiro, Respondent 1)

They cited an example of a current well-known road safety slogan: "*Gerayo Amahoro*", which translates to "arrive safely." The associated campaign is aimed at reducing traffic accidents, and since its launch churches and mosques have joined in promoting the message. Participants wish to see similar efforts put in place to curb unwanted pregnancies.

"Why not put in place similar measures to road safety campaigns to prevent unwanted pregnancies?" (FGD 1, Nyanza, Respondent 2)

3.6 Perceived constraints to providing safe abortion

Decentralized services

This section describes the counsellors' perceptions of constraints to the provision of safe abortion related to organizational barriers within the health system.

Counsellors feel that people are ignorant of the abortion laws, which would explain why some people visit health centers seeking abortion services when they are not eligible under any of the categories provided for in the penal code.

In addition, abortion services are provided at hospitals, not health centers, yet most people visit a health center when seeking services instead of the hospital/district facility. Counsellors wish to establish services at all levels of HCPs.

One participant pointed to the example of dental and ophthalmology practices, where clients feel comfortable and are able to access all the services they need.

"Normally cases of abortion are not managed at the health center; we usually transfer them to the district hospital." (FGD 4, Kicukiro, Respondent 7)

"We do not provide this service at health centers even though the centers are closest to the people. The services are provided at the hospital, but before clients reach the hospital they first pass through the health center." (FGD 3, Kicukiro, Respondent 3)

"How are you going to manage abortion clients when you don't have blood for transfusions, don't have enough equipment, including echography? The services provided at the health center are still lacking." (FGD 1, Nyanza, Respondent 5)

"The challenge for the institutions that offer safe abortion services is that not all doctors will have the necessary skills to conduct safe abortions. Another institutional challenge is that I am sure there aren't enough kits to conduct such services." (FGD 1, Nyanza, Respondent 4)

Concerns were raised about the limited number of psychologists available to provide the necessary counselling for people who access abortion services. Counsellors wish to see psychologists accessible at the health center level.

"I want the number of professional counsellors and psychologists to be increased." (FGD 1, Nyanza, Respondent 6)

Counsellors contend that just because the abortion laws exist, it doesn't mean that people know enough about them. They wish to see awareness raised and people informed about safe abortion, which they feel would eventually reduce the amount of abortion-seeking cases.

"If people are aware of their rights and understand the law, it will reduce the number of the people who seek abortion services." (FGD 1, Nyanza, Respondent 5)

"Like GBV [gender-based violence] services have been integrated into health care services – where victims can access the services without queuing with other patients – anybody who seeks abortion services should be able to do so with a sense of confidentiality." (FGD 1, Nyanza, Respondent 3)

"She visited me at the health center, I advised her when the one responsible for the service would be back on duty. Sometimes, women go to the hospital and are unable to see a doctor ... she might go back there five times without seeing a medical doctor." (FGD 5, Kicukiro, Respondent 5)

3.7 Perceived negative consequences of safe abortion

Study participants are concerned that abortion cases are already common among young people. They are worried about a potential increase in rates of pregnancy and HIV, or other sexually transmitted infections (STIs) among this age group. They are further concerned about whether HCPs have strategies to handle complications that could arise post-abortion.

"The result is that women or girls will engage in unprotected sex. The occurrence of sexually transmitted diseases like HIV, hepatitis and others will increase." (FGD 2, Nyanza, Respondent 3)

"Rwandan youths fear getting pregnant more than they fear contracting diseases … simplifying access to safe abortion will increase abortion cases." (FGD 3, Kicukiro, Respondent 9)

"Won't an increase in abortions mean increased complications for our children? How will we help them if there are complications?" (FGD 3, Kicukiro, Respondent 7)

"Parts of Rwandan society, especially in rural areas, don't approve of increasing awareness of family planning among teenagers; they see it as encouraging adolescents to be sexually active." (FGD 2, Nyanza, Respondent 1)

"Children will be unnecessarily aborted under the guise of safe abortion. A woman will voluntarily sleep with her husband [but later] might decide to have an abortion after a misunderstanding with her husband. I see this as an abuse of children's rights." (FGD 2, Nyanza, Respondent 6).

