



GREAT LAKES INITIATIVE FOR HUMAN RIGHTS AND DEVELOPMENT (G.L.I.H.D.)

February 12, 2016

Human Rights Committee
Human Rights Committee Secretariat
8-14 Avenue de la Paix
CH 1211 Geneva 10
Switzerland

Supplementary information on Rwanda scheduled for review by the Human Rights Committee during its 116th Session

Honorable Committee Members:

This letter is intended to supplement the periodic report and response to List of Issues (LOIs) submitted by Rwanda to the Human Rights Committee (the Committee), for the country's review during the Committee's 116th Session. The Center for Reproductive Rights (the Center)—a global legal advocacy organization that uses the law to advance reproductive freedom as a fundamental human right—and Great Lakes Initiatives for Human Rights and Development (GLIHD)—a Rwandan non-governmental organization that uses public interest litigation to advance human rights and provides legal aid services—hope to further the work of the Committee by providing independent information on Rwanda concerning the rights protected in the International Covenant on Civil and Political Rights (ICCPR).¹

This letter highlights the following issues: lack of access to maternal health care services; unsafe abortion and lack of post-abortion care; aggressive enforcement of laws prohibiting abortion and high incidence of imprisonment for abortion related charges; inadequate access to family planning services and information; and sexual and physical violence against women and girls.

I. THE RIGHT TO EQUALITY AND NON-DISCRIMINATION

It has long been established that the obligation to ensure the rights to non-discrimination and substantive equality for all people underlies all international human rights. Indeed, the ICCPR recognizes that equality is essential to the enjoyment of the rights stipulated in the Convention.² Accordingly, the Committee has urged states to address both de jure and de facto discrimination in private and public spheres.³ It has further noted that ensuring equality requires not only removing barriers but also taking positive measures “to achieve the effective and equal empowerment of women.”⁴ In this regard, the Committee has urged states to “adopt whatever legislation is necessary to give full effect to the principle of equality between men and women,”⁵ develop policies that promote gender equality,⁶ take efforts to eliminate gender stereotypes about women in the family and society,⁷ and address practices such as cutting funds to social programs that have a disproportionate impact on women.⁸ It has also urged states to take affirmative measures to improve social conditions such as poverty and unemployment that impact women's right to equality in healthcare.⁹

A key element of women’s right to equality and nondiscrimination is their ability to exercise reproductive autonomy—that is, to make decisions regarding whether and when to have a child without undue influence or coercion. For women to enjoy reproductive autonomy, their options must not be limited by lack of opportunities or results.¹⁰ To this end, it is crucial that women have access to reproductive health services, and that those services can be accessed with their consent alone.¹¹ In addition, reproductive health services must “be consistent with the human rights of women, including the rights to autonomy, privacy, confidentiality, informed consent and choice.”¹²

Reproductive equality requires states to not only address barriers to accessing reproductive health services but also take positive measures to ensure women’s access to these services, including by using all appropriate means. The Committee has noted that fulfilling the right to equality in the context of health may require amending legislation or administrative regulations and addressing non-legal barriers that impact access to reproductive healthcare, such as the high cost of contraceptive services and supplies, and transportation barriers for women in rural areas.¹³ The Committee has also recommended implementing legal and policy measures to ensure access to a full range of reproductive health care services and information, including contraceptives, family planning counseling, sexuality education, and safe abortion services.¹⁴ In addition, the Committee has noted that young, poor, rural, and minority women often face additional obstacles to reproductive health care, and has recommended that states take extra measures to ensure their access to health.¹⁵

However, despite these standards set by the Committee, women and girls in Rwanda often lack access to comprehensive reproductive health information and services with far-reaching consequences including on their life and health.

II. HIGH INCIDENCE OF MATERNAL MORTALITY AND MORBIDITY

The Committee and other treaty monitoring bodies (TMBs) have framed the issue of maternal mortality as a violation of women’s and girls’ right to health and life.¹⁶ Other TMBs have also confirmed that ensuring equality of health results—including by lowering the maternal mortality rate—is an important indicator of a state’s success in overcoming rights violations.¹⁷ With regards to Rwanda, while multiple TMBs, concerned with the high rate of maternal mortality, have recommended that the state take measures to reduce the rate,¹⁸ and the government has implemented multiple initiatives in order to do so, the rate still remains high and problems with accessing maternal health services remain. A 2015 report from the World Health Organization (WHO) indicates that Rwanda had reduced the maternal mortality ratio (MMR) from the 2010 rate of 381 deaths per 100,000 live births to 290 deaths per 100,000 live births,¹⁹ achieving the UN Millennium Development Goal of reducing the MMR by 75% by 2015.²⁰ While this trend is positive, this rate is still high. As such, the government needs to build up on its success and scale up its efforts in order to achieve the Sustainable Development Goal of reducing the maternal mortality to less than 70 deaths per 100,000 live births.²¹

Further, it is widely recognized that the major causes of maternal mortality during pregnancy and child birth are “severe bleeding (post-partum hemorrhage), infections (sepsis), high blood pressure, obstructed labor and unsafe abortions,” all of which are preventable or manageable by providing access to quality maternal health care services.²² However, Rwanda’s 2015 Demographic Health Survey (2015 RDHS) shows that more than half of women do not attend²³ four antenatal visits as recommended by the WHO.²⁴ Also, while 90% of women were delivered

by a skilled provider, only 41% attended postnatal checkup,²⁵ even though “a large proportion of maternal and neonatal deaths occur during the first 48 hours after delivery.”²⁶

One key reason is that Rwandan women and girls often encounter significant barriers in accessing services. Approximately 23% of patients need to walk for an hour or more than five kilometers to reach the nearest health care facility.²⁷ There also remain, disparities in access to maternal health care services based on geography and socio-economic status. For instance, while 97% of women in the highest wealth quintile attend skilled delivery services, only 84% of women in the lowest quintile attend the same services.²⁸ Further, according to the latest available data from the Ministry of Health, Rwanda has a total of 684 doctors working in private and public health facilities, amounting to approximately only one doctor per 15,806 people²⁹ and only 35 obstetricians and gynecologists.³⁰ Similarly, there are approximately 8,985 nurses amounting to one nurse per 1,203 inhabitants.³¹ According to the President of the Rwanda Midwifery Association, “while the required number of midwives across the country is 3600, only 1100 midwives are deployed in hospitals and health centers.”³² Lack of access to these health professionals is exacerbated as 40% of patients have to travel more than an hour to reach a health care facility.³³ Similarly, despite an increase in the number of health facilities, there are only 46 full-service hospitals in the country for a population of approximately 12 million people.³⁴ According to a report published by the Ministry of Health in 2013, only 48 percent of the health workforce need is met.³⁵ The Vision 2020 initiative—the government’s main development policy—aims to have 10 medical doctors, 20 nurses, and 5 lab assistants for every 100,000 inhabitants,³⁶ but these numbers will still need to be improved upon to make adequate impact.

