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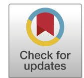
Implementing the liberalized abortion law in Kigali, Rwanda: Ambiguities of rights and responsibilities among health care providers



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A B S T R A C T

Objective: Rwanda amended its abortions law in 2012 to allow for induced abortion under certain circumstances. We explore how Rwandan health care providers (HCP) understand the law and implement it in their clinical practice.

Design: Fifty-two HCPs involved in post-abortion care in Kigali were interviewed by qualitative individual in-depth interviews (n =32) and in focus group discussions (n =5) in year 2013, 2014, and 2016. All data were analyzed using thematic analysis.

Findings: HCPs express ambiguities on their rights and responsibilities when providing abortion care. A prominent finding was the uncertainties about the legal status of abortion, indicating that HCPs may rely on outdated regulations. A reluctance to be identified as an abortion provider was noticeable due to fear of occupational stigma. The dilemma of liability and litigation was present, and particularly care providers' legal responsibility on whether to report a woman who discloses an illegal abortion.

Conclusion: The lack of professional consensus is creating barriers to the realization of safe abortion care within the legal framework, and challenge patients right for confidentiality. This bring consequences on girl's and women's reproductive health in the setting.

Implications for practice: To implement the amended abortion law and to provide equitable maternal care, the clinical and ethical guidelines for HCPs need to be revisited.

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Introduction

Health care providers (HCPs) have a strong influence over abortion care services, and may consequently enhance or curtail women's access to these services, regardless of legal context (Rehnström Loi et al., 2015). The reluctance to provide abortion care is often due to religious and moral convictions against the practice (Onah et al., 2009; Voetagbe et al., 2010; Aniteye and Mayhew, 2013). Therefore, when changing policies and regulations that have an implication on abortion care services, HCPs inner value system and societal norms in the setting have an impact on the realization of the changes (Rehnström Loi et al., 2015).

Rwanda amended its previously strict abortion law in 2012. This was a result of several initiatives, particularly advocacy done by the Rwandan Youth Action Movement. They highlighted the consequences for young women being imprisoned for abortion and put it on the agenda with key stakeholders (Umuhoza et al., 2013). Parallel to this, the Ministry of Health acknowledged that complications arising from unsafe abortions and miscarriages played a significant role in the overarching quest to reduce maternal deaths (Republic of Rwanda. Ministry of Health 2012). Despite

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strong opposition from religious leaders, the law was amended (Umuhoza et al., 2013). It now approves induced abortion for pregnancies resulting from rape, incest or forced marriage, or if the pregnancy seriously jeopardizes the health of the pregnant woman (Republic of Rwanda. Organic Law N° 01/2012/OL of 02/05/2012 2012). The amendment also includes substantial reduction of prison sentencing for a person who provokes an abortion. If this person is a physician, midwife, or pharmacist, a suspension from practicing the profession can be given for 3–5 years (Republic of Rwanda. Organic Law N° 01/2012/OL of 02/05/2012 2012). Any person advertising abortion-inducing materials, drugs or other substances, is also liable to prison time, typically 6 months to 2 years. For a woman to obtain an induced abortion within the legal limits, a formal approval is required from the judicial court, as well as consent from two physicians (Republic of Rwanda. Organic Law N° 01/2012/OL of 02/05/2012 2012).

According to the professional ethics, all HCPs in Rwanda are expected to follow the 'do no harm' policy and to ensure confidentiality of the patient. Yet, the current 'Professional Code of Ethics' also states that nurses and midwives have the right to "refuse to participate in activities contrary to his/her personal moral and professional convictions." (Rwanda Ministry of Health 2009). It is unclear whether physicians have the option to deny offering an induced abortion because of personal moral conviction, it is only stated that: "A medical practitioner shall not practice a voluntary interruption of pregnancy except in the cases and conditions provided by the law" (Rwanda Ministry of Health 2009).

A legal and safe abortion is reportedly difficult to obtain in Rwanda (Umuhoza et al., 2013; J Påfs et al., 2016). Post-abortion care (PAC) is performed but reported to be of insufficient quality (Vlassoff et al., 2015; Ngabo et al., 2012). To address this, the Rwandan Ministry of Health put forth a new guideline meant to increase women's access to PAC services. This included the introduction of misoprostol tablets as a main priority for the treatment of incomplete abortions (Rwanda Ministry of Health 2012).

