

Lived experience of healthcare professionals providing safe abortion in Rwanda

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ABSTRACT

BACKGROUND: Various countries have ratified the law declaring that safe abortion is a fundamental women's right. Rwanda has expanded legal grounds for abortion in Law n° 68/2018 of 30/08/2018, determining offenses and penalties in general. This study aimed to gain an in-depth understanding of how physicians, midwives and nurses perceive safe abortion service provision and their experience of providing the service in Rwanda.

METHODS: A qualitative, descriptive phenomenological method with transcendental theory devised by Husserl Edmund was used to guide this study. A non-random purposive sampling recruited twenty-three informants, and a semi-structured interview guide was used to collect data. The data analysis used NVivo pro 12 software to categorize and code ideas, while the eight steps of transcendental descriptive phenomenology were used to generate the final themes.

RESULTS: Four themes with ten sub-themes were generated: (1) personal feelings and beliefs (humiliation and stigma, guilty and wonder); (2) resilient mechanisms (Clients' protection, institutional support, appreciation of the law); (3) training and (4) informants' recommendations (integrated service, community awareness, psychological support, follow-up).

CONCLUSION: Healthcare providers' willingness to provide safe abortion services depend on the individual's beliefs about abortion. Professionalism and resilient mechanisms are key to sustaining the safe abortion service provision in addition to the law determining offenses and penalties in general in Rwanda.

Keywords: Lived Experiences, Health Professionals, Abortion, Safe Abortion, Rwanda.

INTRODUCTION

The world health organization (WHO) estimated that 22 million abortions are performed unsafely, resulting in the death of an estimated 47 000

women and many with complications [1]. The WHO defines abortion as the end of a pregnancy by removing or expelling an embryo or fetus before it can survive outside the uterus [2]. According to the Guttmacher Institute report,

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an estimated 56.3 million self-induced abortions occur each year worldwide, which puts women's lives in danger [3]. The same report notes that the global annual rate of abortion for all women of reproductive age between 15–44 is estimated to be 35 per 1,000, and this remained the same from 2010–2014. Among them, 26 per 1,000 are abortions for unmarried women. Furthermore, 3 out of 10 (29%) of all pregnancies, and 6 out of 10 (61%) of all unintended pregnancies, ended in self-induced abortions [4]. Chae, Desai, Crowell and Singh [5] note that among the cited 56.3 million abortions, low-and middle-income countries account for 86% of the total abortions and many of them are performed unsafely.

Although different countries have ratified numerous international charters and conventions, including the Universal Declaration of Human Rights of Women in Africa of 2003, also known as the Maputo Protocol, all countries are responsible for achieving sustainable development goals (SDGs), including the reduction of the global maternal mortality ratio to 70 per 100,000 live births by 2030. Unsafe abortion is one of the most common causes of maternal morbidity and mortality [7]. According to the WHO, 4.7–13.2% of maternal deaths are attributed to unsafe abortion, where the developing world accounts for 30 women for every 100 000 who die from unsafe abortions.

The proportion of unsafe abortions was significantly higher in developing countries than in developed countries (49.5% vs. 12.5%) [6]. Similarly, around 7 million women are admitted to hospitals every year in developing countries as a consequence from unsafe abortion [1]. The health risks of abortion depend on whether the procedure is performed safely or unsafely. This suggests that HCPs ensure patients have access to safe abortion services.

Since only medical doctors are permitted to perform and provide safe abortion-related services [2], literature notes that, nurses, and midwives have expanded in first-trimester care related to abortion provision [3]. The international confederation of midwives (ICM) position statement on midwives' provision of abortion-related services states that midwives are capable of providing the service [8]. However, although the mentioned HCPs are capable of providing the services, Aniteye and Mayhew [9] noted that different views are expressed; some said it is sinful and against their religions to provide this service, while others felt it

was a good way to save lives of women.

