**SHADOW REPORT TO THE COMMITTEE ON THE CONVENTION ON THE ELIMINATION OF ALL FORMS OF DISCRIMINATION AGAINST WOMEN (CEDAW)**

**SUBMITTED By**

**The Great Lakes Initiative for Human Rights and Development (GLIHD)**

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**ABOUT GLIHD**

GLIHD is a non-governmental organization that subscribes to the original principles enshrined in international human rights instruments.

GLIHD’s vision is to see the great lakes region where human rights are fairly respected and enjoyed.

GLIHD’s mission is to contribute to the respect and promotion of the rights of individuals and groups in keeping with international human rights framework and obligations of member states.

GLIHD is engaged in public interest litigation with the purpose of creating national human rights jurisdiction to steer national policies on human rights.

Since its creation, GLIHD has intervened in the area of human rights in general and rights of women in particular. Though its project on grassroots based intervention to increase access to domestic, regional and international human rights mechanisms for ordinary people in Africa, GLIHD has dealt with issues of access to justice and legal aid clinic for the most vulnerable; poor women and children have been key beneficiaries.

**EXECUTIVE SUMMARY**

GLIHD takes this opportunity to submit the 10th shadow report of the Government of Rwanda to the Committee on the Elimination of Discrimination Against Women (CEDAW Committee).

**Objective of the Report**

The main objective of this report is to provide key findings on the status of implementation of the CEDAW in view of the Concluding Observations and recommendations made by the CEDAW Committee to the Government of Rwanda reference number CEDAW/C/RWA/CO/6 in 2009. The report provides potential grounds for legal reforms, policy changes and other measures aimed at improving the rights situation of women in Rwanda. It should be noted that, much as some rights have been improved such as the removal of court order as a requirement for abortion from the 2018 penal code, others are yet to be addressed.

**Methodology**

The drafting of this report was based on data collected from studies, national reports, interviews with some key informants (public and private institutions and individual women from district and sectors of Rwanda), national documents including; laws, policies and strategic plans.

**Key Findings**

The report notes progress made by the Government of Rwanda in implementing recommendations contained in previous reports and observations. The report notes with appreciation, legal reform undertaken as well the adoption of various policies, strategic plans and initiatives which have contributed to the improvement of women’s rights in Rwanda.

**HEALTHCARE AND FAMILY PLANNING (Article 12 of CEDAW)**

1. **Family planning**

Positive developments: GLIHD commends the Government of Rwanda for reducing maternal mortality rate especially among teenage mothers

According to the latest Rwanda Demographic Health Survey (RDHS) 2019-2020, overall, 5% of women age 15-19 have begun childbearing: 4% have had a live birth, and 1% were pregnant at the time of the interview. The proportion of teenagers who have begun childbearing rises rapidly with age, from less than 1% at age 15 to 15% at age 19. Teenagers with no education and those in the lowest wealth quintile tend to start childbearing earlier than other teenagers. Teenagers in East province are more likely to start childbearing earlier than their counterparts. However, these teenage pregnancies can be reduced further if teenagers are allowed to access contraceptives.

**Recommendation:**

GLIHD calls upon the CEDAW Committee to recommend the Government of Rwanda to:

• Allow teenagers (age 15-19) to access contraceptives through a revised sexual reproductive and health rights law and medical liability law

1. **Abortion**

GLIHD notes that unlike the 1977 penal code, the 2012 penal code expanded grounds for legal abortion and the 2018 law determining offenses and penalties in general which henceforth removed the court order as a requirement for abortion.

**Areas of concern**

According to findings from the study jointly conducted by Guttmacher Institute and the School of Public Health of the National University of Rwanda an estimated 22 % of unintended pregnancies in Rwanda that end in induced abortion are carried out in unsafe methods due to legal restrictions and strong stigma surrounding abortion. The same study revealed that half of abortions in Rwanda are performed by untrained health providers.

