

October 8, 2012

Committee on Economic, Social and Cultural Rights
Office of the United Nations High Commissioner for Human Rights
Palais des Nations
CH-1211 Geneva 10, Switzerland

Re: Supplementary information on the Republic of Rwanda Submitted to the Pre-Sessional Working Group of the Committee on Economic, Social and Cultural Rights during its 50th Session

Dear Committee Members:

This letter is intended to supplement the periodic report of the Government of the Republic of Rwanda, scheduled for a pre-session review by this Committee during its 48th session. The Center for Reproductive Rights (the Center), an independent nongovernmental organization based in New York, with regional offices in Nairobi, Kenya, Kathmandu, Nepal, and Bogota, Colombia, uses the law to advance reproductive freedom as a fundamental right. With this submission, the Center hopes to further the work of the Committee by providing independent information concerning the rights protected in the International Covenant on Economic, Social and Cultural Rights (the Covenant).

Rwanda has ratified the Covenant and seven other major international human rights treaties and has withdrawn any reservations it previously entered on any of these treaties.¹ Under its legal system, international and regional laws and treaties immediately become part of the national law upon ratification.² Moreover, under Articles 189 and 190 of the Rwandan Constitution, any treaty, which the government has ratified, takes precedence over national laws.³

This pre-session letter provides a summary of several areas of concern and a list of questions that we hope the Committee will raise with the Rwandan delegation prior to the consideration of its report. We wish to bring to the Committee's attention to the following areas of particular concern: the high rates of preventable maternal mortality and morbidity; lack of access to safe abortion services and post-abortion care; aggressive enforcement of laws prohibiting abortion which has resulted in the imprisonment of many women and adolescent girls; women's inadequate access to family planning services and information; and discrimination against people

living with HIV/AIDS. These problems reflect shortfalls in the government's implementation of the Covenant and directly affect the health and lives of women in Rwanda.

Women's Reproductive Health Rights (Article 2(2), 3, 10(2), 12 and 15(1)(b) of the Covenant)

Guaranteeing reproductive rights and access to reproductive and sexual health services is fundamental to women's health and equality. This is recognized in the Covenant and receives broad protection.⁴

The Committee identifies the right to health as a core obligation of the state.⁵ States must comply with the non-discrimination principle, which prohibits discrimination based on race, color, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.⁶ The Covenant also aims to ensure the equal right of men and women to "the enjoyment of the highest attainable standard of physical and mental health," including the benefits of scientific progress.⁷

Recognizing that vulnerable populations face substantial barriers that limit their access to health care services, the Covenant imposes a duty to provide special protection to children as well as pregnant women before and after delivery.⁸ It also establishes "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health."⁹ To that end, it urges states to create conditions that assure access to medical service for all.¹⁰

The Covenant has a comprehensive definition of the right to health.¹¹ Rather than a narrow interpretation where the right to health is simply equated with the right to be healthy, the Committee broadly defines it as a "right to control one's health and body, including sexual and reproductive freedom."¹² Thus, health is an inclusive right that not only includes access to health care but also "[t]he realization of women's right to . . . education and information, including in the area of sexual and reproductive health."¹³ This is "understood as requiring measures to improve child and maternal health, sexual and reproductive health services, including access to family planning, pre- and postnatal care, emergency obstetric services and access to information, as well as to resources necessary to act on that information."¹⁴

Further, the Covenant specifically "requires the removal of all barriers interfering with access to health services, education and information, including in the area of sexual and reproductive health."¹⁵ Despite these protections, women's rights are neglected and violated in Rwanda, particularly their rights to safe pregnancy and childbirth, safe abortion and post-abortion care, and access to comprehensive contraceptive methods and reproductive health services without discrimination.

