

March 15, 2013

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

**Re: Supplementary information on the Republic of Rwanda Scheduled for Review
by the Committee on Economic, Social and Cultural Rights during its 50th Session**

Dear Committee Members:

This letter is intended to supplement the periodic report of the Government of the Republic of Rwanda, scheduled for review by this Committee during its 50th session. The Center for Reproductive Rights (the Center), an independent nongovernmental organization based in New York, with regional offices in Nairobi, Kenya, Kathmandu, Nepal, and Bogota, Colombia, uses the law to advance reproductive freedom as a fundamental right. With this submission, the Center hopes to further the work of the Committee by providing independent information concerning the rights protected in the International Covenant on Economic, Social and Cultural Rights (the Covenant).

Rwanda has ratified the Covenant and seven other major international human rights treaties and has withdrawn any reservations it previously entered on any of these treaties.¹ Under its legal system, international and regional laws and treaties immediately become part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

This letter provides a summary of several areas of concern and a list of questions that we hope the Committee will raise with the Rwandan delegation. We wish to bring to the Committee's attention the following areas of particular concern: the high rates of preventable maternal mortality and morbidity; lack of access to safe abortion services and post-abortion care; aggressive enforcement of laws prohibiting abortion which has resulted in the imprisonment of many women and adolescent girls; women's inadequate access to family planning services and information; discrimination against people living with HIV/AIDS; and discrimination and violence against women and girls. These problems reflect shortfalls in the government's implementation of the Covenant and directly affect the health and lives of women in Rwanda.

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

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

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

Recognizing that vulnerable populations face substantial barriers that limit their access to health care services, the Covenant imposes a duty to provide special protection to children as well as pregnant women before and after delivery.⁸ To that end, the Covenant urges states to create conditions that assure access to medical service for all.⁹

The Covenant has a comprehensive definition of the right to health.¹⁰ Rather than a narrow interpretation where the right to health is simply equated with the right to be healthy, the Committee broadly defines it as a “right to control one’s health and body, including sexual and reproductive freedom.”¹¹ Thus, health is an inclusive right that not only includes access to health care but also “[t]he realization of women’s right to . . . education and information, including in the area of sexual and reproductive health.”¹² This is “understood as requiring measures to improve child and maternal health, sexual and reproductive health services, including access to family planning, pre- and post-natal care, emergency obstetric services and access to information, as well as to resources necessary to act on that information.”¹³

Further, the Covenant specifically “requires the removal of all barriers interfering with access to health services, education and information, including in the area of sexual and reproductive health.”¹⁴ Despite these protections, women’s rights are neglected and violated in Rwanda, particularly their rights to safe pregnancy and childbirth, safe abortion and post-abortion care, and access to comprehensive contraceptive methods and reproductive health services without discrimination.

1. MATERNAL MORTALITY AND MORBIDITY

Maternal death is defined as any death that occurs during pregnancy, childbirth, or within 42 days after birth or termination of pregnancy or its management.¹⁵ Women in Rwanda have a 1-

in-43 lifetime risk of dying from a pregnancy-related cause.¹⁶ Although the 2010 Rwanda Demographic and Health Survey (2010 RDHS) states that the maternal mortality ratio (MMR) is 476 deaths per 100,000 live births, the World Health Organization (WHO) statistics indicate that there are 340 deaths for every 100,000 live births.¹⁷ Regardless of the variation in data, the MMR in Rwanda is higher than the global average of 210 per 100,000 live births.¹⁸

Rwanda has made significant advancements in reducing maternal mortality rates—MMR has fallen from 1,071 per 100,000 live births in 2000 to a recorded 476 per 100,000 in 2010.¹⁹ However, with less than three years remaining to reach the Millennium Development Goal (MDG) targets, the rate of decrease in maternal mortality rate in Rwanda is much slower than that needed to achieve the fifth MDG of 75% reduction in MMR by 2015 (268 per 100,000).²⁰ MMR also remains well-above Rwanda's Vision 2020 goal to decrease MMR to 200 per 100,000 live births.²¹

The Committee has affirmed that states' failure to reduce maternal deaths violates the right to health²² and has defined the provision of maternal health services as a core obligation of Article 12 of the Covenant.²³ As previously noted, under Article 10(2) of the Covenant, states have a duty to provide special protection to mothers during a reasonable period before and after childbirth.²⁴ Since most maternal deaths are preventable,²⁵ the failure by governments to provide the services needed by women to survive childbirth constitutes a violation of their rights.²⁶

While Rwanda states that it has established a maternal health program and highlights the availability of emergency obstetric care in its submission to the Committee,²⁷ significant barriers to accessing maternal health services exist which violate Rwandan women's right to health. About 23% of patients walk for an hour or more than 5km to reach the nearest health care facility.²⁸ There has been an increase in health facility delivery from 45% in 2009 to 69% in 2011²⁹ but, according to the 2010 RDHS, 29% of women in Rwanda still deliver at home in unsanitary and sometimes dangerous conditions.³⁰ The WHO and the Ministry of Health recommend at least four antenatal visits³¹ but less than 35% of Rwandan women received the recommended minimum.³² The WHO also recommends having a postnatal check-up during the first two days after delivery as many maternal deaths occur during this time;³³ however, only 18% of women in Rwanda receive this service.³⁴

The main causes of death during and following pregnancy and childbirth in Rwanda are due to "severe bleeding (post-partum hemorrhage), infections (sepsis), high blood pressure, obstructed labor and unsafe abortions," all of which are preventable or manageable.³⁵ The risks associated with childbirth can be reduced by providing antenatal care and ensuring that all women have access to skilled health professionals during and after childbirth.³⁶

In its 2009 concluding observations, the Committee on the Elimination of Discrimination against Women (CEDAW Committee), which monitors state compliance with the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), urged Rwanda to increase access to health care, especially for rural and elderly women.³⁷ The CEDAW Committee also recommended that obstacles to accessing obstetric services be monitored and steps taken to remove these barriers.³⁸ However, disparities, based on geography and socio-economic status, remain. For instance, poor women in Rwanda are eight times less likely than their wealthier counterparts to have access to skilled care.³⁹ There are even greater inadequacies in access to maternal health care for historically marginalized groups.⁴⁰

Further, severe health workforce shortages exist in the country. Although the number of health care professionals in Rwanda increased from 11,604 in 2008 to 12,465 in 2010,⁴¹ the country still has only one doctor per 18,000 people⁴²—or a total of between 725⁴³ and 633⁴⁴ doctors—and one nurse per 1,700 people.⁴⁵ Additionally there is a severe shortage of midwives—White Ribbon Alliance reports that there are currently only around one hundred midwives practicing in Rwanda in private and public health facilities and a Rwandan newspaper reports there are currently 500 registered midwives,⁴⁶ though it is unclear if all are practicing. Further, the few midwives and other health care professionals in the country are concentrated in urban areas.⁴⁷ This disparity is most felt in rural areas where there are an insufficient number of midwives practicing.⁴⁸ According to the WHO, Rwanda has a critical shortage of health professionals and needs to increase their health workforce by about 140% in order to make a positive difference in the health and life expectancy of the Rwandan population.⁴⁹

In its 2004 concluding observations, the Committee on the Rights of the Child recommended that Rwanda “allocate appropriate resources and develop and implement comprehensive policies and programmes to improve the health situation of children, particularly in rural areas.”⁵⁰ The Health Sector Strategic Plan for 2009-2012 states that more funds will be directed towards addressing the high maternal mortality rate,⁵¹ and in 2010, Rwanda spent about 10.2% of its budget on the health sector.⁵² However, under the Abuja Declaration, the government has an obligation to commit at least 15% of its annual budget to the health sector.⁵³ The Rwandan Government is yet to fulfill this pledge.