Other participants questioned the revision of the law; they are concerned that anyone who wants safe abortion services gets a free pass. They reason that not every rape results in a pregnancy, and said that it is important for a victim of rape to visit a health facility as soon as possible to get prophylactic medication. Therefore, allowing women who didn't do this immediately to later access abortion services presents a problem.

Some participants feel that instead of removing the court order requirement because of the delays involved, it would be preferable to speed up the court process.

"From my perspective, this law is going to cause terrible things in our country … the court process should have been retained in the abortion penal code. To speed up the court process, they should increase the number of judges instead – this would be an act that doesn't violate our culture." (FGD 3, Kicukiro, Respondent 4)

"We encounter many cases of traumatized people who made such decisions [choosing to abort] … without weighing the consequences. Whenever they see their neighbor's living child, it haunts them to think of how their own would be now." (FGD 1, Nyanza, Respondent 6)

"The former law restricted females. Those who were not financially stable would be cautious because of the thought of the court process. But now they will see it as simple as … visiting a health facility when you have a headache." (FGD 2, Nyanza, Respondent 4)

3.8 Religious, cultural and stigma-related barriers to safe abortion

Participants suggested that doctors whose own cultural, religious or other beliefs bar them from performing abortions should be able to avoid seeing clients who are seeking abortion services. Doctors whose beliefs don't preclude them from providing abortion services should be the ones to train in these services, as according to counsellors.

Religious barriers

Counsellors identified faith-based barriers to safe abortion; for example, when a health worker providing access to or performing an abortion

is going against God's will as according to their religion.

"*As a matter of fact, there are some HCPs who say that he or she cannot perform abortions, or God will punish him or her." (FGD 4, Kicukiro, Respondent 3)*

"If I had the power to choose, I would not assist anyone to abort. Taking the life of a living creature created by God, I wouldn't do such a thing." (FGD 2, Nyanza, Respondent 3)

"It happens when a doctor does not want to perform the abortion. They transfer the client [to you], you wonder why the original doctor didn't perform the abortion even though they were able to and in a good place to offer that kind of service. And you send the woman back." (FGD 2, Nyanza, Respondent 6)

"There should be doctors that agree with the abortion law, and some doctors will say 'never, because of my beliefs I cannot do that'." (FGD 1, Nyanza, Respondent 3)

"I work in a religious health center ... I am asking myself about that physician who will always help to abort women's pregnancies, what services will be available to him or her because they may suffer from depression or something else." (FGD 1, Nyanza, Respondent 1)

Stigma-related barriers

Participants were more focused on stigma-related barriers that affect abortion seekers than those that affect doctors or health care counsellors, as reflected by the quotations below.

"A woman/girl will be stigmatized, because she has done something that is not accepted in society. Immediately she starts feeling discomfort. This pushes her to abort to try to relax her mind." (FGD 5, Kicukiro, Respondent 1)

"There can be complications regardless of whether an abortion was performed clandestinely or legally and safely, because sometimes they might even use curettage at a health facility. It can cause stigma when members of the community find out about the abortion." (FGD 2, Nyanza, Respondent 2)

"She decided to kill the baby and … the baby was thrown in the pit, or elsewhere. Those who have aborted are not accepted in the community, they choose to … move to other places just to cover up or cleanse their reputation." (FGD 2, Nyanza, Respondent 3)

"Negative talk about abortion itself is the stigma. The law is still new and people are not yet aware of it; there is hope that with time people will understand it but the stigma is there." (FGD 1, Nyanza, Respondent 6)

Cultural barriers

Cultural norms and taboos are seen as very influential when it comes to barriers to seeking and providing safe abortion services. Going against societal norms can lead to community stigmatization and excommunication for those who seek and perform abortion care. However, participants were quick to reiterate that cultural barriers affect mostly abortion seekers rather than providers, as the following quotations demonstrate.