1. MATERNAL MORTALITY AND MORBIDITY

Maternal death is defined as any death that occurs during pregnancy, childbirth, or within 42 days after birth or termination of pregnancy or its management.¹⁶ Women in Rwanda have a 1-in-43 lifetime risk of dying from a pregnancy-related cause.¹⁷ Although the 2010 Rwanda Demographic and Health Survey (2010 RDHS) states that the maternal mortality ratio (MMR) is 487 deaths per 100,000 live births, the World Health Organization (WHO) statistics indicate that there are 340 deaths for every 100,000 live births.¹⁸ Regardless of the variation in data, the MMR in Rwanda is higher than the global average of 210 per 100,000 live births.¹⁹

Although Rwanda has made significant advancements in reducing maternal mortality rates—MMR has fallen from 1,071 per 100,000 live births in 2000 to a recorded 487 per 100,000 in 2010²⁰—however, with only three years remaining to reach the Millennium Development Goal (MDG) targets, the rate of decrease in maternal mortality rate in Rwanda is much slower than that needed to achieve the fifth MDG of 75% reduction in MMR by 2015 (268 per 100,000).²¹ MMR also remains well-above Rwanda’s Vision 2020 goal to decrease MMR to 200 per 100,000 live births.²²

The Committee has affirmed that states’ failure to reduce maternal deaths violates the right to health.²³ As previously noted, under Article 10(2) of the Covenant, states have a duty to provide special protection to mothers during a reasonable period before and after childbirth.²⁴ Since most maternal deaths are preventable,²⁵ the failure by governments to provide the services needed by women to survive childbirth constitutes a violation of their rights.²⁶

Barriers to accessing health services violate Rwandan women’s right to health. About 23% of patients walk for an hour or more than 5km to reach the nearest health care facility.²⁷ There has been an increase in health facility delivery from 45% in 2009 to 69% in 2010²⁸ but, according to the 2010 RDHS, 29% of women in Rwanda still deliver at home in unsanitary and sometimes dangerous conditions.²⁹ The WHO and the Ministry of Health recommend at least four antenatal visits³⁰ but less than 35% of Rwandan women received the recommended minimum.³¹ The WHO also recommends having a postnatal check-up during the first two days after delivery as many maternal deaths occur during this time;³² however, only 18% of women in Rwanda receive this service.³³

The main causes of death during and following pregnancy and childbirth in Rwanda are due to “severe bleeding (post-partum hemorrhage), infections (sepsis), high blood pressure, obstructed labor and unsafe abortions,” all of which are preventable or manageable.³⁴ The risks associated with childbirth can be reduced by providing antenatal care and ensuring that all women have access to skilled health professionals during and after childbirth.³⁵

In its 2009 concluding observations, the Committee on the Elimination of Discrimination against Women (CEDAW Committee), which monitors state compliance with the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), urged Rwanda to increase access to health care, especially for rural and elderly women.³⁶ The CEDAW Committee also recommended that obstacles to accessing obstetric services be monitored and steps taken to remove these barriers.³⁷ However, disparities based on geography and socio-economic status remain. For instance, poor women in Rwanda are eight times less likely than their wealthier counterparts to have access to skilled care.³⁸

Further, severe health workforce shortages exist in the country. Although the number of health care professionals in Rwanda increased from 11,604 in 2008 to 12,465 in 2010,³⁹ the country still has about 725 doctors,⁴⁰ and there are currently only around one hundred midwives practicing in Rwanda in private and public health facilities with one doctor per 18,000 people and one nurse per 1,700 people.⁴¹ The disparity is most felt in rural areas where there are an insufficient number of midwives practicing.⁴² According to the WHO, Rwanda has a critical shortage of health professionals and needs to increase their health workforce by about 140% in order to make a positive difference in the health and life expectancy of the Rwandan population.⁴³

In its 2004 concluding observations, the Committee on the Rights of the Child recommended that Rwanda “allocate appropriate resources and develop and implement comprehensive policies and programmes to improve the health situation of children, particularly in rural areas.”⁴⁴ The Health Sector Strategic Plan for 2009-2012 states that more funds will be directed towards addressing the high maternal mortality rate,⁴⁵ and in 2010, Rwanda spent about 10.2% of its budget on the health sector.⁴⁶ However, this increase in budget is not sufficient to address continuing high maternal mortality rates.⁴⁷ According to the Health Strategic Plan, “the gap for the prevention and treatment objectives are met, but a gap of US\$28 million still exists for the maternal and child health, family planning, reproductive health and nutrition objective.”⁴⁸ Further, under the Abuja Declaration, the government has an obligation to commit at least 15% of its annual budget to the health sector.⁴⁹ The Rwandan Government is yet to fulfill this pledge.