According to the current report to the Committee, the Government of Rwanda notes that it has taken some steps to increase access to maternal health services and to reduce the high maternal mortality, including by developing Community Health Programmes, increasing health care facilities, and implementing a maternal death audit strategy.³⁷ However, some problems, including with the reporting on maternal mortality, remain. For instance, one part of this Community Health Program RapidSMS—a text messaging system for maternal and neonatal health reporting—is under-utilized and a large number of deaths that take place in private hospitals, which are less likely to conduct reviews, are underreported.³⁸

III. LACK OF ACCESS TO SAFE ABORTION AND POST-ABORTION CARE

This Committee has recognized that states’ duty to protect and ensure the right to life includes a duty to protect women who terminate their pregnancies.³⁹ The recognition of the direct connection between unsafe abortion and high death rates⁴⁰ has also led the Committee to require that states issuing reports on the right to life must inform the Committee of “any measures taken by the State to help women prevent unwanted pregnancies, and to ensure that they do not have to undergo life threatening clandestine abortions.”⁴¹ It has further called upon states to take measures “to ensure that women do not risk their life because of restrictive legal provisions on abortion,” that force them to seek abortions under clandestine, unsafe conditions.⁴²

Particularly regarding Rwanda, multiple human rights monitoring bodies have expressed concern over the restrictive law on abortion and its aggressive enforcement. During the 2015 Universal Periodic Review (UPR) of Rwanda, it was recommended that the government “[e]liminate, as a first step, judicial and administrative barriers that prevent women from accessing safe abortion, and protect women from being reported and arrested or going to jail for unsafe abortion as well as review the penal code in order to decriminalize abortion.”⁴³ In the current LOIs, the Committee asked the government **to indicate, in light of the 2012 amendment of the Penal code’s**

provisions on abortion, the “number of cases of legal abortion requested, the average period of time taken by the courts to make a decision, and the number of abortions actually carried out since the amendment came into force, also indicating the number of cases that were denied authorization and the reason for denial.”⁴⁴

Although the Rwanda considered the UPR recommendation implemented or in the process of being implemented, and responded to the LOIs by listing the expanded grounds for abortion under the amended Penal Code, it has not provided the information requested by the Committee.⁴⁵ Indeed, while the current Penal Code allows abortion when performed to save the life of the woman, protect her health, or when the pregnancy is a result of rape, incest, or forced marriage,⁴⁶ it simultaneously severely limits access to these legal services by adding significant hurdles in order to qualify for a safe and legal abortion. For example, Rwanda’s law requires a “competent Court” to certify that a woman has become pregnant as a result of rape, incest, or forced marriage.⁴⁷ This creates a barrier because stigma, fear, and family pressure prevent many women and girls from reporting incest or sexual violence and engaging with the justice system. In addition, those requiring the termination of a pregnancy have a limited window in which to obtain these services and court proceedings are often cumbersome and ineffective in these time-sensitive contexts. This is particularly problematic since special courts have not been established to hear these cases, which might have facilitated an expedited hearing. Further, the law is not clear whether the sexual violence needs to be proven—which would require investigation by the police and conviction of perpetrator—and therefore would take longer time or whether the mere application by the victim would suffice. Recognizing the burden this type of restriction might create, other countries have refused to include this type of procedural “certification” barrier in their abortion law, determining instead that the woman’s statement that a pregnancy is the result of sexual violence or incest is sufficient to meet the legal indication for termination of pregnancy on those grounds.⁴⁸

In addition, the law also requires that a medical doctor perform the abortion, and seek the “advice of another doctor” when possible before proceeding with the abortion to avoid criminal liability.⁴⁹ This requirement for the involvement of multiple doctors is particularly onerous in a country such as Rwanda with a limited number of doctors, as previously noted.⁵⁰ In addition, experts have repeatedly stated that the consultation requirements are inappropriate and delay access to services.⁵¹ The WHO has also made clear that mid-level providers, such as nurses or clinical officers, can safely and beneficially provide first-trimester abortion services.⁵² Further, fulfilling these requirements can cost money, waste time that women may not have, and dangerously delay critical health care, creating additional significant barriers.

In addition the Committee requested the government **to report on the “legislative status of the Reproductive Health Bill and the changes that it would introduce to the current legislation on abortion.”⁵³** Although the government has not responded to this request, in November 2015, it was reported that the parliamentary Standing Committee on Social Affairs has started debating the Bill and intends to fast-track consultations with stakeholders in order to finalize the legislation.⁵⁴ If passed in its current form, the Reproductive Health Bill⁵⁵ would nullify the reforms and severely limit access to safe and legal abortion services. The Bill would only permit abortion “in case of strong beliefs and decision by a medical team of three (3) authorized medical doctors that the pregnancy or the child born out [of] the pregnancy may have a serious impact on the mother's life.”⁵⁶ This would be a severe setback to the efforts to expand access to safe and legal abortion and to reduce maternal mortality from unsafe abortion. Not only does the bill seek to greatly narrow legal abortion, it also seeks to enhance the procedural barriers to accessing legal services by requiring the authorization of *three* medical doctors. These restrictive provisions would not only contravene

accepted medical practice and standards, as indicated above, they would also directly violate international human rights laws and standards concerning access to safe and legal abortion services.

Aggressive enforcement of the laws on abortion

The criminalization of abortion in Rwanda has great implications: for instance, while the revision of the Penal code reduced the penalty for a woman that induces her own abortion or consents to an abortion from 2-5 years⁵⁷ to 1-3 years,⁵⁸ the penalty is still heavy, and the law is aggressively enforced, resulting in the frequent routine arrest, prosecution, and imprisonment of women and girls for procuring an unlawful abortion.⁵⁹ A research published in 2015 by GLIHD and IPAS revealed that from July 2013 to April 2014, 313 women were imprisoned in five prisons for illegal abortions amounting to almost a quarter of the total female prisoners in these prisons.⁶⁰ Similarly, another study found that, in 2010, of the 114 women in Karubanda Prison—one of Rwanda’s main prisons—one in five were in for procuring illegal abortions, and 90% were 25 years old or younger.⁶¹ It also found that some are serving sentences as long as ten years which were imposed when they were adolescents below the age of 18.⁶²

From the women and girls interviewed in the study conducted by GLIHD, some were victims of sexual violence and abuse.⁶³ For instance, Kelly became pregnant when she was 17 years old and procured an unsafe abortion.⁶⁴ She suffered complications and was reported to the police by the school administration. She pleaded guilty even though she would have qualified for a legal abortion since under Rwandan law any sexual relation under the age of 18 is considered defilement.⁶⁵ The study further showed that in a number of instances, those imprisoned were low-income girls and women.⁶⁶ Many were engaged in sexual relations with men “who were paying for their school, clothing and food.”⁶⁷ One study recounts the story of Carol, a 24 years old low-income woman with “limited knowledge [of] the use of condoms or other contraceptives and did not even know that one can get imprisoned for abortion.”⁶⁸ Heavy bleeding stemming from a clandestine abortion compelled her to seek medical treatment in a hospital. She was taken to prison from the hospital and was given a 10-year sentence.

Further, many health professionals are not aware of the law on abortion⁶⁹ and those who provide abortion services risk prosecution and imprisonment. A 26 year old medical doctor who was sentenced to ten years in prison for helping his sister to procure an abortion stated that their parents had died in the 1994 Genocide, leaving them all alone. He undertook to help her procure an abortion when the man who was responsible for her pregnancy abandoned her. She died during the unsafe abortion, and he was subsequently reported to the police and imprisoned.⁷⁰

Rwanda’s criminalization of abortion through its Penal Code, and the fear of being imprisoned if found to have procured, provided, assisted with procuring, or had knowledge that an illegal abortion was procured continues to heavily stigmatize women seeking access to abortion-related services. One immediate consequence is that women are forced to seek clandestine abortions, often having to travel long distances and, as the statistics show, almost always exposing themselves to unsafe abortion. Many interviewees in one study on abortion in Rwanda noted that they traveled to the Democratic Republic of Congo or Uganda to access abortion.⁷¹ Many were required to remain at the place where the unsafe abortion was procured, mostly in unfamiliar and sometimes unfriendly surroundings, in order to recuperate before making the long journey home.⁷² This further heightens their sense of vulnerability and the stigma attached to abortion.

