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ORIGINAL RESEARCH

The Non-Legal Barriers Experienced Among Adolescent Girls and Young Women in Selected Districts of Rwanda Seeking Safe Abortion Services

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Video abstract

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Background: Despite the legalization of abortion in different sub-Saharan countries, adolescent girls and young women still face barriers while seeking safe abortion services, and Rwanda's adolescent girls and young women are no exception. The present study aims to explore the non-legal barriers and lived experiences of adolescent girls and young women who sought safe abortion services in selected districts in Rwanda.

Methods: Twenty-four In-depth interviews and four focus group discussions were conducted with adolescent girls and young women who had sought safe abortion services in different healthcare facilities in Rwanda, and with other stakeholders. Recruitment of participants was aided by the sexual reproductive health officer at each healthcare facility. Data analysis followed a thematic analysis approach.

Results: The non-legal barriers were mainly the unavailability of safe abortion services, perceived lack of awareness, misinformation about these services, the cost, stigma, and perceived negative influence from parents and peers.

Conclusion: The study was the first one to explore specific non-legal barriers to accessing safe abortion in Rwanda. Study findings indicate that although safe abortion services were made legal under certain circumstances in Rwanda, adolescent girls and young women still face several barriers that hinder them from accessing these services. This shapes their lived experience negatively while seeking these services. The findings can be used by civil societies to redirect their interventions in easing the accessibility of safe abortion services and by policymakers to redesign policies that can be put in practice to ensure improvement of the services given for the progressive development of reproductive health among adolescent girls and young women in Rwanda.

Keywords: abortion, females, female adolescents, life experiences, lived experiences, non-legal barriers, reproductive health services, rwanda, youth

Introduction

According to the WHO, 60% of the 121 million unintended pregnancies that occur globally end in abortion,[1] In Africa, it is estimated that 13% of all pregnancies end in induced abortion, of which 97% are unsafe.[2] Of the 98% unsafe abortions that occur annually, 41% are among adolescent girls and women aged between 15–25 years.[3] The World Health Organization defines unsafe abortion as a procedure for terminating an unintended pregnancy carried out either by persons lacking the necessary skills or in an environment that does not conform to minimal medical standards, or both.[4]

Safe abortion accessibility's legal environment is generally becoming liberal by day, with many Western countries allowing safe abortions up to 12 weeks of gestation.[5] However, the regulation of voluntary safe abortion is different in various states based on their local legislation. In the United States, some states, like Alabama, Arkansas, and others, have banned abortion services regardless of the cause of pregnancy.[6]

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Several countries in sub-Saharan Africa, such as South Africa, Mozambique, Ethiopia, Kenya, Burkina-Faso, Rwanda, Chad, and others have over time legalized Abortion under strict conditions.[7] Rwanda, in particular has legalized abortion under certain circumstances, where abortion is given to women with pregnancies resulting from rape, incest, forced marriage, or if the pregnancy poses a health risk to the woman or fetus.[8,9] Additionally, the abortion is done at district hospitals, by a doctor or a trained midwife, and is only done if the pregnancy is between 3 and 22 weeks of gestation, and exceptions are only made if the pregnancy has health implications to the mother.[10]

However, report findings of a study done in Sub-Saharan Africa about Safe abortion by Guttmacher show that legality does not guarantee safety, availability, and access to quality abortion services, respectively.[2,11,12] These findings are similar to previous studies, like those done in Nepal, that indicated high unsafe abortion complications despite liberal abortion laws.[5] Women seeking safe abortion services in Africa still face several barriers, which range from cultural to religious barriers, the stigma attached to abortion, and service accessibility.[13,14] A study conducted in South Africa highlighted the mistreatment women who sought safe abortion faced from service providers, and how this channeled most women to seek unsafe abortion.[15] Similarly, a study done in Kenya, Kisumu, reported negative experiences that women seeking safe abortion faced, which were more related to the fact that the decision to have a safe abortion was made by their partners, sometimes against their consent.[16] The difficulties and barriers in accessing safe abortion lead adolescent girls and young women to seek unsafe or self-induced abortions, which may lead to a range of different complications, from psychosocial challenges to reproductive health challenges and death.[17,18] A systematic review conducted in Sub-Saharan Africa by Yasaman et al investigated the psychosocial experience of women seeking safe abortion and reported that most women experienced anxiety, stress, and social isolation.[17]