2. UNSAFE ABORTION AND LACK OF POST-ABORTION CARE

The Rwandan Government’s report to the Committee is silent on unsafe abortion and lack of post-abortion care (PAC). Although there is no record of the number of women who die from unsafe abortion in Rwanda,⁵⁰ there is ample evidence of both the high prevalence of unsafe abortion and its serious consequences. While the 2010 RDHS does not provide information on abortion-related maternal mortality, it did find that 24% of all deaths among women in their reproductive years—15 to 49—was due to pregnancy or pregnancy related causes.⁵¹ Further, a 2004 study found that 50% of obstetric complications in four health districts in Rwanda were

abortion-related.⁵² Methods of unsafe abortion include ingesting drugs and herbs and inserting metal objects or other items into the vagina.⁵³

Many of the women and adolescent girls who make up these numbers seek out clandestine and unsafe abortion due to the restrictive abortion law.⁵⁴ Consequently, approximately 40% of abortions in Rwanda result in complications and require medical treatment.⁵⁵ In 2009 alone, 16,700 women were treated for complications resulting from abortion.⁵⁶ About 30% of those who experience complications are ultimately unable to access post-abortion care and treatment at health centers.⁵⁷

The reasons for this lack of access include inadequate equipment and medical supplies in health care facilities and insufficient training of health care providers.⁵⁸ According to a study that was conducted in 2009, only 13% of health centers and 7% of polyclinics have the necessary equipment to provide PAC services.⁵⁹ Moreover, very few providers employ techniques recommended by the WHO for treating uncomplicated post-abortion cases.⁶⁰ Lack of access to PAC is particularly dismal given that 21%—almost a quarter—of women in Rwanda will, during their reproductive years, need medical care for abortion-related complications.⁶¹

In July 2012, Rwanda enacted a new Penal Code, amending its law on abortion. The law continues to criminalize abortion; however, it also creates specific exceptions to criminalization where an abortion is performed to save the pregnant woman's life, protect her physical health or in cases where the pregnancy is a result of rape, incest or forced marriage.⁶² Nonetheless, despite expanding the legal indications for abortion, Rwanda's new Penal Code simultaneously severely limits access to these legal services by requiring women and providers to overcome significant hurdles in order to qualify for a safe and legal abortion. These legal hurdles or procedural barriers are in clear contravention of international human rights standards and accepted international medical practice.

For example, Rwanda's abortion law requires a "competent Court" to certify that a woman has become pregnant as a result of rape, incest or forced marriage.⁶³ This is a serious barrier to women qualifying for this service. It is widely recognized that stigma, fear and family pressure prevent many women from reporting incest or sexual violence and engaging with the justice system. In addition, court proceedings are often cumbersome and ineffective in time-sensitive contexts—women requiring a termination of pregnancy have a limited window in which to obtain these services. Recognizing this, many 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.⁶⁴

Similarly, the law requires that the procedure be performed by a medical doctor, and that a doctor seek the "advice from another doctor" when possible and obtain his/her consent in writing

before proceeding with the abortion.⁶⁵ This can create insurmountable barriers to women's access to safe abortion services. Experts have repeatedly stated that these requirements are not evidenced-based and have recommended against them. For example, the WHO has made clear that mid-level providers, such as nurses or clinical officers, can safely and beneficially provide first-trimester abortion services.⁶⁶ Further, most contemporary legal and policy experts agree that consultation requirements are inappropriate and delay access to services.⁶⁷ This requirement for the involvement of multiple doctors is particularly onerous in a country such as Rwanda with only 725 doctors, as previously noted,⁶⁸ and a population of over ten million people.⁶⁹ Such requirements are also significant barriers for women that can cost money, waste time and dangerously delay critical health care.

In addition to these concerns, it appears that the Rwandan Parliament is currently considering a Reproductive Health Bill⁷⁰ that 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.”⁷¹

If passed, this Bill would be a severe setback to recent 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 the legal indications for 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. We strongly urge the Rwandan Parliament to remove these abortion provisions from the draft bill.

3. AGGRESSIVE ENFORCEMENT OF LAWS PROHIBITING ABORTION AND HIGH INCIDENCE OF IMPRISONMENT FOR ABORTION-RELATED CHARGES

The continued criminalization of abortion in Rwanda also discriminates on the basis of sex, age, and income. As indicated by the case studies below, adolescent girls and low-income women are more likely to turn to clandestine and unsafe abortion and more likely to be prosecuted for terminating a pregnancy. They are also less likely to have the necessary resources to defend themselves in court.