A paucity of reporting in the literature exists on the professional response to Rwanda's amended abortion law. Furthermore, any available evidence draws on scant knowledge about how HCPs addressed the previous law. The aim of this study is to explore how Rwandan HCPs understand the amended law and implement it into their clinical practice.

Method

Ethics

Approval to conduct this study was obtained from Rwanda National Health Research Committee, Kigali (NHRC/2012/PROT/0045). Informed consent was retrieved from all participants, who were verbally informed about the study, and told that they could participant anonymously and withdraw at any time without explanation. All interviews were performed where privacy could be assured.

Setting

Since the genocide in 1994, Rwanda has undergone several demographic changes. Christianity is still the dominant religion, practiced by 93% of the population (44% being Catholic, 38% Protestant, and 12% Adventist). Those of Muslim faith remain a minority of 2%, and only 0.4% of the population report to have no religion (ICF International 2015). As Rwanda has one of the highest population density in sub-Saharan Africa (408 per square km), with a high fertility rate and high number of unintended pregnancies, improving reproductive health has become a top priority (Republic of Rwanda 2012). Several interventions have been initiated, such as providing contraceptives free of charge, which as increased the uptake (ICF International 2015; Republic of Rwanda: Ministry of Health 2012).

Data collection

The participants were recruited purposively at three public hospitals, and through snowball sampling (Bernard, 2006), in Kigali, in October to December 2013, March to April 2014, and March 2016. In total, 52 HCPs were included: 19 physicians (2 registered OB/GYN, 5 residents specializing in OB/GYN, and 12 general practitioners), as well as 24 midwives and 9 nurses. Three HCPs rejected participation without any explanation given. The participants were between 21–53 years old. Data were collected during 32 individual in-depth interviews (IDIs), and 5 focus group discussions (FGDs) containing between four and six participants. Most IDIs were completed at the hospital, except seven, which were conducted in the participant's home or at a restaurant. The FGDs took place at a restaurant where we could use a private room. The IDIs lasted between 30 and 70 min, and the FGDs between 90 and 120 min. All except 2 IDIs were audio recorded. In these cases, detailed notes were taken and summarized for analysis. If it was convenient for the HCP, the interviews were performed in English by the first author, otherwise it was done in Kinyarwanda together with the research assistant who interpreted.

The first author, a 30-year old Swede and social worker by profession, spent a total of 10 months in Kigali over a time period of four years doing her PhD. She worked closely with a Rwandan research assistant, a 30-year old woman with a degree in linguistics, who also interpreted when needed. This two-person team visited the hospitals on a daily basis, did observations, informal conversations and interviewed staff when they had time. This study was part of a bigger research project (J Påfs et al., 2016; Musafili et al., 2017; J Påfs et al., 2016; Påfs et al., 2015).

The study was guided by the methodological framework of Naturalistic Inquiry (Lincoln, 1985), using a semi-structured design to capture emergent perceptions and attitudes towards abortion, PAC and contraceptive counseling, and reflections on the current abortion legislation and guidelines. All interviews followed a semi-structured guide. This guide was revised continuously. After each interview, the team debriefed and agreed upon new question and probes needed to answer the research questions.

Analysis

Thematic analysis was utilized to identify meanings from the dataset (Braun and Clarke, 2006). All interviews were transcribed verbatim into English by either the first author or an external interpreter, and cross-checked by an external interpreter. The transcripts and observation notes were read multiple times, and coded by the first author. The codes were discussed among all co-authors and themes were identified. Preliminary findings were presented to participants throughout the later months of data collection, particularly during two final FGDs in March 2016. After that, the final analysis was done by revisiting the data and the codes, and redefine the themes.

Findings

All HCPs had at least 6 months of professional clinical experience at the maternal wards, and experience providing PAC in hospitals, and/or in public or private health centers. The majority had between 1–4 years of experience, and a few up to 10–15 years. Most of the HCPs had chosen their profession out of interest, while others had chosen it to assure a secure income, or they had been assigned to study the profession based on their grades. All HCPs defined themselves as believers in either Christianity or Islam.

