Rwanda is on the path to achieving its Millennium Development Goal of a maternal mortality ratio of 268/100,000 live births through strengthening all components of its maternal health program. This success is being realized through the rigorous development of policies and implementation of programs to address all of the reasons for maternal mortality, using an integrated approach. One specific area of work has been the reduction of maternal mortality due to unsafe abortion. Two policy documents, the Rwanda Road Map to Accelerate the Reduction of Maternal and Neonatal Morbidity and Mortality 2013-2018 (ARMNM Road Map), and the Guidance Document to Operationalize the Exemptions for Abortion in the Penal Code of 2012 (2014-2018) laid the groundwork for making abortion safe and accessible within the legal framework. The current program builds on previous and ongoing efforts, including the National Comprehensive Postabortion Care Program, to reduce unsafe abortion-related maternal mortality through operationalization of the exemptions for abortion in the Penal Code of 2012.

**BACKGROUND**

In June 2012, Rwanda published the Organic Law Instituting the Penal Code, which provides exemptions from criminal liability for abortion, as specified in articles 162 through 167 (Section 5: Crime of Abortion): “...in cases of rape; incest in the second degree; forced marriage; or when the pregnancy severely jeopardizes the health of the unborn baby or that of mother” (Republic of Rwanda, Organic Law N° 01/2012/OL of 02/05/2012 Organic law instituting the Penal Code, Official Gazette, special issue, June 14, 2012). Since the publication of the Penal Code, several important stages of implementation have been completed with the goal to reduce maternal mortality due to unsafe abortions. Figure 1 outlines the major milestones and accomplishments for the Operationalization of the Exemptions for Abortion in the Penal Code of 2012.

**GENERATION OF EMPIRICAL EVIDENCE AND CAPACITY BUILDING**

After completing the initial stages of implementation, including the development of policy (Guidance Document for the Operationalization of the Penal Code of 2012) and standardized national program resources (National Protocol and Training Curriculum for the Operationalization of the...
**Exemptions for Abortion in the Penal Code of 2012**, this next stage was designed to generate empirical evidence on the current situation since June 2012, while at the same time strengthening the capacity for service provision.

Specific objectives of this stage of implementation include:
1. Identifying the situation in the provision of abortion-related services through health facility and court records since the publication of the Penal Code in June 2012;
2. Assessing perspectives of key informants as well as women in the community on the operationalization of the Penal Code of 2012 and the challenges to accessing safe abortion services;
3. Strengthening the capacity of providers and facilities to offer safe abortion services;
4. Monitoring abortion and gender-based violence (GBV) service provision in the initial program sites;
5. Using evidence to inform the next stages of the operationalization of the Penal Code of 2012.

**PROGRAM SITES**
Program implementation took place at eight sites including Central Hospital of University of Kigali (CHUK), Gihundwe Hospital, Kabutare Hospital, Kacyiru Police Hospital (KPH), Muhima Hospital, Nyagatare Hospital, Rwanda Military Hospital (RMH), Ruhengeri Hospital and seven hospital-affiliated Isange One Stop Centers/GBV Centers (IOSCs/GBV Centers), with the exception of CHUK (Figure 2). A total of six intermediate courts in the same districts were also included.

**METHODOLOGY**
The data collection process was designed to generate evidence using both quantitative and qualitative methodologies and included a retrospective record review of courts and service provision sites since the publication of the Penal Code in June 2012 and prospective monitoring of service provision sites (Figure 3). The assessment for retrospective record review and qualitative inquiry was carried out in collaboration with the University of Rwanda College of Medicine and Health Sciences, School of Public Health, with the approval of the Rwanda National Ethics Committee. Before the initiation of data collection, all collection tools were reviewed and

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**Figure 2: Map of program sites**

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**Figure 3: Data collection process**

**Retrospective Data**
July 2012-June 2014
- Abortion service delivery records from all program hospitals
- IOSC/GBV Center records from all centers affiliated with hospitals
- Records on court orders for abortion from all intermediate courts

**Qualitative Inquiry**
July-October 2014
- In-depth interviews of OB/GYNs
- In-depth interviews of IOSC/GBV Center service providers
- In-depth interviews of court representatives
- Focus group discussions with women

**Prospective Data**
August-December 2014
- Data collection on women who received pregnancy termination services
- Data collection on women and men who received GBV services
finalized with the participation of respective experts and stakeholders during meetings organized by the Ministry of Health (MOH).