In Rwanda, despite the highly restrictive abortion law (penal code of 2012), legal barriers and cultural and religious stigma make it nearly impossible for women to get a safe abortion. This caused an estimated 60,000 women to self-induce as they were requested to seek a court order and ruling. Thus, an annual rate of 25 unsafe abortions per 1,000 women aged 15–44 was and is still recorded in Rwanda [7], and 40% of Rwandan women are subjected to complications related to self-induced abortions that require medical attention [7]. Yet women are likely to experience complications at different rates based on where they obtained the abortion service and who performed it. Thus, the country ratified the existing abortion law in Rwanda to allow women and young girls to access safe abortion services according to the set criteria [10]. The criteria include: (1) the person having abortion had become pregnant as a result of rape; (2) the person having abortion had become pregnant as a result of incest up to the second degree (3) the person having abortion had become pregnant after being subjected to a forced marriage; (4) the pregnant person is a child; and, (5) the pregnancy puts at risk the health of the pregnant person or of the fetus. This highlights the need for HCPs' readiness to help women and young girls. However, little is known about HCPs' experience in providing care related to safe abortions and the impact it has on their personal and professional values in the context of Rwanda. Studies have been conducted in Rwanda to explore the potential providers' perceptions of abortion services, but none have specifically looked at HCPs' experience in providing safe abortions in Rwanda. Thus, this qualitative study aimed to gain an in-depth understanding of the experience of providing safe abortion services from the perspective of HCPs (physicians, nurses and midwives) working in gynecological units responsible for safe abortion service provision from the selected hospitals of Rwanda.

METHODS

Study design: A qualitative descriptive phenomenological method with transcendental theory, devised by Husserl Edmund [11], was used in this study. Using descriptive phenomenology helped to understand the lived experience of midwives, nurses and physicians working in the gynecological unit involved in safe abortion

service provision in Rwanda.

This study was conducted across the five provinces of Rwanda. In total, eight district hospitals were selected according to the following criteria; all four based in Kigali were selected. However, only one district hospital from each of the rest of provinces was selected. Therefore, in the Eastern province, one cross border district hospital was selected based on the service provision to not only Rwandans but also others from the neighboring countries. In Western, a faith-based religious district hospital was selected. In Northern Province, a district hospital with multiple services and based in the rural area was considered, and in Southern Province, the hospital serving the highest number of patients and that receives transfers was selected.

Inclusion criteria included being a physician, nurse or midwife practicing safe abortion service provision and willing to participate in the study. Non-random purposeful sampling was used to identify and select informants. For phenomenological studies, Creswell recommends 5 to 25 informants in total [13]. This study targeted 24 informants, three per selected district hospitals (one midwife, one nurse and one physician). As lived experience may be very unique, the principal of data saturation as stipulated by Polit and Beck [12] was exempted.

Interview guide development: The research team developed an English semi-structured interview guide, which was translated to Kinyarwanda by an independent professional translator. Verification of the translated instrument was checked by the research team to confirm that the meaning and content had not changed. The questions focused on informants' feelings when they are asked to provide safe abortion services, and interpersonal relationships with colleagues who are not working in the gyneco-obstetrical unit or those who work in the gyneco-obstetrical unit but do not serve the purpose. They were also asked how comfortable they feel with the law and the ministerial order, challenges and strategies to overcome these, and how they overcome their personal beliefs while providing the services. Additionally, a structured demographic questionnaire noted the informants' age, gender, religion, and professional qualification. Further, they were asked if they had received special training on safe abortion service provision.

Data collection procedure: Researchers conducted informants recruitment and data collection. The team also considered gender equality. They were knowledgeable about gender and maternal health issues. At each study site, the research team asked to meet the informants in a safe and private area for an introduction and explanation of the study's purpose and procedure. The informants were provided with a letter of information. Researchers respected the rules of preventing COVID-19 which included, but were not limited to, sitting with one meter between a person to another and used the approach of one-on-one interviews. The rules of confidentiality and anonymity were ensured using codes instead of names. For all interviewed informants, the maximum interview time was one hour, and the minimum was 45 minutes. Interviews were in Kinyarwanda.

Approaches for rigor: The trustworthiness (credibility, transferability, dependability and confirmability) of this study followed the criteria of Lincoln and Guba [14].

Data analysis: Data analysis used NVivo pro version 12 software to organize and categorize data based on the informants' ideas. Consequently, eight steps of transcendental-phenomenological reduction devised by Husserl [11,15] guided the process of arriving at the final themes. In this study, the themes were explained using quotes as textual language as informants shared their lived experiences of providing safe abortion services in Rwanda (Table 1).

This study was approved by the University of Rwanda, College of Medicine and Health Sciences/ Institutional Review Board (CMHS-IRB: No 308/CMHS IRB/2021).

