CENTER FOR REPRODUCTIVE RIGHTS

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

April 17, 2015

The Human Rights Committee

Re: Supplementary information for the adoption of list of issues 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 submitted by Rwanda to the Human Rights Committee (the Committee) for the adoption of list of issues, which is scheduled to be reviewed during its 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 that the Center and GLIHD hope the Committee will take into consideration: 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 discrimination 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 requirements, women and girls in Rwanda often lack access to comprehensive reproductive health information 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] This Committee has further recognized that preventable maternal mortality violates women's and girls' rights to equality and non-discrimination.[17] 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.[18] Indeed, the Committee on Economic, Social and Cultural Rights (CESCR Committee) has confirmed that the obligation to ensure reproductive and maternal care, both prenatal and postnatal, should have a priority comparable to minimum core obligations to ensure access to health facilities, goods, and services without discrimination.[19] As such, during its review of Rwanda in 2013, the CESCR Committee expressed concern regarding the high rate of maternal mortality and recommended that the state take measures to reduce the rate.[20]

A report from the World Health Organization (WHO) indicates that the maternal mortality ratio (MMR) in Rwanda has declined from an estimated 1,000 deaths per 100,000 live births in 2000 to 320 deaths per 100,000 in 2013.[21] While this trend is positive and Rwanda is on track to achieve the UN Millennium Development Goal of 75% reduction in MMR by the end of 2015,[22] more efforts are needed to address the ongoing problems in the health sector, discussed below, which continue to contribute to preventable maternal deaths and injuries if Rwanda is to meet its Vision 2020 goal of decreasing the MMR to 200 per 100,000 live births.[23]

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.[24] However, Rwandan women and girls often encounter significant barriers in accessing these services. Approximately 23% of patients need to walk for an hour or more than five kilometers to reach the nearest health care facility.[25] While there has been an increase in health facility delivery from 45% in 2009 to 69% in 2010,[26] 29% of women in Rwanda still deliver at home in unsanitary and sometimes dangerous conditions.[27] The WHO recommends at least four antenatal visits,[28] but, according to the 2010 Rwanda Demographic Health Survey (2010 RDHS), less than 35% of Rwandan women received the recommended minimum.[29] The WHO also recommends having a postnatal checkup during the first two days after delivery as many maternal deaths occur during this time;[30] however, only 18% of women and girls accessed this service, and 80% of women in Rwanda never receive any post-natal checkup. [31]

In its 2009 concluding observations, the Committee on the Elimination of Discrimination against Women (CEDAW Committee) urged Rwanda to increase health care access, especially for rural and elderly women.[32] The CEDAW Committee also recommended that obstacles to accessing obstetric services be monitored and steps be taken to remove these barriers.[33] There remain, however, disparities in access to maternal health care services based on geography and socio-economic status. For instance, low-income women in Rwanda are eight times less likely than their wealthier counterparts to have access to skilled care.[34] 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 people.[35] Similarly, there are approximately 8,985 nurses and 622 midwives nationwide, amounting to one midwife per 17,381 inhabitants and one nurse per 1,203 inhabitants.[36] More recently, one report indicated that an additional 586 midwives would be required in order to reach a 95% skilled birth attendance rate.[37] Lack of access to these health professionals is exacerbated in rural areas, where distance to a health facility can be a barrier to health services.[38] 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.[39] According to the WHO, Rwanda has a critical shortage of health professionals and needs to increase its health workforce by about 140% in order to make a positive difference in the health and life expectancy of the population.[40] The Vision 2020 initiative aims to have 10 medical doctors, 20 nurses, and 5 lab assistants for every 100,000 inhabitants,[41] 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.[42] However, some problems, including with the reporting on maternal mortality, remain. For instance, the RapidSMS text messaging system is under-utilized and a large number of deaths that take place in private hospitals, which are less likely to conduct reviews, are underreported.[43]