From our analysis of the data, the main theme, **"Ambiguities on rights and responsibilities as care provider"** was identified**.**, It addresses the overarching contradictions and tensions identified across the respondents' answers, divided into three sub-themes:

Uncertain understanding and social angst towards the current abortion law

The HCPs expressed uncertainty about the legal status of abortion or how to apply it. At the time of the interview, not all were aware of that changes in the abortion law had taken place, and interpreted induced abortions as strictly illegal. Others were aware of the 2012 amendments, but considered that little had changed in actual practice. Questions from the HCPs arose about how a woman could prove rape or incest, and that the legal process to prove these was time consuming, costly and laborious. A handful of participants had heard rumors about women attempting to access an induced abortion by going through the legal process, but none had heard of a woman being permitted an induced abortion before the pregnancy reached full term. One midwife suggested: "The system makes it impossible for women to get an abortion, because when you realize you are pregnant, it will take too long before the legal process is finished and the baby is born before permission is given" (Midwife, woman, FGD). During the FGDs, discussions arouse on whether a girl, younger than 18 years old, is allowed an induced abortion. Some participants did the interpretation that sex with a person younger than 18 years old is defined as rape.

When posing the question whether induced abortion should be legalized, the HCPs reacted differently. On one hand, there were HCPs who argued that legalizing induced abortions would be against Rwanda's societal norms, and would ultimately "promote immorality instead of discipline and having principles" and would be "focusing on the wrong thing" (MD, man, IDI). On the other hand, there were HCPs who reflected that the current societal norms are posing barriers to preventive measures, and assumed that legalizing abortion could help to change these norms. An example raised was current obstacles for women's access and usage of contraceptives, in particular for unmarried women: "Many girls get pregnant because they are ashamed of asking for contraceptives" (Midwife, woman, FGD). During the same discussion, another midwife added: "Maybe legalizing abortion could give options to girls or women in difficult situations" (Midwife, woman, FGD). This suggestion got both backing and opposition.

Reluctance to be identified as an abortion provider

The HCPs illustrate a negotiation between personal attitudes, professional tasks and interpretation of the law. One midwife exemplifies a commonly stated reasoning: "The law prohibits abortions. As a midwife, I cannot break the law. However, even if the law would change, I could not agree with it, and would still give the same advice to the woman not to have it" (Midwife, woman, IDI). Yet, some described the necessity to subscribe to a professional obligation that comes before their personal values. One obstetrician offered: "If it was a regulation coming from the government, I would do it because I am a physician who works for the government. Nevertheless, as a Christian, I would still be against it." (MD, man, IDI).

HCPs expressed concerns about being associated with induced abortions among their colleagues. One midwife explained how frequent usage of misoprostol had led to negative workplace insinuations: "We had a physician who would sometimes ask for [misoprostol], and even if he needed it to provoke someone's contractions, people would start gossiping that he was going to perform an abortion" (Midwife, woman, FGD). At the time of the study, misoprostol seemed a rare find at health centers and documented in a guarded way. Misoprostol was described as forbidden for use at the community level, though it could be found available underground. These controversies and restrictions were perceived as problematic. Participants described misoprostol as an essential drug to induce labor or to treat postpartum bleeding. The widespread restrictions were questioned as unnecessary, and one general practitioner concluded there would be no more deaths due to induced abortions if community health workers could administer misoprostol. Some of the recently graduated physicians, in particular, problematized misoprostol as currently "criminalized" despite its essential necessity to counteract maternal morbidities.

In their communities, being a health care provider was viewed as a respectable job and associated with saving lives. If abortion would be legalized, this association could be threatened. One midwife offered: "If abortion is legal, it will be a problem. People will be, like, 'this one is a killer because she did abortion on mothers or girls'" (Midwife, woman, FGD). Neither was working with post-abortion care something the HCPs openly shared with members of the community. In the second phase of the interviews (done in 2016), some midwives and nurses had received the comprehensive post-abortion care training. They expressed how the training had updated their skills and made them feel comfortable in being assigned PAC tasks. Yet, they said they had not told anyone outside of work they had participated in such a training. All physicians interviewed expressed a concern that they had not received training in how to induce an abortion. This was raised as an ethical dilemma: "How are we expected to do this, when no one have taught us how to do it properly" (MD, man, FGD).

