CENTER FOR REPRODUCTIVE RIGHTS

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Committee on the Elimination of Discrimination against Women
Human Rights Treaties Division
Office of the United Nations High Commission for Human Rights
Palais Wilson – 52, rue des Pâquis
CH-1201 Geneva, Switzerland

Supplementary information on Rwanda scheduled for review by the Committee on the Elimination of Discrimination against Women during the Pre-Session of the 66th Session

Honorable Committee Members:

This letter is intended to supplement the periodic report submitted by Rwanda to the Committee on the Elimination of Discrimination against Women (the Committee) for the country's review during the Committee's pre-session of the 66th 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—hopes to further the work of the Committee by providing independent information on Rwanda concerning the rights protected in the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW).[1]

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

I. LACK OF ACCESS TO MATERNAL HEALTH SERVICES

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.[2] The Committee has 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.[3] During the 2015 Universal Periodic Review (UPR), it was recommended that Rwanda implement measures to reduce the high maternal mortality and ensure access to maternal health services.[4] During the 2009 review of Rwanda, the Committee recommended that the government put in place a "strategic plan to reduce maternal mortality" and monitor and remove obstacles to accessing obstetric services.[5] In its current report to the Committee, the government has highlighted a number of initiatives that are being implemented to address the issue including the construction of maternity wards; capacity building of midwives; introduction of community based health insurance; and the development of alert systems to track maternal and neonatal life cycle.[6] Despite these efforts, however, the rate still remains high and problems with accessing maternal health services remain. According to a recent report from the World Health Organization (WHO),

Rwanda had achieved the UN Millennium Development Goal of reducing the maternal mortality ratio (MMR) by 75% by 2015.[7] While this trend is positive, the MMR, at 290 deaths per 100,000 live births,[8] remains high, indicating that the government must intensify its efforts in order to achieve the reduction of the MMR to 70 deaths per 100,000 live birth as per its commitments under the Sustainable Development Goals.[9]

Further, it is widely recognized that the major causes of maternal mortality during pregnancy and child birth are "severe bleeding (post-partum hemorrhage), infections (sepsis), high blood pressure, obstructed labor and unsafe abortions," all of which are preventable or manageable by providing access to quality maternal health care services.[10] However, Rwanda's 2015 Demographic Health Survey (2015 RDHS) shows that more than half of women do not attend[11] the minimum four antenatal visits as recommended by the WHO.[12] Also, while 91% of women delivered with the assistance of a skilled provider, only 18% received this care from doctors.[13] Further, 55% did not attend postnatal checkup,[14] even though "a large proportion of maternal and neonatal deaths occur during the first 48 hours after delivery."[15]

A key reason for the low maternal care attendance is that Rwandan women and girls often encounter significant barriers in accessing services. Approximately 23% of patients need to walk for an hour or more than five kilometers to reach the nearest health care facility.[16] 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[17] and only 35 obstetricians and gynecologists.[18] Similarly, there are approximately only 8,895 nurses and midwives serving the entire population.[19] According to the President of the Rwanda Midwifery Association, "while the required number of midwives across the country is 3600, only 1100 midwives are deployed in hospitals and health centers."[20]

Lack of access to these health professionals is exacerbated as 40% of patients have to travel more than an hour to reach a health care facility.[21] 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.[22] According to a report published by the Ministry of Health in 2013, only 48 percent of the health workforce need is met.[23] The Vision 2020 initiative—the government's main development policy—aims to have 10 medical doctors, 20 nurses, and 5 lab assistants for every 100,000 inhabitants,[24] but these numbers will still need to be improved upon to make adequate impact.

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

Multiple human rights monitoring bodies have expressed concern over the restrictive law on abortion in Rwanda and its aggressive enforcement. In 2016, the Human Rights Committee, expressed concern over "the burdensome requirements for seeking permission to undergo abortion, namely, a court order recognizing rape, forced marriage or incest and the authorization of two doctors in the case of jeopardy to the health of the pregnant woman or the fetus."[25] The Human Rights Committee further recommended that the state revise its laws "to ensure that women are not prompted by legal obstacles to resort to clandestine abortions that put their lives and health at risks."[26] In 2009, the Committee expressed concern that "abortion is a punishable offence under Rwandan law" and recommended that the state remove punitive measures imposed on women who undergo abortion.[27] While, in its response, the government has stated that the law on abortion has improved since it "provides an exemption from criminal liability for abortion in

particular instances,"[28] there are still situations under which abortion is criminalized and, as discussed below, aggressive enforcement of the law and imprisonments continue.