"Sometimes the pregnancy is due to incest with her father … in our culture to hear that you had sex with your father, and bore a child from incest is a problem in the family – such a child becomes a societal issue and can be isolated from society." (FGD 3, Kicukiro, Respondent 5)

"Young girls are scared to speak out because they don't have access to counselling. Most impregnated underage girls are those who moved to the city to work, so they don't have anybody to advise them about safe abortion." (FGD 2, Nyanza, Respondent 1)

"Young girls are afraid to access safe abortion. They think they will be seen as adulterous, they worry that when the pregnancy is found out they will be judged as fornicators or prostitutes by society." (FGD 1, Nyanza, Respondent 5)

"Those impregnated by a relative encounter barriers like reluctance to disclose the identity of the person out of fear of creating conflict in the family." (FGD 4, Kicukiro, Respondent 1)

3.9 Raising awareness about safe abortion and the related penal code

Counsellors discussed the lack of community awareness about safe abortion, and considered ways in which information about abortion law might better reach the intended audience.

The counsellors' responses made it clear that there is a knowledge gap when it comes to the penal code. They indicated there is very limited information available at the community level about the laws governing safe abortion in Rwanda.

Participants revealed that at least one or two staff in some health facilities are educated on the subject and able to inform their colleagues about the availability of safe abortion services at district hospitals. But counsellors also said that prior to participating in this study, their own understanding was that anyone had access to safe abortion services. They did not realize that the penal code excluded some categories of women from accessing safe abortion.

Encouraging education and awareness at the community level would be helpful, participants feel, as ordinary people would become aware of who is eligible or not under the penal code. They expressed a wish to decentralize abortion services to

make them available at health centers. But they were quick to add that this would require an increase in health center staffing levels.

"Generally, there's no awareness among communities of the law and the criteria under which a person can legally have access to safe abortion services. The few that make it there, you find they got advice from friends." (KII, Clinical Psychologist, Hospital 2)

"As well as the health workers not having enough information … the number of people judging abortion service seekers negatively is still higher than those that think safe abortion services are ok." (KII, Clinical Psychologist, Hospital 1)

Another area where information is seen as lacking is around people's belief that contraception affects libido, meaning that FP would have a negative impact on a couple's sex life. Education on the subject would result in people not seeing this as a barrier to accessing FP services.

Participants' views regarding the best ways to share information to the community were canvassed and most suggestions revolved around education, as the following quotes demonstrate.

"I think there should be information shared at different levels, aimed at different sectors of the community so that people understand who is eligible for the service." (FGD 1, Nyanza, Respondent 3)

"What should be done is continuous awareness raising … informing people that services are not for everybody but rather for specific conditions, just continuous education like with HIV awareness." (FGD 3, Kicukiro, Respondent 6)

"Again, there is a limited timeframe within which abortion can be conducted, and some women who come to the clinic find out they are weeks past this limit. This should be communicated to the entire community." (FGD 4, Kicukiro, Respondent 1)

"Another example, husbands complain about their wives using family planning [contraception] and changes in their sex life and attribute it to family planning. There needs to be more education to counteract this belief." (FGD 5, Kicukiro, Respondent 7)

3.10 Case studies

Participants were asked to describe some of the cases they have encountered at their health facilities. The main aim was to ascertain whether the majority of cases presenting were eligible under the safe abortion penal code – this is regarded as being representative of the level of community awareness about safe abortion in the country. The cases discussed ranged from those provided for under the code to those that are not eligible under the code. They are presented in the boxes below.