Although Rwanda has made significant progress in improving accessibility to sexual reproductive health, and specifically in providing a legal framework guiding safe abortion accessibility, the utilization and obtainability of these safe abortion services remain a challenge, preventing women, especially adolescent girls and young women, from achieving optimal reproductive health.[8,19] In Rwanda, safe abortion is legally provided in 5 instances, which are: Rape, Incest, a minor, Id the pregnancy resulted from a forced marriage, or if it risks the health of the mother or fetus.[20] Safe abortion services are given in referral hospitals, district hospitals, and medical health centers, which hinders accessibility to women far from these facilities.[21] The majority of Rwanda's population is cultural and religious, with Christianity still the dominant religion, practiced by 93% of the population (44% being Catholic, 38% Protestant, and 12% Adventist). Still, those of the muslim faith remain a minority of 2%. Only 0.4% of the population reports having no religion.[22] Religious beliefs like Christianity, Catholicism, and muslim condemn abortion, which adds to the cultural stigma faced by adolescent girls and women seeking safe abortion. Previous studies have indicated the barriers of these two factors to safe abortion accessibility.[23] However, these barriers and other non-legal barriers lack documented studies done in Rwanda delving into them, and the experiences of adolescent girls and young women who sought or are seeking safe abortion in this country.[8] Therefore, the aim of this study was to investigate other barriers, other than legal challenges, and the lived experiences of adolescent girls and young females who sought or were seeking legal and safe abortion care in different facilities in Rwanda.[20] The findings from this research provided information, valuable to various stakeholders and policymakers in making evidence-based interventions while improving the accessibility and utilization of safe abortion services, and care to adolescent girls and women seeking or given safe abortion services in Rwanda.[20]

This is the first study in Rwanda assessing the non-legal barriers and lived experiences of individuals seeking safe abortions, so the findings can be used by different stakeholders in making safe abortion services more accessible and more effective. The information from this study will be used in contributing to Good Health and Well-being (Sustainable Development Goals 3) by ensuring that adolescent girls and women are given accessible safe abortion services when in need hence leading to healthy lives and well-being. Additionally, the study findings will also contribute to the development of Gender quality (SDG 5) by addressing barriers to accessibility of safe abortion services, hence empowering adolescent girls and women which promotes Gender equality.

Methods

Study Design and Setting

The study employed a phenomenological research design and was conducted in 4 districts of Rwanda, namely Kicukiro and Nyarugenge districts from Kigali City, then Gatsibo and Nyagatare districts located in the Eastern province of

Rwanda. The selection of these districts followed the 2018 data which reported their soaring number of teen pregnancies.[20] Nyagatare recorded 1465 teen pregnancies, and Gatsibo had 1452 teen pregnancies.[24] District hospitals in these districts were selected since, at the time of data collection, safe abortion was only provided from these facilities. Moreover, as suggested by Galvin,[25] having a sample size from diversified areas of Rwanda (eg, urban and rural) was expected to provide us with a variety of insights regarding the lived experience of adolescents and young adults who sought safe abortion.

Study Population and Selection Criteria

A purposive sampling method was used in recruiting participants; the study included adolescents and young adults aged 10 to 24 who had sought safe abortion services and consented to participate. For those under 18, parental permission and participant assent were required. Based on data saturation, 66 participants participated in the study. This included a total of 24 in-depth interviews involving adolescents and young women, as well as 32 participants in four focus group discussions (FGDs).[20] The focus group discussions included one composed of participant guardians/parents whose children sought safe abortion, one with community leaders, one with religious leaders, and another one with teachers.[20] Additionally, to ensure triangulation, ten key informant interviews (KII) with healthcare service providers,[20] etc, were conducted to understand the non-legal challenges faced by adolescent girls and women who sought or are currently seeking safe abortion.[20]

Data Collection Tools

Data was collected using interview guides, which were conducted through in-depth interviews and focus group discussions. The interview guides collected information regarding the available safe abortion services in health facilities, the different challenges adolescent girls and women face while seeking safe abortion services, and the influence of peers and family towards safe abortion accessibility and utilization. Some of the questions asked were the experience of the participant when they were seeking safe abortion services, the social stigma attached to abortion in their respective community, the kind of support provided by their families and peers before and after the safe abortion, and others (Interview guides: Supplementary Material 1). The socioecological model famerwork guided the thematic development of In-depth interviews and Focus group discussions.[20,26] The socio-ecological model explains different levels of influence from individual, interpersonal, organizational, community, and policy factors.[27] Through these different factors, the model allowed researchers to explore the different intersecting levels of influence that shaped the experiences and accessibility of safe abortion services by adolescents.[20] The framework also explored the non-legal barriers and lived experiences of the participants while they were seeking safe abortion, or for the service providers while they were providing safe abortion services.[20] Health Development Initiative's research department staff who were trained in research methods, cultural sensitivity, and data handling, are the ones who conducted the interviews.[20]