Dilemma of liability and litigation

There appeared to be a lack of consensus among the HCPs about the responsibilities involved if an illegal abortion was disclosed. Whereas the participants presented the need to keep the confidentiality of a patient as self-evident, it was still suggested that not all care providers shared that perspective. One physician reflected:

> You are not supposed to say anything about a woman having an abortion to the police. But some health care workers are scared of being arrested for hiding information or they are fearful of condemnation just because of their religious beliefs, and they anyway go ahead and report the woman to the police (MD, man, IDI).

Inadequate insurance of confidentiality was presented as something that could cause distrust in health care. Women were perceived as "careful with what they say because they do not know if a health care worker can keep the secret for them" (Midwife, man, IDI). The aspect of confidentiality seemed to hardly have been raised and discussed at the workplace. Only one younger physician explained how a clinical superior had informed that, "regardless of anything else, we must tell the police that she aborted voluntarily – if she did" (MD, man, IDI). This same physician reflected on conflicts to the medical ethics, especially the priority to always guarantee confidentiality of a patient.

Patients accused as responsible for an abortion was brought up during the discussions. The threat of police investigation made physicians cautious about what they wrote in their patients' medical chart, favoring the most neutral way possible to protect the woman. Induced abortions were therefore often labeled as either 'spontaneous' or as a 'threatened' abortion. The HCPs questioned the necessity of police's invasiveness, and one physician said: "One girl came in (to the clinic), already in handcuffs, for an examination to determine whether the abortion was spontaneous or not. This makes you question the system" (MD, man, FGD).

HCPs expressed a fear of criminal liability and risk of being falsely accused as responsible for an abortion, which caused them to hesitate when giving women advice. Both MDs and midwives

said it is best to inform a woman, who is seeking advice, to keep the pregnancy and inform them that abortion is both an illegal and punishable act. Still some revealed how they had acted clandestinely, explaining how they had assisted women to navigate the system to access an abortion – done under strictest secrecy: “You might face a spy or someone who might report you to the police. This means that it is something that is done but you cannot talk about it because you cannot trust those you tell.” (Nurse, woman, IDI). Another HCP said he had recommended a physician he knows to perform the procedure: “But I told her to not disclose to anyone that it was me who gave the advice to talk with that physician” (MD, man, IDI). Another physician explained – but only after the audio recorder was switched off – how he had helped a woman to abort. One physician expressed a sincere frustration in the current restriction: “Personally, I hate it. It should just be legalized and let each woman decide over their own body” (MD, man, IDI). Another physician questioned inequitable access for some women due to current inconsistencies:

> People may come to see you with huge amount of money and some physicians do not hesitate. It is done. And women who cannot afford it, they go to some other clinic, and then they come to us when there are complications. This is a big issue. (MD, man, IDI)

In line with this, one provider explained how he, while working extra hours at a private clinic, was faced with the dilemma of being asked by his boss to perform an abortion. He refused. The woman left the clinic but came back a few hours later with severe bleeding and claimed she had a motorcycle accident. The physician explained how his boss had scolded him by suggesting the young lady could have paid more money and the complications would have been reduced if he had agreed to give the abortion in the first place. However, the physician’s justification was clear: “I just did not want to risk any litigation.” (MD, man, FGD)

Discussion

This study unveils the ambiguities and dilemmas Rwanda’s maternal health care providers deal with when trying to compromise the amended law with personal values, professional duties, and the societal norms in Rwanda that strongly condemns abortion. An important finding is the inconsistent understanding of the current abortion law. This highlights that HCPs may rely on outdated regulations. At the same time, our findings strongly suggest that HCPs are questioning whether there is a functioning system in place to implement the law and allow for abortions. This has also been highlighted in a recent study from Rwanda (Hodoglugil et al., 2017) and by a local newspaper (Kwibuka, 2016). The newspaper article problematizes that court procedures have taken up to a year, failing to provide the help intended (Kwibuka, 2016). Importantly, the law was revisited and further liberalized in April 2019, now making it possible for girls below 18 year to terminate a pregnancy before week 22 (Taarifa 2019). With these additional amendments, yet evidence pointing at limitations in the system, improvement is needed to ensure girls and women are provided information and health services in line with the juridical changes.