Records were reviewed retrospectively and entered into data extraction forms from the eight hospitals and their affiliated IOSCs/GBV Centers (July 2012-June 2014). In-depth interviews were conducted with key informants in the districts and at the central level. In addition, three focus group discussions (FGDs) were conducted to gather information on perspectives from women on abortion, the Penal Code of 2012, and the accessibility of safe abortion services. For the prospective data collection, data on services related to termination of pregnancy and GBV management were collected from participating facilities between August and December 2014. Box 1 shows the different components of the data collected from the assessment.

**FINDINGS**

**Hospital Services Based on**

**Box 1: Data collection process for the assessment and monitoring**

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<thead>
<tr>
<th>RETROSPECTIVE RECORD REVIEW</th>
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<tr>
<td><strong>July 2012-June 2014</strong></td>
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<tr>
<td>• Record Review in Hospitals: Service delivery records from 8 program hospitals for all women who received pregnancy termination</td>
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<tr>
<td>• Record Review in IOSCs/GBV Centers: GBV records from 7 centers affiliated with hospitals for all women who sought assistance</td>
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<td>• Record Review in Courts: Records on court orders from the 6 courts in the districts</td>
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<th>QUALITATIVE INQUIRY</th>
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<td><strong>July-October 2014</strong></td>
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<tr>
<td>• In-depth interviews conducted with 22 key informants</td>
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<td>• Three focus group discussions with women in the community</td>
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<th>PROSPECTIVE MONITORING</th>
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<tr>
<td><strong>August-December 2014</strong></td>
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<tr>
<td>• Provision of pregnancy termination services in program hospitals for all women</td>
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<tr>
<td>• Provision of GBV-related services at IOSCs/GBV Centers for all women</td>
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**Retrospective Record Review and Prospective Monitoring**

A total of 2,644 records were identified for pregnancy terminations in the retrospective record review (July 1, 2012-June 30, 2014). Prospective monitoring data identified 312 women who received pregnancy termination between August-December 2014. In both periods, the majority of pregnancy terminations (97% and 85% respectively, for retrospective and prospective data collection periods) were due to uterine evacuations for obstetric reasons (e.g. intrauterine fetal death, missed abortion, molar pregnancy, trophoblastic disease, ectopic pregnancy, blighted ovum) (Figure 4). The health of the mother was the reason for 14% of pregnancy terminations during the prospective monitoring period, whereas it had accounted for 1% of pregnancy terminations during the retrospective record review. Only one case of abortion was recorded to terminate a pregnancy as a result of rape, conducted with an approved court order in April 2014.

The majority of pregnancy terminations were conducted using medication methods. However, during the retrospective record review period, 43% of pregnancies were terminated using medical methods compared to 64% during the prospective period (Figure 5). D&C and MVA combined represented slightly more than half of the terminations during the...
retrospective period, and accounted only for 5% of the terminations in the prospective period.

Data on incoming referrals was available for 286 women, only for prospective monitoring. The majority of women were referred from another health facility (86%), 5% came on their own, and 1% were referred by an NGO or another source.

Out of the women who received pregnancy termination services during the prospective monitoring period, and for whom data were available, 82% received contraceptive counseling and 26% received a contraceptive method. Among women who received a contraceptive method, the distribution of methods was approximately 27% injectables, 22% condoms, 21% pills, 15% implants, 12% IUDs, 1% tubal ligation, and 1% cycle beads. Data on contraceptive counseling and methods were not available in the retrospective record review.

During the prospective monitoring period there was one maternal death of a patient who admitted with IUFD, as a result of hemorrhagic shock secondary to uterine rupture. Overall, 87% of women who received pregnancy termination services experienced no side effects or complications before discharge, and only 3% were referred to another facility after receiving treatment. Side effects and complications included abdominal pain (7%), severe bleeding (3%), abdominal pain and severe bleeding (0.3%), infection (0.3%), and abdominal pain and severe bleeding (0.3%)

GBV Services Based on the Retrospective Record Review and Prospective Monitoring
During the period of retrospective record review (July 1, 2012-June 30, 2014), there were 3,763 victims who sought GBV services after sexual violence. Records indicated that 273 women were pregnant at the first visit, and 182 women were recorded as pregnant at a follow up visit. Among women who sought GBV services after experiencing sexual violence and were pregnant, 11 records show a request to terminate the pregnancy. Of these women, only one presented a court order for abortion at the health facility and received an abortion (the same case reported in hospital data above as terminating a pregnancy due to rape).

