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THE QUEST FOR MATERNAL SURVIVAL IN RWANDA - PARADOXES IN POLICY AND PRACTICE

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The Quest for Maternal Survival in Rwanda – Paradoxes in Policy and Practice

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Improved maternal survival has been a global target for decades. Since 1990, maternal deaths have decreased by nearly half – but with stark disparities between countries. In sub-Saharan Africa, a woman's lifetime risk of dying as a result of pregnancy or childbirth is estimated to be more than 100 times higher than for a woman in a high-income country (WHO et al. 2015).

Rwanda stands out among sub-Saharan nations in reducing maternal deaths and was one of the few countries to achieve the Millennium Development Goal 5a by decreasing maternal deaths by 75% between 1990 and 2015 (UNICEF & World Health Organization 2015). Rwanda has managed to improve certain indicators regarding maternal health substantially. Up to 91% of all childbirths are now reported to take place at health facilities (National Institute of Statistic of Rwanda (NISR) et al. 2015), 99% of women go for one antenatal care visit, and 87% attend their first antenatal care visit with their partner for HIV testing (Jennings et al. 2014; National Institute of Statistic of Rwanda (NISR) et al. 2015). Rwanda has also significantly decreased out-of-pocket expenditure for health by introducing its community-based health insurance program (Bucagu et al. 2012).

An important step was also taken in 2012 when the previously strict abortion law was revised to allow induced abortion for pregnancies resulting from rape, incest or forced marriage, or if the "continuation of pregnancy seriously jeopardizes the health of the unborn baby or that of the pregnant woman" (Republic of Rwanda 2012b). To be allowed a legal abortion, approval is needed from the court along with consent from two medical doctors. For cases where the health of the woman is jeopardized, consent from two medical doctors should be enough. To date, healthcare providers' perspectives on induced abortions and abortion care in Rwanda has scarcely been studied (Ngabo et al. 2012). Complications arising from unsafe abortions and miscarriages have been defined as a significant public health challenge for the country (Republic of Rwanda 2012a).

Rwanda is often cited as a success story for its advancements within maternal health, but there is a scarcity of knowledge on how the users of these services actually perceive and experience them. This study therefore seeks to contribute to Rwanda's goal for maternal survival by presenting the perspectives of women who nearly died ('near-miss') during

pregnancy, as well as those of their partners and other recent fathers, community members, and healthcare providers who work within abortion-related care. This will bring forth the bottom-up perspective of policy and practice in relation to maternal care.

THE MATERNAL NEAR-MISS CONCEPT

Maternal near-miss, also referred to as "severe maternal morbidity" or "life-threatening morbidity", is defined as "a woman who nearly died but survived a complication that occurred during pregnancy, childbirth, or within 42 days of termination of pregnancy" (Say et al. 2009). Near-miss can be used to monitor the quality of maternal care and function as a proxy for maternal mortality, as these women often share similar trajectories with women who do die, but can give their own perspective of what actually happened (Pattinson 2003; Filippi et al. 2009). The near-miss criteria for this study were decided together with local obstetricians, corresponding with the WHO definition of near-miss events (Say et al. 2009), and criteria used earlier in other low-resource contexts (Nelissen et al. 2013; Rööst et al. 2009).

METHODS

This research project is a continuation of a joint partnership between Uppsala University and the National University of Rwanda. Ethical approval was obtained from the Rwanda National Health Research Committee, Kigali (NHRC/2012/PROT/0045) and the Institutional Review Board of Kigali University Teaching Hospital.

The study and analysis was guided by the framework of naturalistic inquiry as presented by Lincoln and Guba (1985) (Lincoln & Guba 1985). Data were collected in Kigali, Rwanda between 2013 and 2016 by the main author in close collaboration with a research assistant.

RECRUITMENT AND PARTICIPANTS

Women with a near-miss were purposively recruited from three hospitals: two districts hospitals and one tertiary referral hospital. The partners of women with a near-miss were asked to take part in this study after their partner had given their consent. Community members were recruited by snowball sampling, and health care providers purposively recruited at the three hospitals. For characteristics of the participants see Påfs J. (2016) (Påfs 2016).