Our findings demonstrate that abortion is a subject of controversy both in the clinical setting and the community, and that HCPs identify the consequences it brings on girl’s and women’s reproductive health. The HCPs supporting a decriminalization of abortion argue this as an important aspect in tearing down the present abortion stigma. Yet, previous research claim that decriminalization is not enough because stigma is deeply rooted in cultural or societal norms and moralization (Shellenberg et al., 2014; Norris et al., 2011; Kumar et al., 2009). It has been demonstrated in settings where restricted abortion laws have been liberalized, such as Ethiopia, South Africa and Zambia, that women still undergo unsafe abortions, partly due to the stigma and fear of social sanctions, yet also because of getting inappropriate information from the health care professionals (Coast and Murray, 2016; Singh et al., 2010; Jewkes et al., 2005).

Our findings point at a lack of professional consensus when consulting persons seeking advice or care for an unwanted pregnancy. The HCPs consult women differently depending on their personal values and interpretation of the law. This bring thoughts to the ‘Professional Code of Ethics’ as nurses and midwives have the right to “refuse to participate in activities contrary to his/her personal moral and professional convictions.” (Rwanda Ministry of Health 2009). This is an issue raised within reproductive health care, as the allowance for personal values among HCPs leads to an inequitable provision of care (Rehnström Loi et al., 2015; Fiala and Arthur, 2014). For physicians, the ethical guidelines do state that it is in their duty to provide abortion within the law (Rwanda Ministry of Health 2009), in line with what one of the participants said. Yet, the physicians in our study also claimed they lack proper training to implement this in practice. This argument of not possessing the skills needed may though be a cover up for their actual attitudes of not being willing to provide abortion services. Similar reasoning has been seen among nurses and midwives in other sub-Saharan countries (Rehnström Loi et al., 2015). The lack of skills cannot be an acceptable argument anymore, given the possibility of medical abortions, that can be carried out by midlevel providers and women themselves and are in line with WHOs recommendations (Klingberg-Allvin et al., 2015; Cleeve et al., 2016; Kim et al., 2019). Not only could such task-shifting significantly reduce current costs of PAC and diminish current work-load of health care providers in Rwanda (Vlassoff et al., 2015) – it may also facilitate for HCPs in their ethical dilemma seen in our findings. However, HCPs attitudes play an important role in the implementation of task-shifting (Kim et al., 2019). Additionally, our findings highlight the concern of stigma connected to the implementation and usage of Misoprostol in the clinical practice. The controversial status of Misoprostol is worthy of attention. This does not only have implications for abortion-related care, but also for the quality of maternal health care.

The concern of occupational stigma is a prominent finding among our participants. While being a HCP is explained to be a respectable work in the Rwandan society, an association with abortion could stigmatize their professional title. It is understandable that HCPs express concerns about this and may be hesitant to express support for abortion, also described from studies in Uganda (Cleeve et al., 2019). Stigmatization of abortion providers is a global phenomenon and abortion care is in many settings thought of as ‘dirty work’, and labeled as a demoralizing act (O’Donnell et al., 2011; Martin et al., 2014; Håkansson et al., 2018). In order to implement the law, efforts need to be put on several levels of the society to also ensure that HCPs are not stigmatized, as also noted in a recent publication from Rwanda (Hodoglugil et al., 2017).

The HCPs express fear of legal sanctions, which has an obvious impact on their clinical practice. There is particularly a dilemma in whether a woman who admits she has had an induced abortion is protected in the clinical setting. While our findings illustrate that HCPs aim for assuring patient confidentiality, one HCP pointed out that a supervisor had informed staff about the obligation to report known illegal abortion cases to the police. This is of uttermost concern and has been lifted in other studies from Rwanda, revealing that a subset of women were reported to the police by HCPs after seeking help for their complications after undergoing an unsafe abortion (Umuhoza et al., 2013; Kane, 2015). As also noted by the HCPs in this study, this put women in risk and create inequitable care. Recent studies from the neighboring countries have also pointed out the implications it has on the qual-

ity of care (Cleeve et al., 2019; Izugbara et al., 2015). Our findings indicate that HCPs also take precautionary measures so as to not face liability themselves. This was also seen in a recent study from Senegal, where HCPs obscured induced abortions in medical records so as to not later be held liable (Suh, 2014). This is problematic and jeopardizes the quality of care.