Studies have shown that 47% of all pregnancies in Rwanda are unintended and that 22% of the country’s unintended pregnancies result in induced abortions.⁷³ Many of the women and adolescent girls who make up these numbers seek out clandestine and unsafe abortions due to the restrictive

abortion law.⁷⁴ Overall, half of all abortions in Rwanda are performed by untrained individuals and are considered to be very high risk, with poor rural women being the most likely to go to untrained providers or self-induce.⁷⁵ Consequently, approximately 40% of abortions in Rwanda result in complications and require medical treatment.⁷⁶ Approximately 26,000 women each year are treated for abortion complications, with about 17,000 of these complications likely resulting from induced abortions (65%).⁷⁷ Methods of unsafe abortion include ingesting drugs and herbs and inserting metal objects or other items into the vagina.⁷⁸ In 2012 alone, approximately 18,000 women were treated for complications resulting from unsafe abortion, costing an estimated USD 1.7 million.⁷⁹

The restrictive laws on abortion—particularly the procedural requirements for accessing safe abortion services—have a disparate effect on women based on their age, level of income, and geographical location. For instance, this is reflected in the higher incident of abortion related complications that require treatment in health facilities among low-income women (54-55%) than those in a higher wealth quintile (20% among urban non-poor and 38% of rural non-poor).⁸⁰ The complication rates are highest for procedures carried out by the woman herself (67%) and by traditional healers (61%), the two forms of abortions that adolescents, low-income women, and those living in rural areas are most likely to undergo.⁸¹

Post-Abortion Care

Post-abortion care (PAC) encompasses a set of interventions to respond to the needs of women and girls who have miscarried or induced an abortion.⁸² It has been recognized that PAC should be integrated with other available maternal health services.⁸³ However, the potential for prosecution deters Rwandan women and girls from seeking necessary post-abortion treatment after procuring unsafe abortions.⁸⁴ About 30% of those who experience complications are ultimately unable to access PAC and treatment at health centers.⁸⁵ For those that seek care, barriers to access to quality care include inadequate equipment and medical supplies in health care facilities and insufficient training of health care providers.⁸⁶ Moreover, very few providers employ techniques recommended by the WHO for treating uncomplicated post-abortion cases.⁸⁷

The large demand for PAC services also results in significant costs for individuals and the Rwandan health system as a whole. A 2014 study estimated that the annual average cost of PAC per person in Rwanda is USD 93, while the national cost is USD 1.7 million per year.⁸⁸ The study states that “[s]atisfying all demands for PAC would raise the national cost to USD 2.5 million per year,” adding that “PAC comprises a significant share of total expenditure in reproductive health in Rwanda.”⁸⁹ Improving access to safe abortion would reduce the need for PAC and enhance Rwanda’s ability to provide sufficient access to PAC services.

In March 2012, Rwanda released its first National Comprehensive Treatment Protocol for PAC Services.⁹⁰ The Protocol confirms that health care providers should only use the procedures recommended by the WHO to treat incomplete abortions.⁹¹ Releasing this protocol for PAC indicates that the government recognizes and acknowledges the importance of PAC. However the ongoing lack of adequate access to the service is particularly dismal given that 20%—almost a quarter—of women in Rwanda will, during their reproductive years, need medical care for abortion-related complications.⁹²

Although the Rwandan Government’s current report to the Committee states that measures have been taken to help women “prevent unwanted pregnancies and to ensure they do [not have to] undergo life threatening clandestine abortions,”⁹³ the government has failed to include concrete information regarding these measures. The government has also not reported on the rate of unsafe abortion, and the mortality and morbidity rates as a result.

IV. INADEQUATE ACCESS TO CONTRACEPTIVE INFORMATION AND SERVICES

The Committee has recognized that the right to contraception is rooted in the right to life, rights related to family, and the right to equality and nondiscrimination.⁹⁴ The United Nations Population Fund (UNFPA) has further confirmed that the right to family planning is a fundamental human right tied closely to the recognition of other rights, including the right to life, education, and life with dignity.⁹⁵ The International Covenant on Economic, Social and Cultural Rights guarantees the right to enjoy the benefits of scientific progress, which should include access to family planning services.⁹⁶

In the LOIs the Committee asked the government to provide information on **the steps “taken to ensure access to family planning services and information, including emergency contraception, and to address disparities in access.”**⁹⁷ Although the government has not responded to this request, reports indicate that the government has taken some steps to ensure access. For instance, the Health Sector Strategic Plan 2012-2018 assessed the family planning program and made recommendations including scaling up community based family planning and expanding the distribution of condoms in both the public and private sectors.⁹⁸ Under the Family Planning Strategic Plan 2012-2016, the government aims to achieve a contraceptive prevalence rate of 70% by the end of 2015 and 90% by 2017.⁹⁹ However, in order to achieve this goal, Rwanda needs to address the different challenges, including by increasing the number of health care professionals, investments in health infrastructures and equipment, and improving and monitoring of quality care.¹⁰⁰

In recent years, the use of modern contraceptives among married women in Rwanda has shown some improvement: going from 4% in 2000 to 48% in 2015.¹⁰¹ However, still 19% of married women of child bearing age want to avoid or postpone their pregnancy but are not using contraceptives.¹⁰² This is a slight decrease from 2010 when 21% of married woman had an unmet need for contraceptives.¹⁰³ Only 47% use a modern contraceptive method.¹⁰⁴ Further, adolescent girls, low-income, and rural women often face additional obstacles to accessing family planning services. The 2015 RDHS found that 45% of women in the lowest wealth quintile used modern contraceptives, whereas usage is 50% for women in the highest wealth quintile.¹⁰⁵

This low contraceptive prevalence rate and the high level of unmet need can be attributed to the numerous barriers women encounter in accessing contraceptive information and services. In Rwanda discussing family planning is considered taboo and most women rarely discuss family planning with their husbands.¹⁰⁶ In addition, most health care facilities are religiously affiliated and do not offer contraception.¹⁰⁷ Specifically, 40% of health care facilities are religiously affiliated¹⁰⁸ and 60% of these facilities with religious affiliations do not offer contraception, which amounts to 25% of all facilities.¹⁰⁹ As a result women living in the areas these facilities serve may find it to be more difficult to obtain contraceptives. Unmarried women who use contraceptives suffer cultural stereotyping as they are often assumed to be promiscuous, which further deters use of contraceptives among unmarried sexually active women.¹¹⁰ Due to this, nearly half of all the pregnancies in Rwanda are unintended, amounting to an estimated 276,000 pregnancies.¹¹¹ In 2013, the Committee on Economic, Social and Cultural Rights (CESCR Committee), concerned about the difficulties women encounter in accessing family planning services, particularly in rural areas, recommended that the state ensure access to all women.¹¹² This is particularly important since, maternal deaths in Rwanda could be reduced by a third by addressing the unmet need for modern contraceptive methods.¹¹³

Emergency Contraception

Emergency contraception (EC) is a vital tool for preventing unplanned and unwanted pregnancies and is a critical component of care for survivors of sexual violence.¹¹⁴ Rwanda recognizes that EC should be provided to survivors of sexual violence as soon as possible after the assault.¹¹⁵ EC pills are also included in Rwanda's Essential Drug List.¹¹⁶ However, a survey of clinics showed EC was not readily available.¹¹⁷ For instance, only 16% of facilities surveyed have ever offered EC, noting that the day the survey was taken only 5% of the facilities had EC available.¹¹⁸

A further barrier to access to EC is lack of knowledge of the option. Although the 2015 RDHS key indicators report does not contain information regarding EC, according to the 2010 RDHS, only 39% of men and 23% of women have knowledge of the method, the least known method of contraception in Rwanda.¹¹⁹ In a 2012 Rwanda Ministry of Health, National University of Rwanda School of Public Health and IntraHealth International study, only 5% of the health care providers that were participants reported regularly including EC as part of family planning discussions with patients and almost 40% of the providers said they never include the topic in their discussions.¹²⁰