"I have a case of a 48-year-old lady. She came in pregnant for the eighth time. Her most recent child is 17 years old. She came in very sick and crying with stomach pain. After consultation, she was found to be pregnant. Her husband was HIV positive and she was HIV negative. They had been together for 17 years. She thought she had reached menopause and never wished to give birth again. Because her husband was HIV positive they decided to always use condoms, so other contraception was not necessary. She cried and said that she won't give birth, it would be better for her to die. When the nurse brought her to me for counselling it was challenging, because I could not remember all the information about her rights as provided for by the abortion penal code, to tell her whether she should go to the hospital. I thought she had no legal rights to abort but they have explained to us now that if you're pregnant by your husband as a result of rape, you have the right to access abortion services."

FGD 3, Kicukiro, Respondent 1

"We receive these cases often. I have seen them so many times, especially girls from churches. I had a girl who was a deacon at an ADEPR church; she visited me at the health center. She told me she had an affair with someone, and now her pregnancy test was positive. At that time, she told me, she wanted to abort the pregnancy, or else she was going to drown herself at the dam in Bugesera district. She was a girl who wore long dresses. She was concerned that she would be dismissed from the church services as she wept endlessly. I counselled her, telling her there is no reason to commit suicide. After a long period of time in the consultation room, she started to accept her situation. She said she would go home and stop serving as a deacon in church. In reality, she was not eligible for safe abortion as provided for by the penal code—she slept with her choirmate and both were of age. Often, we see these kinds of cases and try to educate/counsel them. It is challenging to counsel them until they accept their situation. Sometimes, we give them follow-up appointments and, step-by-step, they accept the pregnancy. They even come back for antenatal visits."

FGD 2, Nyanza, Respondent 5

"I encountered more than one case but I will talk about one because I think she was able to get the service she needed. It was a girl aged 17 years … her guardian told me they looked at text messages between the girl and her boyfriend. One message said that if they were not going to stay together, she was going to abort. So, I asked the guardian to send the girl to me so that we could talk about it. I invited her to the health center, we discussed the situation and the decision to abort was agreed upon. It was not the first time she was aborting. I told her that when you make a decision to abort, you have the right to safe abortion. I guided her to the respective departments (under the reason of GBV because she was below 18 years), the guardian signed on her behalf and the abortion was successfully conducted."

FGD 3, Kicukiro, Respondent 2

"We had a case of a primigravida woman who had an undesired pregnancy. The woman decided to abort by herself and used a stick to induce the abortion, but she failed. After failing, she came to me. I tested her and found that pieces of the stick had remained attached to the inner part of her uterus. I immediately sent her to the hospital and they treated her. After recovery, the woman was imprisoned and then released after some days … I am wondering if there should not be special consideration for prostitutes or other people who may attempt this kind of suicide."

FGD 2, Nyanza, Respondent 4

"There was a lady of 23 years, a mother of one working as a cleaner at a school. One evening after work she said she was raped on her way home. She continued home and disclosed to her husband that she had been raped; they did nothing about it, but consciously abstained from sex. After a month, the lady missed her period and returned a positive pregnancy test. She became depressed and her husband argued that he could not raise a child he did not know, so an abortion was carried out."

KII, Clinical Psychologist, Gasabo

"There was a case of a 13-year-old girl who was raped by an unidentified person from the neighborhood. Her mother was bitter that her daughter was raped. We invited her to meet lawyers at the district headquarters. We saw signs of pregnancy and I asked the mother what she thought. The girl was vomiting and the mother suspected her daughter was pregnant. We recommended pregnancy tests which came out positive … I could see the teen was already exhausted and traumatized. I shared with them information on safe abortion services which they happily considered. The girl was very ill so she was admitted that evening. She thought about it overnight and the next day they decided to abort the pregnancy, so I referred them to a gynecologist and the process was successful."

KII, Clinical Psychologist, Kicukiro

"A girl over 18 years old presented saying that she was traveling from her village in Gitarama to Kigali when a boy raped her. I asked her why she had never reported the case to police, she said that because of her age nobody would believe her. No attempt had been made to contact the person that got her pregnant, and she was fearful that this person might report her if she aborted! She

believed her boyfriend didn't know she was pregnant and could not offer her the necessary support. As health personnel there was no way we could contact the culprit, it was not our task. However, we gave her the [abortion] procedure as usual and it was successful. We booked her a follow-up appointment, but she never came back."