Data Collection Procedure

The research team visited selected health centers and requested that data be collected from the facility, and further requested assistance from the sexual reproductive health officer, who is the focal person for adolescent girls and women who come to the facility seeking any sexual reproductive services, including safe abortion services, and follows up on them while providing them with sexual health education. The sexual reproductive health officer then contacted eligible members and informed them about the study, and those who accepted came to the facility where they found research assistants. The Research assistants were stationed at different private areas around the healthcare facilities; however, these stations were liable to change, should the participant not feel comfortable or private. Participants were directed by the healthcare officer to where the research assistant was, and those who showed interest in participating in the study after a brief introduction of the study was given to them, were enrolled. The research assistant provided further explanations about the study and sought written consent before the start of the interview. For minors under 18 years, consent was first sought from their legal guardians, and for those who consented, an assent was sought from the minors after detailing the study objectives, benefits, and any involved risks. Minors/Children were privately interviewed in the absence of their legal guardians or anyone else to avoid breach of confidentiality. Participants who were not comfortable with the designated areas suggested more convenient areas where the interview could be conducted.

In-depth interviews and Key Informant interviews were conducted by three research assistants per interview, with each interview taking one hour. In addition to audio recording during interviews, notes were taken by the research assistants. Focus group discussions were conducted by two research assistants in private areas around the facility. Two research assistants facilitated and recorded audios during the interviews to ensure exhaustive data collection from members of the group, and one research assistant took notes. Interviews were conducted until there were no new responses from participants(saturation). Notes taken from In-depth interviews, key informant interviews, and Focus group discussions were all used in data analysis. The data collection spanned 21 days from the 15th of May to the 5th of June 2024.[20]

Quality Assurance

The research assistants who collected data were well-trained before the start of the study. The training intended to give data collectors a clear understanding of the research, its objectives, and proper data collection skills and interview guide administration.[20] The training also focused on ensuring that data collectors fully understood the data collection and management processes and became proficient in administering the study interview guide. The training content included a concept on qualitative data, tools used in qualitative data, and skills needed for conducting effective in-depth, key informant, and focus group discussion interviews. To assess how understandable, how correct, and how long the data collection tool would take, it was pilot tested in the study district.[20] COREQ (consolidated criteria for reporting qualitative research) guidelines (Supplementary Table 1) were used to report the qualitative data.[28]

Data Cleaning and Analysis

Interviews and Focus group discussions were transcribed word by word in Kinyarwanda and thereafter translated into English. The resulting transcripts were then analysed through thematic analysis.[20,29] Following translation, an initial coding framework was developed using the interview guide, existing studies, and the initial round of coding. For each code, an operational definition was given, and based on this framework, the transcripts were coded using Nvivo 14.0, with several sub-codes emerging as analysis progressed.[20]

Interviews were coded by a team of four coders who maintained a collaborative log to document to resolve any queries. Reassessment of codes was done based on the newly emerging themes, literature, and the objectives of the study. Related codes were grouped into broader macro codes, which were then compared with the data to generate final themes. Verbatim quotes were used to present the results and interpret each theme.[20]

Ethical Consideration

The current study adheres to the ethical principles outlined in the Declaration of Helsinki. The ethical approval was obtained from the Rwanda's National Ethics Committee (RNEC-73/2024). The district and facility's leadership were formerly told about the study and requested permission before enrolling adolescent girls and young women for the study. A personal written consent form was obtained from each participant prior to the start of data collection. For participants younger than 18 years, Consent was sought from their parents, after which assent was also sought from each participant. The consent process included permission for the use of anonymized responses and direct quotes in publication. Finally, those who consented were included in the study. No personal data was collected.