Conceptual Frameworks

To conceptualize delays in seeking, reaching and receiving care, the 'three delays model' (see Thaddeus and Maine 1994) was used both in designing the research questions and sorting the data. To conceptualize policy implementation from the users, the bottom-up approach to policy implementation was used. The bottom-up approach sees policy implementation as complex, non-linear and interactive (Buse et al. 2012).

Main Findings and Discussion

Criminal Label on Early-pregnancy Health Needs

The women who wanted to have an abortion faced a lack of safe care options, which resulted in their resort to seek unsafe solutions, and subsequently contributed to the near-miss event. Even though of the amendments to the abortion law in 2012, the women in our study were not aware of these options, and it is likely that the information regarding the necessary circumstances to allow abortions have not reached the grassroots level. The healthcare providers expressed that nothing had changed in practice, partly due to the laborious court procedures involved in trying cases for legality. A recent newspaper article confirms this and reports that the Rwanda Law Reform Commission has proposed that court procedures should be changed because today such a procedure may take up to a year and that, therefore, the "law isn't helping the people it was intended to protect" (Kwibuka 2016).

Rwanda is identified as being exceptional in its realization of the abortion law in the region. In one prison, 21 out of 114 women were imprisoned due to an illegal abortion, and 90% of them were 25 years old or younger (Umuhoza et al. 2013). This was also reflected in our findings as one young woman had been reported to the police by her neighbor, who had assumed she had provoked the termination of her pregnancy. In line with this finding, a recent report claims that women who have had a spontaneous abortion have faced charges or imprisonment in Rwanda (Kane 2015). Such a situation may pose an obstacle for women seeking care, regardless of whether the abortion is provoked or spontaneous, as they may be at risk of being prosecuted.

In relation to the current abortion law, our findings highlight a paradox in the dual duties of healthcare providers. While most healthcare providers expressed their reliance on a professional code of ethics, assuring patient confidentiality, one healthcare provider pointed out that a supervisor had informed staff about the obligation to report known illegal abortion cases to the police. It has been revealed that a subset of women imprisoned for abortion in Rwanda were reported by healthcare providers after seeking help for their complications after undergoing an unsafe abortion (Kane 2015; Umuhoza et al. 2013). Also, from the healthcare providers' perspective in our study, this was highlighted as a potential cause for delayed care-seeking among women. In addition, our findings indicate that healthcare providers may take precautionary measures so as to not face liability themselves. This was also seen in a recent study from Senegal, where healthcare providers obscured induced abortions in medical records so as to not later be held liable (Suh 2014). This may also contribute to the underreporting of abortion-related maternal morbidity and mortality in Rwanda.

The availability of misoprostol is another aspect worthy of attention. The top-down intention of promoting the usage of misoprostol prior to other types of treatment is to expand access to post-abortion care, along with task-shifting this service to allow it to be offered at health center level. However, the bottom-up perspective of the interviewed healthcare providers in our study expressed a restricted availability of misoprostol and, thus, an inconsistency in the implementation of this policy. A recent study from neighboring Uganda demonstrates that midwives can provide it as successfully as physicians in post-abortion care, as well as the acceptability by women of using misoprostol (Klingberg-Allvin et al. 2015; Cleeve et al. 2016). The restricted availability of misoprostol in Rwanda does not only have implications for abortion-related care, but may also have consequences for women in later stages of pregnancy as this is a cheap and effective measure for inducing labor and treating post-partum hemorrhage (Derman et al. 2007; Gülmezoglu et al. 2001).

The recent amendment to the abortion law in Rwanda has been argued to be an important step as abortion has long since been a taboo topic (Umuhoza et al. 2013). However, in settings where abortions have been legalized, such as Ethiopia and South Africa, and liberalized, such as Zambia, it has been demonstrated that women still undergo unsafe abortions, partly due to a lack of knowledge of the law, but also due to the stigma and fear of