The implications are particularly significant in Rwanda because the abortion law is aggressively enforced. Adolescent girls and women are routinely arrested, prosecuted, and imprisoned for procuring an unlawful abortion.⁷² A 2011 study by Youth Action Movement Rwanda, documents testimonials of survivors of unsafe abortion and women and girls imprisoned for illegal abortion. Some of the women who are in prison for abortion-related charges are serving sentences as long as ten years which were imposed when they were adolescents below the age of 18.⁷³

As of 2010, of the 114 women in Karubanda Prison, one of Rwanda's main prisons, 21—almost one in five—were in for procuring illegal abortions, and 90% of the 21 were 25 years old or younger.⁷⁴ Many of these women were the victims of sexual violence and abuse. “Anne” (now 21 years old) was imprisoned in 2007 and is serving a nine year sentence for terminating a pregnancy resulting from sexual abuse by her teacher when she was 17 years old.⁷⁵ She had to drop out of school because pregnancy is “against school regulations.”⁷⁶ She decided to terminate the pregnancy and then was reported to the police by her elder brother.

The study further showed that in a number of instances, those imprisoned were low-income girls and women,⁷⁷ or were orphaned as a result of the 1994 genocide,⁷⁸ and engaged in transactional sex for money to meet essential needs such as food, school fees, and accommodation.⁷⁹ In one case, “Carol” who at 24 years had only served two out of a ten year sentence, noted that she was a 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.”⁸⁰ Heavy bleeding stemming from a clandestine abortion compelled her to seek medical treatment in a hospital. She was taken to prison from the hospital.

Those who assist in the procuring of an unsafe and illegal abortion are also prosecuted and imprisoned. 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.⁸¹

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 has heavily stigmatized women seeking access to abortion-related services. One immediate consequence is that women are forced to seek out clandestine abortion, often having to travel long distances and, as the statistics show, almost always exposing themselves to unsafe abortion. Many interviewees in the 2011 study on abortion in Rwanda noted that they traveled to the Democratic Republic of Congo or Uganda, to access abortion.⁸² 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.⁸³ This further heightened their sense of vulnerability and the stigma attached to abortion.

4. INADEQUATE ACCESS TO FAMILY PLANNING SERVICES AND INFORMATION

Access to family planning services is an effective means of reducing maternal mortality.⁸⁴ Addressing the unmet need for modern contraceptive methods and maternal health care in Rwanda would reduce maternal deaths by a third.⁸⁵ Although the number of women who have access to family planning services has increased, there still remains a large unmet need. Only 25% of Rwandan women use modern contraception;⁸⁶ forty percent of women wanting to use contraception are unable to do so.⁸⁷ This is in large part due to financial and geographic barriers.

The right to enjoy the benefits of scientific progress, which is guaranteed in the Covenant, should include access to family planning services. However, there are socioeconomic and geographic disparities in the use of modern contraception among women in Rwanda. Modern contraception use is 57% in the wealthiest quintile but only 43% in the poorest quintile.⁸⁸ Women with no formal education and living in rural areas have the most difficulty accessing family planning services; only 45% use modern methods of contraception.⁸⁹ Geographically, a significantly higher percentage of women use modern contraception in urban areas such as Kigali (28%) compared to a low of 4% in Gikongoro.⁹⁰

The Rwandan Government has an obligation to ensure adequate access to family planning information and services. Its failure to ensure access to these essential services impedes “the full realization of the right to health.”⁹¹

5. DISCRIMINATION AGAINST PEOPLE LIVING WITH HIV

As mentioned briefly above, the Rwandan Parliament is currently considering a Reproductive Health Bill, which ostensibly seeks to address barriers to reproductive health services in hospitals and facilities.⁹² However, provisions in the proposed bill that require mandatory HIV testing without informed consent are deeply troubling and violate the right to the health, privacy and nondiscrimination enumerated in the Covenant, CEDAW, International Covenant on Civil and Political Rights (ICCPR) and the Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa (Maputo Protocol).⁹³