Adolescents' Access to Family Planning Information and Services

Adolescent girls run a disproportionate risk of dying during or after childbirth and are more vulnerable to pregnancy-related complications.¹²¹ Also, as the 2015 RDHS notes, early childbearing constraints adolescent girl's ability to pursue educational opportunities,¹²² thereby limiting her job opportunities. However, in addition to the general barriers to accessing reproductive and health services in Rwanda, adolescents and youths face particular challenges, including misconceptions, lack of youth-friendly services/providers, and social stigma associated with use of the services that are available.¹²³ This is significant as approximately 29.5% of the entire population is between 10-19 years old and, although the fertility rate for 15-19 year olds declined from 60 per 1,000 in 1992 to 41 per 1,000 in 2010, this population continues to suffer from a higher unmet need for health services than similarly situated populations.¹²⁴

Approximately, 7% of girls age 15-19 have begun child bearing—that is, they have either given birth or are pregnant.¹²⁵ This is a slight increase from the 2010 when 6% of the same age group has started childbearing.¹²⁶ At age 19, 21% have begun childbearing.¹²⁷ A strong inverse relationship exists between early childbearing and education. According to 2015 RDHS, 13% of adolescents without formal education started childbearing, compared to only 9% of adolescents with primary education and 4% of adolescents with secondary education.¹²⁸ Adolescent pregnancy also disproportionately affects low-income girls, who are almost twice as likely to start childbearing as their counterparts in the highest wealth quintile, 11% and 6% respectively.¹²⁹

In one study that documented the role that the lack of information and education in respect to health services plays in the unintended pregnancies of adolescents, the young women interviewed cited a variety of factors, ranging from a lack of knowledge of where to access reproductive health services to misconceptions about their ability to use contraceptive methods (e.g. the pill) themselves rather than relying on their male sexual partners to use condoms, as contributing to their unintended pregnancies.¹³⁰ Another assessment conducted in 2011 also found that adolescents and youth are often unable to discuss sexual issues freely with their parents, which further restricts their ability to access reproductive health services.¹³¹

Social stigma connected to adolescent sexual activity is also a barrier to adequate access for adolescents. This is evidenced by the fact that the unmet need for family planning in Rwanda is much higher for unmarried women age 15-19. According to the 2010 RDHS, 48% of unmarried

women age 15-19 have an unsatisfied demand for modern methods as opposed to nineteen percent of married women in the same age group.¹³²

V. SEXUAL AND PHYSICAL VIOLENCE AGAINST WOMEN AND GIRLS

The right to be free from discrimination includes the right to be free from gender-based violence and harmful practices. In its 2009 Concluding Observations, the CEDAW Committee expressed concern regarding discriminatory laws and practices in Rwanda.¹³³ The CEDAW Committee further expressed concern regarding “the persistence of deeply rooted, traditional patriarchal stereotypes regarding the role and responsibilities of women and men in the family and in the wider community which result in violence against women....”¹³⁴ In 2012, the Committee Against Torture indicated the dearth of comprehensive data on domestic violence in Rwanda is a concern and further recommended women victims in Rwanda be provided with assistance and that the government “facilitate the lodging of complaints by women against perpetrators, and ensure prompt, impartial and effective investigations of all allegations of sexual violence as well as prosecute suspects and punish perpetrators.”¹³⁵ More recently, in 2013, the CESCRC Committee stated its concern regarding the high incidences of violence in Rwanda, including sexual violence, despite legislations and other measures adopted by the government, and the lack of information on investigations, prosecutions, convictions and penalties for perpetrators.¹³⁶

The Committee, seeking additional information on the issue of gender based violence (GBV) in Rwanda, requested the government **to provide disaggregated data (by sex, age and geographical location) the number of complaints received, investigated, and prosecuted; the conviction rate and type of penalty imposed; and the protection measures including compensation provided to victims.**¹³⁷ It further requested the government to “**elaborate on the scope and geographical coverage of the support services provided by the Isange One-Stop Centre in relation to the demand, and explain whether the State party intends to provide legal assistance and free medical services to all victims of gender-based and/or domestic violence.**”¹³⁸ In its response to the LOIs and current report to the Committee, the Rwandan Government stated that it has “zero tolerance to domestic violence and other types of gender-based violence” and details a number of initiatives that are being implemented to curb gender based violence including laws that punish both sexual and physical violence, mechanisms for reporting and investigation of the crimes of violence, awareness raising campaigns and the services available to victims.¹³⁹ For instance, specialized units within the national police and prosecution offices as well as helpline and online services have been established to handle GBV cases and provide support to victims.¹⁴⁰ Currently, according to the government’s response, 12 Isange One-Stop Centers have been established in various district hospitals and there is a plan to have one in each district (30 in total) by the end of 2016.¹⁴¹ These centers provide “free, 24-hour medical, psychological counselling and medico-legal services and emergency safe houses for victims.”¹⁴² However, the both the state’s report and its response to the LOIs fail to provide information on the rate of sexual and physical violence and the corresponding rate of conviction as well as the impact of these various initiatives in reducing violence as requested by the Committee.

According to a recent news report, Rwanda “continues to have one of the highest incidences of gender-based and domestic violence in Africa”¹⁴³ Citing a report from the United Nations Development Programme, the article states that one in three Rwandan women has suffered or continues to suffer violence from male relatives.¹⁴⁴ Although the 2015 RDHS key indicators report does not contain data on the issue, the 2010 RDHS reported that, nearly half of all women between the ages of 15 and 49 have experienced physical or sexual violence at least once in their lifetime.¹⁴⁵ About 41% of all women in Rwanda have experienced physical violence since reaching the age of

15.¹⁴⁶ Ninety-five percent of the victims who were currently married women between the ages of 15 and 49 reported that they had been abused by their current husband or partner.¹⁴⁷ Twenty two percent of women have also experienced sexual violence during their lifetime¹⁴⁸ and 51% of this group had been abused by a current or former husband, partner, or boyfriend.¹⁴⁹ Additionally, 13% of women ever married had experienced sexual violence in the twelve months preceding the survey.¹⁵⁰ Between 2005 and 2008 there were over 2,000 cases of rape reported to the police and 259 reported cases of women being killed by their husbands.¹⁵¹

Economics and education seem to bear on a woman's experience with physical violence in Rwanda. Women's experience of physical violence is highest in the lowest wealth quintile (49%), and is lowest in the highest wealth quintile (33%).¹⁵² The proportion of women who have experienced physical violence declines steeply with education, from 53 percent of women with no education to 24 percent of women with secondary and higher education.¹⁵³

Rwanda also suffers from a prevalence of sexual and physical violence against children. For instance, 9% (almost 1 out of every 10) of the students at the Gahanga Primary School—which was the subject of media reports due to sexual abuse—reported that they had been sexually abused at least once, according to a survey conducted by the school in 2007.¹⁵⁴ The Rwanda National Police report that between 2005 and 2008 there were 10,000 cases of child defilement.¹⁵⁵ In 2009 there were 1,570 cases of child rape recorded.¹⁵⁶ The Rwanda National Police also report that there were 863 cases of violence against children reported between January and July 2012,¹⁵⁷ and 1,682 and 1,445, cases of defilement resisted in 2012 and 2013, respectively.¹⁵⁸ It should be noted that these statistics do not give a comprehensive portrayal of the issue since gender-based violence, particularly sexual violence, tends to be under-reported.¹⁵⁹