In addition, despite the above recommendations, the law severely limits access to legal abortion, even in situations when the procedure is allowed, that is to save the life of the woman, protect her health, or when the pregnancy is a result of rape, incest, or forced marriage,[29] by adding significant hurdles. 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.[30] This creates a barrier because stigma, fear, and family pressure prevent many women and girls from reporting incest or sexual violence and engaging with the justice system. In addition, those requiring the termination of a pregnancy have a limited window in which to obtain these services and court proceedings are often cumbersome and ineffective in these time-sensitive contexts. This is particularly problematic since special courts have not been established to hear these cases, which might have facilitated an expedited hearing. Further, the law is not clear whether the sexual violence needs to be proven—which would require investigation by the police and conviction of perpetrator—and therefore would take longer time or whether the mere application by the victim would suffice. Recognizing the burden this type of restriction might create, other countries have refused to include this type of procedural "certification" barrier in their abortion law, determining instead that the woman's statement that a pregnancy is the result of sexual violence or incest is sufficient to meet the legal indication for termination of pregnancy on those grounds.[31]

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.[32] 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.[33] In addition, experts have repeatedly stated that the consultation requirements are inappropriate and delay access to services.[34] 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.[35] Further, fulfilling these requirements can cost money, waste time that women may not have, and dangerously delay critical health care, creating additional significant barriers. During the 2015 UPR of Rwanda, it was recommended that the government "[e]liminate, as a first step, judicial and administrative barriers that prevent women from accessing safe abortion, and protect women from being reported and arrested or going to jail for unsafe abortion as well as review the penal code in order to decriminalize abortion."[36] Yet, the barriers remain.

In March 2016, the parliament passed and submitted for the President's signature a law which is intended to govern reproductive health issues.[37] Although some problematic provisions, such as the requirement that three doctors certify that a pregnancy may have a serious impact on a woman's life before a woman can obtain an abortion, have been removed, the current version still remains with provisions that are of concern. For instance, in listing key components of reproductive health, the law leaves out some essential services such as ante and postnatal care and abortion services. It also gives the right to decide on one's reproductive health only to persons who have attained majority age[38] which under Rwanda law can either be 18 or 21.[39] This is concerning since, as discussed below, despite their high need, adolescents face a number of barriers in accessing reproductive health services, and this provision will exacerbate the situation by denying their right to make decisions about their reproductive health and seek the services as recognized by international and regional human rights laws.

Aggressive enforcement of the laws on abortion

The criminalization of abortion in Rwanda has great implications: for instance, while the revised Penal code reduced the penalty for a woman that induces her own abortion or consents to an abortion from 2-5 years[40] to 1-3 years, the penalty is still heavy,[41] and the law is aggressively enforced, resulting in the frequent routine arrest, prosecution, and imprisonment of women and girls for procuring an unlawful abortion.[42] Research published in 2015 revealed that from July 2013 to April 2014, 313 women were imprisoned in five prisons for illegal abortions amounting to almost a quarter of the total female prisoners in these prisons.[43] Similarly, another study found that, in 2010, of the 114 women in Karubanda Prison—one of Rwanda's main prisons—one in five were in for procuring illegal abortions, and 90% were 25 years old or younger.[44] It also found that some are serving sentences as long as ten years which were imposed when they were adolescents below the age of 18.[45]

From the women and girls interviewed in the 2015 study, some were victims of sexual violence and abuse or statutory rape.[46] For instance, Kelly became pregnant when she was 17 years old and procured an unsafe abortion.[47] She suffered complications and was reported to the police by the school administration. She pleaded guilty even though she would have qualified for a legal abortion since under Rwandan law any sexual relation under the age of 18 is considered defilement or statutory rape.[48]

The study further showed that in a number of instances, those imprisoned were low-income girls and women.[49] Many were engaged in sexual relations with men "who were paying for their school, clothing and food."[50] For instance, Carol, a 24 years old low-income woman with "limited knowledge [of] the use of condoms or other contraceptives and did not even know that one can get imprisoned for abortion."[51] Heavy bleeding stemming from a clandestine abortion compelled her to seek medical treatment in a hospital. She was taken to prison from the hospital and was given a 10-year sentence.