Methodological considerations

This study was composed of an interdisciplinary research team, including both Scandinavian and Rwandan members, which strengthened the work with insider and outsider perspectives (Bernard, 2006). The first author spent extended periods in the setting, conducting observations and interviews, and coordinating closely with the research assistant who was skilled at relaying our sensitive questions. The first author reflected continuously on her positionality as a foreigner, as well as how her background and preunderstanding may influence her interpretation of the setting. The first author and the research assistant had a tight collaboration and continuously discussed the thematic area of abortion and the data collected.

The translations and transcripts were validated through cross-checking by an external interpreter, and the findings member-checked for validation (Rwanda Ministry of Health 2012; ICF International 2015). There are a few limitations to this study: firstly, certain aspects related to HCPs occupation were not covered in the interviews, such as whether the 'payment-for-performance' scheme influences HCPs' motivations and priorities to abortion care. Secondly, the interviews did not cover historical aspects, which may impact on the viewpoint on abortion in this setting. This study was limited to focus on current legal reform and reflections, yet, future studies could benefit from an exploration on this.

Conclusion

The liberalized abortion law in Rwanda has yet to gain momentum among maternal health care providers. This study shed lights on the tensions confronting personal values against the procedure of induced abortion, as well as the dilemmas between professional duties and ethics, and the ambiguity of legal regulations. For these dilemmas to not challenge patients right for confidentiality and access to safe abortions within the legal framework, changes are required. For the amended law to be realized in practice, the need for clarity on professional guidelines on the issue of abortion care is evident, as well as a long-term strategy to tackle abortion stigma in the society.

Ethical approval

Approval to conduct this study was obtained from Rwanda National Health Research Committee, Kigali (NHRC/2012/PROT/0045).

Declaration of Competing Interest

The authors declare they have no competing interests.

CRediT authorship contribution statement

Jessica Påfs: Writing - review & editing, Formal analysis. **Stephen Rulisa:** Writing - review & editing, Formal analysis. **Marie Klingberg-Allvin:** Writing - review & editing, Formal analysis. **Pauline Binder-Finnema:** Writing - review & editing, Formal analysis. **Aimable Musafili:** Writing - review & editing, Formal analysis. **Birgitta Essén:** Writing - review & editing, Formal analysis.

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References

Aniteye, P., Mayhew, S.H, 2013. Shaping legal abortion provision in Ghana: using policy theory to understand provider-related obstacles to policy implementation. Heal. Res. Policy Syst 11, 23. doi:10.1186/1478-4505-11-23.

Bernard, H.R., 2006. Research Methods in Anthropology: Qualitative and Quantitative Approaches. Rowman Altamira, Oxford, UK.

Braun, V., Clarke, V., 2006. Using thematic analysis in psychology. Qual. Res. Psychol. 3, 77–101. http://eprints.uwe.ac.uk/11735/1/thematic_analysis_revised_-_final.doc.

Cleeve, A., Byamugisha, J., Gemzell-Danielsson, K., Mbona Tumwesigye, N., Atuhairwe, S., Faxelid, E., et al., 2016. Women's acceptability of misoprostol treatment for incomplete abortion by midwives and physicians - Secondary Outcome analysis from a randomized controlled equivalence trial at district level in Uganda. PLoS ONE 11, e0149172. doi:10.1371/journal.pone.0149172.

Cleeve, A., Nalwadda, G., Zadik, T., Sterner, K., Klingberg-Allvin, M, 2019. Morality versus duty – A qualitative study exploring midwives' perspectives on post-abortion care in Uganda. Midwifery 77, 71–77.

Coast, E., Murray, S.F., 2016. "These things are dangerous": understanding induced abortion trajectories in urban Zambia. Soc. Sci. Med. 153, 201–209. doi:10.1016/j.socscimed.2016.02.025.

Fiala, C., Arthur, J.H, 2014. "'Dishonourable disobedience"'—why refusal to treat in reproductive healthcare is not conscientious objection. Psychosom. Gynaecol. Obstet. 1, 12–23.