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.[44] The recognition of the direct

connection between unsafe abortion and high death rates[45] 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."[46] 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.[47] In addition, the United Nations Special Rapporteur on the Right to Health has confirmed that the criminalization of abortion and other reproductive health services violates the right to health by imposing barriers that interfere with accessibility to safe health care services and with individual decision-making in health-related matters.[48] Such criminalization also perpetuates gender stereotypes, and marginalizes and disempowers women by forcing them to choose between making personal decisions about their health and well-being or facing criminal liabilities.[49] Similarly, several human rights bodies have found that both restrictive abortion laws and the failure to ensure access to abortion when it is legal are incompatible with international human rights obligations, amounting to violations of the rights to life and health, the right to be free from torture and cruel, inhuman and degrading treatment, and the right to be free from discrimination.[50] The CEDAW Committee and the UN Special Rapporteur on the Right to Health have specifically called on states to decriminalize abortion.[51]

Particularly regarding Rwanda, multiple treaty monitoring bodies have expressed concern over the restrictive law on abortion and its aggressive enforcement. In 2013, the CESCR Committee urged the Rwandan Government "to revise its laws in order to reduce the scope and the severity of the punishment for abortion and to facilitate access to professional medical services with a view to eliminating the practice of unsafe abortions that place the lives of women and girls at risk."[52] This is similar to the recommendation the CEDAW Committee issued in 2009 that asked Rwanda to "review its legislation relating to abortion with a view to removing punitive provisions imposed on women who undergo abortion…."[53]

Although in July 2012 Rwanda amended its Penal Code to allow 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,[54] the new Penal Code 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.[55] 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. Recognizing the burden this type of restriction might create, 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.[56]

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.[57] 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.[58] In addition, experts have repeatedly stated that the consultation requirements are inappropriate and delay access to services. [59] 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.[60] 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 to these concerns, as of 2012, the Rwandan Parliament was considering a Reproductive Health Bill[61] 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."[62] Information about the current status of the Bill is not easily accessible; however, if passed, this Bill 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 implication because the law, which carries heavy penalties,[63] is aggressively enforced, and women and girls are routinely arrested, prosecuted, and imprisoned for procuring an unlawful abortion.[64] A study by Youth Action Movement Rwanda, which documented the testimonials of these women and girls, found that some are serving sentences as long as ten years which were imposed when they were adolescents below the age of 18.[65] According to this study, 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.[66] Many of these women were the victims of sexual violence and abuse.[67] For instance, Anne—who was 20 years old during the interview—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.[68] She had to drop out of school because pregnancy is "against school regulations."[69] She decided to terminate the pregnancy and then was reported to the police by her elder brother.[70]

The study further showed that in a number of instances, those imprisoned were low-income girls and women,[71] and engaged in transactional sex for money to meet essential needs such as food, school fees, and accommodation.[72] In one case, Carol, who at 24 years old 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."[73] Heavy bleeding stemming from a clandestine abortion compelled her to seek medical treatment in a hospital. She was taken to prison from the hospital.

Medical professionals who provide abortion services 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.[74]

Despite the review of the Penal Code which reduced the prison terms to be imposed in some instances, aggressive enforcement of the law and imprisonments continue. Consequently, 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.[75] 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.[76] This further heightens their sense of vulnerability and the stigma attached to abortion.

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—were due to pregnancy or pregnancy related causes.[77] Approximately 26,000 women each year are treated for abortion complications, with about 17,000 of these complications likely resulting from induced abortions (65%).[78] Methods of unsafe abortion include ingesting drugs and herbs and inserting metal objects or other items into the vagina.[79]

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.[80] Many of the women and adolescent girls who make up these numbers seek out clandestine and unsafe abortions due to the restrictive abortion law.[81] 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.[82] Consequently, approximately 40% of abortions in Rwanda result in complications and require medical treatment.[83] In 2012 alone, approximately 18,000 women were treated for complications resulting from unsafe abortion, costing an estimated USD 1.7 million.[84]

The restrictive laws on abortion 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).[85] 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.[86]

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.[87] It has been recognized that PAC should be integrated with other available maternal health services.[88] However, the potential for prosecution deters Rwandan women and girls from seeking necessary post-abortion treatment after procuring

unsafe abortions.[89] About 30% of those who experience complications are ultimately unable to access PAC and treatment at health centers.[90]

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.[91] Moreover, very few providers employ techniques recommended by the WHO for treating uncomplicated post-abortion cases.[92] As of 2010, just 10% of all health facilities in Rwanda had the equipment for the recommended method and almost 40% of the health facilities lacked the trained staff to use the equipment, leaving only about 6% of all the country's facilities having both the equipment and trained staff to provide the service.[93]