Many health professionals are not aware of the law on abortion[52] and those who provide abortion services risk prosecution and imprisonment. A 26 year old medical doctor who was sentenced to ten years in prison for helping his sister to procure an abortion stated that their parents had died in the 1994 Genocide, leaving them all alone. He helped 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.[53]

Consequently, Rwanda's criminalization of abortion 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.[54] 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.[55] This further heightened their sense of vulnerability and the stigma attached to abortion.

Studies have shown that 47% (nearly half) of all pregnancies in Rwanda are unintended and that 22% of the country's unintended pregnancies result in induced abortions.[56] Many of the women and adolescent girls who make up these numbers seek out clandestine and unsafe abortions due to

the restrictive abortion law.[57] 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.[58] Consequently, approximately 40% of abortions in Rwanda result in complications and require medical treatment.[59] Approximately 26,000 women each year are treated for abortion complications, with about 17,000 of these complications likely resulting from induced abortions (65%).[60] Methods of unsafe abortion include ingesting drugs and herbs and inserting metal objects or other items into the vagina.[61]

The restrictive laws on abortion—particularly the procedural requirements for accessing safe abortion services— have a disparate effect on women based on their age, level of income, and geographical location. For instance, this is reflected in the higher incident of abortion related complications that require treatment in health facilities among low-income women (54-55%) than those in a higher wealth quintile (20% among urban non-poor and 38% of rural non-poor).[62] The complication rates are highest for self-induced abortions (67%) and procedures performed 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.[63]

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.[64] It has been recognized that PAC should be integrated with other available maternal health services.[65] However, the potential for prosecution deters Rwandan women and girls from seeking necessary post-abortion treatment after procuring unsafe abortions.[66] About 30% of those who experience complications are ultimately unable to access PAC and treatment at health centers.[67]

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.[68] Moreover, very few providers employ techniques recommended by the WHO for treating uncomplicated post-abortion cases.[69] 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.[70]

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.[71] 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."[72] 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.[73] The Protocol confirms that health care providers should only use the procedures recommended by the WHO to treat incomplete abortions.[74] 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.[75]

III. INADEQUATE ACCESS TO CONTRACEPTIVE INFORMATION AND SERVICES

The Committee, during the review of Rwanda in 2009, recommended that the government take measures to reduce unwanted pregnancies including by making contraceptives accessible and raising awareness of the public about family planning.[76] In response, the government, without providing specifics, has indicated that it has "continued its efforts to improve the health status of Rwandans by improving the national health system," family planning and "reproductive health status in line with Millennium Development Goals."[77] Indeed, 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.[78] Under the Family Planning Strategic Plan 2012-2016, the government aims to achieve a contraceptive prevalence rate of 90% by 2017.[79] 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.[80]

In recent years, the use of modern contraceptives among married women in Rwanda has shown a lot of improvement: going from 4% in 2000 to 48% in 2015.[81] However, still 19% of married women[82] and 12 % of unmarried women[83] of child bearing age want to avoid or postpone their pregnancy but are not using contraceptives. This is a slight decrease from 2010 when 21% of married woman had an unmet need for contraceptives.[84] Only 47% use a modern contraceptive method.[85] Further, there is disparity in access to contraceptives based on a woman's status. For instance, the 2015 RDHS found that 45% of women in the lowest wealth quintile used modern contraceptives, whereas usage is 50% for women in the highest wealth quintile.[86]

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.[87] In addition, health care facilities that are religiously affiliated do not offer contraception.[88] This is particularly problematic since 40% of health care facilities in Rwanda are religiously affiliated[89] 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.[90] Due to this, nearly half of all the pregnancies in Rwanda are unintended, amounting to an estimated 276,000 pregnancies.[91]