During the prospective monitoring period (August-December 2014), 550 cases of sexual violence sought GBV services at program IOSCs/GBV Centers. Of these, 527 (96%) were female and 23 (4%) were male (Figure 6). A great majority (84%) were minors, 18 years old or younger (Figure 7).

Out of the 527 women seen at IOSCs/GBV Centers between August and December 2014, 84 (16%) were pregnant as a result of rape, incest or forced marriage. Of those, rape was reported to account for approximately 96% of pregnancies, followed by forced marriage (2%) and incest (1%).

Among women who were pregnant as a result of rape, incest or forced marriage, four of them (5%) were

Figure 5: Pregnancy terminations at hospitals by method: a comparison of the retrospective record review and prospective monitoring data

![Figure 5](image-url)

1Data on pregnancy termination with more than one method was not collected during the retrospective record review.
2Other methods include oxytocin, electric aspiration, D&E, C-section, laparotomy, and vaginal delivery.
3Data on pregnancy termination method not available for four cases.
reported to have asked to terminate the pregnancy. It is important to note that women are usually counseled to accept their pregnancy, and records are completed after counseling, with the possibility of women changing their minds after being counseled. Three of these women were referred to the court, but records show that none of them came back with a court order (Figure 8). Overall, when both retrospective and prospective data were assessed together, all eligible women who asked to terminate their pregnancy (with the exception of one woman described above) were lost to follow-up and never returned to the facility with a court order.

Findings from Record Review of the Courts
A review of records from the six Intermediate Courts in site districts revealed that since the Penal Code was published in June 2012, there had been only one identified case of a court order for abortion, which was approved.

Findings from the Qualitative Inquiry
The in-depth interviews and focus group discussions yielded some important information and insights about the barriers and challenges for the operationalization of the Penal Code of 2012. The common themes with some exemplary quotes are summarized here. Box 2 provides examples of cases reported by service providers. With some rare exceptions, such as the case of a 14-year-old who was able to terminate the pregnancy with a court order, the providers shared many tragic stories of how girls and women were not able to obtain a court order and thus terminate their pregnancies as a result of rape or incest.

Silence and stigma around rape and abortion: While stigma can influence provider’s attitudes about the provision of abortion-related services, there are also different ways in which stigma around rape and abortion inevitably influence a woman’s decision-making power for accessing abortion care. The general consensus among health provider respondents was that many victims of rape would try to
Box 2: Examples of cases reported from the qualitative assessment

Case of a 14-year-old terminating her pregnancy as a result of rape with a court order
A 14-year-old admitted to the facility with her mother. She was pregnant and she had a court order that the pregnancy was a result of rape. According to the IOSC that received her: “She was raped by three robbers who came to her home in December 2013, and on the next day she was brought here with a requisition form. We gave her prophylaxis, which she didn’t take saying it tastes bad. Then, she came back later, 6-8 weeks pregnant. She went to get a court order that allowed her to abort with the help of a registered doctor.”
According to the OB/GYN department, the patient was first seen by a nurse, with a court order, but she was turned away. Then the mother went to see the hospital director. Her request was granted and the young girl was provided an abortion successfully with misoprostol. (Kigali Province)

Case of a 17-year-old house maid brought to the facility by her boss when she was pregnant due to rape
“Another case is of a maid who was brought here by her boss after she was raped by another worker but it was too late, and she was already pregnant. We did consultation, reported to the police and talked to her boss how he can help her. She was 17 by then. She used to come here and I would ask doctors to do ultrasound for her for free. I kept calling her boss to know how she is doing and asked them to let her keep the job and earn some money. After six months she went back home to Cyangugu and we wrote her a transfer and noted that she was a GBV victim so that she can give birth at the health center for free. I contacted the focal point and they kept following this case. What I don’t know is if the suspect who raped her got caught or not.” (Kigali Province)

Case of a pregnant 22-year-old raped by her brother, who was counseled to accept her pregnancy and not to commit suicide
“The last I remember is a case of a 22 year old girl (orphan who was raised by her brother until she was able to get a job as a house maid) who was raped by her only-living brother working in Kigali when he came to Huye to visit his young sister and raped her that night. The young woman came already pregnant and she requested an abortion as she could not stand a pregnancy from her brother and she threatened to commit suicide if the pregnancy was not terminated. She was examined and underwent a number of tests. The pregnancy was confirmed and she was counselled to accept the pregnancy and drop out her ideas to kill herself. She left the hospital and never came back. She did not want to go to police station to avoid filing a case against her brother who returned to Kigali after raping her and never contacted her anymore.” (Southern Province)

hide the situation and would not consider reporting it, or if she becomes pregnant as a result of rape, it would be too embarrassing for the woman to disclose her situation and ask for a court order.