KII, Clinical Psychologist, Kicukiro

"The most recent case is a 17-year-old girl who sought abortion services. She was escorted by her mother and a community health worker, they said she had been sexually abused but on examination we found the pregnancy was at 30 weeks so it was not possible to abort. It was difficult for them to take in our decision but after counselling they agreed to give birth. We recently visited them and they and the baby are doing fine."

KII, Clinical Psychologist, Nyanza

"A girl over 18 years old claimed she was sexually abused and came seeking abortion. The doctor recommended she see a psychologist. We determined that she wasn't eligible [for an abortion] for reasons including that she was over 18 and had never reported sexual abuse before. We found out she had been planning a wedding with her boyfriend but there had been a misunderstanding between them, which was the main reason she was seeking abortion services."

KII, Clinical Psychologist, Nyanza

"A 16-year-old girl claimed she was impregnated by a boy in the neighborhood. The girl said that she heard from the community that when you get pregnant under the age of 18 you can access safe abortion services so she wanted to abort. Her mother escorted her to the facility for tests and to be added to the GBV registry but not to abort, as she [the mother] believed God would punish them for it. While the daughter wanted an abortion, her mother wanted her to give birth – she even volunteered to take care of the baby. The girl was convinced to see out the pregnancy and give birth but I found out that it wasn't her wish. After she gave birth she rejected the child. She said that she never wanted to give birth, and that her mother should take the baby. It was really a psychological challenge to convince her to hold her baby. She frequently isolated herself and we were confronted by the extent to which she rejected her baby. Later we found out that the child's father's family called her a 'dustbin' where everybody dumped their rubbish, and as a result she never wanted to look at the baby because of the ugly words her mother-in-law had said. She even asked her mother to take the baby to the boy's family – 'tell them it's their rubbish', she said."

KII, Clinical Psychologist, Nyanza

"There was a young girl of 16 years attending a public school. Escorted by her mother, she came to us seeking safe abortion services. I sat down with them for counselling. The mother said the girl's brother showed her sexual messages between the girl and a certain boy, but the girl says she doesn't know the person who raped her. When she was asked how she knew at her age that she was pregnant, she said she didn't know anything but just felt discomfort in her stomach. We conducted a pregnancy test and the results showed that she was seven months pregnant. We asked the mother how it was possible that they just learned of a seven-month pregnancy! They wanted to abort but we had to explain that we couldn't terminate a pregnancy at seven months. Whoever advised the girl to seek safe abortion is a person they had regular conversations with."

KII, Clinical Psychologist, Nyaruguru

3.11 Study strengths and limitations

3.11.1 Strengths

- One of the major strengths of this study is that the FGDs were composed of counsellors from different medical backgrounds and specialties. They included HCPs such as, psychologists, nurses and midwives. Having counsellors from diverse backgrounds and with diverse experiences of SRHR greatly enriched the group discussion.

- Methods and tools of data collection were reviewed and validated by individuals from the field of SRHR research.

- Ethical approval for this study was obtained from the CMHS IRB.

- Counsellors willingly and openly shared their opinions about the abortion law.

- The research team consisted of two researchers who closely collaborated throughout the entire research process (i.e. on tool development, data collection and data analysis). Hence, this study and its processes meet the accepted benchmarks for trustworthiness.

3.11.2 Limitations

- Participants in the study were counsellors who had been invited for one-day training. A few of the FGDs were conducted while the training session was still in progress. This might have compromised their attention.

- Participants were HCPs who are still part of Rwandan society. Therefore, their thoughts and opinions might have been influenced by the prevailing cultural norms, customs and taboos surrounding abortion.