Results

Participants' Demographics

A total of 24 adolescent girls and young women and 10 Key informants participated in the study. The majority of adolescent girls and young women were 18 years and above, single and unemployed; only a small number were students. A large number of Key informants were women aged above 18 years. Table 1 shows the social demographics of in-depth interview participants. Table 2 shows the social demographics of Key-informant interview participants. Table 3 shows the themes and sub-themes that represent the study's findings.

The analysis resulted in two major themes, which were (i) Service availability and accessibility, and ii) Interpersonal and social factors. The results are presented according to the mentioned categories.

Table 1 Demographics for Participants in the In-Depth Interview

Respondent Demographics	Frequency (n=24)
Age	
<=18	5
>18	19
Marital Status	
Single	22
Married	1
Divorced	1
Employment Status	
Unemployed	9
Student	5
Hawker	4
Sex Worker	2
Works in Saloon	1
Peasant	1
Farmer	1
Bartender	1
District	
Nyarugenge	11
Gatsibo	5
Nyagatare	4
Kicukiro	3
Nyamasheke	1

Table 2 KIIs Demographics

Socio-Demographics of Participants (All KIs were >18 years	Frequency (n=12)
Age	
>18	12
Gender	
Female	7
Male	5

(*Continued*)

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Table 2 (Continued).

Socio-Demographics of Participants (All KIs were >18 years	Frequency (n=12)
Employment status	
Small-scale trader	1
Farmer	1
Midwife	1
Forensic medicine specialist	1
SRHR Officer	1
GBV Officer	1
Nurse	1
Coordinator of the Poor Women's Development Network	1
Gynecologist	1
Clinical Psychologist	1
Pastor	1
Medical doctor	1
Districts	
Gasabo	2
Gatsibo	1
Kicukiro	1
Nyagatare	4
Nyarugenge	4

Table 3 An Overview of the Study Theme and Sub-Themes

Themes	Sub-Themes
Perceived service availability and accessibility	Perceived unavailability of safe abortion services in the proximity
	Perceived limited awareness and misinformation of safe abortion services
	Perceived negative medical practitioner's perceptions, beliefs, and attitudes
Perceived interpersonal and social factors	Perceived lack of professional and inter-personal confidentiality
	Perceived negative parental, guardians, and peer influence
	Perceived fear of health complications and stigma
	Perceived stigma and negative community beliefs. (stigma included Self-stigma, Community level, School environment, Family level, and Hospital environment stigma)
	Perceived high financial cost of safe abortion costs

Theme 1: Service Availability and Accessibility

The availability and ease of accessibility of services shaped the lived experience and the barriers adolescent girls and young women faced while seeking safe abortion services.

Sub-Theme 1: Inadequate Tools and Unavailability of Safe Abortion Services in the Proximity

Most participants reported the unavailability and lack of reliable tools or service providers for safe abortion services at the healthcare facilities in the proximity. This imposed burdensome transport fees and time, and hindered legal and safe abortion care accessibility.[20]

> They told me that they were going to use a machine to remove the remaining contents. After some time, the doctor told me that the machines had a problem and told me that there was another way they were going to use to remove what was remaining, but that I would not be able to give birth again. Fortunately, the remaining things came out suddenly, said a 30-year-old participant from Nyarugenge.

> When I arrived at the hospital…I approached one of the doctors and waited for her assistance, but she was too busy for me. Then I sought help from other doctors, and they directed me to the same person, but she advised me to seek assistance elsewhere. This led to a significant waste of time, and despite my efforts that day, I received no help at all, reported a 20-year-old woman from Kigali.

> …the transportation costs from my home to the hospital, a journey that took around two hours every day. If we talk about just the cost of transportation, it was about 50,000 rwf, Said a 17-year-old from Nyagatare.

This troubling situation emphasizes the critical need for safe, dependable, and accessible abortion services to avoid health complications and ensure comprehensive care for all women.[20]

Furthermore, post-abortion care, specifically antibiotics and counselling, should be given right after abortion. However, in some instances, service providers dismiss adolescent and young women's needs and instructs them to manage their own issues, which reflects limitations in abortion care services in some facilities.

> I was not given any advice, rather the doctor told us that if you have started bleeding then you can go home, as he had a lot of patients waiting to see him, reported a 25-year-old participant, Nyagatare.

> Take care of yourself like a woman who has just given birth and have nutritious meals and soup so that your life can return to normal, reported a 24-year-old Nyamirambo participant receiving safe abortion care in a maternity ward.