RESULTS

Demographic characteristics

A total of twenty-three physicians, nurses and midwives who work at the selected eight district hospitals took part in this study. Demographic results note that the mean age of informants was thirty-four years old, the youngest was twenty-five and the oldest was fifty-one. Many had an advanced diploma (n=13), while only two had master's degrees. The majority of them work in urban institutions (n=14). In terms of qualification level, Midwives were many (n=10) compared to gynecologists and obstetricians (n=4), general

practitioners (n=4) and nurses (n=5). Half of the participants were catholic by religion (n=12), 6 Anglicans, 4 Adventists and one Pentecostal and more than a half (n=18) had the experience of providing safe abortion services of less than or equal to two years. Half of them (n=13) had no training about safe abortion, while some of them (n=8) were trained once. Only one participant had safe abortion-related training three times.

As seen in Table 1, lived experiences of midwives, nurses and physicians involved in the provision of safe abortion services were themed and sub-themed into:

Theme One: Personal feelings and beliefs

Informants revealed their feelings about social norms and beliefs with regards to safe abortion services provision and how their colleagues consider them:

Humiliation and stigma: Humiliation and stigma by the HCP's peers and sometimes by members of the community were notified. *"Sometimes we are humiliated because it is a termination of pregnancy; secondly, they stigmatize us saying that we lost our culture and identity,"* 'the community considers us as murderers' No 4. Personal beliefs play a vital role the denial of the service. *"... when I am not on day duty, they tell clients to wait for me until I come back"* No 11. As they are considered criminals, this promotes stigma. *"Those who do*

not work in this service treat us as killers or like criminals. Also, "They consider it a crime" No. 8 and 1, respectively.

Feelings of guilt and wonder: Feeling guilty was prevalent *"...at the beginning, I felt guilty of murder. I was guilty that I helped someone to murder her own child"* No 9. Also, *"It is hard for me to see the result from ultrasound noting that there are cardiac activities; I immediately wonder how I will feel after inducing and receiving the products with activities..."* No. 15.

Theme Two: Resilient mechanisms

Informants stipulate that though they had different beliefs while providing safe abortion services, they came up with strategies to overcome these beliefs.

Clients protection: Thinking of clients' benefits first was the cornerstone of being able to overcome their emotions and beliefs. *"I live a normal life because I am licensed to help people that I care for and respond to their needs. This helps me to go beyond my emotions"* No 6. Another motivating reason was the fact that clients may opt to perform self-induced abortions that may result in infections and deaths. *"...depending on what I used to see here, especially infections and deaths related to self-induced abortions, we have rooms to go beyond our beliefs and provide the services for the clients 'benefits"* No 11. Finally, professionalism helps the participants to be resilient as well. *"As I said, our profession is not just a job; instead, it is*

Lived experiences of midwives, nurses and physicians involved in the provision of safe abortion services

Themes	Sub-themes
Personal feeling and beliefs	Humiliation and stigma Guilty and wonder
Resilient Mechanisms	Clients protection Institutional support Appreciation of the law
Training	
Participants recommendation	Integrated services (Service like others) Community awareness Psychological support Follow up

a vocation; this gives me strengths to help clients” No 5.

Institutional support: Informants appreciated the hospital's support in the service provision. *“The hospital provides us with equipment such as MVA kits, gels, and the medicines we need. No any other extra help”* No 13. In addition to the hospital support, Informants expressed their appreciation toward the Rwanda Society of Obstetricians and Gynecologists (RSOG) for their support regarding the training about service provision; *“Apart from the hospital support, another help is from the RSOG’s team who come to explain to us how we can do this”* No 18, 21.