- Rwanda has characteristics of a patriarchal society and hence professional counsellors' opinions about abortion can be influenced by societal gender role expectations.

- The findings are limited to the experiences of its participants, but can be considered comparable to those of counsellors in other provinces of Rwanda where safe abortion services are provided.

- There is lack of information regarding the abortion law – this made it difficult to discuss some of the aspects of the penal code,

as some participants were learning about it for the first time during the study.

- Due to the COVID-19 pandemic, all KIIs were conducted via telephone to limit physical contact with different people. This might have limited the benefit of face-to-face and physical observation by the interviewer.

4 CONCLUSIONS AND RECOMMENDATIONS

4.1 Conclusions

Policy-makers should be concerned when some of the implementers of the law, such as health care counsellors, have personal misgivings about the applicable law. Evidence suggests that the subject of abortion in Rwandan society remains very sensitive even among professional counsellors.

Some counsellors seem to have difficulty making a distinction between legal safe abortion and unsafe abortion. Their perspectives are more influenced by religious and cultural beliefs than the professional counselling environment they work in – a few of the counsellors' viewpoints are influenced by the existing legal framework.

Among professional counsellors there was limited knowledge regarding the grounds on which females could seek safe abortion services. They had no information concerning the penal code revision that removed the requirement of obtaining a court order before seeking safe abortion services. There are counsellors working at the health center level who consider safe abortion equivalent to surrendering the country to Satan, while others question why the country is committed to performing abortions instead of taking preventive measures against unwanted pregnancies. The study found a noticeable but slight difference in opinions about abortion service provision between counsellors from hospitals and those from health centers. Counsellors working at the hospital level showed more liberal inclinations.

These are clear indications that there is a need for more training to raise awareness about safe abortion among professional counsellors. Furthermore, there is a need to clarify the grounds under which an abortion can be provided. According to the law, not anyone who wants a safe abortion is allowed one; rather they are reserved for those provided for by the Rwandan law. Lastly, there is need for professional consensus on safe abortion – this will help to mitigate barriers to the realization of safe abortion care within the current legal framework, and ensure confidentiality of service seekers and reduce preventable consequences.

4.2 Recommendations

- Safe abortion services should be decentralized and integrated into health centers' service packages. Confidentiality should be improved and aimed at reducing stigma surrounding abortion. Currently safe abortion services are provided at district hospitals, which are geographically far away from many rural-based people.

- Use various platforms such as social media, radio talk show series such as *Urunana*, television talk shows and monthly community work such as *umuganda, umugoroba wababyeyi* to disseminate information on safe abortion.

- With the assistance of the Ministry of Health, RBC, and Civil Society Organizations, health care counsellors should be trained to improve their knowledge of the safe abortion law aimed at helping to dismantle abortion-related stigma.

- Community health workers should play a central role in raising awareness about the legal provision on safe abortion and awareness against abortion related stigma in their communities.

- Build champion counsellors among counsellors as a pillar of awareness-raising to fellow counsellors. Make a distinction between unsafe and safe abortion as provided for by the safe abortion law.

- Develop a communication strategy for coordination of, as well as tailored messaging aimed at all CSOs working in the domain of SRHR, with the intent of avoiding backlash from the general public and misinterpretation by faith-based groups.

- CSOs should develop a well-tailored awareness-raising strategy for counsellors and other HCPs on safe abortion.

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ANNEX

Annex 1: Interview guide for counsellors

Barriers and attitudes toward safe abortion in Rwanda: Perceptions of counsellors

Instructions for interviewers: Use the introduction letter to introduce yourself and to explain the objectives of the study. Respond to any questions the respondent may have, and provide further information as appropriate. Confirm that the interview results will be kept confidential and ask for permission to use the voice recorder. When asking questions, follow up with appropriate probes, as necessary. Ask the interviewee to sign the informed consent form.