Sexual violence and other discriminatory practices in Rwandan schools also significantly interfere with access to education for girls. A June 2011 survey conducted by the State Minister in charge of Primary and Secondary Education found that over 600 children were sexually, physically, and psychologically abused in the previous two years across the country.¹⁶⁰ Those incidents resulted in at least 110 pregnancies.¹⁶¹ The Minister concluded the abuse was committed by relatives, teachers, and other community members, explaining that “[m]ale teachers in most primary schools take advantage of their positions to abuse pupils who fear and respect them.”¹⁶²

VI. RECOMMENDATIONS

We hope that the Committee will consider addressing the following recommendations to the government of Rwanda:

1. The government should continue its efforts to reduce the high rate of maternal mortality and improve access to maternal health information and services including ante-natal, delivery, and post-natal care to ensure that it continues to be on track to achieve the Sustainable Development Goals. Such measures should include increasing the number of health care facilities equipped and staffed to handle basic and emergency obstetric care, especially in low-income and rural areas, and increasing the number of skilled health care providers able to offer quality and convenient antenatal care and post-natal care, as well as skilled assistance during childbirth. The government should also facilitate free transportation to quality health care facilities for women in low-income and rural areas.
2. The government should ensure that women and girls have access to safe abortion services, and that its abortion law is in line with its obligations under international and regional treaties, including by revising the law to remove the court and two doctors authorization

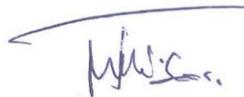
requirements to access abortion. It should set up a mechanism for reviewing the long sentences already imposed on some women for illegal abortion to commute their sentences or grant them pardons. It should further ensure that health care facilities are well equipped and health care professionals are trained to provide PAC services.

3. The government should take concrete steps to ensure an adequate and consistent supply of contraceptives, including emergency contraception, initiate civic education campaigns to ensure sufficient and non-discriminatory access to family planning information and services and develop comprehensive guidelines obligating health care facilities to provide accurate and comprehensive family planning information, without discrimination.
4. The Government should continue its efforts to implement measures to address the high gender-based violence and provide victims with the necessary medical and legal services. It should also take all steps necessary to prevent, investigate, and prosecute incidents of physical and sexual violence against women and girls. Further, the government should gather data on the issue to monitor and evaluate the effectiveness of the different initiatives it is implementing.

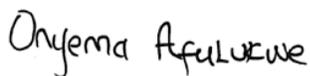
We hope this information is useful during the Committee's review of Rwanda. If you have any questions, or would like further information, please do not hesitate to contact the undersigned.



Evelyne Opondo
Regional Director
Africa Program
Center for Reproductive Rights



Tom Mulisa
Executive Director
Great Lakes Initiative for
Human Rights Development



Onyema Afulukwe
Senior Legal Advisor
Africa Program
Center for Reproductive Rights

¹ International Covenant on Civil and Political Rights, *adopted* Dec. 16, 1966, art. 3, G.A. Res. 2200A (XXI), U.N. GAOR, 21st Sess., Supp. No. 16, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 171 (*entered into force* Mar. 23, 1976) (*acceded* Dec. 22, 1993) [hereinafter ICCPR].

² *Id.*, art. 2.

³ Human Rights Committee, *Concluding Observation: Jordan*, para. 7, U.N. Doc. CCPR/C/JOR/CO/4 (2010).

⁴ Human Rights Committee, *General Comment No. 28: Article 3 (The equality of rights between men and women)*, (68th Sess., 2000), in *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, para. 3, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. I) (2008) (emphasis added) [hereinafter Human Rights Committee, *Gen. Comment No. 28*].

⁵ Human Rights Committee, *Concluding Observation: Dominican Republic*, para. 10, U.N. Doc. CCPR/C/DOM/CO/5 (2012).

⁶ Human Rights Committee, *Concluding Observation: Guatemala*, para. 8, U.N. Doc. CCPR/C/GTM/CO/3 (2012).

⁷ Human Rights Committee, *Concluding Observation: Cape Verde*, para. 8, U.N. Doc. CCPR/C/CPV/CO/1 (2012).

⁸ Human Rights Committee, *Concluding Observation: Canada*, para. 20, U.N. Doc. CCPR/C/79/Add.105 (1999).

⁹ Human Rights Committee, *Concluding Observation: Kyrgyzstan*, para. 401, U.N. Doc. U.N. Doc. A/55/40 (2000).

¹⁰ Rebecca Cook, *Human Rights and Reproductive Self Determination*, 44 THE AMERICAN UNIVERSITY LAW REVIEW 975, 1007 (1995).

¹¹ *Id.* at 1007.

¹² Committee on the Elimination of Discrimination against Women (CEDAW Committee), *General Recommendation No. 24: Article 12 of the Convention (women and health)*, (20th Sess., 1999), in *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, art. 24, para. 31(e), U.N. Doc. HRI/GEN/1/Rev.9 (Vol. II) (2008) [hereinafter CEDAW Committee, *Gen. Recommendation No. 24*].

¹³ Human Rights Committee, *Concluding Observation: Canada*, para. 20, U.N. Doc. CCPR/C/79/Add.105 (1999) (expressing concern over cuts to social welfare programs that have disproportionately harmed women, especially single mothers, and recommending making an assessment of the impact of such cuts and taking action to redress any discriminatory effects); *Guatemala*, CCPR/C/GTM/CO/3 para. 8 (2012) (calling on the state to adopt and implement gender equality legislation and to “develop additional policies to promote genuine gender equality” which especially address the needs of indigenous women and Afro-descendent women who face multiple forms of discrimination); *Republic of Korea*, U.N. Doc. CCPR/C/KOR/CO/3 para. 12 (2006) (recommending that the Republic of Korea ensure “equal access to social services” after the HRC received information that immigrants faced numerous non-legal barriers in accessing healthcare despite a 2003 law granting them the legal right to access the national healthcare system on an equal basis of citizens).

¹⁴ *See, e.g.*, Human Rights Committee, *Concluding Observations: Argentina*, para. 14, U.N. Doc. CCPR/CO/70/ARG (2000); *Poland*, para. 12, U.N. Doc. CCPR/C/POL/CO/6 (2010).

¹⁵ CENTER FOR REPRODUCTIVE RIGHTS, *Preventing Maternal Mortality and Ensuring Safe Pregnancy*, in BRINGING RIGHTS TO BEAR 9 (2008).

¹⁶ Committee on Economic, Social and Cultural Rights (ESCR Committee), *General Comment No. 14: The right to the highest attainable standard of health (Art. 12)*, (22nd Sess., 2000), in *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. I) (2008) [hereinafter ESCR Committee, *Gen. Comment No. 14*]; *see, e.g.*, CEDAW Committee, *Concluding Observations: Belize*, para. 56, U.N. Doc. A/54/38 (1999); *Colombia*, para. 393, U.N. Doc A/54/38 (1999); *Dominican Republic*, para. 337, U.N. Doc A/53/38 (1998); *Madagascar*, para. 244, U.N. Doc A/49/38, (1994).

¹⁷ CEDAW Committee, *Gen. Recommendation No. 24*, *supra* note 12, para. 27.

¹⁸ CESCR Committee, *Concluding Observations: Rwanda* para.26 (2013) UN Doc E/C.12/RWA/CO/2-4; CEDAW Committee, *Concluding Observations: Rwanda* para. 35 & 36 U.N. Doc. CEDAW/C/RWA/CO/6 (2009); CRC Committee, *Concluding Observations: Rwanda*, para. 48 & 49 U.N. Doc. CRC/C/15/Add.234 (2004).

¹⁹ WORLD HEALTH ORGANIZATION (WHO) ET AL., *TRENDS IN MATERNAL MORTALITY: 1990-2015* 75 (2015).