social sanctions (Singh et al. 2010; Jewkes et al. 2005; Coast & Murray 2016). The consequences of abortion-related stigma were prominent in our findings. Apart from the threat of death due to hiding abortion-related symptoms out of fear of stigma, stigma also brings consequences beyond mere survival. We identified social sanctions associated with losing employment due to the suspicion of an illegal abortion. Furthermore, it has been reported that having an abortion or facing an unwanted pregnancy may cause girls to drop out of school, while boys can continue as usual (Berry 2015; Ladi 2015). This imbalance in responsibility for abortions has also been pointed out by others, as a woman may often feel pushed, directly or indirectly, by her intimate partner to undergo an abortion (Cook et al. 2003). This gender imbalance is important to bear in mind in Rwanda's overarching quest for gender equity. While healthcare providers can be seen as important implementers in tearing down abortion stigma, they expressed reluctance to further legalization of abortion, which was identified as partly being due to an unwillingness to have their profession associated with abortion. The stigmatization of abortion providers is a global phenomenon (Martin et al. 2014) and is an aspect of the professional role that requires mandated support.

Imposed Uptake of (suboptimal) Maternal Care

Institutionalized maternal care, and particularly facility-based childbirth, was identified as mandatory by the women and men in this study. While most of the participants seemed to support the policy of facility-based childbirth, they questioned the system of fines if women were unable to reach the facility on time. The women's near-miss experiences shed light on a number of barriers to optimal care. Experiences of not being listened to, or not given proper explanations by healthcare providers, were shared by the near-miss women, as well as their partners. A recent observational study from Rwanda validates our women's narratives, reporting that women were overlooked, shouted at, and being forced to give birth on their backs against their wishes (Rosen et al. 2015). A further occurrence found in our study was that of women being held at the facility until they were able to pay for their treatment. All of these aspects can be identified as examples of 'disrespectful care', as conceptualized by others (Freedman et al. 2014; Bohren et al. 2015; World Health Organization 2014; Freedman & Kruk 2014). Addressing the problem of disrespectful care is emphasized as an important interlinking factor in improving quality of care and maternal health (Molina et al. 2016; Miller et al. 2016; Renfrew et al. 2014).

The consequences of disrespect seem to have contributed to women's delayed care-seeking, expressed as a fear of coming 'too early' for antenatal care and childbirth. Disrespect in the care encounter may make women hesitant to raise concerns, which again can contribute to why symptoms, such as hypertensive disorders, go unnoticed. Another aspect of disrespect is that healthcare providers may withhold important information. Women in our study expressed having received inadequate information regarding certain symptoms to pay attention to, and factors associated with the near-miss. It has been identified elsewhere that women of lower socioeconomic and educational status may be treated as being unable to comprehend medical issues, and are therefore not provided adequate explanations by healthcare providers (Berry 2008; Pell et al. 2013). In line with our findings, the need to strengthen communication, both between patient–provider and provider–provider, and between healthcare facilities, were noted as being important aspects in a recent report covering maternal death audits from Rwanda (Sayinzoga et al. 2016).

Parallel to this top-down goal of facility-based childbirths, the women described an uptake of traditional medicine. Traditional medicine was mostly sought as a preventive measure, or 'to get ready', for childbirth. This was a combination of a wish to protect oneself from 'witchcraft', and/or a wish to increase the intensity of contractions. The latter was also identified as a measure taken to enhance admission and care. Similar strategies taken have been identified in, for example, Burkina Faso prior to seeking care at a biomedical facility (Østergaard 2015). Other identified factors for turning to traditional medicine in our study were to treat symptoms when public maternal care had not been of help. One supportive factor for this was that the traditional healer also offered other payment options than money, or the possibility to arrange a payment plan, also recognized as an incentive in other settings (Leach et al. 2008). While the community-based health insurance scheme was identified as a supportive factor for care-seeking, costs were still a barrier. The payment system in place, requiring that most costs are covered prior to treatment, may delay the provision of care. On the other hand, the practice of fining women for not giving birth at a facility, while at the same time imposing sanctions such as women being 'locked in' if they are not able to pay for care, can also be identified as a paradox in the system.