The reported quotation represents the poor counselling given after abortion, which indicates that the participant was uncomfortable with what she was told, instead of advice about how she would recover her mental and physical health post abortion.[20]

Sub-Theme 3: Limited Awareness and Misinformation of Safe Abortion Services

Participants mentioned an initial lack of awareness about the availability of safe abortion services, and others mentioned being given wrong information by friends or family regarding these services. Several beliefs and myths surrounding abortion services like infertility, death, and others were some of the challenges adolescent girls and young women were scared of as they sought safe abortion services.

> I believe the main issue is the lack of information and support provided to people seeking safe abortion services. Many are fearful of legal repercussions because they are unaware of the process and their rights, reported a 24-year-old woman, Kicukiro.[20]

> Due to our lack of information, we sometimes don't know the procedure to follow to get an abortion. Mentioned a mother during FGD.[20]

> I received little information in school, and in the community amongst my friends about abortion being possible in health centers and the requirements like court permission, signature of the person responsible for the pregnancy, etc. However, I was not a hundred percent sure, reported a 25-year-old from Gatsibo.

> I don't know, if I knew safe abortion services were available in my community, I would not have come here in Kigali, I would have gone there instead, reported a 23-year-old lady after a 6-hour journey to Kigali seeking Safe abortion services.

Inadequate safe abortion information makes adolescent girls and women look for other unsafe abortion means, hence risking their health[20]

> …. I didn't know about safe abortion services but instead knew about traditional abortion services because I had tried with the second one (pregnancy) although it really didn't work but instead almost killed me. It was some mixed thick green liquid things they gave me to drink and put some banana-like thing down there (vagina). So, I did it for like 2 days, but I almost died … spent two weeks in a coma, mentioned a 22-year-old woman from Nyarugenge.

Sub-Theme 4: Negative Medical Practitioner's Perceptions, Beliefs, and attitudes[20]

One of the mentioned barriers was the negative attitudes, and beliefs of service providers. Although some adolescent girls and young women reported being given the services after being insulted, some were denied the services completely.

> Healthcare providers still have stereotypes on the concept of abortion, whereby they don't want to be considered allies in the sin (killing the unborn baby in the process of abortion), even though the court case won't include them. There were about 4 doctors who judged me right away and denied any service, mentioned a Nyarugenge 30-year-old woman.[20]

> My main concern with the doctors was their reluctance to perform the procedure. I pleaded with them for nearly two days, and even when they eventually performed the procedure at the last minute, it felt like they did so merely to get rid of me and prevent further complaints or disclosures. The overall experience was far from satisfactory. Reported a 20-year-old woman from Kigali.[20]

> Sometimes healthcare providers hesitate to provide safe abortion services due to fears about potential complications, such as the risk of death. I know friends who were refused by doctors and had to seek help from other hospitals as a result. Mentioned a 20-year-old from Nyarugenge.[20]

Theme 2: Social and Interpersonal factors[20]

Adolescent girls and women had barriers that were based on their social interactions, their relationships, and their immediate environment. Friends, family, and peer influence were among the significant factors that discouraged or motivated participants to seek safe abortion services. The different social factors like cultural beliefs, stigma, and the economic status of the participants are among the barriers that hinder convenient accessibility and utilization of comprehensive, legal, and safe abortion care services.[20]

Sub-Theme 1: Lack of Inter-Personal and Professional confidentiality[20]

Professional confidentiality is essential in comprehensive safe abortion services, however, some participants reported situations where they felt their information was not kept private. Adolescent girls and young women also reported that they trusted the community health workers, local leaders, and friends to keep their information secret, but were always disappointed by learning that their information was out to the public. This challenge hinders adolescent girls and women from seeking safe abortion services.[20]

> I met the gynecologist but even then, the nurses associated lacked confidentiality; everyone knew about my case at this point, as they isolated me as well. This was very hurtful indeed. Reported a 30-year-old lady, Nyarugenge.[20]

> …. It was the local village leader who took me to the health facility, after finding me where my boyfriend had taken me to get the abortion medications from. The local village leader then called my parents. My parents were unaware of the situation and were surprised. Reported, an 18-year-old young woman, Gatsibo.[20]

Sub-Theme 2: Negative Guardians, Parental, and Peer influence[20]

Most participants reported consulting parents, friends or relatives about the decision to have a safe abortion. The attitudes and beliefs of those participants consulted had a hand in the decision they took. Their influence can be either positive or negative.