²⁰ *Id.*, at 26.

²¹ SUSTAINABLE DEVELOPMENT GOALS, GOAL 3 TARGETS (2015) available at <http://www.un.org/sustainabledevelopment/health/>.

²² Overseas Development Institute, *Briefing Paper: Delivering Maternal Health: Why Is Rwanda Doing Better than Malawi, Niger and Uganda?* 1 (2012), available at <http://www.odi.org.uk/resources/docs/7696.pdf>.

²³ National Institute of Statistics of Rwanda, et al., *Rwanda Demographic Health Survey 2014-2015: Key Indicators* 16 (2015) available at <http://dhsprogram.com/pubs/pdf/PR65/PR65.pdf> [hereinafter 2015 RDHS: key indicators].

²⁴ WHO, GLOBAL HEALTH OBSERVATORY, *Antenatal care (at least 4 visits)* (2012),

http://www.who.int/gho/urban_health/services/antenatal_care_text/en/index.html (last visited March 11, 2015).

²⁵ 2015 RDHS: key indicators, *supra* note 24, tbl. 9.

²⁶ *Id.*, at 17.

²⁷ See DEPARTMENT FOR INTERNATIONAL DEVELOPMENT (DFID), THE WHITE RIBBON ALLIANCE FOR SAFE MOTHERHOOD, RWANDA STRATEGIC PLAN 2010-2013 AND ONE YEAR OPERATIONAL PLAN 9 (2010), available at http://hdc.dfid.gov.uk/wp-content/uploads/2012/05/275007_RW-Consultancy-to-Finalise-the-Strategic-Plan-for-White-Ribbon-Alliance-Rwanda-2010-2013_Strategic-Plad.n.pdf.

²⁸ 2015 RDHS: key indicators, *supra* note 24, tbl. 9.

²⁹ MINISTRY OF HEALTH RWANDA, *Rwanda Annual Health Statistics Booklet 20* (2013), available at http://www.moh.gov.rw/fileadmin/templates/MOH-Reports/MOH_Booklet_2012_final_September_2013.pdf

³⁰ UNFPA ET AL., THE STATE OF THE WORLD'S MIDWIFERY 2014: A UNIVERSAL PATHWAY. A WOMAN'S RIGHT TO HEALTH 158 (2014).

³¹ *Id.*

³² United Nations Rwanda, *Health Workers call for increase number of midwives*, May 7, 2015 available at <http://www.rw.one.un.org/press-center/news/health-workers-call-increased-number-midwives> (last accessed Feb. 10, 2015).

³³ PMNCH ET AL., SUCCESS FACTORS FOR WOMEN'S AND CHILDREN'S HEALTH 23 (2014), available at http://www.who.int/pmnch/knowledge/publications/rwanda_country_report.pdf [hereinafter PMNCH ET AL., SUCCESS FACTORS].

³⁴ Human Rights Committee, *Consideration of reports submitted by States parties under article 40 of the Covenant – Fourth periodic reports of States parties due in April 2013: Rwanda*, para. 6, U.N. Doc. CCPR/C/RWA/4 (2014) [hereinafter *Consideration of reports*].

³⁵ MINISTRY OF HEALTH AND SOCIAL WELFARE, HUMAN RESOURCE FOR HEALTH COUNTRY PROFILE 2012/2013 34 (2013).

³⁶ REPUBLIC OF RWANDA, RWANDA VISION 2020 25 (2000), available at http://www.gesci.org/assets/files/Rwanda_Vision_2020.pdf.

³⁷ See *Consideration of reports: Rwanda*, *supra* note 35, paras. 123-130.

³⁸ WHO, *Country Accountability Framework: Assessment* (2012), available at http://www.who.int/classifications/Rwanda_Scorecard_and_Roadmap.pdf.

³⁹ Human Rights Committee, *Concluding Observation: Chile*, para. 15, U.N. Doc. CPR/C/79/Add.104 (1999).

⁴⁰ International Covenant on Civil and Political Rights, *adopted* Dec. 16, 1966, art. 3 & 26, G.A. Res. 2200A (XXI), U.N. GAOR, 21st Sess., Supp. No. 16, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 171 (*entered into force* Mar. 23, 1976) (*acceded* Dec. 22, 1993).

⁴¹ Human Rights Committee, *General Comment No. 28: Article 3 (The equality of rights between men and women)*, (68th Sess., 2000), in *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, para. 10, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. I) (2008).

⁴² *Consideration of reports*, *supra* note 39, para. 167.

⁴³ Human Rights Council, *Report of the Working Group on the Universal Periodic Review: Rwanda*, para. 134.45 U.N. Doc. A/HRC/31/8 (2015).

⁴⁴ Human Rights Committee, *List of issues in relation to the fourth periodic report of Rwanda*, para. 7 U.N. Doc. CCPR/C/RWA/Q/4 (2015) [hereinafter *Rwanda: List of issues*].

⁴⁵ Human Rights Committee: *List of issues in relation to the fourth periodic report of Rwanda: Replies of Rwanda to the list of issues*, para. 24 U.N. Doc./CCPR/C/RWA/Q/4/Add.1 [hereinafter *Replies of Rwanda to the list of issues*].

⁴⁶ The Penal Code (2012), GOVERNMENT GAZETTE [REPUBLIC OF RWANDA], arts. 165-166 [hereinafter Penal Code].

⁴⁷ *Id.*, arts. 164-166.

⁴⁸ For example, when Ethiopia liberalized its abortion law in 2004 to include an exception for rape and incest, see art. 551(1)(a), it included an accompanying provision in its Penal Code stating: “In the case of terminating pregnancy in accordance with sub-article (1) (a) of Article 551 the mere statement by the woman is adequate to prove that her pregnancy is the result of rape or incest.” The Criminal Code of the Federal Democratic Republic of Ethiopia (2004), art. 552(2).

⁴⁹ Penal Code, *supra* note 47, arts. 164-166

⁵⁰ Fred Ndoli, *Number of doctors to double by 2017*, THE NEW TIMES (Mar. 19, 2011), <http://www.newtimes.co.rw/section/article/2011-03-19/29442/>.

⁵¹ For example, the United Kingdom's House of Commons Science and Technology Committee in its 2007 report *Scientific Developments Relating to the Abortion Act 1967* stated: “We were not presented with any good evidence that, at least in the first trimester, the requirement for two doctors' signatures serves to safeguard women or doctors in any meaningful way, or serves any other useful purpose. We are concerned that the requirement for two signatures may be causing delays in access to abortion services. If a goal of public policy is to encourage early as opposed to later abortion, we believe there is a strong case for removing the requirement for two doctors' signatures. We would like [to] see the requirement for two doctors' signatures removed.” SCIENCE AND TECHNOLOGY COMMITTEE, HOUSE OF COMMONS, SCIENTIFIC DEVELOPMENTS RELATING TO THE ABORTION ACT 1967: TWELFTH 13

REPORT OF SESSION 2006–07 para. 99 (2007), available at

<http://www.publications.parliament.uk/pa/cm200607/cmselect/cmsctech/1045/1045i.pdf>.

⁵² See Marge Berer, *Provision of Abortion by Mid-Level Providers: International Policy, Practice and Perspectives*, 87 BULLETIN OF THE WHO 58 (2009), available at <http://www.who.int/bulletin/volumes/87/1/07-050138/en/>.

⁵³ *Rwanda: List of issues*, *supra* note 45.

⁵⁴ Eugene Kwibuka, *Legislators' opinion divided as 8-year-old Reproductive Health Bill returns for debate*, The New Times, Nov. 19, 2015 available at <http://www.newtimes.co.rw/section/article/2015-11-19/194531/> (last visited Jan. 18, 2016).

