Supplementary Information for the Review of the Republic of Rwanda during the 88th Session of the Committee on the Elimination of Discrimination against Women

(13 May 2024 - 31 May 2024)

Honorable Committee Members,

Introduction

The Center for Reproductive Rights ("**the Center**"), the Health Development Initiative ("**HDI"**) and the Great Lakes Initiative for Human Rights and Development ("**GLIHD**") make this submission to the Committee on the Elimination of Discrimination against Women ("**theCommittee**") to provide supplementary information regarding the fulfilment of state obligations related to the sexual and reproductive health and rights of women and girls, by the Republic of Rwanda ("**Rwanda**"), as provided for in the Convention on the Elimination of All Forms of Discrimination Against Women ("**CEDAW Convention"**). We hope that this submission will assist the Committeein its review ofRwanda.

The Center is an international non-governmental legal advocacy organization that uses the law to advance reproductive freedom as a fundamental human right that all governments are legally obligated to respect, protect, and fulfill. HDI is a national non-governmental organization that works in Rwanda, to empower rights holders and duty bearers and other stakeholders to advance the realization of the right to health for all. GLIHD is a national non-governmental organization, also operating in Rwanda, whose mission is to contribute to the respect and promotion of the rights of individuals and groups as they are enshrined in the international human rights framework and to advocate for their fulfillment by member states.

Background

The right to good health is enshrined in Article 21 of the Constitution of Rwanda with Article 45 of the Constitution mandating the state to "*mobilize the population for activities aimed at good health and to assist them in the realization of those activities*." The right to health is underpinned by other related rights also enshrined in the Constitution of Rwanda including the right to life (Article 12); the right to inviolability of a human being (Article 13); freedom from discrimination (Article 16); the right to equality before the law (Article 15); the right to respect of privacy (Article 23); and the right to information (Article 38).

The right to access healthcare services and information in Rwanda is also provided for by statute including in Law N°49/2012 of 22/01/2013, Establishing Medical Professional Liability Insurance, which acknowledges, among others:[1]

1. the right to access medical procedures without facing discrimination of any kind;
2. the right to patient safety which includes the right not to suffer poor functioning of health services; the right not to suffer adverse events or errors when seeking healthcare services; the right to access to medical procedures that meet such an acceptable standard as set by the Ministry of Health; and the right to reliable results from medical procedures;
3. the right to services that uphold a person's right to life, dignity, and privacy;
4. the right to information; and
5. the right to give and withdraw consent.

With regards to reproductive health in particular, Law N° 21/2016 Of 20/05/2016 relating to Human Reproductive Health provides for the right to equal access to reproductive health services by all persons; the right to education on reproductive health; and the right of pregnant women and newborns to receive care, amongst other factors.

Rwanda is also bound by international laws that it has ratified[2] many of which recognize the right to health such as the CEDAW Convention and the International Covenant on Economic, Social and Cultural Rights, both of which enshrine the right to health in Article 12; and the Convention on the Rights of the Child which recognizes the right to the highest attainable standard of health in Article 24. Regionally, Rwanda is bound by the Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa ("**theMaputoProtocol**") which expressly provides for reproductive rights in Article 14; the African Charter on Human and People's Rights which enshrines the right to the best attainable state of physical and mental health in Article 16; and the African Charter on the Rights and Welfare of the Child which provides for children's right to the best attainable state of physical mental and spiritual health in Article 14.

Despite the right to health, including sexual and reproductive health being provided for in domestic, and applicable regional and international laws, women and girls in Rwanda still have inadequate access to reproductive health services and information. This submission will highlight the challenges that women and girls in Rwanda face when seeking maternal health services; contraceptive services; and safe abortion services. It will also highlight issues concerning mandatory HIV testing and disparities in distribution of health human resources.