Adolescent Maternal Health

Approximately 6% of girls in Rwanda have either given birth or are pregnant by age 19.⁵⁴ Adolescents in rural areas are more likely to start childbearing earlier than urban adolescents, 6% and 5% respectively.⁵⁵ Adolescent girls run a disproportionate risk of dying during or after childbirth⁵⁶ and are more vulnerable to pregnancy-related complications.⁵⁷

Further, a strong inverse relationship exists between early childbearing and education. According to the 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.⁵⁸ 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.⁵⁹ Adolescent pregnancy also has a detrimental impact on girls' right to education and economic wellbeing. The 2010 RDHS notes that "early childbearing seriously affects a woman's ability to pursue an education, thereby limiting her job opportunities."⁶⁰

2. UNSAFE ABORTION AND LACK OF POST-ABORTION CARE

The Rwandan Government's report to the Committee is silent on unsafe abortion and lack of post-abortion care (PAC). Although there is no record of the number of women who die from unsafe abortion in Rwanda,⁶¹ there is ample evidence of both the high prevalence of unsafe abortion and its serious consequences. While the 2010 RDHS does not provide information on abortion-related maternal mortality, it did find that 24% of all deaths among women in their reproductive years—15 to 49—was due to pregnancy or pregnancy related causes.⁶² Further, a 2004 study found that 50% of obstetric complications in four health districts in Rwanda were abortion-related.⁶³ Methods of unsafe abortion include ingesting drugs and herbs and inserting metal objects or other items into the vagina.⁶⁴

Many of the women and adolescent girls who make up these numbers seek out clandestine and unsafe abortion due to the restrictive abortion law.⁶⁵ Consequently, approximately 40% of abortions in Rwanda result in complications and require medical treatment.⁶⁶ In 2009 alone, 16,700 women were treated for complications resulting from abortion.⁶⁷ About 30% of those who experience complications are ultimately unable to access post-abortion care and treatment at health centers.⁶⁸

The reasons for this lack of access include inadequate equipment and medical supplies in health care facilities and insufficient training of health care providers.⁶⁹ According to a study that was conducted in 2009, only 13% of health centers and 7% of polyclinics have the necessary equipment to provide PAC services.⁷⁰ Moreover, very few providers employ techniques recommended by the WHO for treating uncomplicated post-abortion cases.⁷¹ Lack of access to PAC is particularly dismal given that 21%—almost a quarter—of women in Rwanda will, during their reproductive years, need medical care for abortion-related complications.⁷²

In July 2012, Rwanda enacted a new Penal Code, amending its law on abortion. The law continues to criminalize abortion; however, it also creates specific exceptions to criminalization where an abortion is performed to save the pregnant woman's life, protect her health or in cases where the pregnancy is a result of rape, incest or forced marriage.⁷³ Nonetheless, despite expanding the legal indications for abortion, Rwanda's new Penal Code simultaneously severely limits access to these legal services by requiring women and providers to overcome significant hurdles in order to qualify for a safe and legal abortion. The rate of unsafe abortion is directly

correlated to the extent that a state's abortion laws are restrictive or penal.⁷⁴ In Rwanda, the high rate of unsafe abortion is sustained in large part by these legal hurdles and procedural barriers in clear contravention of international human rights standards and accepted international medical practice. This includes the WHO's latest guidelines on safe abortion which provide that state officials must create an enabling environment "to ensure that every woman who is legally eligible has ready access to safe abortion care" and to remove "barriers that hinder access to and timely provision of safe abortion care."⁷⁵

For example, Rwanda's abortion law requires a "competent Court" to certify that a woman has become pregnant as a result of rape, incest or forced marriage.⁷⁶ This is a serious barrier to women qualifying for this service. It is widely recognized that stigma, fear and family pressure prevent many women from reporting incest or sexual violence and engaging with the justice system. In addition, court proceedings are often cumbersome and ineffective in time-sensitive contexts—women requiring a termination of pregnancy have a limited window in which to obtain these services. Recognizing this, many countries have refused to include this type of procedural "certification" barrier in their abortion law, determining instead that the woman's statement that a pregnancy is the result of sexual violence or incest is sufficient to meet the legal indication for termination of pregnancy on those grounds.⁷⁷

Similarly, the law requires that the procedure be performed by a medical doctor, and that a doctor seek the "advice of another doctor" when possible and obtain his/her consent in writing before proceeding with the abortion.⁷⁸ This can create insurmountable barriers to women's access to safe abortion services. Experts have repeatedly stated that these requirements are not evidenced-based and have recommended against them. For example, the WHO has made clear that mid-level providers, such as nurses or clinical officers, can safely and beneficially provide first-trimester abortion services.⁷⁹ Further, most contemporary legal and policy experts agree that consultation requirements are inappropriate and delay access to services.⁸⁰ This requirement for the involvement of multiple doctors is particularly onerous in a country such as Rwanda with only 725 doctors, as previously noted;⁸¹ and a population of over ten million people.⁸² Such requirements are also significant barriers for women that can cost money, waste time and dangerously delay critical health care.

In addition to these concerns, it appears that the Rwandan Parliament is currently considering a Reproductive Health Bill⁸³ 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."⁸⁴ If passed, this Bill would be a severe setback to recent efforts to expand access to safe and legal abortion and to reduce maternal mortality from unsafe abortion. Not only does the bill seek to greatly narrow the legal indications for abortion, it also seeks to increase 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.⁸⁵ We strongly urge the Rwandan Parliament to remove these abortion provisions from the draft bill.

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

The United Nations Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health [hereinafter “UN Special Rapporteur on Health”] has confirmed in his 2011 report that the criminalization of abortion and other reproductive health services violate 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.⁸⁶ 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 and criminal penalties.⁸⁷ As the United Nations Office of the High Commissioner on Human Rights notes, several human rights bodies, including the Human Rights Committee, the Committee against Torture, and the CEDAW Committee, have found restrictive abortion laws and failure to ensure access to abortion when it is legal are incompatible with international human rights obligations, amounting to violations of the right to life, health, the right to be free from torture and cruel, inhuman and degrading treatment and the right to be free from discrimination.⁸⁸ The CEDAW Committee and the UN Special Rapporteur on the Right to Health have specifically called on states to decriminalize abortion.⁸⁹

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

The implications are particularly significant in Rwanda because the law is aggressively enforced. Adolescent girls and women are routinely arrested, prosecuted, and imprisoned for procuring an unlawful abortion.⁹⁰ A 2011 study by Youth Action Movement Rwanda documents testimonials of survivors of unsafe abortion and women and girls imprisoned for illegal abortion [hereinafter “the testimonials”]. Some of the women who are in prison for abortion-related charges are serving sentences as long as ten years which were imposed when they were adolescents below the age of 18.⁹¹

As of 2010, of the 114 women in Karubanda Prison, one of Rwanda's main prisons, 21—almost one in five—were in for procuring illegal abortions, and 90% of the 21 were 25 years old or younger.⁹² Many of these women were the victims of sexual violence and abuse. “Anne” (now 21 years old) was imprisoned in 2007 and is serving a nine-year sentence for terminating a pregnancy resulting from sexual abuse by her teacher when she was 17 years old.⁹³ She had to drop out of school because pregnancy is “against school regulations.”⁹⁴ She decided to terminate the pregnancy and then was reported to the police by her elder brother.

Rwanda's criminalization of abortion through its Penal Code, and the fear of being imprisoned if found to have procured, provided, assisted with procuring, or had knowledge that an illegal abortion was procured has heavily stigmatized women seeking access to abortion-related services. One immediate consequence is that women are forced to seek out clandestine abortion, often having to travel long distances and, as the statistics show, almost always exposing themselves to unsafe abortion.

Many interviewees in the testimonials noted that they traveled to the Democratic Republic of Congo or Uganda, to access abortion.⁹⁵ 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.⁹⁶ This further heightened their sense of vulnerability and the stigma attached to abortion.

The testimonials further show that in a number of instances, those imprisoned were low-income girls and women,⁹⁷ or were orphaned as a result of the 1994 genocide,⁹⁸ and engaged in transactional sex for money to meet essential needs such as food, school fees, and accommodation.⁹⁹ In one case, “Carol” who at 24 years had only served two out of a ten year sentence, noted that she was a low income woman with “limited knowledge [of] the use of condoms or other contraceptives and did not even know that one can get imprisoned for abortion.”¹⁰⁰ Heavy bleeding stemming from a clandestine abortion compelled her to seek medical treatment in a hospital. She was taken to prison from the hospital.