A quote from a participant from Nyagatare, aged 25 years, reported that[20]

> My dad and older brother kept abusing me everyday and even deserted the family home, my mom struggled with keeping up with the expenses and would abuse me too, when I was better, I left home and started working as a maid in Nyagatare so that I am away from the abuse I was subjected to

> We went to an anniversary of my friend and I heard them talking bad things about me. I don't want to say the words they used were not good at all. They were saying that I should not abort because it is God who raises the children, reported a 22-year-old participant, Gatsibo.[20]

> My grandmother refused me from getting abortion services, so I left the health facility thinking about dying. I found a child we live with at home and then I entered the house and drank cow's medicine. I drank it without diluting it, I felt dizzy but I wondered why I wasn't dying. I went back to the house and drank water and then came back to the banana plantation. I was dizzy and I passed out. I don't know How I left the place. I found myself at the hospital in the morning, mentioned a 17-year-old adolescent, Nyagatare District.[20]

> I told him about my decision to have an abortion, and he didn't say anything. However, our relationship ended. Reported a 17-year-old adolescent, Gatsibo District.[20]

Sub-Theme 3: Fear of Health Complications and Stigma

Participants were scared of different health complications post abortion like heavy bleeding. Infections, or even death. This fear stemmed from what they had heard from the community that some women get when they undergo abortion. Stigma and social isolation were other significant challenges participants faced while they were seeking safe abortion.

Fear of Health Complications

Participants reported experiencing fear of complications related to abortion, like death, infertility and others they had ever heard of. Having not undergone any medical procedure before made the whole idea of medical abortion very scary for most participants which led to prior hesitation.

> I first hesitated, and I was afraid because I would hear that if you have an abortion you can die, or that you grow thin and people find out. Reported a 20-year-old young woman, Kicukiro district.[20]

> I got pregnant unexpectedly and it was hard for me to accept. When I told the person who got me pregnant, he suggested that we do an abortion, but I told him I did not want to abort because it may kill me, mentioned an FDG parent, Gatsibo district.[20]

Fear of Stigma

Cultural and social stigma attached to abortion was a significant barrier for adolescent girls and women seeking safe abortion services. Participants reported fear of stigmatizing experiences which they had seen or heard of "most of the time people fear to go to the hospital thinking that they will be judged" reported a participant about her experience at 19 years old.[20]

> I was afraid that people would find out and start to abuse me or call me names, reported a 17-year-old, Gatsibo district.[20]

> Hesitations and fear were rooted in the experience of a neighbor who had an abortion …. And was exposed to the public, and they insulted her in different ways. I wondered, what if I ended up like that? Reported a 24-year-old young woman, Kicukiro district.

Sub-Theme 4: Financial Costs of Safe Abortion services[20]

The financial costs incurred while looking for safe abortion services and when paying for them was a burden for several participants. It was reported expensive and unaffordable for some participants.

> I paid 50,000 Rwandan francs, which is very expensive for a poor person like me. Financial barriers still prevent many people from seeking safe abortions because I know someone who gave up due to this barrier, reported a 25-year-old young woman, Kicukiro district.[20]

> Financial barriers are significant. It's not just about affording the service itself, but also the additional costs like transport, meals during the process, and deciding how to allocate limited funds between abortion and other urgent needs. I paid the doctor 60,000 Rwandan francs, and the other medicines I had to buy later to relieve the pain, along with the fruits I needed, cost about 80,000 Rwandan francs in total. Reported a 24-year-old young woman, Kicukiro district.[20]

> I paid 60,000 rwf to the doctor that did the procedure of abortion. I, however, developed complications after as the pregnancy was not fully terminated and spent 2 weeks at hospital, where I got more medicine and even underwent an echography, where I spent 310,000 rwf, reported a 25-year-old young woman, Gatsibo district.[20]

Sub-Theme 5: Negative Community Beliefs and Stigma[20]

The different negative beliefs and stigma about safe abortion in communities hindered adolescent girls and women from accessing safe abortion services. Fear of negative attitudes, discrimination, shame, and guilt the community attaches to safe abortion was among the major challenges participants faced while seeking safe abortion services.

Stigma Classification

In-depth interviews and focus group discussions indicated that there was personal, societal, educational institutional, hospital, and family level stigma.[20]

Internalised-Stigma.

> I keep having memories of what happened; I think about it a lot. Sometimes, I even see myself as a killer because of the stigma associated with abortion—it feels like a sin. Reported a 17-year-old adolescent, Gatsibo district.[20]

Community Level.