According to Article 14 of the Bill, a medical doctor who deems it “necessary” to test a child or any other person for HIV may “do so without asking for any authorization and show the result to the guardian or care provider.”⁹⁴ This directly violates Rwanda’s obligations under the ICESCR and ICCPR. Compulsory HIV testing violates ICCPR 17.1 which states that “No one shall be subjected to arbitrary or unlawful interference with his privacy. . . .”⁹⁵ Non-consensual medical treatment violates “the right to control one’s health and body, including sexual and reproductive freedom, and the right to be free from interference, such as the right to be free from . . . non-consensual medical treatment. . . .”⁹⁶ HIV testing without a patient’s consent also undermines trust in the public trust system and violates the Covenant’s nondiscrimination principle.⁹⁷

Compulsory HIV testing relies on coercion and is harmful to the Rwandan Government's goal to improve access to reproductive health services.⁹⁸ Rwanda should adhere to internationally accepted standards governing confidentiality and informed consent and respect patients' rights to privacy and health. Compliance with these laws and standards is also integral to effective HIV prevention and treatment strategies.

We hope that the Committee will consider addressing the following questions to the Government of Rwanda:

1. What concrete steps have been taken to implement the Health Strategic Plan 2009-2012 and reduce maternal deaths in Rwanda? In particular, what is the government doing to address insufficient access to and quality of emergency obstetric care?
2. What steps has the government taken to ensure the adequate recruitment, training, and retention of health workers, and sufficient equipping of health care facilities to reduce injuries and deaths due to pregnancy and childbirth-related complications, particularly given the severe shortage of doctors and midwives in the country?
3. What measures has the government undertaken to address unsafe abortion which is one of the leading causes of maternal morbidity in Rwanda? What concrete steps is the government taking to determine the precise number of maternal deaths due to unsafe abortion? How will it ensure its citizens are informed of the new abortion law and the expanded grounds for access to safe and legal abortion?
4. What is the government doing to ensure that further reform of the abortion laws brings the country into conformity with international human rights standards? Specifically, what efforts has the government undertaken to remove the provisions in the propose Reproductive Health Bill which pose significant barriers to women's access to safe and legal abortion?
5. How many women are currently in prison on abortion-related charges? How many abortion providers are in prison for abortion-related charges? Considering that the new Penal Code reduces prison sentences for those who procure an abortion from 5 – 15 years to 1 – 3 years, will the government set up a mechanism for reviewing the long sentences already imposed on some for illegal abortion to commute their sentences or grant them pardons?
6. What steps are being taken to ensure access to a wide range of family planning services and information including emergency contraceptives? What measures has the government taken to ensure the recruitment, training and retention of youth-friendly health workers, and access to sexuality education for adolescents? Are integrated service

programs being developed to address the difficulties in accessing family planning services that women who are poor, without formal education, or who live in rural areas currently experience?

7. Have structures been set up to tackle the rights violations and discrimination experienced by people living with HIV/AIDS. In particular, will the government amend provisions in the proposed Reproductive Health Bill that require compulsory HIV testing, and disclosure of results without consent?

We hope that this information is useful to the Committee during its review of the Rwandan Government's compliance with the Covenant. If you have any questions, or would like further information, please do not hesitate to contact the undersigned.