Those who assist in the procuring of an unsafe and illegal abortion are also prosecuted and imprisoned. A 26-year-old medical doctor who was sentenced to ten years in prison for helping his sister to procure an abortion stated that their parents had died in the 1994 genocide, leaving them all alone. He undertook to help her procure an abortion when the man who was responsible for her pregnancy abandoned her. She died during the unsafe abortion and he was subsequently reported to the police and imprisoned.¹⁰¹

4. INADEQUATE ACCESS TO FAMILY PLANNING SERVICES AND INFORMATION

The Committee has consistently recognized that lack of access to family planning information and services violates the right to health¹⁰² and that low contraceptive prevalence contributes to unsafe abortion and maternal death.¹⁰³ The United Nations Population Fund 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 a life with dignity,¹⁰⁴ rights that Rwanda has an affirmative duty to protect.¹⁰⁵ The 1994 International Conference on Population and Development also recognized that individuals and couples have the right to attain the highest standard of sexual and reproductive health.¹⁰⁶ Inherent in this right is the “freedom to decide if and when to reproduce and the right to be informed and to have access to safe, effective, affordable and acceptable methods of family planning. . . .”¹⁰⁷

In its submission to the Committee, Rwanda states that it is taking important steps to reduce poverty by establishing family planning programmes.¹⁰⁸ Although the number of women who have access to family planning services has increased, there still remains a large percentage of the population who do not use modern contraception and a many women with unsatisfied demand. Only 25% of Rwandan women use modern contraception;¹⁰⁹ of the 40% of women who have a demand for, or want to use, family planning, 26% are unable to do so.¹¹⁰ The unsatisfied demand is generally higher for women with less income and education¹¹¹ and is also generally higher for women living in rural areas than those in urban areas.¹¹² Yet, access to family planning services is an effective means of reducing maternal mortality.¹¹³ Addressing the unmet need for modern contraceptive methods and maternal health care in Rwanda would reduce maternal deaths by a third.¹¹⁴

According to a recent Guttmacher report, the dominant constraints on the use of modern contraceptives are “negative attitudes toward family planning and failing structures of provision.”¹¹⁵ In Rwanda, discussing family planning is considered taboo and most women have either never discussed family planning with their husband or have done so only once or twice.¹¹⁶ Additionally, health centers rarely inform their female clients about the reproductive health care available, and some do not offer reproductive health care services.¹¹⁷

There is a much higher unsatisfied demand for family planning in Rwanda for unmarried women age 15-19 compared to all other groups, including married women of the same age and unmarried women in different age groups. Forty-eight percent of unmarried women age 15-19 have an unsatisfied demand for modern methods.¹¹⁸ This is significantly higher than the average unsatisfied demand for modern methods of all unmarried women in Rwanda, 26%, and the average for all women in Rwanda, 37%.¹¹⁹

The unsatisfied demand for modern methods is also higher in the 20-24 age group, 31%, compared to all unmarried women, besides those 15-19 years old.¹²⁰ As indicated by the Youth Movement Action Rwanda study, one underlying reason for a higher incidence of younger women with unsatisfied demand for contraception is a lack of access to information about reproductive health and contraception, including emergency contraception.¹²¹ Many girls explained that they had never heard of contraceptives, or had limited or no knowledge of different types available.¹²² While there may be many cultural and other reasons for the higher percentage of unsatisfied demand for younger women, the differences are in part due to inadequate provision of family planning information and services.¹²³

The right to enjoy the benefits of scientific progress, which is guaranteed in the Covenant, should include access to family planning services. However, there are socioeconomic and geographic disparities in the use of modern contraception among women in Rwanda. Modern contraception use is 57% in the wealthiest quintile but only 43% in the poorest quintile.¹²⁴ Women with no formal education and living in rural areas have the most difficulty accessing family planning services; only 45% use modern methods of contraception.¹²⁵ Geographically, a significantly higher percentage of women use modern contraception in urban areas such as Kigali (28%), compared to a low of 4% in Gikongoro, a rural region.¹²⁶

Only 39% of men and 23% of women have knowledge of emergency contraception, the least known method of contraception in Rwanda.¹²⁷ The Rwandan Government has an obligation to ensure adequate access to family planning information and services, including emergency contraceptives. Its failure to ensure access to these essential services impedes “the full realization of the right to health.”¹²⁸

5. DISCRIMINATION AND STIGMA AGAINST PEOPLE LIVING WITH HIV

Discrimination and stigma against people living with HIV is a human rights violation.¹²⁹ This Committee has noted that, “[s]tates have a special obligation . . . to prevent any discrimination on internationally prohibited grounds in the provision of health care and health services, especially with respect to the core obligations of the right to health.”¹³⁰ General Comment 14 also reiterates state obligations to fulfill “the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups,”¹³¹ including women.

HIV/AIDS discrimination and stigma pose great challenges in slowing the spread of HIV/AIDS and significantly impede the goal of universal treatment, care and support.¹³² HIV/AIDS discrimination is prevalent in health care facilities as well as other settings in Rwanda. In a recent UNAIDS report, 88% of respondents of a survey in Rwanda had been denied family planning services because they were living with HIV.¹³³ Additionally, the report found being

HIV positive was a significant reason for individuals being denied access to other services such as educational, work and accommodation services.¹³⁴

A USAID report documents the prevalence of stigma and discrimination against people living with HIV in Rwanda.¹³⁵ Discriminatory practices in the study included: “not providing treatment for HIV-positive patients or not admitting them for care; discontinuing care or treatment for other conditions when a patient’s HIV status is discovered; not performing surgeries or other invasive procedures despite obvious need; overcharging HIV-positive patients; and testing patients without their consent.”¹³⁶ In the study, every provider surveyed showed some level of fear of exposure to HIV,¹³⁷ which is one of the primary reasons for stigma among health care providers.¹³⁸ The study found that 76%, of respondents were aware of common practices by health care facilities that are discriminatory toward persons living with HIV, and 89% were aware of common practices by health care providers that discriminate against these patients.¹³⁹

Mandatory HIV Testing Under the Proposed Reproductive Health Bill

As mentioned briefly above, the Rwandan Parliament is currently considering a Reproductive Health Bill, which ostensibly seeks to address barriers to reproductive health services in hospitals and facilities.¹⁴⁰ However, provisions in the proposed bill that require mandatory HIV testing without informed consent are deeply troubling and violate the right to health, privacy and nondiscrimination enumerated in the Covenant, CEDAW, International Covenant on Civil and Political Rights (ICCPR) and the Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa (Maputo Protocol).¹⁴¹

According to Article 14 of the Bill, a medical doctor who deems it “necessary” to test a child or any other person for HIV may “do so without asking for any authorization and show the result to the guardian or care provider.”¹⁴² This directly violates Rwanda’s obligations under the Covenant and ICCPR. Compulsory HIV testing violates ICCPR 17.1 which states that “No one shall be subjected to arbitrary or unlawful interference with his privacy. . . .”¹⁴³ Non-consensual medical treatment violates “the right to control one’s health and body, including sexual and reproductive freedom, and the right to be free from interference, such as the right to be free from . . . non-consensual medical treatment. . . .”¹⁴⁴ HIV testing without a patient’s consent also undermines trust in the public health system and violates the Covenant’s nondiscrimination principle.¹⁴⁵

Compulsory HIV testing relies on coercion and is harmful to the Rwandan Government’s goal to improve access to reproductive health services.¹⁴⁶ Furthermore, compulsory HIV testing may further stigmatize HIV and could discourage individuals from seeking all types of health care. Rwanda should adhere to internationally accepted standards governing confidentiality and

informed consent and respect patients' rights to privacy and health. Compliance with these laws and standards is also integral to effective HIV prevention and treatment strategies.

6. DISCRIMINATION AND VIOLENCE AGAINST WOMEN AND GIRLS

This Committee has imposed upon states the obligation to promote equality and nondiscrimination through 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.”¹⁴⁷ Throughout its 2009 Concluding Observations on Rwanda, the CEDAW Committee expressed concern about discriminatory laws and practices in the country¹⁴⁸ as well as “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. . . .”¹⁴⁹ The CEDAW Committee also recommended that Rwanda urgently review the provisions [of the Bill on The Prevention and Punishment of Gender-Based Violence] likely to generate direct or indirect discrimination against women.”¹⁵⁰

Likewise, in its 2012 concluding observations on Rwanda, the Committee against Torture asked Rwanda to adopt a comprehensive strategy to combat gender-based violence.¹⁵¹ It further expressed concern about the lack of comprehensive data on domestic violence and recommended that Rwanda provide women victims with assistance and “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.”¹⁵²

Gender- based violence (GBV) including sexual and physical violence, continues to be a serious problem in Rwanda. The 2010 RDHS report indicates that nearly half of all women between the ages of 15 and 49 had experienced physical or sexual violence at least once in their lifetime.¹⁵³ Data also showed that a large percentage of all women in Rwanda—about 41%-- had experienced physical violence since reaching the age of 15.¹⁵⁴ 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.¹⁵⁵ The 2010 RDHS report also indicated that 22% of women had experienced sexual violence during their lifetime¹⁵⁶ and 51% of this group had been abused by a current or former husband, partner, or boyfriend.¹⁵⁷ Additionally, 13% of women ever married had experienced sexual violence in the twelve months preceding the survey.¹⁵⁸ 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.¹⁵⁹

The WHO recognizes that violence against women is a major public health problem and a violation of women's human rights, which can result in physical, mental, sexual and reproductive, and maternal health problems.¹⁶⁰ Similarly, health practitioners recognize that gender-based violence has many consequences on women's lives including . . . “the

psychological impact of violence, loss of personal freedom, diminished capacity to participate in public life, and a dramatically increased risk of acquiring HIV and other STIs.”¹⁶¹

Sexual and physical violence against children is also prevalent in Rwanda. In 2007, the Gahanga Primary School in Kicukiro District conducted a survey in which 9% of the students reported that they had been sexually abused at least once.¹⁶² The Rwanda National Police report that between 2005 and 2008 there were 10,000 cases of child defilement.¹⁶³ In 2009 there were 1,570 cases of child rape recorded.¹⁶⁴ The Rwanda National Police also report that there were 863 cases of violence against children reported between January and July 2012.¹⁶⁵ Since gender-based violence tends to be under-reported,¹⁶⁶ these statistics do not give a comprehensive portrayal of the issue.