According to the Rapid Assessment conducted by GLIHD, findings indicate that 90% of health centers have at least a midwife who can perform Post Abortion Care (PAC) services after training and that health centers have enough nurses available in different levels A1 and A2 who can support in the provision of safe abortion services. Therefore, it is feasible to train and assign specifically trained mid-wives and nurses to handle safe abortion services at first level.

Moreover, In Rwanda, Health Centers serve as the first entry level for accessing health services and thus are well placed in terms of accessibility due to their proximity to persons seeking different health services. Consequently, they are well placed to offer safe abortion services.

In 2003, WHO’s safe abortion guidance recommended that abortion services be provided at the lowest appropriate level of the health-care system. It states that vacuum aspiration can be provided at primary-care level up to 12 completed weeks of pregnancy and medical abortion up to 9 completed weeks of pregnancy, and that mid-level health workers can be trained to

provide safe, early abortion without compromising safety. It includes mid-level providers: midwives, nurse practitioners, clinical officers, physician assistants, and others. Training includes a bimanual pelvic examination to determine pregnancy and positioning of the uterus, uterine sounding, trans-cervical procedures, provision of abortion, and skills for recognition and management of complications. (Bulletin of the World Health Organization)

The role of mid-level health workers is growing in many aspects of health care, both in developing countries because of the crisis in human resources in health systems, and in developed countries to reduce the cost of health care when procedures allow for a lower cadre of providers than physicians. As Iyengar described in 2005: "Measures for de medicalizing primary health services include adoption of simpler technology and service protocols, authorization and training of less qualified providers, simplification or elimination of facility requirements, the establishment of robust referral links to hospitals, increasing user control and self-medication."(Iyengar SD. Introducing medical abortion within the primary health system: comparison with other health interventions and commodities. Reproductive Health Matters 2005; 13: 13-9 doi: 10.1016/S0968-8080(05)26217-1 pmid: 16291482.)

Examples of countries where Mid-level healthcare providers can provide abortion services include; the Unites States of America, Kenya and Ethiopia. In the United States of America for example, physician assistants, certified by the Board of Medical Practice in the United States of America (USA), have been permitted to carry out early abortions in the states of Montana and Vermont since 1975. (Freedman MA, Jillson D, Coffin RR, Novick LF. Comparison of complication rates in first trimester abortions performed by physician assistants and physicians. Am J Public Health 1986; 76: 550-4 doi: 10.2105/AJPH.76.5.550 pmid: 2870654.)

In Kenya (an Eastern Africa member state like Rwanda) and Ethiopia; both states advance more than Rwanda to liberate midlevel health care providers as trained health professionals are allowed to perform abortion (article 26 par 4 of Kenya constitution). In Ethiopia since the enactment of the new law of 2005 efforts have been undertaken to improve the access to safe abortion and related care by training midlevel health care providers.

GLIHD is concerned with doctor authorization requirement for an abortion when the pregnancy is threatening the health of the woman (article 166 of the Penal Code) bearing in mind the limited number of available medical doctors based on the ratio of 1 doctor per 15,806 patients.

Under article 125, Paragraph 2 of the 2018 Law determining offenses and penalties in general, a requirement of a medical doctor to perform an abortion was maintained. The article provides that; “A recognized medical doctor performs an abortion. Conditions to be satisfied for a medical doctor to perform an abortion are determined by an Order of the Minister in charge of health.”

Subsequently, in line with implementing the provisions of article 125, Paragraph 2 of the law determining offenses and penalties, a Ministerial Order N°002/MoH/2019 of 08/04/2019 determining conditions to be satisfied for a medical doctor to perform an abortion was published.

Therefore, according to the current legal status quo, only a medical doctor is allowed to perform safe abortion services. The requirement for only a medical Doctor to provide safe abortion services risk to limit the anticipated dividends of expanding access and affordability of safe abortion services and its positive outcomes in relation safeguarding reproductive health and rights due to scarcity of medical Doctors and unaffordability due to high cost of services.