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.[92] Rwanda recognizes that EC should be provided to survivors of sexual violence as soon as possible after the assault.[93] EC pills are also included in Rwanda's Essential Drug List.[94] However, a survey of clinics showed EC was not readily available.[95] For instance, only 16% of facilities surveyed have ever offered EC, noting that the day the survey was taken only 5% of the facilities had EC available.[96]

A further barrier to access to EC is lack of knowledge of the option. According to the 2015 RDHS, EC is the least known modern contraceptive method: only 35% of women and 45% of men have knowledge of EC.[97] 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.[98] A 2015 survey of University of Rwanda students also revealed that less than half the students have heard about EC and only 5.4% have used the method.[99]

Adolescents' Access to Family Planning Information and Services

Adolescent girls run a disproportionate risk of dying during or after childbirth and are more vulnerable to pregnancy-related complications.[100] As the 2015 RDHS notes, early childbearing constraints adolescent girls' ability to pursue educational opportunities, [101] thereby limiting their employment opportunities. However, in addition to the general barriers to accessing reproductive and health services in Rwanda, adolescents and youths face particular challenges, including misconceptions, lack of youth-friendly services/providers, and social stigma associated with use of the services that are available.[102] This is significant as approximately 29.5% of the entire population is between 10-19 years old[103] and the fertility rate for 15-19 year olds is 45 per 1,000 according to the 2015 RDHS.[104]

Approximately, 7% of girls age 15-19 have begun child bearing—that is, they have either given birth or are pregnant.[105] This is a slight increase from the 2010 when 6% of the same age group has started childbearing.[106] At age 19, 21% have begun childbearing.[107] A strong inverse relationship exists between early childbearing and education. According to 2015 RDHS, 13% of adolescents without formal education started childbearing, compared to only 9% of adolescents with primary education and 4% of adolescents with secondary education.[108] 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, 11% and 6% respectively.[109]

In one study that documented the role that the lack of information and education in respect to health services plays in the unintended pregnancies of adolescents, the young women interviewed cited a variety of factors, ranging from a lack of knowledge of where to access reproductive health services to misconceptions about their ability to use contraceptive methods (e.g. the pill) themselves rather than relying on their male sexual partners to use condoms, as contributing to their unintended pregnancies.[110] 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.[111]

IV. SEXUAL AND PHYSICAL VIOLENCE AGAINST WOMEN AND GIRLS

In its 2009 Concluding Observations, the Committee expressed concern regarding discriminatory laws and practices in Rwanda.[112] Further, while commending the state for some of the measures it has implemented to combat gender based violence, the Committee expressed concern regarding "the prevalence of different forms of violence against women, in particular sexual violence and domestic violence" and the lack of information on the extent of the problem.[113] In 2012, the Committee Against Torture also 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."[114] More recently, in 2013, the Committee on Economic, Social and Cultural Rights 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.[115]

In its recent report to the Committee, the government discussed a number of commendable initiatives it's implementing to curb the level of physical and sexual violence against women. For instance, it passed laws and policies such as the Law against Gender based Violence, the National Policy against Gender-based Violence and the Strategic Plan for Fighting against Gender based Violence (2011-2016) to punish perpetrators and provide support services to the victims.[116] It is also implementing a project with UN Women called "Safe Cities Free of Violence against Women and Girls" with the aim of increasing "women and girls safety in public spaces."[117] In addition, it has established the Anti-GBV Directorate and *Istange One Stop Centers* in district hospitals to respond to GBV cases and provide services to victims of violence.[118] The government, however, has not included statistics to indicate whether the incidences of GBV have decreased as a result of these initiatives.