⁵⁵ The private bill was introduced by members of the Parliament but has spent the last five years making rounds between the Chamber of Deputies and the Senate. Emmanuel R. Karake, *Rwanda: Bill to Increase Access to Reproductive Health Spends Five Years in Parliament*, THE NEW TIMES (Aug. 17, 2012), <http://www.newtimes.co.rw/section/article/2012-08-17/56294/>.

⁵⁶ Reproductive Health Bill (2007), art. 23 (Rwanda), available at <http://consciencelaws.org/archive/documents/2013-rwanda-rh-bill.pdf>.

⁵⁷ United Nations, Rwanda: Abortion Policy (2002) available at <http://www.un.org/esa/population/publications/abortion/>.

⁵⁸ Pursuant to the Penal Code, a person might face imprisonment of anywhere from one year up to twenty years and fine of 50,000 to 2,000,000 Rwandan francs as criminal liability for abortion; see Penal Code, *supra* note 47, arts. 162-164.

⁵⁹ See, e.g., IPAS, WHEN ABORTION IS A CRIME: RWANDA (2015) available at <http://www.glihd.org/wp-content/uploads/2015/10/STUDY-WHEN-ABORTION-IS-A-CRIME-RWANDA.pdf> [hereinafter IPAS, WHEN ABORTION IS A CRIME]; See also ARBEF, STORIES ON UNSAFE ABORTION (2012) (unpublished research) (on file with the Center for Reproductive Rights) [hereinafter STORIES ON UNSAFE ABORTION].

⁶⁰ IPAS, WHEN ABORTION IS A CRIME: RWANDA (2015), *supra* note 60, at 8.

⁶¹ STORIES ON UNSAFE ABORTION, *supra* note 60, at 4.

⁶² *Id.*

⁶³ See IPAS, WHEN ABORTION IS A CRIME: RWANDA (2015), *supra* note 60.

⁶⁴ *Id.*, at 15.

⁶⁵ *Id.*, at 14.

⁶⁶ *Id.*, at 9.

⁶⁷ *Id.*, at 14.

⁶⁸ STORIES ON UNSAFE ABORTION, *supra* note 60, at 4.

⁶⁹ IPAS, WHEN ABORTION IS A CRIME: RWANDA (2015), *supra* note 60, at 11.

⁷⁰ STORIES ON UNSAFE ABORTION, *supra* note 60, at 4.

⁷¹ *Id.* at 9.

⁷² See, generally, *id.*

⁷³ BASINGA ET AL, UNINTENDED PREGNANCY AND INDUCED ABORTION IN RWANDA 19 (2012) hereinafter [BASINGA ET AL, UNINTENDED PREGNANCY].

⁷⁴ See STORIES ON UNSAFE ABORTION, *supra* note 60, at 4.

⁷⁵ GUTTMACHER INSTITUTE, FACT SHEET: ABORTION IN RWANDA, (Apr. 2013), www.gutmacher.org/pubs/FB-Abortion-in-Rwanda.html [hereinafter FACT SHEET: ABORTION IN RWANDA].

⁷⁶ *Id.*

⁷⁷ BASINGA ET AL, UNINTENDED PREGNANCY. *supra* note 74, at 5.

⁷⁸ BASINGA ET AL., ABORTION INCIDENCE AND POSTABORTION CARE IN RWANDA, 43 STUDIES IN FAMILY PLANNING 11, 16 (2012) [hereinafter ABORTION INCIDENCE AND POSTABORTION CARE IN RWANDA].

⁷⁹ Guttmacher Institute, In Rwanda, Treating Complications from Unsafe Abortion Drains Scarce Health Resources (2014), available at <https://gutmacher.org/media/nr/2014/05/30/index.html>.

⁸⁰ BASINGA ET AL, UNINTENDED PREGNANCY. *supra* note 74, at 17.

⁸¹ FACT SHEET: ABORTION IN RWANDA, *supra* note 76.

⁸² Sneha Barot, *Implementing Postabortion Care Programs in the Developing World: Ongoing Challenges* 17 GUTTMACHER POLICY REVIEW 1 (2014), available at <http://www.gutmacher.org/pubs/gpr/17/1/gpr170122.html>.

⁸³ BASINGA ET AL, UNINTENDED PREGNANCY. *supra* note 74, at 24.

⁸⁴ *Id.*

⁸⁵ *Id.* at 5.

⁸⁶ ABORTION INCIDENCE AND POSTABORTION CARE IN RWANDA, *supra* note 79, at 17-18.

⁸⁷ *Id.* at 18.

⁸⁸ Michael Vlassoff, et al., *The health system cost of post-abortion care in Rwanda*, OXFORD JOURNALS 1-11 (2014).

⁸⁹ *Id.*

⁹⁰ BASINGA ET AL, UNINTENDED PREGNANCY. *supra* note 74, at 25.

