PAA 2016: Abortion Section
Operationalization of Exemptions for Legal Abortion in the Rwandan Penal Code: Challenges of Translating Law and Policy into Practice
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Introduction
The Rwandan Ministry of Health (MOH) strategy for decreasing overall maternal deaths specifically includes the reduction of maternal mortality due to unsafe abortion. To that end, 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)(PC2012). Previously in Rwanda, the only type of abortion permitted was therapeutic abortion, when the continuation of a pregnancy threatened the life of the mother or unborn baby. Under the revised penal code, termination services are available for additional health indications based on medical determination. However, a court order is required to terminate pregnancies as a result of the crimes of rape, incest or forced marriage.

Concerted efforts by the MOH to operationalize the exemptions in the Penal Code have laid the foundation for potentially expanding the provision of high quality, safe abortion services for women and girls in Rwanda. While the success to-date represents progress, much work remains to be done and the process has not been without challenges. In examining our research findings and experience throughout the process, we have identified important and persistent barriers to accessing safe abortion services within the new legal framework and documented challenges in the transition from law on paper to actual provision of services supported by policy development, training of health care providers, and community sensitization.

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. Over the course of approximately two years, the process for operationalization of the PC2012 followed a framework that included a reiterative process of gathering quantitative and qualitative information and feeding it back to policy development activities along with a consultation process involving all concerned parties including representatives from the MOH, Ministry
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of Justice, and Rwanda National Police. Figure 1 outlines the major milestones and accomplishments for the Operationalization of the Exemptions for Abortion in the Penal Code of 2012.

Methods:
To facilitate operationalization of the revised penal code, we conducted health system research which included 3 components: training & orientation, community sensitization and prospective monitoring of service provision, and data collection. Prospective data collection and monitoring of service provision related to termination of pregnancy and gender based violence (GBV) management was conducted between August 2014 and December 2015 from the participating facilities in the eight initial sites. In addition, between April 2015 and December 2015, scale up monitoring and data collection was extended to six newly designated referral hospitals. The Obstetrics and Gynecology department of each hospital and affiliated the Isange One Stop Centers/GBV Centers (IOSCs)/GBV Centers served as points of entry for women seeking abortion related services.

We used all available programmatic data including issues raised during monitoring and evaluation visits to identify challenges and lessons learned. We also proposed solutions and highlighted areas for further action.

Results
Many challenges arose during our efforts to operationalize the exemptions in the penal code. Some due to lack of awareness of the exemptions on multiple fronts: health system, including providers, judicial system, including police and courts, and communities. Other issues stem from limited capacity among providers and a weak health system.

A lack of community awareness of the new exemptions in the Penal Code of 2012 means that many eligible women and girls resort to unsafe abortions or continue with an unwanted pregnancy. Even women who do request court orders for termination of pregnancy resulting from rape often come at an advanced stage of their pregnancy. In many cases, such evidence is difficult to gather. In the case of the perpetrator being a family member, a woman may not want to testify against her assailant, despite desperately wanting an abortion. Victims are also commonly asked to question their decision, creating delays in the court order. This has led to resignation and discouragement. For some women, they have resorted to acts of desperation, including suicidal tendencies.

Silence and stigma around rape and abortion inhibits communication between local health facilities, local courts, and district implementers. Meetings between local courts, administration, police, and health and GBV facilities have helped participants clarify specific issues to help women access services. Although more orientation and training is necessary, there is already a reduction in abortion stigma among hospital staff. Even so, some providers refused to provide abortion services due to personal beliefs. Pre-service counseling by midwives and nurses at hospitals now helps determine which women will continue to receive a termination or not, while previously very few nurses were qualified to provide counseling.
Eligibility for services is not well understood. For example, in Rwanda, pregnancies among minors are considered under the Penal Code as child defilement and should be treated as rape cases. It should be noted that many victims used IOSC/GBV centers as their first point of contact and most of the victims of sexual violence were minors. Only one minor was identified at the implementing sites who had obtained a safe abortion after experiencing rape, incest or forced marriage since July 2012.

Case example: A 14-year-old admitted to the facility with her mother. She was pregnant and she had a court order that the pregnancy was as a result of rape. According to the IOSC that received her: “She was raped by three robbers who came to her home... 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)

Findings from qualitative research point out the difficulties in getting court orders, particularly in the context of stigma and violence:

“[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

“Lack of evidences [is the major challenge to getting a court order]. Most of rape suspects are not punished due to lack of evidences. And then when released, they [perpetrators] usually abuse victims [further] and mock them [because they reported rape]. Victims get justice only when the suspects plead guilty. Otherwise getting evidences [to prove rape] is the biggest issue.” -- Health provider

Other issues related to facility capacity and missed opportunities for improved service provision also emerged. Mid-level providers have been contributed to service provision by providing counseling, psychosocial, legal, and follow-up services. However, they are not permitted to perform terminations which potentially limits access. Although the vast majority of clients receive post abortion family planning counseling, contraceptive uptake is low and most women leave the facility without a method.

**Conclusion**
The case for Rwanda is unique for demonstrating the commitment of the decision makers to move from law to its implementation through establishing policy guidelines and launching prace in a relatively short period of time to make abortion safer in the country. Though significant progress has been made, myriad challenges remain to fully translating policy into practice. Our examination of the evidence identifies several areas for further action in health and legal services. Some of these challenges
highlighted can be addressed by raising community awareness through the involvement of communities, civil society organizations, and stakeholders from all respective multi-sectorial institutions (health, legal, gender equality, police services). Others may require integration of services to close crucial gaps. For example, improved integration of health services could help ensure that clients receive contraception at the time of termination.

As the Ministry of Health expands the program to make abortion safer in Rwanda within the legal framework, addressing stigma and silence around rape and other forms of GBV should be a major objective. The requirement for a court order appears to be one of the main obstacles to women receiving terminations to which they are entitled under the legal framework.

Successes for implementation and efforts to address challenges should be advanced through the re-iterative process of monitoring, supervision, generation of evidence, and formulation of next steps based on evidence.