Discriminatory Practices Against Girls and the Right to Education

As mentioned above, there is also a strong inverse relationship between early childbearing and education. In its 2009 concluding observations, the CEDAW Committee noted that in Rwanda there is a low enrollment rate of girls in secondary and higher education and a high dropout rate.¹⁶⁷ The high dropout rate is attributed primarily to teenage pregnancy, gender-based violence and early marriage.¹⁶⁸ The CEDAW Committee has also expressed concern that the dropout rate stems from “traditional attitudes” and that “pregnant girls who leave school as a result of the measure of suspension encounter difficulties in resuming their studies.”¹⁶⁹ Furthermore, in cases where there are reports of abuse by teachers and school officials, survivors may be reluctant to return to school or to excel in classes out of fear of being noticed by the abuser.¹⁷⁰ These crimes often go unreported because the victim fears social stigma, negative repercussions at school, or further abuse at the hands of the investigating agency.¹⁷¹

This Committee recognizes that “[e]ducation is both a human right in itself and an indispensable means of realizing other human rights.”¹⁷² Further this Committee affirms that education has a vital role in empowering women and safeguarding children from sexual exploitation.¹⁷³ Article 10 of CEDAW protects the rights of women and girls to an education and obligates states to reduce female student dropout rates and to organize programs for those who have left school prematurely.¹⁷⁴ Further, this Committee imposes on states the obligation to ensure that education is non-discriminatory in all aspects,¹⁷⁵ including accessibility.¹⁷⁶

Sexual violence and other discriminatory practices in Rwandan schools significantly interfere with access to education for girls. While information is limited, there are some examples. In June 2011 the State Minister in charge of Primary and Secondary Education conducted a survey, finding that over 600 children were sexually, physically, and psychologically abused in the previous two years across the country, resulting in at least 110 pregnancies.¹⁷⁷ The Minister attributed the abuse to relatives, teachers and other community members explaining, “[m]ale

teachers in most primary schools take advantage of their positions to abuse pupils who fear and respect them."¹⁷⁸

The story of one rural secondary school illustrates the significant educational and health barriers for girls in Rwanda. A news article reports that at the Groupe Scolaire Nsinda, a secondary school in the Rwamagana district, 26 girls between the ages of 14 and 17 are pregnant or recently gave birth and 11 of the girls have dropped out of school.¹⁷⁹ Some of the pregnancies have been linked to a former school administrator¹⁸⁰ or teachers at the school,¹⁸¹ though some of the girls have also given statements attributing the pregnancies to relations with individuals outside of the school.¹⁸² Additionally, school officials are being blamed for not addressing the issue in an urgent manner.¹⁸³ Although the Rwandan government states that it is an offense to impregnate a school girl,¹⁸⁴ and Rwanda has enacted the Act Concerning the Prevention and Suppression of Gender-Based Violence,¹⁸⁵ nothing indicates that these laws or policies have been effective.

While in Rwanda it is an offense to suspend or expel pregnant girls from school and there is an official policy of "readmitt[ing] [girls] in schools after delivery,"¹⁸⁶ it is unclear that the remittance policy is followed.¹⁸⁷ Additionally, financial and other barriers prevent girls who have given birth from attending and returning to school.¹⁸⁸ Physical and sexual violence and all other discriminatory practices impede the realization of the human rights of women and girls.

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

1. What concrete steps have been taken to implement the 2009-2012 Health Strategic Plan and reduce maternal deaths in Rwanda and what is being done to allocate adequate resources to the implementation of these measures to ensure success? In particular, what is the government doing to address insufficient access to and quality of emergency obstetric care?
2. What steps has the government taken to ensure the adequate recruitment, training, and retention of health workers, and sufficient equipping of health care facilities to reduce injuries and deaths due to pregnancy and childbirth-related complications, particularly given the severe shortage of doctors and midwives in the country?
3. What measures has the government undertaken to address unsafe abortion, which is one of the leading causes of maternal morbidity in Rwanda? What concrete steps is the government taking to collect data on the number of maternal deaths due to unsafe abortion? How will it ensure its citizens are informed of the new abortion law and the expanded grounds for access to safe and legal abortion?

4. What is the government doing to ensure that further reform of the abortion laws brings the country into conformity with international human rights standards? Specifically, what efforts has the government undertaken to remove the provisions in the proposed Reproductive Health Bill, which pose significant barriers to women's access to safe and legal abortion?
5. Considering that the new Penal Code reduces prison sentences for those who procure an abortion from 5 – 15 years to 1 – 3 years, will the government set up a mechanism for reviewing the long prison sentences already imposed on some women for procuring an abortion to commute their sentences or grant them pardons? Likewise, will it review the sentences of those who were imprisoned for abortion-related offences, which are no longer criminal offenses under the new Penal Code, including those abortions performed to preserve the woman's physical or mental health or in cases where the pregnancy was a result of rape, incest or forced marriage?
6. What steps are being taken to ensure access to a wide range of family planning services and information including emergency contraceptives? What measures has the government taken to ensure the recruitment, training and retention of youth-friendly health workers, and access to sexuality education for adolescents? Are integrated service programs being developed to address the difficulties in accessing family planning services that women who are poor, without formal education, or who live in rural areas currently experience?
7. Have structures been set up to tackle the rights violations and discrimination experienced by people living with HIV/AIDS. In particular, will the government amend provisions in the proposed Reproductive Health Bill that require compulsory HIV testing, and disclosure of results without consent?
8. What steps have been taken to gather comprehensive data about and address the physical and sexual violence against women and girls?
9. What steps have been taken to reduce the very high dropout rate of girls from school, particularly in secondary school, including by monitoring the incidence of sexual violence in schools and equipping school administrators and the police to prevent such violence, investigate any occurrences, prosecute and punish perpetrators? What is being done to eliminate policies, practices, or other barriers preventing pregnant girls and girls who have given birth from attending and/or returning to school?

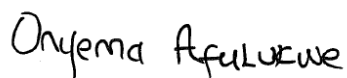
We hope that the Committee will consider making the following recommendations to the Government of Rwanda:

1. Rwanda should increase the number of health care facilities equipped and staffed to handle basic and emergency obstetric care, especially in low-income and rural areas, and increase the number of skilled health care providers able to offer quality and convenient ANC and post-natal care, as well as skilled assistance during childbirth. The government should also facilitate free transportation to quality health care facilities for women in low-income and rural areas.
2. The government should collect, record, and publish comprehensive data on the number of maternal deaths from unsafe abortion and publicize the abortion provisions in the new Penal Code which provide increased access to safe and legal abortion.
3. The government should take all necessary steps to harmonize its abortion law with its obligations under international and regional treaties, and remove the provisions in the proposed Reproductive Health Bill that would pose significant barriers to women's access to safe and legal abortion.
4. As the new Penal Code reduces prison sentences for those who procure an abortion from 5 – 15 years to 1 – 3 years, the government should set up a mechanism for reviewing the long sentences already imposed on some for illegal abortion to commute their sentences or grant them pardons. It should also review the sentences of those who were imprisoned on abortion-related charges that are no longer offenses under the new Penal Code, including those abortions performed to preserve the woman's physical or mental health or in cases where the pregnancy was a result of rape, incest or forced marriage.
5. The government should take concrete steps to ensure an adequate and consistent supply of contraceptives, including emergency contraceptives, initiate civic education campaigns to ensure sufficient and non-discriminatory access to family planning information and services and develop comprehensive guidelines obligating health care facilities to provide accurate and comprehensive family planning information, without discrimination.
6. The government should implement strategies to reduce stigmatization and discrimination of persons living with HIV/AIDS, especially in health care facilities. It should ensure that the laws and policies already in place, particularly in health care facilities, prevent and prohibit discrimination against those living with HIV/AIDS. Further, it should amend the provisions in the proposed Reproductive Health Bill that require compulsory HIV testing, and disclosure of results without consent, which are counterproductive to providing effective health care and violate human rights.