-
- ⁹¹ *Id.*
- ⁹² ABORTION INCIDENCE AND POSTABORTION CARE IN RWANDA, *supra* note 79, *supra* note 79, at 13.
- ⁹³ *Consideration of reports: Rwanda*, *supra* note 35, para. 123.
- ⁹⁴ Human Rights Committee, *Concluding Observation: Albania*, para. 14, U.N. Doc. CCPR/CO/82/ALB (2004); *Hungary*, para. 11, U.N. Doc. CCPR/CO/74/HUN (2003); *Mali*, para. 14, U.N. Doc. CCPR/CO/77/MLI (2003); *Viet Nam*, para. 15, U.N. Doc. CCPR/CO/75/VNM (2002).
- ⁹⁵ UNITED NATIONS POPULATION FUND (UNFPA), *BY CHOICE NOT BY CHANCE: FAMILY PLANNING, HUMAN RIGHTS AND DEVELOPMENT 1* (2012).
- ⁹⁶ International Covenant on Economic, Social and Cultural Rights, *adopted* Dec. 16, 1966, art. 15(1), G.A. Res. 2200A (XXI), U.N. GAOR, Supp. No. 16, U.N. Doc. A/6316 (1966) (*entered into force* Jan. 3, 1976); *see also* Policy Project, *Contraceptive Security*, available at <http://www.policyproject.com/matrix/ContraceptiveSecurity.cfm>.
- ⁹⁷ *Rwanda: List of issues*, *supra* note 45, para. 7.
- ⁹⁸ REPUBLIC OF RWANDA MINISTRY OF HEALTH, FAMILY PLANNING STRATEGIC PLAN 2012-2016 6-7 (2012), available at <http://www.moh.gov.rw/fileadmin/templates/Docs/Rwanda-Family-Planning-Strategic-2012-2013.pdf> [hereinafter FAMILY PLANNING STRATEGIC PLAN].
- ⁹⁹ *Id.*
- ¹⁰⁰ PMNCH ET AL, SUCCESS FACTORS, *supra* note 34.
- ¹⁰¹ 2015 RDHS: Key indicators, *supra* note 24, at 11.
- ¹⁰² *Id.*, at 13.
- ¹⁰³ *Id.*, at 14.
- ¹⁰⁴ *Id.*, at 12.
- ¹⁰⁵ *Id.* at 13.
- ¹⁰⁶ Dieudonné Muhoza Ndaruhuye et al., *Demand and Unmet Need for Means of Family Limitation in Rwanda*, 35(3) INT'L PERSPECTIVES ON SEXUAL & REPRODUCTIVE HEALTH 122 (Sept. 2009) [hereinafter *Demand and Unmet Need for Means of Family Limitation*]
- ¹⁰⁷ JULIE SOL, FAMILY PLANNING IN RWANDA – HOW A TABOO TOPIC BECAME PRIORITY NUMBER ONE 22 (2008), available at <http://www.ppdafrica.org/docs/SEAPACOH2010/fpRwanda.pdf>.
- ¹⁰⁸ *Id.*
- ¹⁰⁹ *Demand and Unmet Need for Means of Family Limitation*, *supra* note 108, at 123.
- ¹¹⁰ ABORTION INCIDENCE AND POSTABORTION CARE IN RWANDA, *supra* note 79, at 2.
- ¹¹¹ UNINTENDED PREGNANCY, *supra* note 78, at 19.
- ¹¹² CESCRO Committee, *Concluding Observations: Rwanda*, para. 26 U.N. Doc. E/C.12/RWA/CO/2-4 (2013).
- ¹¹³ *Health Providers Trained on Family Planning*, UNFPA RWANDA (May 26, 2012), countryoffice.unfpa.org/rwanda/2012/05/26/5061/health_providers_trained_on_family_planning/ (last visited Apr. 8, 2015).
- ¹¹⁴ WHO, *Emergency Contraception Fact Sheet No. 244* (2012), available at <http://www.who.int/mediacentre/factsheets/fs244/en/>.
- ¹¹⁵ Jill Thompson et al., ACCESS TO EMERGENCY CONTRACEPTION AND SAFE ABORTION SERVICES FOR SURVIVORS OF RAPE: A REVIEW OF POLICIES, PROGRAMMES AND COUNTRY EXPERIENCES IN SUB-SAHARAN AFRICA, STEP UP RESEARCH REPORT 12 (2014), available at http://www.popcouncil.org/uploads/pdfs/2014STEPUP_EC-SA_Report.pdf.
- ¹¹⁶ Revitalizing the Emergency Contraception Agenda, *Counting What Counts: Tracking access to emergency contraception in Rwanda* (2013), available at http://www.cecinfo.org/custom-content/uploads/2013/09/Rwanda_2013.pdf.
- ¹¹⁷ International Consortium for Emergency Contraception, *Counting What Counts: Tracking Access to Emergency Contraception in Rwanda 1* (2015) [hereinafter *Counting What Counts*].
- ¹¹⁸ *Id.*
- ¹¹⁹ National Bureau of Statistics (Rwanda), *Rwanda Demographic and Health Survey 2010*, 86 (2011), available at <http://www.measuredhs.com/pubs/pdf/FR259/FR259.pdf> [hereinafter 2010 RDHS].
- ¹²⁰ *Counting What Counts*, *supra* note 119.
- ¹²¹ WHO & UNFPA, PREGNANT ADOLESCENTS: DELIVERING ON GLOBAL PROMISES OF HOPE 10 (2006).
- ¹²² 2015 RDHS: Key indicators, *supra* note 24, at 9.
- ¹²³ FAMILY PLANNING STRATEGIC PLAN, *supra* note 100.
- ¹²⁴ *Id.* at 18.
- ¹²⁵ 2015 RDHS: Key indicators, *supra* note 24, at 10.
- ¹²⁶ 2010 RDHS, *supra* note 121, at 75.
- ¹²⁷ 2015 RDHS: Key indicators, *supra* note 24, at 10.
- ¹²⁸ *Id.*

¹²⁹ *Id.*

¹³⁰ *See, e.g.*, Association Rwandaise pour le Bien-Être Familial (ARBEF), ABORTION AND YOUNG PEOPLE IN RWANDA (2012) available at <http://www.rutgers.international/sites/rutgersorg/files/pdf/2011%20YAM%20booklet%20of%20personal%20stories%20on%20abortion.pdf>.

¹³¹ MINISTRY OF HEALTH, RAPID ASSESSMENT OF ADOLESCENT SEXUAL REPRODUCTIVE HEALTH PROGRAMS, SERVICES AND POLICY ISSUES IN RWANDA (2011).

¹³² The 2015 DHS Key Indicators report does not contain information on the level of unmet need for unmarried women aged 15-19: 2010 RDHS, *supra* note 121, at 238.

¹³³ CEDAW Committee, *Concluding Observations: Rwanda*, U.N. Doc. CEDAW/C/RWA/CO/6 (2009).

¹³⁴ *Id.* para. 21.

¹³⁵ CAT Committee, *Concluding Observations: Rwanda*, para. 16, U.N. Doc. CAT/C/RWA/CO/1 (2012).

¹³⁶ CESCRC Committee, *Concluding Observations: Rwanda* para.26 (2013) UN Doc E/C.12/RWA/CO/2-4

¹³⁷ *Rwanda: List of issues*, *supra* note 45, para. 6.

¹³⁸ *Id.*

¹³⁹ *See, Consideration of reports: Rwanda*, *supra* note 35, paras. 23-30; *see also Replies of Rwanda to the list of issues*, *supra* note 46, para. 14-23.

¹⁴⁰ *Replies of Rwanda to the list of issues*, *supra* note 46, para. 17.

¹⁴¹ *Id.*, para. 19.

¹⁴² *Id.*

¹⁴³ Nishtha Chugh, *A Drive to Beat Rwanda's Gender-Based Violence*, THE GUARDIAN (Nov. 22, 2013), <http://www.theguardian.com/global-development-professionals-network/2013/nov/22/rwanda-gender-based-violence>.

¹⁴⁴ *Id.*

¹⁴⁵ 2010 RDHS, *supra* note 121, at 246.

¹⁴⁶ *Id.* at 241.

¹⁴⁷ *Id.* at 243.

¹⁴⁸ *Id.*

¹⁴⁹ *Id.* at 245.

¹⁵⁰ *Id.* at 246.

¹⁵¹ Joseph Kamugisha, *Gender based violence should be society's big health concern*, THE NEW TIMES (Mar. 10, 2009), <http://www.newtimes.co.rw/section/article/2009-03-09/7519/> [hereinafter Kamugisha, *Gender based violence*].

¹⁵² 2010 RDHS, *supra* note 121, at 242 (noting, however, that the relationship is not linear).

¹⁵³ *Id.*, at 242.

¹⁵⁴ Eugene Mutara, *Grim Defilement Stats at City Primary School*, THE NEW TIMES (Sept. 3, 2007), <http://www.newtimes.co.rw/section/article/2007-09-03/1071/>.

¹⁵⁵ Kamugisha, *Gender based violence*, *supra* note 153.

¹⁵⁶ CAT Committee, *Concluding Observations: Rwanda*, para. 16, U.N. Doc. CAT/C/RWA/CO/1 (2012).

¹⁵⁷ Rwanda National Police, *Let Us End Violence against Children*, (Aug. 9, 2012),

<http://www.police.gov.rw/content/let-us-end-violence-against-children> (last visited Mar. 11, 2013).

¹⁵⁸ Rwanda National Police, *New Rwanda National Police bell against GBV, child abuse*, (August 25, 2014) (last visited Feb. 12, 2016).

¹⁵⁹ *See* Rwanda National Police, *Police urges public to report GBV cases* (May 23, 2012), <http://www.hope-mag.com/index.php?com=news&option=read&ca=1&a=237> (last visited Feb. 12, 2016).

¹⁶⁰ Stephen Rwembeho, *Minister Cautions against Child Abuse in Schools*, THE NEW TIMES (Aug. 24, 2011), <http://www.newtimes.co.rw/section/article/2011-08-23/34264/>; Bosco R. Asiimwe, *Survey Exposes Abuse in Schools*, THE NEW TIMES (Aug. 21, 2011), <http://www.newtimes.co.rw/section/article/2011-08-21/34181/>.

¹⁶¹ *Id.*

¹⁶² *Id.*