1. Inadequate access maternal health services

[1]Article 3-13, Law N°49/2012 of 22/01/2013 Establishing Medical Professional Liability Insurance.
[2]Article 95, Constitution of the Republic of Rwanda

In its 10th Periodic Report to the Committee, Rwanda submits that its maternal mortality ratio (MMR) declined from 210 deaths per 100,000 live in 2014/15 to 203 2019/2020.[3] While this reduction in MMR is commendable, the current MMR is still almost three times the MMR of less than 70 deaths per 100,000 live births which the country has committed to achieving by 2030 as part of the Sustainable Development Goals.[4] Furthermore, research into the main causes of maternal mortality in the main referral hospital in Rwanda between 2017 and 2019 shows that majority of the cases of maternal mortality are preventable as they can be attributed to factors such as lack of qualified personnel and lack of facilities which necessitate referrals that, in turn, result in delay in receiving care.[5]

The government also submits that the percentage of pregnant women delivering in health facilities increased from 91 per cent to 93 percent while delivery assistance by skilled providers improved from 91 per cent to 94 percent during the same period.[6] These numbers are commendable but tell an incomplete story, as even though women are accessing delivery services in health facilities, the majority of women and girls face challenges seeking antenatal and post-natal care. With regards to antenatal care, the timing and number of visits is an issue of concern because between 2015-2020, only 47% of women had the recommended 4 antenatal visits, while 53% of women had less than 4 visits. Further, 27% of women had the first visit during the 4th or 5th month of pregnancy and 10% had their first visit during the 6th or 7th month.[7] With regards to post-natal care, 30% of women received no postnatal care at all.[8] This lack of care can be attributed to the lack of availability of medical facilities[9] and trained personnel which is exacerbated by an insufficient public transportation system which means that women need to walk far distances to access medical facilities or, alternatively, pay transportation costs which they can seldom afford. The cost of accessing maternity services also served as a barrier to poor women and women with large families. Loss of income when women take the time that they need to seek health services also operates as a key barrier for women, including those who are farmers as, even when they are pregnant,

[3] Committee on the Elimination of Discrimination against Women, Tenth periodic report submitted by Rwanda under Article 18 of the Convention, due in 2021 (2021). Paragraph 219, U.N. Document CEDAW/C/RWA/10.

[4] Goal 3: Ensure healthy lives and promote well-being for all at all ages, United Nations Department of Economic and Social Affairs: Sustainable Development. Accessed on 30th May 2022. Available at: https://sdgs.un.org/goals/goal3

[5] Rulisa S., Ntihinyurwa P., et al., *Causes of Maternal Mortality in Rwanda, 2017–2019*, Obstetrics and Gynecology (2021). Accessed on 30th May 2022. Available at: https://www.researchgate.net/publication/354505476_Causes_of_Maternal_Mortality_in_Rwanda_2017-2019/link/614ad8de3c6cb31069840c3f/download

[6] Committee on the Elimination of Discrimination against Women, Tenth periodic report submitted by Rwanda under Article 18 of the Convention, due in 2021 (2021). Paragraph 219, U.N. Document CEDAW/C/RWA/10.

[7] Rwanda Demographic Health Survey 2019-2020, Pag 132

[8] Rwanda Demographic Health Survey 2019-2020, Pag 137

[9] Lack of access to facilities, especially in rural areas is discussed in more detail later in this shadow report

they are unlikely to seek maternal health services during farming season unless they are suffering from a serious health issue. This means that they do not seek routine antenatal care.[10]

In light of the foregoing, it is clear that the state still has more to do to fulfill its obligation to ensure the availability and accessibility of all maternity health services to women and girls and it is yet to fulfill its obligations under national law, specifically, Law N° 21/2016 Of 20/05/2016 Relating to Human Reproductive Health which recognizes that safe delivery for the mother and the newborn is a key component of reproductive health[11] and mandates that both pregnant women and new mothers have a right to healthcare to ensure their wellbeing.[12] It is also yet to fulfill its obligations under Article 12 of the CEDAW Convention which requires the state to "…*ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation*…"[13]

2. Lack of access to contraceptive services

The government of Rwanda, in its report, states that "… *the percentage of women using contraceptive methods of family planning has increased from 53 per cent to 64 per cent during the same period*…". [14] Unfortunately, this is the rate of contraceptive use among married women only. The rate of contraceptive use among unmarried sexually active women and girls is lower at 50% with girls aged 15-19 years having a contraceptive prevalence rate of 18% and women aged 20-14 years having a contraceptive prevalence rate of 38%. This is relatively low in comparison to the contraceptive prevalence rate among women above the age of 25 years which is 57%.[15] These numbers show that young and unmarried women and girls lack adequate access to contraceptive services. This is further supported by the data on the unmet need for contraception. The unmet need for contraception among sexually active, unmarried women is 37%.[16] However, data disaggregated according to age and marital status shows that younger, unmarried women have a higher rate of unmet need for contraception with unmarried 15-19 year old girls and young women having an unmet need for contraception of 59.1% and unmarried young women aged 20-24 having an unmet need for contraception of 47%. This is in comparison to married 15-19 year old girls and women whose unmet need for contraception is at 7.6% and married 20-24 year old women whose unmet need is at 7.8%.[17]