Please complete this form for each interviewee including summaries of responses. This summary form should be completed immediately after the interview is completed. Include any important verbatim quotes in the summary. Whenever possible, do an 'overall assessment of the interview' and identify surprising issues.

Date: _____ Place: _____Duration of the interview: _____
Tape recorded (circle): Yes/No

Background information (use a separate sheet to collect as much info as possible)

What is your function at this hospital? _____
How long have you worked at this hospital? _____
What is your education? _____
What is your experience? _____
Interviewee number_____

1. Understanding SRHR issues, such as limited FP and abortion services

To what extent are counsellors aware of the consequences of unmet needs of FP?
To what extent are health care counsellors/professionals aware of the magnitude of women treated for or dying of unsafe abortion?
To what extent are health professionals aware of the magnitude of women in prison on abortion charges?

2. What do you know about the law that determines conditions to be satisfied for a medical doctor to perform an abortion?
(Note: If the respondent is not familiar with the Organic Law N° 01/2012/OL of 02/05/2012 instituting the Penal Code, provide information.)

3. Please tell me about the safe abortion services at your facility.
Which treatment methods are used?
Which methods are most commonly used?

4. What are the most common reasons for safe abortion at your facility?

5. In your opinion, what was the relevance of having a court process and approval before someone could access safe abortion services?

6. How relevant is the removal of the court order before a client can seek abortion services?

7. What do you think are some of the challenges that hospitals face in the provision of safe abortion services?
Attitudes toward abortion (individual level to be probed more)
Lack of trained providers?
Materials and equipment to provide quality services?

8. Perceptions of your own facility to provide safe abortion
How important do you perceive unsafe abortion is an issue in Rwanda?
To what extent do you think abortion should be on the political agenda?
Which spaces do you feel safest and most comfortable to speak about the issue of unsafe abortion?
To what extent do counsellors feel they have personal and professional responsibility to provide safe abortion counselling?

9. Think about women who have experienced child defilement, rape, incest, forced marriage or require a therapeutic abortion. What are some of the challenges that these women face to accessing safe abortion services?

What are the challenges for women who require a therapeutic abortion?
What are the challenges for women who have experienced child defilement, rape, incest or forced cohabitation?
What are the challenges resulting from abortion-related stigma?

10. How can these challenges be addressed?
For a child who has experienced defilement?
For women who qualify for a therapeutic abortion?
For women who have experienced child rape, incest or forced marriage?

How can the stigma related to abortion be addressed?

11. What do hospitals need to better to support the provision of safe abortion services?
(i.e. training, staffing, equipment, financial, other)

12. When a woman comes to terminate her pregnancy as a result of GBV (rape, defilement, incest or forced marriage), what are the procedures for her to receive safe abortion at your health facility?
What support services are provided at your facility (psychosocial, legal, other)?
How does this facility follow-up with women after abortion?
What would you propose to make it easier for women to navigate through the service process?

13. In your opinion, how easy or difficult is it for a woman to receive a safe abortion at your health facility?

Community awareness
14. In your opinion, what information is missing in the community about safe abortion services?

In your opinion, what information does the community need to know about safe abortion?
How can this information be provided?

Cases
Can you please describe the last case you received at your facility of a woman who experienced rape, child defilement, incest or forced marriage, was pregnant and wanted a safe abortion (answer even if the woman did not receive the service)?

Can you please also describe the last case you received at your facility of a woman who came to seek safe abortion whose case is not provided for under any provisions of the penal code related to safe abortion services?
[Let the interviewee narrate the case from admission to discharge; interrupt only if not clear or if there is a need for clarification.]

Gaps for improvement of abortion services
In your opinion, what else do you think needs to be done to improve safe abortion services?

Do you have any other questions for me? [Respond to any questions as appropriate)

Thank the interviewee for their time.

Ask the interviewee's name and gender.

Note: If the interviewee has mentioned any documents, resources, etc., that would be useful for this assessment, ask for copies, where to find them, etc., to be used for final analysis and report writing.

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