Rwanda "continues to have one of the highest incidences of gender-based and domestic violence in Africa."[119] The 2015 RDHS reported that, 44% of all women between the ages of 15 and 49 have experienced physical or sexual violence at least once in their lifetime.[120] Thirty-four percent of ever married women between the ages of 15 and 49 reported that they had been abused by their current husband or partner.[121] The report also indicated that 22% of women age 15-49 had experienced sexual violence during their lifetime[122] which has not shown any improvement from the 2010 RDHS rate.[123] The most common perpetrators of violence are current or former spouses or partners or boyfriends.[124] Economics and education seem to bear on a woman's experience with physical violence in Rwanda. Women's experience of physical violence is highest in the lowest wealth quintile (43.7%) and is lowest in the highest wealth quintile (29.9%).[125] The proportion of women who have experienced physical violence also declines with education, from 40.5% of women with no education to 26.4 percent of women with secondary and higher education.[126]

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.[127] The Rwanda National Police report that between 2005 and 2008 there were 10,000 cases of child defilement.[128] In 2009 there were 1,570 cases of child rape recorded.[129] The Rwanda National Police also report that there were 863 cases of violence against children reported between January and July 2012.[130] It should be noted that these statistics do not give a comprehensive portrayal of the issue since GBV, particularly sexual violence, tends to be under-reported.[131]

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.[132] Those incidents resulted in at least 110 pregnancies.[133] 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."[134]

V. 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 further 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 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? What steps is the government taking to further revise the law on Reproductive health to make it more comprehensive and to protect the right of adolescents to make decisions about their reproductive health?

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 that women and girls can access PAC without fear of prosecution and 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. Please provide information on the level of physical and sexual violence against women and girls and measures the government is 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?

[1] Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), *adopted* Dec. 18, 1979, G.A. Res. 34/189, 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) [hereinafter CEDAW].
[2] Committee on Economic, Social and Cultural Rights (ESCR Committee), *General Comment No. 14*: The right to the highest attainable standard of health (Art. 12), (22nd Sess., 2000), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. I) (2008) [hereinafter ESCR Committee, *Gen. Comment No. 14*]; *see, e.g.*, CEDAW Committee, *Concluding Observations: Belize*, para. 56, U.N. Doc. A/54/38 (1999); *Colombia*, para. 393, U.N, Doc A/54/38 (1999); *Dominican Republic*, para. 337, U.N. Doc A/53/38 (1998); *Madagascar*, para. 244, U.N. Doc A/49/38, (1994).
[3] *See* in general Committee on the Elimination of Discrimination against Women (CEDAW Committee), *General Recommendation No. 24: Article 12 of the Convention (women and health)*, (20th Sess., 1999), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. II) (2008) [hereinafter CEDAW Committee, *Gen. Recommendation No. 24*].
[4] Human Rights Council, *Report of the Working Group on the Universal Periodic Review: Rwanda*, para. 135.66, 135.67, U.N. Doc. A/HRC/31/8 (2015) [Hereinafter 2015 UPR Rwanda].
[5] CEDAW Committee, *Concluding Observations: Rwanda*, para. 35, 36, U.N. Doc. CEDAW/C/RWA/CO/6 (2009); *See* similar recommendations CESCR Committee, *Concluding Observations: Rwanda*, para.26, UN Doc E/C.12/RWA/CO/2-4 (2013); CRC Committee, *Concluding Observations: Rwanda,* para. 48, 49 U.N. Doc. CRC/C/15/Add.234 (2004).
[6] CEDAW Committee, *Consideration of reports submitted by States parties under article 18 of the Convention: Seventh to ninth periodic reports of States parties due in 2014: Rwanda,* para, 33, 56, U.N. Doc. CEDAW/C/RWA/7-9 (2015) [hereinafter Periodic Report of State Parties : Rwanda].
[7] WORLD HEALTH ORGANIZATION (WHO) ET AL., TRENDS IN MATERNAL MORTALITY: 1990-2015 26 (2015).
[8] *Id*., at Annex 19.
[9] Sustainable Development Goals, *Goal 3: Ensure healthy lives and promote well-being for all at all ages, available at* http://www.un.org/sustainabledevelopment/health/.
[10] 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.
[11] National Institute of Statistics of Rwanda, et.al., *Rwanda Demographic Health Survey 2014-2015: Key Findings* 8 (2015) *available at* http://dhsprogram.com/pubs/pdf/SR229/SR229.pdf [hereinafter 2015 RDHS: Key Findings].
[12] WHO, GLOBAL HEALTH OBSERVATORY, *Antenatal care*, http://www.who.int/gho/maternal_health/reproductive_health/antenatal_care_text/en/ (last visited June 8, 2016).
[13] National Institute of Statistics of Rwanda et.al., *Rwanda Demographic and Health Survey 2014-2015* 121 (2016) *available at* http://dhsprogram.com/pubs/pdf/FR316/FR316.pdf [hereinafter 2015 RDHS].
[14] 2015 RDHS: Key Findings, *supra* note 11.
[15] 2015 RDHS, *supra* note 13, at 122.
[16] *See* THE WHITE RIBBON ALLIANCE FOR SAFE MOTHERHOOD, RWANDA STRATEGIC PLAN 2010-2013 AND YEAR ONE OPERATIONAL PLAN 9 (2010) [hereinafter WHITE RIBBON ALLIANCE, RWANDA STRATEGIC PLAN 2010-2013] *available at* http://www.heart-resources.org/wp-content/uploads/2012/05/275007_RW-Consultancy-to-Finalise-the-Strategic-Plan-for-White-Ribbon-Alliance-Rwanda-2010-2013_Strategic-Plan.pdf.
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[19] *Id.*
[20] United Nations Rwanda, Health Workers call for increase number of midwives, May 7, 2015 *available at* http://www.rw.one.un.org/press-center/news/health-workers-call-increased-number-midwives.
[21] PMNCH ET AL., SUCCESS FACTORS FOR WOMEN'S AND CHILDREN'S HEALTH 23 (2014), *available at* http://www.who.int/pmnch/knowledge/publications/rwanda_country_report.pdf [hereinafter PMNCH, SUCCESS FACTORS].