7. The government should take all steps necessary to prevent, investigate, and prosecute incidents of physical and sexual violence against women and girls. The government should document and publish comprehensive data on the incidents of such violence, including data on the investigations and criminal prosecutions.
8. The government should take concrete steps to prevent girls from dropping out of school. Specifically the government should collect and publish comprehensive data on the precise number of dropouts and their reasons for dropping out, improve government and school policies to prevent sexual violence, and investigate and prosecute perpetrators. It should also eliminate all policies and barriers that prevent pregnant school girls and those who have already given birth from attending or returning to school.

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

Sincerely,



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Legal Adviser, Africa Program
Center for Reproductive Rights



Alisha Bjerregaard
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¹ International Covenant on Economic, Social and Cultural Rights, *adopted* Dec. 16, 1966, GA Res. 2200A (XXI), U.N. GAOR, Supp. No. 16, U.N. Doc. A/6316 (1966) (*entered into force* Jan. 3, 1976) [hereinafter ICESCR]; Rule of law in Armed Conflict Projects, *Rwanda: International Treaties Adherence* (2009), http://www.geneva-academy.ch/RULAC/international_treaties.php?id_state=185 (last visited Sept. 28, 2012).

² Government of Rwanda, *Consideration of reports submitted by States parties under article 19 of the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment: Initial reports of States parties due in 2010: Rwanda*, para. 4, CAT/C/RWA/1 (2011).

³ *Id.*

⁴ ICESCR, *supra* note 1, art. 12.

⁵ Committee on Economic, Social and Cultural Rights (ESCR Committee), *General Comment No. 14, The right to the highest attainable standard of health (Art. 12)*, (22nd Sess., 2000), in *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, at 78, para. 43(a), U.N. Doc. HRI/GEN/1/Rev.9 (Vol. I) (2008) [hereinafter ESCR Committee, *Gen. Comment No. 14*].

⁶ ICESCR, *supra* note 1, art. 2(2).

⁷ *Id.* arts. 12(1) & 15(1)(b).

⁸ *Id.* art. 10(2).

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- ¹⁰ Audrey R. Chapman, *Monitoring Women's Right to Health Under the International Covenant on Economic, Social and Cultural Rights* 44 Am. U. L. Rev. 1157, 1158 (1995).
- ¹¹ ESCR Committee, *Gen. Comment No. 14*, *supra* note 5, para. 8.
- ¹² *Id.* para. 21.
- ¹³ *Id.* para. 14.
- ¹⁴ *Id.* para. 21.
- ¹⁵ WHO ET AL., TRENDS IN MATERNAL MORTALITY: 1990-2010 4 (2012) available at http://www.unfpa.org/webdav/site/global/shared/documents/publications/2012/Trends_in_maternal_mortality_A4-1.pdf [hereinafter TRENDS IN MATERNAL MORTALITY].
- ¹⁶ NATIONAL BUREAU OF STATISTICS (RWANDA), RWANDA DEMOGRAPHIC AND HEALTH SURVEY 2010, 238 (2011), available at <http://www.measuredhs.com/pubs/pdf/FR259/FR259.pdf> [hereinafter 2010 RDHS].
- ¹⁷ *Id.*; WHO, RWANDA: HEALTH PROFILE 1 (2010), available at <http://www.who.int/gho/countries/rwa.pdf> [hereinafter RWANDA: HEALTH PROFILE].
- ¹⁸ RWANDA: HEALTH PROFILE, *supra* note 17, at 1.
- ¹⁹ 2010 RDHS, *supra* note 16, at 238; TRENDS IN MATERNAL MORTALITY, *supra* note 15, at 43. United Nations Development Programme, *MDGs Progress and the macroeconomic state of Rwanda* (2012), <http://www.undp.org/content/rwanda/en/home/mdgoverview/mdgs-progress-and-the-macroeconomic-state-of-rwanda--2012/> (last visited Sept. 28, 2012) (recorded 487 per 100,000 live births in 2010). In either case, the MMR in Rwanda has fallen significantly.
- ²⁰ Paulin Basinga et al., *Abortion Incidence and Postabortion Care in Rwanda*, 43(1) STUDIES IN FAM. PLANNING, 11, 11 (2012), available at <http://onlinelibrary.wiley.com/doi/10.1111/j.1728-4465.2012.00298.x/pdf>; UNITED NATIONS POPULATION FUND (UNFPA), MATERNAL MORTALITY REDUCTION PROGRAMME IN RWANDA (2011), available at [http://rwanda.unfpa.org/drive/MaternalMortalityReductioninRwanda\(VLR\).pdf](http://rwanda.unfpa.org/drive/MaternalMortalityReductioninRwanda(VLR).pdf).
- ²¹ THE WHITE RIBBON ALLIANCE FOR SAFE MOTHERHOOD, RWANDA STRATEGIC PLAN 2010-2013 AND ONE YEAR OPERATIONAL PLAN 10 (2010), 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 [hereinafter RWANDA STRATEGIC PLAN 2010-2013].
- ²² ESCR Committee, *Gen. Comment No. 14*, *supra* note 5, para. 52.
- ²³ *Id.* para. 44.
- ²⁴ ICESCR, *supra* note 1, art. 10(2).
- ²⁵ WHO, *Maternal Mortality, Fact Sheet No. 348* (2012), <http://www.who.int/mediacentre/factsheets/fs348/en/index.html> (last visited Sept. 28, 2012) [hereinafter WHO, *Maternal Mortality*].
- ²⁶ See CENTER FOR REPRODUCTIVE RIGHTS, *Preventing Maternal Mortality and Ensuring Safe Pregnancy, in BRINGING RIGHTS TO BEAR* (2008), available at http://reproductiverights.org/sites/default/files/documents/BRB_Maternal%20Mortality_10.08.pdf.
- ²⁷ Government of Rwanda, *Implementation of the International Covenant on Economic, Social and Cultural Rights: Combined 2nd to 4th periodic reports submitted under articles 16 & 17 of the Covenant*, paras. 245-246, U.N. Doc. E/C.12/RWA/2-4 (2011) [hereinafter Rwanda Government Report (2011)]. In Rwanda's report, it is unclear what services are provided by the Maternal and Child Health Program or how many women have access to them. It is also unclear how many women have access to emergency obstetric care in light of the logistical barriers and the shortage of health care workers.
- ²⁸ RWANDA STRATEGIC PLAN 2010-2013, *supra* note 21, at 9.
- ²⁹ Cathy Mugeni et al., *Community Performance-based Financing in Health: Incentivizing Mothers and Community Health Workers to Improve Maternal Health Outcomes in Rwanda* 15 (World Conference on Social Determinants of Health, Draft Background Paper, 2011), available at http://www.who.int/sdhconference/resources/draft_background_paper20_rwanda.pdf.
- ³⁰ 2010 RDHS, *supra* note 16, at 115.
- ³¹ WHO, Global Health Observatory, *Antenatal care (at least 4 visits) (2012)*, http://www.who.int/gho/urban_health/services/antenatal_care_text/en/index.html (last visited Sept. 28, 2012); 2010 RDHS, *supra* note 16, at 110.

