Bixby Center for Population, Health & Sustainability
UNIVERSITY OF CALIFORNIA, BERKELEY

@ FIGO

Vancouver Convention Center, Canada | October 4-9, 2015

BIXBY CENTER PRESENTATIONS

In Collaboration with Rwandan Partners
With Sponsorship from VSI

Monday, October 5th | 8h00 - 9h30 | Room 112 | FCS04.8

Presenter: Nuriye Sahin Hodoglugil, MD, MA, DrPH | Bixby Associate Fellow

Abortion Services for Victims of Gender-based Violence in Rwanda: Challenges due to Stigma and Lack of Evidence (1395)

Tuesday, October 6th | 9h55 - 11h25 | Room 117 | FCS33.8

Presenter: Fidele Ngabo, MD | Rwanda Ministry of Health

Transforming Law into Policy and Practice: The Case of Making Abortion Safer in Rwanda (1386)

Friday, October 9th | 8h00 - 9h30 | Room 217 | FCS98.1

Presenter: Ndola Prata, MD, MSc | Bixby Director

Abortion Service Provision in Rwanda Since Penal Code of 2012: An Assessment of Medical and Legal Systems (1389)

POSTER PRESENTATIONS

Monday, October 6th

Presenter: Sarah Jane Holcombe, PhD, MPH, MPPM | Bixby Associate Fellow

- P0017: Obstetrician-Gynecologists & Their Professional Societies as Contributors to Abortion Law Reform: the Cases of Ethiopia, Rwanda, and Mozambique
- P0963: Patient Perceptions of Midwifery Care, Debre Markos, Ethiopia

* UCGHI Center of Expertise on Women's Health & Empowerment Call For Papers *

We are accepting submissions on Women's Empowerment, Pregnancy & Childbirth for a special journal supplement in BMC Pregnancy & Childbirth.
Deadline to submit is December 15th!
For further details, please see the call on the UCGHI website .

< http://www.ucghi.universityofcalifornia.edu/news-events/items/2015-call-for-papers-bmc-pregnancy.aspx >

The Bixby Center for Population, Health, and Sustainability, a campus-wide research group at UC Berkeley, is dedicated to helping achieve slower population growth within a human right framework by addressing the unmet need for family planning. The Center seeks to improve the health outcomes of world's poorest and most vulnerable women and their families.
Visit us at bixby.berkeley.edu or contact us at bixbycenter@berkeley.edu !

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About our presentations:

Abortion services for victims of gender-based violence in Rwanda: Challenges due to stigma and lack of evidence (1395)

Nuriye Nalan Sahin Hodoglugil, Fidele Ngabo, Felix Sayingoza, Eugene Ngoga, Laetitia Nyirazinyoye, Evangeline Dushimeyezu, Eugene Kanyamanza, Ndola Prata

A total of 22 in-depth interviews with key stakeholders (including health care providers from hospitals and gender based violence centers, administrators, and representatives from the intermediate courts and Ministry of Justice) and three focus group discussions (urban and rural single women ages 18-24; urban married women ages 25-45) were conducted between June-October 2014 to identify barriersfor accessing safe abortion services within the legal framework in Rwanda since the Penal Code was published in 2012. Stigma around rape and abortion emerged as a very strong theme preventing victims of sexual violence to speak up and seek care; victims were more likely to arrive at the health facility after they were pregnant. Due to stigma and the challenges to get a court order, legal termination of pregnancy does not appear as an accessible option. The requirement of hard medical evidence by the courts; time required to collect evidence and convict the perpetrator; and inability to admit with the first 72 hours of assault hinders victims to present their cases legally. Addressing stigma and silence around rape and other forms of GBV should be a major objective while making abortion safer in Rwanda.

Transforming Law into Policy and Practice: The Case of Making Abortion Safer in Rwanda (1386)

Fidele Ngabo, Felix Sayingoza, Eugene Ngoga, Nuriye Nalan Sahin Hodoglugil, Joanna Ortega, Eugene Kanyamanza, Evangeline Dushimeyezu, Ndola Prata

Rwanda Ministry of Health (MOH) undertook an initiative to operationalize the exemptions for abortion in the Penal Code of 2012 (PC2012). PC2012 allowed for exemptions for abortion in cases of rape, incest, forced marriage, or when pregnancy jeopardizes the health of the unborn baby or pregnant woman. The re-iterative process of generation of evidence to feed into policy and program activities included: i) in-depth interviews with key informants and experts; ii) focus groups with potential beneficiaries; iii) assessment of services; iv) capacity development activities; v) policy development in consultation with key stakeholders. As a result of the program: a five-year national strategic plan to address unsafe abortion related maternal mortality was developed along with a National Protocol and training package; service provision capacity was strengthened; evidence was generated through an assessment of services; and community leaders were sensitized. Provision of safe abortion services with emphasis on medical, legal and psycho-social aspects were initiated in August 2014 at eight facilities. Grounded in the efforts to align national laws with the Maputo Protocol, Rwanda sets up an excellent role model in the region for transitioning from law to practice for protecting women's rights to abortion even with a relatively restrictive legal framework.

Abortion Service Provision in Rwanda Since Penal Code of 2012: An Assessment of Medical and Legal Systems (1389)

Ndola Prata, Fidele Ngabo, Felix Sayingoza, Eugene Ngoga, Joanna Ortega, Evangeline Dushimeyezu, Eugene Kanyamanza, Julie Wieland, Nuriye Nalan Sahin Hodoglugil

A comprehensive assessment was conducted to identify the status of legal abortion service provision in Rwanda based on data from: 1) retrospective record review (RRR) from eight district hospitals and their affiliated gender based violence (GBV) centers and intermediate courts for the same districts (July 2012-June 2014); 2) 22 in-depth interviews with key stakeholders and three focus group discussions with women; and 3) prospective operations research (POR) for monitoring of service provision at the health facilities (August-December 2014). RRR identified 3,763 records at the GBV centers; and of the 273 cases pregnant at admission, there was only one termination of a pregnancy as a result of rape. Of the 527 female victims identified during the POR, 84 were pregnant and none came back with a court order for termination. Of the 312 uterine evacuation cases at hospitals during POR, 85% were for obstetric reasons (intrauterine fetal death, missed abortion, trophoblastic disease, etc.); followed by pregnancy termination due to maternal health reasons (14%) and fetal impairment (1%). Medical termination was 64%. Despite the high numbers of GBV related pregnancies, hospitals were not receiving eligible women, most likely due to stigma and difficulties of getting court orders.