Allowing mid-level Healthcare Professional to provide safe abortion services in Rwanda will facilitate expanding accessibility and affordability to all women and adolescent girls who qualify for and seek safe abortion services in accordance with the law.

This report specifically seeks to inform the CEDAW Committee on the existing barriers/challenges that still hinder access to and affordability of safe abortion services despite the tremendous strides made in law and practice, by the Government of Rwanda.

**Recommendations:**

GLIHD calls upon the CEDAW Committee to recommend the Government of Rwanda to:

1. to allow Mid -Level healthcare professionals (Nurses and Midwives) to provide safe abortion services
2. (ii) initiate appropriate legal and policy reforms leading to ensuring that mid-level healthcare professionals are permitted to provide safe abortion services in both law and practice.
3. Increase awareness campaigns on sexual and reproductive health
4. **Area of concern on Mandatory HIV Testing**

GLIHD is concerned with the following Mandatory HIV Testing in the law

Article 10 (20) of the Law n° 21/05/2016 of 20/05/2016 relating to human reproductive health provides: “No person shall undergo unconsented HIV/AIDS testing. However, mandatory testing may be required upon request by competent organs in accordance with the law.” The Law does neither define the “competent organs” nor explain under which circumstances the “competent organs” can compel an individual to undergo HIV Testing.

**Recommendation:**

GLIHD calls upon the CEDAW Committee to recommend the Government of Rwanda to:

Define the “competent organs” in the law

1. **Area of concern on exclusion of prostheses and other devices in the Mutual Health Insurance**

Mutual Health Insurance to which majority of the population are subscribed to does not cover prostheses and other devices for people with physical disability.

**Recommendation:**

To review Mutual Health Insurance law so as to increase the scope and include prostheses and other devices for people with disability in the mutual health insurance scheme

1. **Area of concern on disparity in geographic distribution of human resources**

There is unequal distribution of human resources in health facilities whereby most qualified health professionals are in urban areas

**Recommendation:**

Reduce disparity on geographic distribution of human resources in the health sector

1. **Area of concern on limitation to access to healthcare services by minors**

Limitation to access to healthcare services Article 11 of the Law No 49/2012 on medical professional liability insurance does not allow minors to seek healthcare services without the prior consent of their parents or legal guardians.

**Recommendation:**

To review the law to allow minors to seek healthcare services without prior consent of their parents or legal representatives.

**REFERENCES**

**A. LAWS AND CONVENTIONS**

1. Law N° 21/05/2016 relating to human reproductive rights as well as the progressive adoption of Law No. 68/2018 determining offences and penalties in general modifying Organic law no. 01/2012 instituting the Penal Code in relation to provisions related to legal abortion.

2.The Organic Law No 01/2012/OL of 02/05/2018 instituting the

penal code.

3. Law N°54/2011 of 14/12/2011 relating to the rights and the

protection of the child

4. Statutes for Public Service."(Iyengar SD. Introducing medical abortion within the primary health system: comparison with other health interventions and commodities. Reprod. Health Matters 2005; 13: 13-9 doi: 10.1016/S0968-8080(05)26217-1 pmid: 16291482.)

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6. International covenant on social, economic and cultural rights (ICESCR),

7. Convention on the Elimination of all forms of Discrimination against Women, (CEDAW)

8. The African Charter of Human and People’s Rights (ACHPR), as well as the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol).

9. Article 26 of the Constitution of the Republic of Kenya

10. Articles 12, 14, 15, 16, 21 and 23 of the Constitution of the Republic of Rwanda.

**B. POLICIES AND STRATEGIES**

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2. Ministry of Gender and Family Promotion, The National

Policy against Gender Based Violence (2011).

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**C. REPORTS AND SURVEYS**

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at <<https://www.guttmacher.org/pubs/unintended-pregnancyRwanda.pdf>> Accessed on 18 August 2015.

2. Rapid Assessment conducted by GLIHD, 2020.

3. National Institute of Statistics of Rwanda “RDHS 2019-2020, page 14”