“Given our culture, [rape is] embarrassing, some girls will be like; “how will others see me if I go to ask for a court order”… So, there is stigma because of our culture.” (Health provider)

“Keeping secrets is a big part of our culture. For example, we had a case of a houseboy who raped four girls of the same family and when their parents found out, they kept quiet about it thinking that it would be a shame if people came to know that their girls were raped.” (Health provider)

“I think the challenge can be our culture, victims may think they are going to commit a crime or they may die during the abortion process because they would be doing wrong. Most of time they end up accepting the pregnancy.” (IOSC provider)

Challenges to getting a court order lead to resignation and discouragement: Many respondents highlighted that the process for obtaining a court order is challenging, and there may be many reasons that women who are victims of rape, incest or forced...
marriage may not get a court order even if they want to terminate their pregnancies. A woman showing up with a court order was a rare event, and providers felt they did not have any options other than counseling women to accept the pregnancy.

“I have never seen of anyone who brought a court order to receive [an] abortion. We received victims who wanted abortions but we asked them to go to the court and they said it would take [a] long time. And so we counseled them into keeping the pregnancy. I personally advised my patients to seek a court order or to accept the pregnancy due to my beliefs.” (Health provider)

 “[Major challenges are] delays in obtaining the court order and frustration of eligible women… It takes time and courage and many efforts and financial means to go through the long procedures to obtain a court order. Accordingly to the legal process we know, [it takes so much time] that by the time a victim gets a court order, she will end up giving birth to a baby.” (Health provider)

“The challenge is that women requesting [a] court order for pregnancy termination come at [an] advanced stage of their pregnancy. Victims take time to question their conscience because the law is kind of new. This creates delays in beginning the process… So, I think that it is better if victims start the process early to avoid regrets and pain all their lives... [Many cases] fail to get a court order due to these delays.” (Legal official)

“For incest cases, families do not want to tell the truth to protect its own who did it. And, it is hard to establish incest without evidence and so it makes it hard to get a court order.” (Health provider)

**Difficulties in getting direct evidence on rape cases for court orders:** Legal officials expressed their views on the process of obtaining court orders for legal abortions. One important part of the legal documentation is the physical and testimonial evidence of rape, incest or forced marriage. In many cases such evidence is difficult to gather. This might result in further delays of the legal procedures and impact the right to services for the women involved.

“First of all in the court we request evidences to establish rape, incest or forced marriage. If evidences are insufficient, the victim will never get the court order for abortion. There is no challenge related to the court procedures or delays because such cases are treated as emergencies. For instance, how can you prove the pregnancy is [the] result of incest without [a] DNA test? DNA [tests] can be only done on the child after birth [...] For example for rape, if the rapist was not convicted, and if the rapist does not plead guilty, there is no way the court order for abortion can be issued. For incest again the law is silent about incest in case of rape (rape committed by a relative) because sometimes close relatives commit incest willingly.” (Legal official)

“You may hear on radio that a woman was raped by her father or uncle... Even a real prostitute can never wish to have sex with her father. [However], once pregnant, she may go through the court to have the right to abort, but first the father will have to be judged for rape. Otherwise there will be no proof of incest for the court to give her a court order for abortion due to lack of evidences.” (Legal official)

“[The evidence] depends on how the suspect justifies himself [denies rape]; interpretation of events... If the doctor writes in the medical report that [rape] is “probable”, we have to discuss about it in a meeting with doctors, police staff and parquet [court] workers to see where it seems to be a challenge. We all [understand] that interpretation is a problem. But when it happens, we have to call the doctor to come forward and explain why he used the word ‘probable.’” (Legal official)

**Challenges in service delivery at Isange One Stop Centers/GBV Centers:** Providers working at IOSCs/GBV Centers highlighted some important issues to address: i) women arrive at the Center when they are pregnant, asking for pregnancy termination after rape or incest, when it is not possible to prove their case with evidence; ii) many IOSCs/GBV Centers do not have a safe room or sufficient number of beds for women; iii) lack
of awareness of the the Penal Code; and iv) delays in some of the services available at night or over the weekends due to a limited number of providers on duty.