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- ³² 2010 RDHS, *supra* note 16, at 111.
- ³³ See THE PARTNERSHIP FOR MATERNAL, NEWBORN AND CHILD HEALTH, *Postnatal Care, in OPPORTUNITIES FOR AFRICA'S NEWBORNS* 79-90 (2006), available at http://www.who.int/pmnch/media/publications/aonsectionIII_4.pdf.
- ³⁴ 2010 RDHS, *supra* note 16, at 118.
- ³⁵ 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>.
- ³⁶ WHO, *Maternal Mortality*, *supra* note 25.
- ³⁷ Committee on the Elimination of Discrimination against Women (CEDAW Committee), *Concluding Observations: Rwanda*, para. 36, U.N. Doc. CEDAW/C/RWA/CO/6 (2009).
- ³⁸ *Id.*
- ³⁹ WHO, DEPT. OF MAKING PREGNANCY SAFER, RWANDA: COUNTRY PROFILE 5 (2007), available at <http://www.afro.who.int/en/clusters-a-programmes/frh/making-pregnancy-safer/mps-country-profiles.html> [hereinafter WHO, RWANDA: COUNTRY PROFILE].
- ⁴⁰ U.N. Human Rights Council, *Report of the Independent Expert on Minority Issues Addendum, Mission to Rwanda, Gay McDougall*, para. 68, U.N. Doc. A/HRC/19/56/Add.1 (Nov. 28, 2011).
- ⁴¹ AFRICAN HEALTH WORKFORCE OBSERVATORY & WHO, HUMAN RESOURCES FOR HEALTH COUNTRY PROFILE: RWANDA 23 (2009), available at http://www.hrh-observatory.afro.who.int/images/Document_Centre/rwanda_hrh_country_profile.pdf [hereinafter HUMAN RESOURCES FOR HEALTH].
- ⁴² RWANDA STRATEGIC PLAN 2010-2013, *supra* note 21, at 10.
- ⁴³ See Fred Ndoli, *Number of doctors to double by 2017*, THE NEW TIMES (MAR. 19, 2011), <http://www.newtimes.co.rw/news/index.php?i=14569&a=39370>.
- ⁴⁴ Clinton Foundation *Up Close: Africa 2012: Day 5*, July 20, 2012, <http://www.clintonfoundation.org/main/clinton-foundation-blog.html/2012/07/20/africa-2012-day-5/>; Maria Kaitesi, *Doctors Deployed to Rural Hospitals*, THE NEW TIMES, Sept. 20, 2012, <http://www.newtimes.co.rw/news/index.php?i=15121&a=58535&icon=Results&id=2>. Another article indicates there were 661 doctors in 2011. *Having Nice Medical Facilities Without the Skills is Useless*, THE RWANDA FOCUS, June 11, 2012, <http://focus.rw/wp/2012/06/having-nice-medical-facilities-without-the-skills-is-useless/>.
- ⁴⁵ RWANDA STRATEGIC PLAN 2010-2013, *supra* note 21, at 10.
- ⁴⁶ One article indicates that there are 500 midwives registered in Rwanda, though it is unclear if they are all practicing. Maria Kaitesi, *Number of Midwives Low*, THE NEW TIMES (May 6, 2012), <http://www.newtimes.co.rw/news/index.php?i=14984&a=11974>; RWANDA STRATEGIC PLAN 2010-2013, *supra* note 21, at 10.
- ⁴⁷ RWANDA STRATEGIC PLAN 2010-2013, *supra* note 21, at 10.
- ⁴⁸ *Id.*
- ⁴⁹ HUMAN RESOURCES FOR HEALTH, *supra* note 41, at 8.
- ⁵⁰ Committee on the Rights of the Child, *Concluding Observations: Rwanda*, para. 49(a), U.N. Doc. CRC/C/15/Add.234 (2004).
- ⁵¹ GOVERNMENT OF RWANDA, MINISTRY OF HEALTH, HEALTH SECTOR STRATEGIC PLAN JULY 2009 – JUNE 2012, 36, 43 (2009), available at http://transition.usaid.gov/rw/our_work/for_partners/images/rwandahealthsectorstrategicplanii.pdf.
- ⁵² HUMAN RESOURCES FOR HEALTH, *supra* note 41, at 8.
- ⁵³ WHO, THE ABUJA DECLARATION TEN YEARS ON 1 (2011), available at http://www.who.int/healthsystems/publications/abuja_report_aug_2011.pdf.
- ⁵⁴ 2010 RDHS, *supra* note 16, at 76.
- ⁵⁵ *Id.*
- ⁵⁶ WHO & UNFPA, PREGNANT ADOLESCENTS: DELIVERING ON GLOBAL PROMISES OF HOPE 5, 10 (2006), available at http://whqlibdoc.who.int/publications/2006/9241593784_eng.pdf.
- ⁵⁷ *Id.* at 13-15.
- ⁵⁸ 2010 RDHS, *supra* note 16, at 76.
- ⁵⁹ *Id.*
- ⁶⁰ *Id.* at 75.
- ⁶¹ Basinga, *supra* note 20, at 11.
- ⁶² RDHS 2010, *supra* note 17, at 238.

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- ⁶³ Basinga, *supra* note 20, at 11.
- ⁶⁴ *Id.* at 16.
- ⁶⁵ See, e.g., ARBEF, Stories on Unsafe Abortion (2012) (unpublished research) (on file with the Center for Reproductive Rights) [hereinafter Stories on Unsafe Abortion].
- ⁶⁶ Basinga, *supra* note 20, at 11.
- ⁶⁷ *Id.*
- ⁶⁸ *Id.* at 16.
- ⁶⁹ *Id.*
- ⁷⁰ *Id.* at 19.
- ⁷¹ *Id.*
- ⁷² *Id.* at 16.
- ⁷³ PENAL CODE (2012) GOVT. GAZETTE, at 210-212, arts. 164-166 (Rwanda).
- ⁷⁴ Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, *Interim rep. of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, transmitted by Note of the Secretary-General*, para. 25, U.N. Doc. A/66/254 (Aug. 3, 2011) (by Anand Grover) [hereinafter SRRH, *Interim rep.* (2011)]. (citing WHO, *Safe Abortion: Technical and Policy Guidance for Health Systems* (Geneva, 2003), p. 86).
- ⁷⁵ WHO, SAFE ABORTION: TECHNICAL AND POLICY GUIDANCE FOR HEALTH SYSTEMS 9 (2nd ed. 2012), available at http://apps.who.int/iris/bitstream/10665/70914/1/9789241548434_eng.pdf.
- ⁷⁶ PENAL CODE (2012) GOVT. GAZETTE, at 210-212, art. 164 (Rwanda).
- ⁷⁷ 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).
- ⁷⁸ PENAL CODE (2012) GOVT. GAZETTE, at 211, art. 165 (Rwanda).
- ⁷⁹ See Marge Berer, *Provision of Abortion by Mid-Level Providers: International Policy, Practice and Perspectives*, 87 BULLETIN OF THE WHO 58 (2009).
- ⁸⁰ 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>.
- ⁸¹ See Ndoli, *supra* note 43.
- ⁸² 2010 RDHS, *supra* note 16, at 3.
- ⁸³ The private bill was introduced by members of the Parliament but has spent the last five years making rounds between the Chamber of Deputies and the Senate. Emmanuel R. Karake, *Rwanda: Bill to Increase Access to Reproductive Health Spends Five Years in Parliament*, THE NEW TIMES (Aug. 17, 2012), <http://www.newtimes.co.rw/news/index.php?i=15087&a=57182>.
- ⁸⁴ 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.
- ⁸⁵ See Women’s Reproductive Health Rights section, notes 4-17.
- ⁸⁶ SRRH, *Interim rep.* (2011), *supra* note 74, para. 21.
- ⁸⁷ See *id.* para. 17.
- ⁸⁸ Report of the United Nations High Commissioner for Human Rights, *Practices for Adopting a Human Rights-Based Approach to Eliminate Preventable Maternal Mortality and Human Rights*, para. 26, U.N. Doc. A/HRC/18/27 (2011); see specifically, 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, *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*, at 358, para. 31(c), U.N. Doc. HRI/GEN/1/Rev.9 (Vol. II) (2008) [hereinafter CEDAW Committee, *Gen. Recommendation No. 24*]; 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).

⁸⁹ CEDAW Committee, *Gen. Recommendation No. 24*, *supra* note 88, para. 31(c); SRRH, *Interim rep.* (2011), *supra* note 74, para. 65(h).

⁹⁰ *See, e.g.*, *Stories on Unsafe Abortion*, *supra* note 65.

⁹¹ *Id.*

⁹² *Id.* at 4.

⁹³ *Id.*

⁹⁴ *Id.*

⁹⁵ *Id.* at 9-10.

⁹⁶ *See, generally, id.*

⁹⁷ *Id.*

⁹⁸ *See, e.g., id.* at 6.

⁹⁹ *Id.*

¹⁰⁰ *Id.* at 4.

¹⁰¹ *See id.*

¹⁰² CENTER FOR REPRODUCTIVE RIGHTS & UNIVERSITY OF TORONTO PROGRAMME OF REPRODUCTIVE AND SEXUAL HEALTH LAW, *BRINGING RIGHTS TO BEAR: AN ANALYSIS OF THE WORLD OF U.N. TREATY MONITORING BODIES ON REPRODUCTIVE AND SEXUAL RIGHTS* 117 (2002). This is supported by the Committee's Concluding Observations to the following countries as cited in this publication. *See, e.g.*, ESCR Committee, *Concluding Observations: Armenia*, para. 15, U.N. Doc. E/C.12/1/Add.39 (1999); *Cameroon*, para. 25, U.N. Doc. E/C.12/1/Add.40 (1999); *Dominican Republic*, para. 15, U.N. Doc. E/C.12/1/Add.16 (1997); *Dominican Republic*, para. 22, U.N. Doc. E/C.12/Add.6 (1996); *Honduras*, para. 27, U.N. Doc. E/C.12/1/Add.57 (2001); *Paraguay*, para. 16, U.N. Doc. E/C.12/1/Add.1 (1996); *Poland*, para. 12, U.N. Doc. E/C.12/1/Add.26 (1998); *Saint Vincent and the Grenadines*, para. 12, U.N. Doc. E/C.12/1/Add.21 (1997).