These differences can be attributed to legal, social and structural barriers. Legal barriers include lack of consonance in the law governing adolescent sexual activity and reproductive health. On the one hand, the

[10]Tuyisenge G., Hategeka C., Kasine Y. et al., *Mothers' perceptions and experiences of using maternal health-care services in Rwanda*, Women & Health (2018). Accessed on 30th May 2022. Available at: https://doi.org/10.1080/03630242.2018.1434591
[11] Article 3, Law N° 21/2016 Of 20/05/2016 Relating to Human Reproductive Health
[12] Article 6, Law N° 21/2016 Of 20/05/2016 Relating to Human Reproductive Health
[13] Article 12, Convention on the Elimination of All Forms of Discrimination Against Women.
[14] Committee on the Elimination of Discrimination against Women, Tenth periodic report submitted by Rwanda under Article 18 of the Convention, due in 2021 (2021). Paragraph 219, U.N. Document CEDAW/C/RWA/10.
[15] Rwanda Demographic Health Survey 2019-2020, Page 100
[16] Rwanda Demographic Health Survey 2019-2020, Page 105
[17] Rwanda Demographic Health Survey 2019-2020, Table 7.13.2 at Page 116.

law in Rwanda, through Law N°68/2018 of 30/08/2018 Determining Offences and Penalties In General, decriminalized consensual non-coercive non-exploitative sexual activity among adolescents aged 14-18 years.[18] On the other hand, the law governing access to reproductive health services and information, Law N° 21/2016 Of 20/05/2016 Relating to Human Reproductive Health, expressly provides that only persons above the age of 18 can make decisions on their reproductive health.[19] This builds on the provisions of Law N°49/2012 of 22/01/2013 Establishing Medical Professional Liability Insurance, which provides that minors cannot access health services without consent from parents or guardians.[20] Thus, the provisions of the law provide conflicting views on whether consensual and non-coercive adolescent sexual activity, along with the crucial need for sexual and reproductive health services and information when adolescents are sexually active, are really accepted. They also create barriers by requiring adolescents to obtain 3rd party authorization to access services and information, which dissuades adolescent and young women from seeking services and healthcare providers from providing services, including contraceptive services.[21]

This conflict is compounded by the social barriers which include the cultural and traditional beliefs that young, unmarried people, especially women and girls, should not be sexually active.[22] These beliefs result in stigma that prevents young women from accessing contraceptive services, even though they are sexually active as, in Rwanda, 43.5% of women aged 20-24 had their first sexual experience at 20 years and 20.8% had their first sexual experience by 18 years.[23]

The situation is further exacerbated by the fact that where young women and girls are able to overcome this stigma, they are faced with the issue of lack of access to services as 40% of healthcare facilities in Rwanda are run by the Catholic Church which does not provide modern contraceptives. [24]

Some of the consequences of the above situation are grave. According to Rwanda Demographic Health Survey (RDHS) 2019-2020, overall: only17.4% of sexually active adolescent girls aged between 15-19 are using modern contraceptives; 5% of women aged 15-19 have begun childbearing with 4% having had a live birth, and 1% being pregnant at the time of the interview; andthe proportion of teenagers who have begun childbearing rises rapidly with age, from less than 1% at age 15 to 15% at age 19. Already vulnerable populations including those with lower levels of education and those from lower socio-economic backgrounds are most affected. Adolescents with no education and those in the lowest wealth