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.[94] 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."[95] 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.[96] The protocol confirms that health care providers should only use the procedures recommended by the WHO to treat incomplete abortions.[97] Releasing this protocol for PAC indicates that the government recognizes and acknowledges the importance of PAC. However the ongoing lack of adequate access to PAC 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.[98]

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,"[99] the Rwandan 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 FAMILY PLANNING 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.[100] 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.[101] 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. [102]

In recent years, the use of modern contraceptives among married women in Rwanda has shown some improvement: going from 4% in 2000 to 45%. 2010.[103] However, still 19% of married women of child bearing age want to avoid or postpone their pregnancy but are not using contraceptives.[104] According to the 2010 RDHS, 48% of unmarried women age 15-19 have an unsatisfied demand for modern methods.[105] Only 29% of women aged 15 to 49 use some form of contraceptive method and 25% use a modern contraceptive method.[106] Further, adolescent girls,

low-income, and rural women often face additional obstacles to accessing family planning services. The 2010 RDHS found that 43% of women in the lowest wealth quintile used contraceptives, whereas usage is 57% for women in the highest wealth quintile.[107] Geographically, a significantly higher percentage of women use modern contraception in urban areas such as Kigali (28%), compared to a low of 4% in Gikoro, a rural region.[108]

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.[109] In addition most health care facilities are religiously affiliated and do not offer contraception.[110] Specifically, 40% of health care facilities are religiously affiliated[111] and 60% of these facilities with religious affiliations do not offer contraception, which amounts to 25% of all facilities.[112] 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.[113] Due to this, nearly half of all the pregnancies in Rwanda are unintended, amounting to an estimated 276,000 pregnancies.[114] In 2013, the 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.[115] This is particularly important since, maternal deaths in Rwanda could be reduced by a third by addressing the unmet need for modern contraceptive methods,[116]

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.[117] 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.[118] 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.[119]

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.[120] Rwanda recognizes that EC should be provided to survivors of sexual violence as soon as possible after the assault.[121] EC pills are also included in Rwanda's Essential Drug List.[122] However, a survey of clinics showed EC was not readily available.[123] For instance, one study showed that 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.[124]

A further barrier to access to EC is lack of knowledge of the option. According to the 2010 RDHS, only 39% of men and 23% of women have knowledge of EC, the least known method of contraception in Rwanda.[125] 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.[126]

Adolescents' Access to Family Planning Information and Services

Adolescent girls run a disproportionate risk of dying during or after childbirth[127] and are more vulnerable to pregnancy-related complications.[128] Also, as the 2010 RDHS notes, "early childbearing seriously affects a woman's ability to pursue an education, thereby limiting her job opportunities."[129] 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.[130] 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.[131]

Approximately, 6% of girls in Rwanda have either given birth or are pregnant by age 19.[132] A strong inverse relationship exists between early childbearing and education. According to 2010 RDHS, 25% of adolescents without formal education started childbearing, compared to only 6% of adolescents with primary education and 4% of adolescents with secondary education.[133] Adolescent pregnancy also disproportionately affects low-income girls, who are more than twice as likely to start childbearing as their counterparts in the highest wealth quintile, 9% and 4% respectively.[134]

The interviews conducted by Youth Action Movement Rwanda, previously referenced, also document the role that the lack of information and education in respect to health services plays in the unintended pregnancies of adolescents.[135] The young women interviewed cite 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.[136] 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.[137]

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. Forty-eight percent 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.[138]

V. DISCRIMINATION AND 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. The CEDAW Committee defines gender-based violence as violence "directed against a woman because she is a woman or that affects women disproportionately" and "includes acts that inflict physical, mental or sexual harm and suffering, threats of such acts, coercion and other deprivations of liberty."[139] According to international and regional human rights standards, states are obligated to advance equality and address discrimination by means of the "elimination of prejudices, customary and all other practices that perpetuate the notion of

inferiority or superiority of either of the sexes, and stereotyped roles for men and women."[140] Article 3 of the ICCPR, which provides for the equal enjoyment by both sexes of the Covenant's rights,[141] is also violated where governments fail to enact or enforce laws protecting women's physical safety and integrity.