¹⁰³ ESCR Committee, *Concluding observations: Dominican Republic*, paras. 28-29, U.N. Doc. E/C.12/DOM/CO/3 (2010); *see also* ESCR Committee, *Concluding observations: Philippines*, para. 31, U.N. Doc. E/C.12/PHL/CO/4 (2008); *Nicaragua*, paras. 26-27, U.N. Doc. E/C.12/NIC/CO/4 (2008); *Azerbaijan*, para. 30, U.N. Doc. E/C.12/1/Add.104 (2004); *Poland*, para. 12, U.N. Doc. E/C.12/1/Add.26 (1998).

¹⁰⁴ UNFPA, *BY CHOICE, NOT BY CHANCE: FAMILY PLANNING, HUMAN RIGHTS AND DEVELOPMENT 1*, (2012), *available at*

http://www.unfpa.org/webdav/site/global/shared/documents/publications/2012/EN_SWOP2012_Report_1.pdf [hereinafter *BY CHOICE, NOT BY CHANCE*].

¹⁰⁵ As a party to the International Covenant on Civil and Political Rights [hereinafter ICCPR] and ICESCR, *supra* note 1, Rwanda must protect the rights in articles 6 and 10 of the ICCPR and article 10 of the ICESCR. *See* International Covenant on Civil and Political Rights, G.A. Res. 2200A (XXI), U.N. GAOR, 21st Sess., Supp. No. 16, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 171 (*entered into force* Mar. 23, 1976); ICESCR, *supra* note 1.

¹⁰⁶ *See also*, International Conference on Population and Development, Summary of the Program of Action, (1994) <http://www.un.org/ecosocdev/geninfo/populatin/icpd.htm#chapter7> (last visited Mar. 7, 2013).

¹⁰⁷ ESCR Committee, *Gen. Comment No. 14*, *supra* note 5, FN 12. *See also*, International Conference on Population and Development, *supra* note 111; *BY CHOICE, NOT BY CHANCE*, *supra* note 104, at iv.

¹⁰⁸ *See* Rwanda Government Report (2011), *supra* note 27, para. 30(b).

¹⁰⁹ 2010 RDHS, *supra* note 16, at 87.

¹¹⁰ *Id.* at 95.

¹¹¹ This is true with the exception of wealthy unmarried women; those in the two highest wealth quintiles have a higher unmet need than women in lower income quintiles. 2010 RDHS, *supra* note 16, at 95-96.

¹¹² 2010 RDHS, *supra* note 16, at 96 Total unmet need for all women is 11% in rural areas and 8% in urban areas.

¹¹³ WHO, *Maternal Mortality*, *supra* note 25.

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- ¹¹⁴ UNFPA, *Health Providers Trained on Family Planning* (2012), http://rwanda.unfpa.org/2012/05/26/5061/health_providers_trained_on_family_planning/ (last visited Sept. 28, 2012).
- ¹¹⁵ Dieudonné Muhoza Ndaruhuye et. al, *Demand and Unmet Need for Means of Family Limitation in Rwanda*, 35(3) INT'L PERSPECTIVES ON SEXUAL & REPRO. HEALTH (Guttmacher Institute, 2009), available at <http://www.guttmacher.org/pubs/journals/3512209.html>.
- ¹¹⁶ *Id.*
- ¹¹⁷ *Id.*
- ¹¹⁸ 2010 RDHS, *supra* note 16, at 95-96. While 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 age 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. *Id.*
- ¹¹⁹ *Id.* at 96.
- ¹²⁰ *Id.*
- ¹²¹ ASSOCIATION RWANDAISE POUR LA BIEN ETRE FAMILIAL (ARBEF), ABORTION AND YOUNG PEOPLE IN RWANDA (2011), available at <http://www.rutgerswpf.org/sites/default/files/YAM%20booklet%20of%20personal%20stories%20on%20abortion.pdf>.
- ¹²² *Id.*
- ¹²³ See 2010 RDHS, *supra* note 16, at 95-96. The RDHS found that exposure to family planning messages and contact of nonusers with family planning providers was significantly lower for the 15-19 age group. 40% of the women and 25% of men in this group did not hear a family planning message in the last few months on the radio, television or in a magazine. 92% of women in this age group did not discuss family planning with a community health worker or at a health facility in the last year. Within the 20-24 age group, 33% of women and 16% of men had no media exposure to family planning messages and 76% of nonusers did not discuss family planning with a community health worker or at a health facility in the last year. *Id.*
- ¹²⁴ *Id.* at 89.
- ¹²⁵ *Id.*
- ¹²⁶ WHO, RWANDA: COUNTRY PROFILE, *supra* note 39, at 10.
- ¹²⁷ 2010 RDHS, *supra* note 16, at 86.
- ¹²⁸ ESCR Committee, *Gen. Comment No. 14*, *supra* note 5, para. 30.
- ¹²⁹ JOINT UNITED NATIONS PROGRAMME ON HIV AND AIDS (UNAIDS), 26TH MEETING OF THE UNAIDS PROGRAMME COORDINATING BOARD NON-DISCRIMINATION IN HIV RESPONSES 4-5 (2010), available at http://www.unaids.org/en/media/unaids/contentassets/documents/priorities/20100526_non_discrimination_in_hiv_en.pdf [hereinafter 26TH MEETING OF THE UNAIDS PROGRAMME COORDINATING BOARD NON-DISCRIMINATION IN HIV RESPONSES].
- ¹³⁰ ESCR Committee, *Gen. Comment No. 14*, *supra* note 5, para. 19.
- ¹³¹ *Id.* para. 43(a).
- ¹³² RACHEL JEAN-BAPTISTE, HIV/AIDS-RELATED STIGMA, FEAR, AND DISCRIMINATORY PRACTICES AMONG HEALTHCARE PROVIDERS IN RWANDA. OPERATIONS RESEARCH RESULTS 1 (2008), available at http://www.hciproject.org/sites/default/files/Rwanda_stigma_2008.pdf [hereinafter HIV/AIDS-RELATED STIGMA, FEAR, AND DISCRIMINATORY PRACTICES] (citing UNAIDS, REDUCING HIV STIGMA AND DISCRIMINATION: A CRITICAL PART OF NATIONAL AIDS PROGRAMMES. Geneva: Joint United Nations Programme on HIV/AIDS, (2007)).
- ¹³³ 26TH MEETING OF THE UNAIDS PROGRAMME COORDINATING BOARD NON-DISCRIMINATION IN HIV RESPONSES, *supra* note 129, at 6.
- ¹³⁴ *Id.*
- ¹³⁵ HIV/AIDS-RELATED STIGMA, FEAR, AND DISCRIMINATORY PRACTICES, *supra* note 132.
- ¹³⁶ *Id.* at 3.
- ¹³⁷ *Id.* at 22.
- ¹³⁸ *Id.* (citing Nyblade L, Carr D. TOWARDS A STRONGER RESPONSE TO HIV AND AIDS: CHALLENGING STIGMA. Prepared for the Department for International Development of the United Kingdom by the International Center for Research on Women. http://www.aidsportal.org/repos/DFID_HIVstigma_paperrev.pdf, undated; accessed online July 2008).
- ¹³⁹ *Id.* at iii.

¹⁴⁰ The private bill was introduced by members of the Parliament but has spent the last five years making rounds between the Chamber of Deputies and the Senate. Karake, *supra* note 83.

¹⁴¹ Rwanda has signed and ratified the Maputo Protocol, Convention on the Elimination of All Forms of Discrimination against Women, International Covenant on Economic, Social and Cultural Rights and International Covenant on Civil and Political Rights. See Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol), 2nd Ordinary Sess., Assembly of the Union, *adopted* July 11, 2003, art. 14(2)(c), CAB/LEG/66.6 (*entered into force* Nov. 25, 2005); Convention on the Elimination of All Forms of Discrimination against Women, *adopted* Dec. 18, 1979, art. 10, G.A. Res. 34/180, U.N. GAOR, 34th Sess., Supp. No. 46, at 193, U.N. Doc. A/34/46, U.N.T.S. 13 (*entered into force* Sept. 3, 1981) [hereinafter CEDAW]; ICCPR, *supra* note 105; ICESCR, *supra* note 1.

¹⁴² Reproductive Health Bill (2007), art. 14 (Rwanda), *available at* http://www.rwandaparliament.gov.rw/parliament/Chamber_of_Deputies_Publications.aspx?catid=726CB1A9-3C2C-4E44-BBA5-D1B52E5BCCD8.3C2C-4E44-BBA5-D1B52E5BCCD8.

¹⁴³ ICCPR, *supra* note 105, art. 17(1).