Appreciation of the law: All Informants appreciated the law and Ministerial order. *“I think this law came at the right time because clients were doing it the wrong way, causing deaths in the community. Now, those who are informed about the law come to request the service. I am sure that deaths related to self-induced abortions are reduced”* No 21. Informant No 14 revealed that; *“this law has come to solve these problems because now it is being done by educated people and done in good condition. I am confident that this will reduce self-induced abortions related deaths. Thank you”*. Additionally, informant No. 20 expressed that it was not easy for them to provide abortion services. However, as the law determining offenses and penalties, in general, is there, they provide safe abortion services. *“At the beginning, it was a challenge to us, but because there is an existing law and has a clear meaning, we really do”*. No. 20

Theme Three: Training

Informants revealed that many of their colleagues do not know how safe abortion services are provided. *“Those who do not work in this service do not understand it, others’ beliefs continue to dominate their understandings and there is a need to inform them”* No 2. Another participant stipulated the limitation of the training. *“The first obstacle is that we are not trained enough; only in-service self-training by our colleagues. The team is still small; when one of us is off or busy with another assignment, the client does not receive support saying that they are not trained”* No 1. *“Training should continue and reach other HCPs, which can help them to understand better about new protocols, because this service is currently needed.”* No 16.

Theme Four: Participants' recommendations

Integrated service: Informants proposed integrating this service into other existing hospital services to increase coordination; *“After the government ratified the law that allows girls or women to have abortions, we have many clients here who come to seek abortion services. When the service is integrated, no one can refuse to provide it, and the client confidently goes back happy”* No 14.

Community awareness: The community's lack of awareness hinders the service's access; *“Perhaps another obstacle is that this is a new medical service, and the general public does not understand it well. Anyone who seeks this service may feel embarrassed if it is known in her community. So, the community should be informed about this”*. No 15. Also, *“Community awareness is needed to support the victims”* No 9. *“The community is not informed about the law, and they consider us murderers”*. No 15. Also, *“The families, in general, do not have enough information and sometimes are embarrassed to help or accompany the person who seeks the service”* No 16.

Psychological support: Informants revealed the need for psychological support to the HCPs who provide this service. *“... we need psychological support, and protect us from stigma”* No 9. They further expressed their feelings about women and young girls' psychological support and stated that, *“In fact, when the law started to be used, it helped people, especially those who seek abortion services but their psychological support is still low, and that requires more educational sciences to prevent culpability and for the providers as well”* No 8. This agrees with the following participant; *“...the main reason I am saying this is that we have experienced a kind of trauma where a friend of mine who helped a woman to abort, when the embryo came, he started resuscitating, forgetting that the main reason was to terminate her. So, she started calling for help and ran away; she went through three days of trauma. That is why there is a need to strengthen women and young girls’ psychological support and HCPs as well”* No. 6.

Follow up: In line with informants' recommendations, creating hope among clients who have undergone safe abortions is needed as having a safe abortion is not the end of life. *“I also feel that this person needs a follow-up to show her that a better future is waiting for her”*

No 16. Women and young girls' empowerment is paramount to help them believe in themselves after having a safe abortion. *"...the only problem I have is that those young girls quit their schools and probably no one to help them to restore their identity"* No. 11.

DISCUSSION

When healthcare providers are trained and equipped with the necessary knowledge and skills, they can effectively deliver the services, including one safe abortion. Many of the challenges of the safe abortion service provision notified in the present study results are similar to the other findings. Literature notes the strong influence of HCPs over safe abortion service provision where many believed that they cannot at least provide this service due to their personal beliefs and can impede the access of the service among users [16]. Our findings also note that HCPs feelings of guilt and wonder, as well as personal beliefs, are not far from what was observed in other studies. This includes the conscientious objections that raise multiple contradictory issues and consequently affect access to services as well [17]. These findings are consistent with those of Glenton and colleagues, where the authors highlighted that people's attitudes towards abortion are likely to be influenced by their moral or religious beliefs, their views and experiences regarding woman's roles and women's rights, and their views of the rights of women and the fetus. The results of the present study agree with the findings of Pafs and colleagues [16] on HCP's testimonies of violating social norms and beliefs when it comes to the safe abortion service provision. HCP's who are not involved in safe abortion services provision view their colleagues as murderers who lack values [18,19]. Similarly, Cleeve and colleagues [20] reveal that different societies perceive safe abortions as an evil and barbaric act, which is consistent with the present study's findings. Rehnstrom Loi et al. [21] emphasize the effect of values and societal norms as a crucial parameter to consider for the provision of safe abortion in other literature [9]. Our findings note the resilient mechanism, which is motivated by the fact that HCPs are licensed to practice and save lives of individuals. Consequently, the high number of unsafe abortions in Rwanda which cost lives of women and girls increased HCPs professionalism in relation to safe abortion

provision to those fulfilling criteria. However, those who desire to provide the service face kinds of humiliation and stigma.