In its 2009 Concluding Observations, the CEDAW Committee expressed concern regarding discriminatory laws and practices in Rwanda.[142] 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…."[143] 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."[144] More recently, in 2013, the CESCR 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.[145]

In its current report to this Committee, the Rwandan Government states 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.[146] However, the report fails 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.

However, according to a recent news report, Rwanda "continues to have one of the highest incidences of gender-based and domestic violence in Africa"[147] Citing a report from the United Nations Development Programme, the articles states that one in three Rwandan women has suffered or continues to suffer violence from male relatives.[148] 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.[149] About 41% of all women in Rwanda have experienced physical violence since reaching the age of 15.[150] 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.[151] The 2010 RDHS report also indicated that 22% of women had experienced sexual violence during their lifetime[152] and 51% of this group had been abused by a current or former husband, partner, or boyfriend.[153] Additionally, 13% of women ever married had experienced sexual violence in the twelve months preceding the survey.[154] 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.[155]

Economics and education seem to be 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%).[156] 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.[157]

Rwanda also suffers from a prevalence of sexual and physical violence against children. For instance, 9% (almost1outof 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.[158] The Rwanda National Police report that between 2005 and 2008 there were 10,000 cases of child defilement.[159] In 2009 there were 1,570 cases of child rape recorded.[160] The Rwanda National Police also report that there were 863 cases of violence against children reported between January and July 2012.[161] 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.[162]

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.[163] Those incidents resulted in at least 110 pregnancies.[164] 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."[165]

Services to victims of sexual violence and gender-based violence are available through "Isange One Stop Centers."[166] These centers provide "comprehensive services such as: medical care, psycho-social support, police and legal support, and the collection of legal evidence."[167] According to a 2013 evaluation report, there is only one such Center, which is located in Kacyiru Police Hospital in Kigali. [168] The evaluation also found that from 2009-2012, 4,725 gender-based violence victims sought treatment from this Center, and, although the rate of convictions was not available, 2,327 out of these cases were prosecuted.[169] Action has been recently taken to expand the number of Isange One Stop Centers, but the situation will have to be monitored to verify whether the expanded access improves the overall climate for women and girls who are victims of gender-based violence.[170]

VI. QUESTIONS

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

1. What concrete steps have been taken to reduce maternal deaths in Rwanda? In particular, what is the government doing to address insufficient access to and quality of emergency obstetric care?

2. Beyond Vision 2020, what immediate steps is the government taking 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 current 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? Specifically, what efforts has the government undertaken to ensure that its laws on abortion are in line with international

and regional human rights treaties, including by removing the third party authorization requirements stipulated in the Penal Code before women and girls can access abortion?

4. What measures is the government undertaking to review the sentences of, and grant pardons to, women and girls who are currently in prison for illegal abortions based on the previous law? What steps is the government taking to ensure all health care facilities are equipped with the WHO recommended technologies for PAC?

5. What steps are being taken to ensure access to a wide range of family planning services and information, including emergency contraception, and to address the disparities in access? 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?

6. What measures is the government taking to address the high physical and sexual violence against women and girls and to eliminate impunity for perpetrators? What steps is the government taking to ensure that victims of violence have access to comprehensive legal, medical, and pyscho-social services, including by expanding the Isange One Stop Centers?

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.

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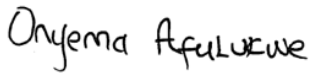

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A/HRC/18/27 (2011); *see* Human Rights Committee, *Concluding Observations*: *Argentina*, para. 14, CCPR/CO/70/ARG (2000); *Peru*, para. 20, U.N. Doc. CCPR/CO/70/PER (2000); *Morocco*, para. 29, U.N. Doc. CCPR/CO/82/MAR (2004). *See also* CEDAW Committee, Gen. Recommendation No. 24, *supra* note 12, para. 31(c); Human Rights Committee, *Concluding Observations*: *Sri Lanka*, para. 12, U.N. Doc. CCPR/CO/79/LKA (2003); Committee against Torture (CAT Committee), *Concluding Observations*: *Chile*, para. 6(j), U.N. Doc. CAT/C/CR/32/5 (2004); CEDAW Committee, *Concluding Observations: Chile*, para. 19, U.N. Doc. CEDAW/C/CHI/CO/4 (2006).