“The problem is people came too late into the pregnancy, and we may not have the evidences if she is raped or not.” (Health provider)

“Catching the suspects is a challenge, either they sneak away or they are caught too late after victims start taking ARV medicines, when it may be unnecessary. Safe room is very small, it only has 3 beds. When we have many clients [to stay] we take them to the hospital.” (Health provider)

“In the evening and weekend shifts victims are not well received, because of limited number of service providers. In case of emergency, GBV victims may not be identified immediately and prevention therapy may be delayed or denied, and evidences may no longer be collected [in a timely manner].” (Health provider)

Consequences if legal abortion cannot be accessed: Girls and women who deliver a child conceived as a result of rape can be rejected by their families and by society; terminated from their schools and lose the opportunity to continue with their education; and incur financial hardship. Additionally, children born to victims are stigmatized (ikinyendaro; “bastard”) and the risk of child neglect and abuse is increased. Providers pointed out that deliveries by girls under the age of 18 pose a great risk to the mother and the infant, and reported of cases where cesarean sections were conducted on 14-year-old or 17-year-old mothers because of their young age. The common practice of silence due to stigma, coupled with the difficulty of getting a court order, is causing some women who are actually eligible for exemptions, to resort to unsafe abortion:

“I see many challenges to [the Penal Code’s] implementation due to people's [lack of] understanding. The penal code is supposed to help women. From a Rwandan cultural perspective, abortion is killing. Similarly, going to court is to go public ("kwiha rubanda", making private business public). Actually women should dare [to go public] and this needs to be strengthened [in the community] and be [the] subject of sensitization activities. Since the revised penal code was signed none came to request a court order but we receive many criminal cases from the police of women who committed [illegal] abortion and some of them were eligible based on exemptions.” (Legal official)

RECOMMENDATIONS: IMPLICATIONS FOR POLICY AND PRACTICE
Findings point to the following issues to be addressed in the further operationalization of the Penal Code of 2012:

A. Health Services Aspects
• Train providers on the Penal Code; termination of pregnancy methods; prevention and management of GBV; stigma-free counseling and service provision
• Expand services to all district hospitals
• Strengthen IOSCs/GBV Centers in their unique role to help victims, including integration of the provisions of the Penal Code of 2012 in patient counseling and services
• Standardize the correct registry and recording of abortion cases
• Ensure the availability of necessary equipment and medicines

B. Legal and Police Aspects
• Train legal and police personnel on the Penal Code; rights of women and minors; women-centered management of GBV; and stigma-free and confidential services
• Address challenges to getting a court order for all victims of GBV and facilitate the process for minors

C. Cross-cutting Issues
• Raise community awareness through the involvement of communities, civil society organizations and stakeholders from all respective multisectoral institutions (health, legal, gender equality, and police services)
• Continue to work to reduce stigma around rape and abortion
• Address the missed opportunities for the special protection of minors
• Ensure that financial resources are available for quality services
• Advance successes for implementation through the re-iterative process of monitoring, supervision, generation of evidence and formulation of next steps based on evidence.

WAY FORWARD

On February 11, 2015, The Operationalization of Exemptions for Abortion in the New Penal Code of 2012: Evidence for Action meeting was conducted as a forum to discuss the findings presented in this brief and to begin the development of program expansion and scale-up based on the evidence and lessons learned from the initial implementation. The program will continue under support from the Bixby Center for Population, Health and Sustainability at the University of California, Berkeley. During this next phase of program expansion, the MOH will work with the Bixby Center to prioritize the program recommendations discussed during the dissemination meeting, including the following:

• Raising community awareness on the exemptions provided in the Penal Code of 2012, including civil society organizations, community health workers (CHWs), local leaders, health providers, parents and peers;
• Training all qualified personnel (healthcare providers, police, social workers, IOSC/GBV Center staff, psychologists, pharmacists, etc.) at all district hospitals and health centers to work as a team to provide abortion services;
• Integrating safe abortion services into the pre-service curriculum of medical and nursing schools;
• Strengthening collaboration between relevant ministries and institutions for identification of priorities and provision of quality services (MOH, MINJUST, MIGEPROF, Ministry of Education and RNP);
• Further clarifying child defilement as a form of rape by the MINJUST and other parties, to facilitate minor victims’ access to safe abortion services;
• Strengthening IOSC/GBV centers for prompt and uninterrupted provision of services for GBV management including psychosocial counseling; legal assistance; reintegration to society; and termination of pregnancy;
• Clarifying the process for referrals (within and among facilities) to ensure that eligible women can receive services without barriers.

REFERENCES


For a copy of the full technical report contact: bixbycenter@berkeley.edu.