[22] Human Rights Committee, *Consideration of reports submitted by States parties under article 40 of the Covenant – Fourth periodic reports of States parties due in April 2013: Rwanda*, para. 6, U.N. Doc. CCPR/C/RWA/4 (2014) [hereinafter *Consideration of reports*].
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[26] *Id*.
[27] CEDAW Committee, *Concluding Observations: Rwanda*, paras. 35, 36 U.N. Doc. CEDAW/C/RWA/CO/6 (2009).
[28] Periodic Report of State Parties : Rwanda, *supra* note 6, para. 33.
[29] The Penal Code (2012), GOVERNMENT GAZETTE [REPUBLIC OF RWANDA], arts. 165-166 [hereinafter Penal Code].
[30] *Id*., arts. 164-166.
[31] 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).
[32] Penal Code, *supra* note 30, arts. 164-166.
[33] 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/.
[34] 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.
[35] *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/.
[36] 2015 UPR Rwanda, *supra* note 4, paras. 134.45, 134.79, 134.81, 135.16.
[37] Reproductive Health Bill, art. 1.
[38] *Id*., art. 7.
[39] In Rwanda, while the civil code puts the age of majority to be 21, other laws such as the Child Law and the Law on the Prevention and Punishment of Gender-based-Violence specify 18 as the age of majority: Christine Umubyeyi, *Access to Justice in Civil Matter: A Critical Analysis of Legal Representation of Minors Under Guardianship in Rwanda* 12-13 (2011) *available at* http://repository.up.ac.za/bitstream/handle/2263/18653/Umubyeyi_Acces%282011%29.pdf?sequence=1.
[40] United Nations, Rwanda: Abortion Policy (2002) *available at* http://www.un.org/esa/population/publications/abortion/.
[41] 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 30, arts. 162-164.
[42] *See, e.g.*, IPAS, WHEN ABORTION IS A CRIME: RWANDA (2015) *available at* http://www.glihd.org/wp-content/uploads/2015/10/STUDY-WHEN-ABORTION-IS-A-CRIME-RWANDA.pdf [hereinafter IPAS, WHEN ABORTION IS A CRIME: RWANDA]; *See also* 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].