> I used to have a neighbor who people always said she had aborted nearly five times. They called her a murderer, and she ended up getting depressed. She eventually left her home and strangely lost weight. It's clear that she was deeply affected by the stigma she faced, reported a 20-year-old young woman, Nyarugenge district.

> …It's difficult when everyone is against you and your situation becomes the talk of the town. It's a significant challenge, reported a 25-year-old young woman, Kicukiro district.[20]

School Environment. Some of the participants reported being challenged by the stigma and discrimination they faced at school once colleagues knew that they had safe abortion.

> People would talk about me every time they saw me, and at school, everyone would stare. This behavior made me feel very uncomfortable, reported an 18-year-old adolescent girl, Gatsibo district.[20]

Family Level. For many participants, the decision of seeking safe abortion services was highly influenced by their families, where some participants felt abandoned and unsupported by their families, which made their experience of seeking safe abortion services unpleasant and challenging.

> So, after the abortion, my sister was constantly insulting me, telling me how terrible it was to have it, reported a 22-year-old, Nyarugenge district.[20]

> My dad and older brother kept abusing me every day and even deserted the family home, my mom struggled with keeping up with the expenses and would abuse me too, when I was better I left home and started working as a maid in Nyagatare so that I am away from the abuse I was subjected to

Hospital Environment. The hospital environment was another major challenge for different participants. Participants mentioned that they lacked a specified room for only adolescent girls and women seeking safe abortion services, and therefore were inconvenienced by how services were given to them, like other patients, and how rooms had to be shared with other patients.

> Personally, at the hospital, you would meet mothers who have had miscarriages. After learning about which service you need, they would judge you and isolate you because it looks absurd to them how I would willingly terminate a pregnancy that they wanted, reported a 30-year-old woman, Nyarugenge district.

A Nyagatare based healthcare provider mentioned that,[20] "…it is mostly shame and fear, young girls feel so shy when they come for those services, you see our building isn't even enough for the usual mothers, so now she comes she gets a bed next to a neighbor she knows, or sees someone who knows her family and they find it hard"

He asked me to come during the lunch break when there wouldn't be many people around at the hospital, reported a 25-year-old, Kicukiro resident, indicating her dissatisfaction with the hospital's operating hours.[20]

Discussion

The present study explored the non-legal barriers and lived experiences of adolescents and women who sought safe abortion services in Rwanda. Data reported in the current study indicated different lived experiences and challenges that are not legally based faced by adolescent girls and young women seeking safe abortions.[20] The identified non-legal barriers were about accessibility and availability of the services, and the interpersonal and societal factors.

Similar to other studies, unavailability and lack of access to safe abortion services were a major challenge faced by adolescent girls and women in need. This was mainly because of the lack of services in their proximity, the lack of tools or equipment necessary for quality services. These findings are similar to what a study in Ethiopia revealed. It indicated that poorly equipped healthcare facilities were also a challenge to women seeking safe abortion services.[30] These findings resonate with what a similar study in Ghana reported, where women seeking safe abortion services were burdened by inaccessible and unavailable services, which they regarded as costly.[31]

The study findings indicated that most participants were initially unaware or had misinformation about legal and safe abortion care services, which presented a hindrance to seeking and accessing safe abortion services.[20] Their misinformation was mostly shaped by their social networks and cultural norms. Adolescent girls and women who were aware and had correct information about safe abortion, from their social networks, SRHR public programs, and others, reported a more positive lived experience than those who were not aware or did not have the correct information. These findings are similar to the findings of a literature review done by C.Espinoza et al, which reported that adolescent girls who lacked knowledge of abortion services delayed seeking care due to fear of stigma, lack of resources, and provider bias which led to negative experiences,[32] and this is consistent to findings of a scoping review done in Asia from 2010–2020 which reported that lack of knowledge about abortion, usually led adolescent girls and women to unsafe practices and negative physical and emotional consequences.[33] Likewise, another study done in South Africa showed that the information about safe abortion services determined the decisions individuals made in regard to abortion and impacted their experience.[34]

Study findings indicate that the beliefs and attitudes of service providers were some of the barriers adolescent girls and young women face while seeking safe abortion services. Healthcare providers with poor attitudes towards abortion gave negative attitudes and poor-quality abortion services to those in need. Similar studies have been done in different countries including India, South Africa, Nigeria, and Ethiopia, and they have indicated that the moral duties and beliefs of healthcare personnel affect so much how they give safe abortion services to those in need.[35–38]