The concern of stigma and humiliation is the most noticeable finding in this study. Given that some HCPs humiliate and stigmatize their counterparts, it is understandable that for some providers, providing the service is not an option. This attitude of stigmatizing and humiliating HCPs who provide safe abortion services was also revealed in the literature [8]. There is also a broader literature on the stigma, criminal consideration and unwillingness of some HCPs to provide these services because of a range of personal, social and structural reasons which may further limit the availability of the service [4,22,23]. Nevertheless, most HCPs agree that the lives of those who are denied the service face poor health outcomes in the future [9]. In this study, participants explicitly indicated that whenever they think of the complications of unsafe abortion, they immediately feel encouraged to help those who come for the service, despite the stigma. The desire to protect the client from the complications of an unsafe abortion is a source of resilience the providers utilize. Building new and stronger ties with people you care about and the communities is a strong mechanism promoting resilience to a certain crisis [24]. Managing a critical service like safe abortion requires stable emotions and the ability to ensure the service can be provided by a colleague in case personal beliefs dominate [25]. Subsequently, the findings from this study reveal different facilitators that helped the study informants to be resilient; among others, the law and ministerial order. Law and Ministerial order for safe abortion in Rwanda. Rwanda has reviewed and rectified the abortion law determining offenses and penalties in general (and the Ministerial Order No.002/MoH/2019 of 8 April 2019 [10]). Article 9 on access to abortion services recommends that a HCP be ready to provide safe and comprehensive abortion services when clients fit in a list of five criteria. Literature notes the usefulness of the law if it is clear and understood by those using it [7,26]. Our findings note that HCPs who have been informed about the law and the Ministerial order and who are trained to provide the service, have advanced knowledge and skills in providing safe abortion. The study findings highlight among the informant's recommendations that although the

law and ministerial order are in place, they reveal the lack of awareness among women and young girls as beneficiaries, the community and other HCPs who are not providing the service. Therefore, the lack of awareness among HCPs who are not providing the service may play a vital role in the shortage of staff who are able to provide this service. Literature noted many barriers related to the shortage of staff and highlights the limitation of access to safe abortion services among people who need them [27]. The present study's findings reported an overload of tasks among HCPs who provide the service as they also serve other services. Similarly, the literature points out the lack of HCPs trained on safe abortion services as a solid barrier to accessing the service [4].

Training regarding safe abortion service provision was also pointed out as something needed to enhance abortion service provision among HCPs and service users. The experience of a health development initiative (HDI)'s training conducted in August 2020 about rights pertaining to safe abortion in medical students revealed that participants ended with a greater understanding of the need for the service [28]. The fact that HCPs are trained to provide services, they feel empowered to serve such services. Thus, the study findings suggest that the literature suggests strengthening service provision to include training, counseling related to safe abortion [29], and emotional support among HCPs and service users [4] as the study findings suggest.

The study population was only those HCPs who deliver the service of safe abortion. There is a need for a study that assesses the knowledge and attitude of all HCPs towards safe abortion provision. This study was based on a qualitative descriptive phenomenology design that involves only a small sample size. Hence there is a need for a quantitative study that will use a large sample size.

The effective delivery of safe abortion services will depend not only on HCPs but also on the beneficiaries of this service. Thus, since this study was conducted on HCPs only, there is a need to study the lived experience of beneficiaries seeking safe abortion services.

Assessing community awareness, perception and attitude towards safe abortion service delivery is also needed to strengthen the service.

CONCLUSION

It is inescapable that achieving a better outcome for safe abortion services requires not only the existence of a law permitting it but also the positive experience of those who provide the service. This study aimed to examine the lived experience of healthcare professionals providing safe abortion services in Rwanda. The study results revealed that the law in place helps them provide the service and the ministerial order related to safe abortion service provision in Rwanda; however, they also reported feelings of humiliation and stigma. Feeling guilty and wondering about providing safe abortion was seen as related to personal beliefs, which suggest professional collaboration among colleagues to be able to save lives. Resilience and professionalism are tied to what HCPs are called to provide, while training and institutional supports are the predictors of effective service provision. Psychological support for both service users and the providers for the best service delivery in terms of safe abortion and patients' satisfaction to promote positive mental health outcomes is needed.

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