Håkansson, M., Oguttu, M., Gemzell-Danielsson, K., Makenzius, M, 2018. Human rights versus societal norms: a mixed methods study among healthcare providers on social stigma related to adolescent abortion and contraceptive use in Kisumu, Kenya. BMJ Glob. Heal. 3, e000608. doi:10.1136/bmjgh-2017-000608.

Hodoglugil, N.N.S., Ngabo, F., Ortega, J., Nyirazinyoye, L., Ngoga, E., Dushimeyezu, E., et al., 2017. Making abortion safer in Rwanda: operationalization of the penal code of 2012 to expand legal exemptions and challenges. African J. Reprod. Heal. March African J. Reprod. Heal. 21, 82–83. https://search-proquest-com.ezproxy.cul.columbia.edu/docview/1933250837/fulltextPDF/CBBCA17656E64C1BPQ/1?accountid=10226.

Izugbara, C.O., Egesa, C., Okelo, R., 2015. 'High profile health facilities can add to your trouble': women, stigma and un/safe abortion in Kenya. Soc. Sci. Med. 141, 9–18. doi:10.1016/j.socscimed.2015.07.019.

Jewkes, R.K., Gumede, T., Westaway, M.S., Dickson, K., Brown, H., Rees, H, 2005. Why are women still aborting outside designated facilities in metropolitan south Africa? BJOG An. Int. J. Obstet. Gynaecol. 112, 1236–1242. doi:10.1111/j.1471-0528.2005.00697.x.

Kane, G., 2015. When Abortion is a crime: Rwanda. Chapel Hill, NC https://www.ipas.org/resources/when-abortion-is-a-crime-rwanda.

Kim, C., Sorhaindo, A., Ganatra, B, 2019. WHO guidelines and the role of the physician in task sharing in safe abortion care. Best Pract. Res. Clin. Obstet. Gynaecol..

Klingberg-Allvin, M., Cleeve, A., Atuhairwe, S., Tumwesigye, N.M., Faxelid, E., Byamugisha, J., et al., 2015. Comparison of treatment of incomplete abortion with misoprostol by physicians and midwives at district level in Uganda: a randomised controlled equivalence trial. Lancet 385, 2392–2398. doi:10.1016/S0140-6736(14)61935-8.

Kumar, A., Hessini, L., Mitchell, E.M.H, 2009. Conceptualising abortion stigma. Cult. Health Sex 11, 625–639. doi:10.1080/13691050902842741.

Kwibuka, E., 2016. Penal code review to relax law on abortion. The New Times 8. http://www.newtimes.co.rw/section/article/2016-03-21/198191/.

Lincoln, Y.S., 1985. Guba EG. Naturalistic Inquiry. Sage, Beverly Hills, CA.

Martin, L.A., Debbink, M., Hassinger, J., Youatt, E., Harris, L.H, 2014. Abortion providers, stigma and professional quality of life. Contraception 90, 581–587. doi:10.1016/j.contraception.2014.07.011.

Musafili, A., Persson, L-A, Baribwira, C., Påfs, J., Mulindwa, P.A., Essén, B, 2017. Case review of perinatal deaths at hospitals in Kigali, Rwanda: perinatal audit with application of a three-delays analysis. BMC Pregnancy Childbirth 17.

National Institute of Statistic of Rwanda (NISR), Ministry of Health (MOH), ICF International. Rwanda Demographic and Health Survey 2014-2015. Rockville, Maryland USA: NISR, MOH, and ICF International; 2015.

Ngabo, F., Zoungrana, J., Faye, O., Rawlins, B., Rosen, H., Levine, R., et al., 2012. An Assessment of Health Facility and Community Readiness to Offer Postabortion Care Findings from a National Health Facility Survey in Rwanda. Baltimore, Maryland, USA.

Norris, A., Bessett, D., Steinberg, J.R., Kavanaugh, M.L., Zordo, S.D., Becker, D., 2011. Abortion stigma: a reconceptualization of constituents, causes, and consequences. Women's Heal Issues 21, 49–54.

O'Donnell, J., Weitz, T.A., Freedman, L.R, 2011. Resistance and vulnerability to stigmatization in abortion work. Soc. Sci. Med. 73, 1357–1364. doi:10.1016/j.socscimed.2011.08.019.