¹⁴⁴ ESCR Committee, *Gen. Comment No. 14*, *supra* note 5, para. 8.

¹⁴⁵ ICESCR, *supra* note 1, art. 2(2).

¹⁴⁶ HUMAN RIGHTS WATCH, *Rwanda: Revise Reproductive Health Bill: Compulsory HIV Testing, Sterilization of Disabled Violate Rights* (Jul. 1, 2009), <http://www.hrw.org/news/2009/07/01/rwanda-revise-reproductive-health-bill>.

¹⁴⁷ ESCR Committee, *Concluding Observations of Reports Submitted by States Parties Under Articles 16 and 17 of the Covenant*, 35th session, E/C.12/LYB/CO/2 (2006).

¹⁴⁸ CEDAW Committee, *Concluding Observations: Rwanda*, U.N. Doc. CEDAW/C/RWA/CO/6 (2009).

¹⁴⁹ *Id.* para. 21.

¹⁵⁰ *Id.* para. 26.

¹⁵¹ CAT Committee, *Concluding Observations: Rwanda*, para. 16, U.N. Doc. CAT/C/RWA/CO/1 (2012).

¹⁵² *Id.*

¹⁵³ 2010 RDHS, *supra* note 16, at 246.

¹⁵⁴ *Id.* at 241.

¹⁵⁵ *Id.* at 243.

¹⁵⁶ *Id.*

¹⁵⁷ *Id.* at 245.

¹⁵⁸ *Id.* at 246.

¹⁵⁹ Joseph Kamugisha, *Gender based violence should be society's big health concern*, THE NEW TIMES (Mar. 10, 2009), <http://www.newtimes.co.rw/news/index.php?i=13830&a=14024>.

¹⁶⁰ WHO, *Violence Against Women Factsheet*, Nov. 2012, <http://www.who.int/mediacentre/factsheets/fs239/en/> (last visited Mar. 11, 2013).

¹⁶¹ Report of the Special Rapporteur on Violence against Women, Its Causes and Consequences, *Report of the Special Rapporteur on Violence against Women, Its Causes and Consequences, Rashida Manjoo*, para. 46, U.N. Doc. A/HRC/17/26 (May 2, 2011) (citing Allan Rosenfield, Caroline Min and Joshua Bardfield, pp. 3-4 "Global women's health and human rights: an introduction", in *Women's Global Health and Human Rights*, edited by Padmini Murthy and Clyde Lanford Smith, Jones & Bartlett Publishers, Sudbury, Massachusetts (2010)).

¹⁶² Eugene Mutara, *Grim Defilement Stats at City Primary School*, THE NEW TIMES (Sept. 4, 2007), <http://www.newtimes.co.rw/news/index.php?i=1277&a=671>.

¹⁶³ Kamugisha, *supra* note 159.

¹⁶⁴ CAT Committee, *Concluding Observations: Rwanda*, para. 16, U.N. Doc. CAT/C/RWA/CO/1 (2012).

¹⁶⁵ Rwanda National Police, *Let Us End Violence against Children*, Aug. 9, 2012, <http://www.police.gov.rw/content/let-us-end-violence-against-children> (last visited Mar. 11, 2013).

¹⁶⁶ See, Rwanda National Police, *Police urges public to report GBV cases*, May 23, 2012, <http://www.police.gov.rw/content/police-urges-public-report-gbv-cases> (last visited Mar. 11, 2013).

¹⁶⁷ CEDAW Committee, *Concluding Observations: Rwanda*, para. 31, U.N. Doc. CEDAW/C/RWA/CO/6 (2009).

¹⁶⁸ Christine Kampire, *Teenage Pregnancy Remains Main Factor in Rwandan Dropout Rate*, GLOBAL PRESS INSTITUTE (Jun. 14, 2012), <http://www.globalpressinstitute.org/africa/rwanda/teenage-pregnancy-remains-main-factor-rwandan-dropout-rate>; see also, CEDAW Committee, *Concluding Observations: Rwanda*, para. 31, U.N. Doc. CEDAW/C/RWA/CO/6 (2009) (finding that early pregnancies cause the high dropout rate).

¹⁶⁹ CEDAW Committee, *Concluding Observations: Rwanda*, para. 31, U.N. Doc. CEDAW/C/RWA/CO/6 (2009).

¹⁷⁰ HUMAN RIGHTS WATCH, SCARED AT SCHOOL: SEXUAL VIOLENCE AGAINST GIRLS IN SOUTH AFRICAN SCHOOLS 61 (2001), http://www.hrw.org/reports/2001/safrica/ZA-FINAL-04.htm#P650_108246.

¹⁷¹ *Id.*

¹⁷² ESCR Committee, *General Comment No. 13, The right to education (art. 13)*, (21st Sess., 1999), in *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, at 63, para. 1, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. I) (2008) [hereinafter ESCR Committee, *Gen. Comment No. 13*].

¹⁷³ *Id.*

¹⁷⁴ CEDAW, *supra* note 141, art. 10.

¹⁷⁵ ESCR Committee, *Gen. Comment No. 13, supra* note 172, para. 31.

¹⁷⁶ *Id.* paras. 6(b), 31.

¹⁷⁷ Stephen Rwembeho, *Minister Cautions Against Child Abuse in Schools*, THE NEW TIMES (Aug. 24, 2011), <http://www.newtimes.co.rw/news/index.php?i=14727&a=44491>; Bosco R. Asiimwe, *Survey Exposes Abuse in Schools*, THE NEW TIMES (Aug. 22, 2011), <http://www.newtimes.co.rw/news/index.php?i=14725&a=44400>.

¹⁷⁸ Rwembeho, *supra* note 177.

¹⁷⁹ Jean de la Croix Tabaro, *Investigations into school pregnancy scandal launched*, THE NEW TIMES (Feb. 7, 2013), <http://newtimes.co.rw/news/index.php?i=15261&a=6364>; Sunny Ntayombya, *Teenage Pregnancies Our Fault*, THE NEW TIMES (Feb. 6, 2013), <http://allafrica.com/stories/201302060163.html>.

¹⁸⁰ Stephen Rwembeho, *Rwanda: Pregnancy Scandal Hits Rwamagana School*, THE NEW TIMES (Feb. 4, 2013), <http://www.newtimes.co.rw/news/index.php?i=15259&a=63566&icon=Results&id=2>. The article reports that one of the school's teachers links the pregnancies to the former school administrator, but the case is still being investigated.

Id.

¹⁸¹ *Rwanda: Parents Should Open Up to Their Children About Sex Education*, THE NEW TIMES (Feb. 5, 2013), <http://www.newtimes.co.rw/news/index.php?i=15259&a=63566&icon=Results&id=2>.

¹⁸² Tabaro, *supra* note 179.

¹⁸³ *Id.*

¹⁸⁴ Republic of Rwanda, *Evaluation of the Implementation of the Beijing Declaration and Programme of Action*, sec. 2, tbl. 2.2.1 (2009), available at

https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=3&ved=0CEYQFjAC&url=http%3A%2F%2Fwww.migeprof.gov.rw%2FIMG%2Fdoc%2FBEIJING_15_REGIONAL_RWANDA_REPORT_02_July_2010_1_-2.doc&ei=7lg_UZLkCeuA0AHN-

[IDIAg&usq=AFQjCNG0RO2XH0mHZALqj6xfZSKRYtBv4g&sig2=MKxn65VJQUGka5vwPf1lcw&bvm=bv.43287494,d.dmQ](https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=3&ved=0CEYQFjAC&url=http%3A%2F%2Fwww.migeprof.gov.rw%2FIMG%2Fdoc%2FBEIJING_15_REGIONAL_RWANDA_REPORT_02_July_2010_1_-2.doc&ei=7lg_UZLkCeuA0AHN-IDIAg&usq=AFQjCNG0RO2XH0mHZALqj6xfZSKRYtBv4g&sig2=MKxn65VJQUGka5vwPf1lcw&bvm=bv.43287494,d.dmQ) [hereinafter *Evaluation of the Implementation of the Beijing Declaration and Programme of Action*].

¹⁸⁵ Rwanda Government Report (2011), *supra* note 27, paras. 164, 177(d).

¹⁸⁶ *Evaluation of the Implementation of the Beijing Declaration and Programme of Action, supra* note 184, sec. 2.

¹⁸⁷ See Thoughts From Rwanda, *Sexual Abuse and Rape in the Home*, Aug. 8, 2011,

<http://fromrwanda.blogspot.com/2011/08/sexual-abuse-and-rape-in-home.html> (last visited Mar. 11, 2013).

According to this article, numerous schools in Rwanda refuse to readmit girls any pregnant girls.

¹⁸⁸ Kampire, *supra* note 168.