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[55] *Id*., arts. 164-166

[56] 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).

[57] Penal Code, *supra* note 54, arts. 164-166

[58] 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/.

[59] 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.

[60] *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/.

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[62] 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.

[63] 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 54, arts. 162-164.

[64] *See*, *e.g.*, ASSOCIATION RWANDAISE POUR LE BIEN-ÊTRE FAMILIAL (ARBEF), ABORTION AND YOUNG PEOPLE IN RWANDA (2012) (unpublished research) (on file with the Center for Reproductive Rights) [hereinafter ABORTION IN RWANDA].

[65] *Id*.

[66] *Id*. at 9.

[67] ABORTION IN RWANDA, *supra* note 64.

[68] *Id*.

[69] *Id*.

[70] *Id*.

[71] *Id*.

[72] *Id*.
[73] *Id*. at 9.
[74] ABORTION IN RWANDA, *supra* note 64
[75] *Id*. at 9.
[76] *See* ABORTION IN RWANDA, *supra* note 64.
[77] 2010 RDHS, *supra* note 27, at 238.
[78] Basinga et al, UNINTENDED PREGNANCY AND INDUCED ABORTION IN RWANDA 5 (2012) hereinafter [UNINTENDED PREGNANCY].
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[81] *See, e.g.*, ABORTION IN RWANDA, *supra* note 64.
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[89] *Id*.
[90] *Id*. at 5.
[91] *Abortion Incidence and Postabortion Care in Rwanda*, *supra* note 79, at 17-18.
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[99] *Consideration of reports*, *supra* note 39, para. 123.
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[102] 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.
[103] *Id*.
[104] 2010 RDHS, *supra* note 27, at 94
[105] 2010 RDHS, *supra* note 27, at 96. The chart also indicates that women in this age group have only a 0.9% unmet need, this is because the demand for family planning is also low for the group, 2%. In other words only 0.9% of all the women in this age group surveyed have an unmet need, because most do not have a demand for family planning.
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[124] *Id*.
[125] 2010 RDHS, *supra* note 27, at 86.
[126] *Counting What Counts*, *supra* note 123.
[127] WHO & UNFPA, PREGNANT ADOLESCENTS: DELIVERING ON GLOBAL PROMISES OF HOPE 10 (2006).
[128] *Id*. at 13-15.
[129] 2010 RDHS, *supra* note 27, at 75.
[130] FAMILY PLANNING STRATEGIC PLAN, *supra* note 117.
[131] *Id*. at 18.
[132] 2010 RDHS, *supra* note 27, at 75.
[133] *Id*. at 76.
[134] *Id*.
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[136] *See generally*, *id*.
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[142] CEDAW Committee, *Concluding Observations*: *Rwanda*, U.N. Doc. CEDAW/C/RWA/CO/6 (2009).
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[165] *Id*.
[166] *See ISANGE One Stop Center for Gender Based Violence*, IMBUTO FOUNDATION, *available at* http://www.imbutofoundation.org/what-we-do/health-projects/family-package/one-stop-center-for-gender-based/article/the-first-lady-mrs-jeannette (last visited Mar. 12, 2015).
[167] *Id*.
[168] Tania Bernath et al., FINAL EVALUATION OF RWANDAN GOVERNMENT AND ONE UN ISANGE ONE STOP CENTRE FINAL REPORT 6 (2013).
[169] *Id.* at 23-24.
[170] Press Release, WHO, Rwandan Government and WBG Sign Agreement to Help Survivors of Sexual and Gender-Based Violence in Rwanda (Aug. 6, 2014), *available at* http://www.worldbank.org/en/news/press-release/2014/08/06/rwandan-government-and-wbg-sign-agreement-to-help-survivors-of-sexual-and-gender-based-violence-in-rwanda (announcing the World Bank's Commitment to provide loans of USD 15 million "to provide community and health services for survivors of sexual and gender-based violence (SGBV) by expanding the *Isange One Stop Centers* while promoting gender equality, behavioral change and violence prevention in Rwanda").