Adolescent girls and women in this study reported consulting family or friends before deciding to have a safe abortion. The negative beliefs and attitudes of the individuals they consulted burdened the ease of deciding on having a safe abortion and faced stigma from it. These findings resonate with findings of a study done in Thailand and another one conducted in Zambia which showed that adolescent girls women who had social support were not challenged by stigma, and the advice and support from trusted others shaped the abortion trajectory individuals took, how and where they sought the services, and their experience while seeking the abortion services.[3,11] Similarly a study done in Kenya reported that women seeking abortion services in this country were burdened by the negative influence of their peers and guardians.[39]

Data from the current study revealed that most participants had a fear of stigma which is often attached to abortion in their context. Similarly, a study done in Kenya assessing the perspective of women seeking safe abortion services indicated that stigma was the major hindrance they faced.[40] These findings agree with what a similar study done in India and Kenya which reported that cultural and social norms were among the barriers women faced while seeking safe abortion services.[41]

The study findings about the experience of participants who were given comprehensive services, particularly pre- and post-abortion counseling services, were not any different from what was found in other previous studies, which mentioned that adolescent girls and women who were counseled before and after abortion had a better experience of abortion than those who were not.[42,43] This was because pre-abortion counseling gave adolescent girls and women a better understanding of the services they were going to be given, and reassurance about their safety, and the post-abortion counseling gave participants insight into better family planning methods and other practices that would help them keep a healthy life after abortion.

Despite the similarities of this study's findings and previous studies, some reported findings contradict these results. A study by Astrid et al,[44] found that in countries with legal reforms, religious beliefs, and stigma gradually cease to be a barrier for women seeking safe abortion services. Additionally, a study done in Sudan reported that targeted funding for reproductive services can help mitigate the challenge of financial cost, for adolescent girls and women.[45] Awareness and misinformation in many studies have been denoted as strong barriers, but a recent systemic review noted that adolescents receive more reproductive health information than usually assumed from trusted sources.[46] The evidence provided above shows that in non-liberalized societies, policymakers need to be innovative if this public challenge of unsafe abortion is to be addressed.

Methodological Consideration of Study

Among the main strengths of the current research is that the selection of participants was purposive,[20] and the information they provided about non-legal barriers to safe abortion is reliable and can be used by different CSOs and policymakers in improving reproductive health services. Trustworthiness was ensured by observing the credibility, dependability, transferability, and confirmability of the study results.[47] However, this study was only conducted in 3 districts in Rwanda, and therefore, findings cannot be generalized to the whole of Rwanda. Additionally, Participants recruited were at varying stages and durations since their abortion, and this may have caused recall biases and differences in experiences and messages communicated.

Conclusion

The present study provides important information about the lived experience and non-legal barriers faced by adolescent girls and young women who had previously sought safe abortion services. The findings of the study showed that although safe abortion in Rwanda has been legalized in specific circumstances, adolescent girls and women in those specific categories still have several challenges while seeking and accessing these services. For the appropriate achievement of effective accessibility of safe abortion services, and a good experience for those seeking them, the mentioned barriers should be addressed. We recommend expanding VCAT (Values Clarification and Attitude Transformation) training to all healthcare facilities providing safe abortion to reduce provider stigma. We also encourage government institutions and Civil societies to extend their interventions into the community and co-design them with the community to increase impact. Future studies should dedicate longer periods for data collection to ensure consistency of the reported barriers and experiences, as well as add a quantitative component to ensure accuracy and consistency of the findings.

Abbreviations

WHO, World Health Organization; NGO, Non-Governmental organization; HDI, Health Development Initiative; CHW, Community Health Workers; FP, Family Planning.

Data Sharing Statement

The data will be availed to academic parties upon request from Health Development Initiative, at https://info@hdirwanda.org or at https://hdirwanda.org.

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Author Contributions

All authors made a significant contribution to the work reported, whether that is in the conception, study design, execution, acquisition of data, analysis and interpretation, or in all these areas; took part in drafting, revising or critically reviewing the article; gave final approval of the version to be published; have agreed on the journal to which the article has been submitted; and agree to be accountable for all aspects of the work.

Disclosure

The authors report no conflicting or competing interests for this work.

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