Sincerely,

Onyema Afulukwe
Legal Adviser, Africa Program
Center for Reproductive Rights

Alisha Bjerregaard
Legal Adviser, Africa Program
Center for Reproductive Rights

-
- ¹ International Covenant on Economic, Social and Cultural Rights, *adopted* Dec. 16, 1966, GA Res. 2200A (XXI), U.N. GAOR, Supp. No. 16, U.N. Doc. A/6316 (1966), (entered into force Jan. 3, 1976) [hereinafter ICESCR]; Rule of law in Armed Conflict Projects, *International Treaties Adherence* (2009), http://www.geneva-academy.ch/RULAC/international_treaties.php?id_state=185 (last visited Sept. 28, 2012).
- ² Government of Rwanda, *Consideration of reports submitted by States parties under article 19 of the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment: Initial reports of States parties due in 2010: Rwanda*, para. 4, CAT/C/RWA/1 (2011).
- ³ *Id.*
- ⁴ ICESCR, *supra* note 1, art. 12.
- ⁵ 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), at 88-89, para. 43(a) U.N. Doc. E/C.12/2000/4 (2000) [hereinafter ESCR Committee, *General Comment No. 14*].
- ⁶ ICESCR, *supra* note 1, art. 2(2).
- ⁷ *Id.* arts. 12 & 15(1)(b).
- ⁸ *Id.* art. 10(2).
- ⁹ *Id.* art. 12.
- ¹⁰ World Health Organization (WHO), Regional Office for the Eastern Mediterranean, *Health and Human Rights: International Covenant on Economic, Social and Cultural Rights* (2004), available at http://www.who.int/hhr/Economic_social_cultural.pdf.
- ¹¹ Audrey R. Chapman, *Monitoring Women's Right to Health Under the International Covenant on Economic, Social and Cultural Rights* 44 Am. U. L. Rev. 1157, 1158 (1995).
- ¹² ESCR Committee, *General Comment No. 14*, *supra* note 5, at 79, para. 8.
- ¹³ *Id.* at 83, para. 21.
- ¹⁴ *Id.* at 81, para. 14.
- ¹⁵ *Id.* at 83, para. 21.
- ¹⁶ WHO ET AL., TRENDS IN MATERNAL MORTALITY: 1990-2008, 4 (2010), available at <http://www.who.int/reproductivehealth/publications/monitoring/9789241500265/en/index.html>.
- ¹⁷ NATIONAL BUREAU OF STATISTICS (RWANDA), RWANDA DEMOGRAPHIC AND HEALTH SURVEY 2010, 238 (2011), available at <http://www.measuredhs.com/pubs/pdf/FR259/FR259.pdf> [hereinafter 2010 RDHS].
- ¹⁸ *Id.*; WHO, RWANDA: HEALTH PROFILE 1 (2010), available at <http://www.who.int/countries/rwa/en/> [hereinafter RWANDA: HEALTH PROFILE].
- ¹⁹ RWANDA: HEALTH PROFILE, *supra* note 18, at 1.
- ²⁰ 2010 RDHS, *supra* note 17, at 238; United Nations Development Programme, *MDGs Progress and the macroeconomic state of Rwanda (2012)*, <http://www.undp.org.rw/mdgs.html> (last visited Sept. 28, 2012).
- ²¹ Paulin Basinga et al., *Abortion Incidence and Postabortion Care in Rwanda*, 43(1) STUDIES IN FAM. PLANNING, 11, 11 (2012), <http://onlinelibrary.wiley.com/doi/10.1111/j.1728-4465.2012.00298.x/pdf>; UNITED NATIONS POPULATION FUND (UNFPA), MATERNAL MORTALITY REDUCTION PROGRAMME IN RWANDA (2011), available at [http://rwanda.unfpa.org/drive/MaternalMortalityReductioninRwanda\(VLR\).pdf](http://rwanda.unfpa.org/drive/MaternalMortalityReductioninRwanda(VLR).pdf).
- ²² DEPARTMENT FOR INTERNATIONAL DEVELOPMENT (DFID), THE WHITE RIBBON ALLIANCE FOR SAFE MOTHERHOOD, RWANDA STRATEGIC PLAN 2010-2013 AND ONE YEAR OPERATIONAL PLAN 10 (2010), http://hdrc.dfid.gov.uk/wp-content/uploads/2012/05/275007_RW-Consultancy-to-Finalise-the-Strategic-Plan-for-White-Ribbon-Alliance-Rwanda-2010-2013_Strategic-Plan.n.pdf [hereinafter DFID, RWANDA STRATEGIC PLAN 2010-2013].
- ²³ ESCR Committee, *General Comment No. 14*, *supra* note 5, at 91, para. 52.
- ²⁴ ICESCR, *supra* note 1, art. 10(2).
- ²⁵ WHO, *Maternal Mortality, Fact Sheet No. 348* (2012), <http://www.who.int/mediacentre/factsheets/fs348/en/index.html> (last visited Sept. 28, 2012) [hereinafter WHO, *Maternal Mortality*].
- ²⁶ See CENTER FOR REPRODUCTIVE RIGHTS, *Preventing Maternal Mortality and Ensuring Safe Pregnancy*, in BRINGING RIGHTS TO BEAR (2008), available at http://reproductiverights.org/sites/default/files/documents/BRB_Maternal%20Mortality_10.08.pdf.
- ²⁷ DFID, RWANDA STRATEGIC PLAN 2010-2013, *supra* note 22, at 9.
- ²⁸ Cathy Mugeni et al., *Community Performance-based Financing in Health: Incentivizing Mothers and Community Health Workers to Improve Maternal Health Outcomes in Rwanda* 15 (World Conference on Social Determinants of