[43] IPAS, WHEN ABORTION IS A CRIME: RWANDA, *supra* note 42, at 8.
[44] ABORTION IN RWANDA, *supra* note 42, at 9.
[45] *Id*.
[46] *See* IPAS, WHEN ABORTION IS A CRIME: RWANDA, *supra* note 42.
[47] *Id*., at 16.
[48] *Id*., at 14.
[49] *Id*., at 9.
[50] *Id*., at 14.
[51] ABORTION IN RWANDA, *supra* note 42, at 9.
[52] IPAS, WHEN ABORTION IS A CRIME: RWANDA, *supra* note 42, at 11.
[53] ABORTION IN RWANDA, *supra* note 42.
[54] *Id.* at 9.
[55] *See Id.*
[56] BASINGA ET AL, UNINTENDED PREGNANCY AND INDUCED ABORTION IN RWANDA 19 (2012) hereinafter [BASINGA, UNINTENDED PREGNANCY].
[57] *See, e.g.*, ABORTION IN RWANDA, *supra* note 42.
[58] GUTTMACHER INSTITUTE, FACT SHEET: ABORTION IN RWANDA, (Apr. 2013) *available at* www.guttmacher.org/pubs/FB-Abortion-in-Rwanda.html [hereinafter GUTTMACHER FACT SHEET].
[59] *Id*.
[60]BASINGA, UNINTENDED PREGNANCY, *supra* note 56, at 5.
[61] BASINGA ET AL., ABORTION INCIDENCE AND POSTABORTION CARE IN RWANDA, 43 STUDIES IN FAMILY PLANNING 11, 16 (2012) [hereinafter BASINGA, ABORTION INCIDENCE AND POSTABORTION CARE IN RWANDA].
[62] BASINGA, UNINTENDED PREGNANCY, *supra* note 56, at 17.
[63] GUTTMACHER FACT SHEET, *supra* note 58.
[64] Sneha Barot, *Implementing Postabortion Care Programs in the Developing World: Ongoing Challenges* 17 GUTTMACHER POLICY REVIEW 1 (2014), *available at* http://www.guttmacher.org/pubs/gpr/17/1/gpr170122.html.
[65] BASINGA, UNINTENDED PREGNANCY, *supra* note 56, at 24.
[66] BASINGA, ABORTION INCIDENCE AND POSTABORTION CARE IN RWANDA, *supra* note 61, at 16.
[67] BASINGA, UNINTENDED PREGNANCY, *supra* note 56, at 17.
[68] BASINGA, ABORTION INCIDENCE AND POSTABORTION CARE IN RWANDA, *supra* note 61, at 17-18.
[69] *Id*. at 18.
[70] BASINGA, UNINTENDED PREGNANCY, *supra* note 56, at 18.
[71] Michael Vlassoff, et al., *The health system cost of post-abortion care in Rwanda*, OXFORD JOURNALS 1-11 (2014).
[72] *Id*.
[73] BASINGA, UNINTENDED PREGNANCY, *supra* note 56, at 25.
[74] *Id*.
[75] BASINGA, ABORTION INCIDENCE AND POSTABORTION CARE IN RWANDA, *supra* note 61, at 13.
[76] CEDAW Committee, *Concluding Observations: Rwanda*, para. 36, U.N. Doc. CEDAW/C/RWA/CO/6 (2009).
[77] Periodic Report of State Parties : Rwanda, *supra* note 6, para. 56.
[78] REPUBLIC OF RWANDA MINISTRY OF HEALTH, FAMILY PLANNING STRATEGIC PLAN 2012-2016 6-7 (2012), *available at* http://www.moh.gov.rw/fileadmin/templates/Docs/Rwanda-Family-Planning-Strategic-2012-2013.pdf [hereinafter FAMILY PLANNING STRATEGIC PLAN].
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[80] PMNCH, SUCCESS FACTORS, *supra* note 21.
[81] 2015 RDHS, *supra* note 13, at 11.
[82] *Id*., at 13.
[83] *Id*., Tbl. 7.12.2.
[84] *Id*., at 14.
[85] *Id*., Tbl. 6.
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[90] BASINGA, ABORTION INCIDENCE AND POSTABORTION CARE IN RWANDA, *supra* note 61, at 12.
[91] BASINGA, UNINTENDED PREGNANCY, *supra* note 56, at 19.
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[99] Josee Uwamariya, et.al., *Sexual Activity and Emergency Contraception among Female Students in the University of Rwanda* 175 Int'l Journal of Tropical Disease & Health 8(4) 170-177 (2015).
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[106] National Institute of Statistics of Rwanda et.al., *Rwanda Demographic Health Survey 2010* 75 (2012) [hereinafter 2010 RDHS].
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