Onah, H.E., Ogbuokiri, C.M., Obi, S.N., Oguanuo, T.C, 2009. Knowledge, attitude and practice of private medical practitioners towards abortion and post abortion care in Enugu, south-eastern Nigeria. J. Obstet. Gynaecol. (Lahore) 29, 415–418.

Påfs, J., Musafili, A., Binder Finnema, P., Klingberg Allvin, M., Rulisa, S., Essén, B., 2015. "They would never receive you without a husband": paradoxical barriers to antenatal care scale-up in Rwanda. Midwifery doi:10.1016/j.midw.2015.09.010.

Påfs, J., Musafili, A., Binder-Finnema, P., Klingberg-Allvin, M., Rulisa, S., Essén, B, 2016a. Beyond the numbers of maternal near-miss in Rwanda – a qualitative study on women's perspectives on access and experiences of care in early and late stage of pregnancy. BMC Pregnancy Childbirth 16, 257. doi:10.1186/s12884-016-1051-4.

Påfs, J., Rulisa, S., Musafili, A., Essen, B., Binder-Finnema, P, 2016b. 'You try to play a role in her pregnancy' - a qualitative study on recent fathers' perspectives about childbearing and encounter with the maternal health system in Kigali, Rwanda. Glob. Health Action 9, 31482.

Rehnström Loi, U., Gemzell-Danielsson, K., Faxelid, E., Klingberg-Allvin, M, 2015. Health care providers' perceptions of and attitudes towards induced abortions in sub-saharan Africa and Southeast Asia: a systematic literature review of qualitative and quantitative data. BMC Public Health 15, 139. doi:10.1186/s12889-015-1502-2.

Republic of Rwanda, 2012. Rwanda Vision 2020. Revised in 2012. Kigali, Rwanda http://www.minecofin.gov.rw/fileadmin/General/Vision_2020/Vision-2020.pdf.

Republic of Rwanda. Ministry of Health, 2012. Annual Report 2011-2012. Kigali, Rwanda.

Republic of Rwanda. Organic Law N° 01/2012/OL of 02/05/2012, 2012. Organic Law Instituting the Penal Code. Kigali, Rwanda.

Republic of Rwanda: Ministry of Health, 2012. Family Planning Policy. Kigali, Rwanda.

Rwanda Ministry of Health, 2009. Professional Code of Ethics. Kigali, Rwanda.

Rwanda Ministry of Health, 2012. National Comprehensive Treatment Protocol for Postabortion Care Services. Kigali, Rwanda.

Shellenberg, K.M., Hessini, L., Levandowski, B a., 2014. Developing a scale to measure stigmatizing attitudes and beliefs about women who have abortions: results from ghana and zambia. Women Health 54, 599–616. doi:10.1080/03630242.2014.919982.

Singh, S., Fetters, T., Gebreselassie, H., Abdella, A., Gebrehiwot, Y., Kumbi, S., et al., 2010. The estimated incidence of induced abortion in Ethiopia, 2008. Int. Perspect. Sex Reprod. Health 36, 16–25. doi:10.1363/3601610.

Suh, S., 2014. Rewriting abortion: deploying medical records in jurisdictional negotiation over a forbidden practice in Senegal. Soc. Sci. Med. 108, 20–33. doi:10.1016/j.socscimed.2014.02.030.

Taarifa. Rwanda legalises abortion with conditions. 2019. https://taarifa.rw/2019/04/11/rwanda-legalises-abortion-with-conditions/.

Umuhoza, C., Oosters, B., van Reeuwijk, M., Vanwesenbeeck, I, 2013. Advocating for safe abortion in Rwanda: how young people and the personal stories of young women in prison brought about change. Reprod. Health Matters 21, 49–56. doi:10.1016/S0968-8080(13)41690-7.

Vlassoff, M., Musange, S.F., Kalisa, I.R., Ngabo, F., Sayinzoga, F., Singh, S., et al., 2015. The health system cost of post-abortion care in Rwanda. Health Policy Plan 30, 223–233. doi:10.1093/heapol/czu006.

Voetagbe G., Yellu N., Mills J., Mitchell E., Adu-amankwah A., Jehu-appiah K., et al. Midwifery tutors ' capacity and willingness to teach contraception, post-abortion care, and legal pregnancy termination in Ghana. 2010;:1–6.