-
- Health, Draft Background Paper, 2011), *available at* http://www.who.int/sdhconference/resources/draft_background_paper20_rwanda.pdf.
- ²⁹ 2010 RDHS, *supra* note 17, at 115.
- ³⁰ 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 Sept. 28, 2012); 2010 RDHS, *supra* note 17, at 110.
- ³¹ 2010 RDHS, *supra* note 17, at 111.
- ³² See THE PARTNERSHIP FOR MATERNAL, NEWBORN AND CHILD HEALTH, *Postnatal Care, in OPPORTUNITIES FOR AFRICA'S NEWBORNS 79-90 (2006)*, *available at* http://www.who.int/pmnch/media/publications/aonsectionIII_4.pdf.
- ³³ 2010 RDHS, *supra* note 17, at 118.
- ³⁴ 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>.
- ³⁵ WHO, *Maternal Mortality*, *supra* note 25.
- ³⁶ Committee on the Elimination of Discrimination against Women, *Concluding Observations: Rwanda*, para. 36, U.N. Doc. CEDAW/C/RWA/CO/6 (2009).
- ³⁷ *Id.*
- ³⁸ WHO, DEPT. OF MAKING PREGNANCY SAFER, RWANDA: COUNTRY PROFILE, 5 (2007), *available at* <http://www.afro.who.int/en/clusters-a-programmes/frh/making-pregnancy-safer/mps-country-profiles.html> [hereinafter WHO, RWANDA: COUNTRY PROFILE].
- ³⁹ AFRICAN HEALTH WORKFORCE OBSERVATORY (AHO) & WHO, HUMAN RESOURCES FOR HEALTH COUNTRY PROFILE: RWANDA 23 (2009), *available at* http://www.hrh-observatory.afro.who.int/images/Document_Centre/rwanda_hrh_country_profile.pdf [hereinafter HUMAN RESOURCES FOR HEALTH].
- ⁴⁰ See Fred Ndoli, *Number of doctors to double by 2017*, THE NEW TIMES, <http://www.newtimes.co.rw/news/index.php?i=14569&a=39370> (last visited Apr. 18, 2012).
- ⁴¹ DFID, RWANDA STRATEGIC PLAN 2010-2013, *supra* note 22, at 10.
- ⁴² *Id.*
- ⁴³ HUMAN RESOURCES FOR HEALTH, *supra* note 39, at 8.
- ⁴⁴ Committee on the Rights of the Child, *Concluding Observations: Rwanda*, para. 49(a), CRC/C/15/Add.234 (2004).
- ⁴⁵ GOVERNMENT OF RWANDA, MINISTRY OF HEALTH, HEALTH SECTOR STRATEGIC PLAN JULY 2009 – JUNE 2012, 36 (2009), *available at* transition.usaid.gov/rw/our.../rwandahealthsectorstrategicplanii.pdf [hereinafter HEALTH SECTOR STRATEGIC PLAN].
- ⁴⁶ HUMAN RESOURCES FOR HEALTH, *supra* note 39, at 8.
- ⁴⁷ HEALTH SECTOR STRATEGIC PLAN, *supra* note 45, at 36.
- ⁴⁸ *Id.*
- ⁴⁹ WHO, THE ABUJA DECLARATION TEN YEARS ON 1 (2011), *available at* http://www.who.int/healthsystems/publications/abuja_report_aug_2011.pdf.
- ⁵⁰ Basinga, *supra* note 21, at 11.
- ⁵¹ RDHS 2010, *supra* note 15, at 238.
- ⁵² Basinga, *supra* note 21, at 11.
- ⁵³ *Id.* at 16.
- ⁵⁴ See, e.g., ARBEF, *Stories on Unsafe Abortion (2012)* (unpublished research) (on file with the Center for Reproductive Rights) [hereinafter *Stories on Unsafe Abortion*].
- ⁵⁵ Guttmacher Institute, *Key Facts on Abortion in Rwanda (2012)*.
- ⁵⁶ Basinga, *supra* note 21, at 11.
- ⁵⁷ *Id.* at 14-16.
- ⁵⁸ *Id.* at 16.
- ⁵⁹ *Id.* at 16 & 19.
- ⁶⁰ *Id.* at 19.
- ⁶¹ *Id.* at 16.
- ⁶² PENAL CODE (2012) GOVT. GAZETTE, at 210-212, arts. 165-166 (Rwanda).
- ⁶³ *Id.* art. 165.
- ⁶⁴ 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).