While measures to limit the use of traditional medicine have been discussed at policy level (Republic of Rwanda: Ministry of Health 2015), these traditional medicines, particularly those taken prior to childbirth, are assessed as potentially harmful for the woman and newborn (Beste Md et al. 2015; Kamatenesi-Mugisha & Oryem-Origa 2007). From the bottom-up perspective, a fine system was already in place at some health centers as a way to sanction women who had taken traditional medicine, which had made these women take them in secret instead, and brought about potential paradoxical consequences such as not allowing unsealed bottles to be distributed inside the health facilities. Other studies point out that the uptake of biomedical care in sub-Saharan Africa often continues in parallel with traditional medicine, and that increased uptake of public health care requires *trust* in the provided care (Chapman 2003; Østergaard 2015). In our findings, *distrust* was present as women and men expressed a will to seek treatment at another facility the next time, to take actions outside of the public healthcare system, or they did not have faith in the advised treatment. However, the issue of trust and context-specific patient satisfaction warrants further exploration in this setting.

Men Required yet Dismissed in Maternal Care

The findings in this study highlight how the top-down initiative of increasing men's involvement at the first antenatal care encounter has turned into a requirement with potential implications for women's access to care. It was identified that women who arrived at the first antenatal care appointment alone were turned away and asked to return with their partner. This could lead to women attending antenatal care with a man who is not necessarily the partner – in order to access care. Obviously, this heightens the vulnerability of women who are pregnant outside of partnership and increases women's dependency upon men, which subsequently reinforces normative relationships. This is in contrast to Rwanda's agenda for gender equity. The consequences of women being denied access to care or put last in line in the implementation of male involvement for antenatal care has also been revealed in recent studies from Kenya and Malawi (Pell et al. 2013; Kululanga et al. 2012) and Tanzania (Callaghan-Koru et al. 2016).

Our findings suggest that the structural changes of involving men in antenatal care may have opened up an increased interest for men to take part in maternal care. A reason that men wanted to participate in antenatal care and childbirth appeared to be

the wish to gain more insight into maternal issues and to ensure quality of care for their partner. Other studies in sub-Saharan settings, however, pointed out that men were reluctant to join their partner due to disrespectful healthcare providers (Ganle & Dery 2015; Larsson et al. 2010). It may be that the reflections of the men in our study were formed by the experience of their partners' near-miss, similar to findings from Uganda (Kaye et al. 2014), and that they therefore express an increased wish to participate in maternal care. However, the men's expressed interest in participating in their partners' antenatal care may also be due to participation being enforced.

While the men were interested in taking part in pregnancy-related information and care, they perceived that healthcare providers excluded them from this. Similar perceptions have been identified in another study from Rwanda (Doyle et al. 2014). This could be seen as a persisting norm to uphold maternal care as a female domain. Limited access and insight may provoke men's distrust in the public health system and healthcare providers. Also, some of the women expressed a wish to involve their partners in pregnancy-related care. For male involvement to serve its purpose of improving maternal health outcomes and gender equity, the initial aim should be revisited and clarified at both policy and health system level, but also at grassroots level. Other studies have highlighted the positive aspects of male involvement in promoting gender equity (Comrie-Thomson et al. 2015; Levtov et al. 2014). The high number of men attending antenatal care in Rwanda provides an opportunity to increase men's awareness about maternal health, however, if the aim is to also promote gender equity, persisting societal gender norms need to be addressed.

CONCLUSION

This study highlights paradoxical outcomes in the implementation of maternal care policies in Rwanda. The recent amendment to the abortion law and the priority of reducing abortion-related deaths provides a momentum for change. Yet, access to induced abortion in public maternal care was non-existent and the findings point at fear of litigation and stigma, which posed hurdles for women's care-seeking in early pregnancy. Giving birth at a health facility was perceived as mandatory, and meanwhile disrespectful care and distrust in public healthcare services was prominent. This may lead to delayed care-seeking and suboptimal maternal health outcomes – potentially reinforcing adherence to traditional medicine. In contrast to the increased number of men attending antenatal care,

the findings revealed a perceived obligation to be accompanied by a man in order to receive care. This requirement placed women in a dependent situation on men in their care-seeking – which is contrary to Rwanda's agenda of empowering women. Meanwhile, men perceived themselves as being excluded and dismissed in maternal care. The current maternal health system is thus missing the opportunity to embrace men's interest to take part in childbearing, which may also provoke distrust in the available care.

To better ensure that health care corresponds with the agenda for maternal survival, this study gives reason to pause and consider the perspectives of those being asked to practice them and to continue to strengthen the maternal health system to avoid contradictory results.

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