⁶⁵ PENAL CODE (2012) GOVT. GAZETTE, at 211, art. 166 (Rwanda).

⁶⁶ See Marge Berer, *Provision of Abortion by Mid-Level Providers: International Policy, Practice and Perspectives*, 87 BULLETIN OF THE WHO 58 (2009).

⁶⁷ 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 REPORT OF SESSION 2006–07, para. 99 (2007), available at <http://www.publications.parliament.uk/pa/cm200607/cmselect/cmsctech/1045/1045i.pdf>.

⁶⁸ See Ndoli, *supra* note 40.

⁶⁹ 2010 RDHS, *supra* note 17, at 3.

⁷⁰ 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 (2012), <http://www.newtimes.co.rw/news/index.php?i=15087&a=57182> (last visited Sept. 29, 2012).

⁷¹ Reproductive Health Bill (2007), art. 23 (Rwanda), available at http://www.rwandaparliament.gov.rw/parliament/Chamber_of_Deputies_Publications.aspx?catid=726CB1A9-3C2C-4E44-BBA5-D1B52E5BCCD8.

⁷² See, e.g., Stories on Unsafe Abortion, *supra* note 54.

⁷³ *Id.*

⁷⁴ *Id.* at 4.

⁷⁵ *Id.*

⁷⁶ *Id.*

⁷⁷ *Id.*

⁷⁸ See, e.g., *id.* at 6.

⁷⁹ *Id.*

⁸⁰ *Id.* at 4.

⁸¹ See *id.*

⁸² *Id.* at 9.

⁸³ See, generally, *id.*

⁸⁴ WHO, *Maternal Mortality*, *supra* note 25.

⁸⁵ UNFPA, *Health Providers Trained on Family Planning* (2012), http://rwanda.unfpa.org/2012/05/26/5061/health_providers_trained_on_family_planning/ (last visited Sept. 28, 2012).

⁸⁶ 2010 RDHS, *supra* note 17, at 87.

⁸⁷ *Id.* at 95.

⁸⁸ *Id.* at 89.

⁸⁹ *Id.*

⁹⁰ WHO, RWANDA: COUNTRY PROFILE, *supra* note 38, at 10.

⁹¹ ESCR Committee, *General Comment No. 14*, *supra* note 5, para. 12.

⁹² 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. Karake, *supra* note 70.

⁹³ Tanzania has signed and ratified the Maputo Protocol, Convention on the Elimination of All Forms of Discrimination against Women, International Covenant on Economic, Social and Cultural Rights and International Covenant on Civil and Political Rights. See Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa, 2nd Ordinary Sess., Assembly of the Union, adopted July 11, 2003, art. 14(2)(c), CAB/LEG/66.6 (entered into force Nov. 25, 2005); Convention on the Elimination of All Forms of Discrimination against Women, adopted Dec. 18, 1979, art. 10, G.A. Res. 34/180, U.N. GAOR, 34th Sess., Supp. No. 46, at 193,

U.N. Doc. A/34/46, U.N.T.S. 13 (*entered into force* Sept. 3, 1981); International Covenant on Civil and Political Rights, 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) [hereinafter ICCPR]; ICESCR, *supra* note 1.

⁹⁴ Reproductive Health Bill (2007), art. 23 (Rwanda), *available at* http://www.rwandaparliament.gov.rw/parliament/Chamber_of_Deputies_Publications.aspx?catid=726CB1A9-3C2C-4E44-BBA5-D1B52E5BCCD8.3C2C-4E44-BBA5-D1B52E5BCCD8.

⁹⁵ ICCPR, *supra* note 93, art. 17.1.

⁹⁶ ESCR Committee, *General Comment No. 14*, *supra* note 5, at 79, para. 8.

⁹⁷ ICESCR, *supra* note 1, art. 2(2).

⁹⁸ HUMAN RIGHTS WATCH, *Rwanda: Revise Reproductive Health Bill: Compulsory HIV Testing, Sterilization of Disabled Violate Rights* (2009), <http://www.hrw.org/news/2009/07/01/rwanda-revise-reproductive-health-bill> (last visited Sept. 28, 2012).