[18] Article 133, Law Nº68/2018 of 30/08/2018 Determining Offences and Penalties in General
[19] Article 7, Law N° 21/2016 Of 20/05/2016 Relating to Human Reproductive Health
[20] Article 11, Law N°49/2012 of 22/01/2013 Establishing Medical Professional Liability Insurance
[21] The Committee on The Elimination of Discrimination Against Women, General Recommendation No. 24: Article 12 of the Convention (Women and Health) (1999). Paragraphs 14 and 21.
[22] Schwandt et al. "*Family planning in Rwanda is not seen as population control, but rather as a way to empower the people": examining Rwanda's success in family planning from the perspective of public and private stakeholders*. Contraception and Reproductive Medicine (2018). Accessed on 30th May 2022. Available at: https://contraceptionmedicine.biomedcentral.com/track/pdf/10.1186/s40834-018-0072-y.pdf
[23] Rwanda Demographic Health Survey 2019-2020, Page 69.
[24] Schwandt et al. "*Family planning in Rwanda is not seen as population control, but rather as a way to empower the people": examining Rwanda's success in family planning from the perspective of public and private stakeholders*. Contraception and Reproductive Medicine (2018). Accessed on 30th May 2022. Available at: https://contraceptionmedicine.biomedcentral.com/track/pdf/10.1186/s40834-018-0072-y.pdf

quintile tend to start childbearing earlier than other teenagers.[25]Despite, its introduction, the government is yet to pass draft bill No. 21/2016 on Human Reproductive Health, which seeks to lower the age of access to contraceptives for minors, to 15 years. This legislative delay continues to restrict adolescents' access to contraceptives, underscoring the urgent need for policymakers to prioritize the bill and ensure its timely enactment.

3. Lack of access to safe abortion

Each year in Rwanda, 98 /1000 pregnancies are unintended, and 28/1000 pregnancies end in abortion.[26]Many of these are unsafe. Half of all abortions in Rwanda are self-administered by the women and girls themselves or by individuals who lack any specialist training, such as traditional healers, creating very high-risk situations and, as a result, 8% of the maternal mortality in the country is caused by unsafe abortion.[25]

Unsafe abortion persists in Rwanda, in part because of legal barriers.Although Law N°68/2018 of 30/08/2018 Determining Offenses and Penalties in General, removed the condition requiring that a woman or girl seeking abortion services must obtain a court order certifying that the pregnancy is as a result of rape, defilement or incest, it still requires that abortion services be provided by a doctor and allows the Government to impose additional conditions through ministerial orders.[27]

Unsafe abortion persists in Rwanda, in part because of legal barriers. The State's assertion in its report that "*…the law N° 68/2018 of 30/08/2018 determining offenses and penalties in general removed barriers hindering women and girls to legal and safe abortion..*."[27] does not entirely capture the lived realities of women and girls in Rwanda. Although Law N°68/2018 of 30/08/2018 Determining Offenses and Penalties in General, removed the condition requiring that a woman or girl seeking abortion services must obtain a court order certifying that the pregnancy is as a result of rape, defilement or incest, it still requires that abortion services be provided by a doctor and allows the Government to impose additional conditions through ministerial orders.[28] The law provides that "*A recognized medical doctor performs an abortion. Conditions to be satisfied for a medical doctor to perform an abortion are determined by an Order of the Minister in charge of health*."[29]It also prohibits girls under 18 years from accessing abortion services without parental consent, unless the parents are unable to agree with each other or disagree with the adolescent or child. Additionally, parents must request an abortion for their children by submitting a written request to a doctor.[30]

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[25]Brief-5_Contraceptives_Final.pdf (hdirwanda.org)

[26]Rulisa S., Ntihinyurwa P., et al., Causes of Maternal Mortality in Rwanda, 2017–2019, Obstetrics and Gynecology (2021). Accessed on 30th May 2022. Available at: https://www.researchgate.net/publication/354505476_Causes_of_Maternal_Mortality_in_Rwanda_2017-2019/link/614ad8de3c6cb31069840c3f/download

[27] Committee on the Elimination of Discrimination against Women, Tenth periodic report submitted by Rwanda under Article 18 of the Convention, due in 2021 (2021). Paragraph 223, U.N. Document CEDAW/C/RWA/10.

[28] Article 125, Law N°68/2018 of 30/08/2018 Determining Offenses and Penalties in General.

[29] Article 125, Paragraph 2

[30] Article 126, Law N°68/2018 of 30/08/2018 Determining Offenses and Penalties in General.

Pursuant to this law, Ministerial Order N°002/MOH/2019 Of 08/04/2019 Determining Conditions to be Satisfied for a Medical Doctor to Perform an Abortion was passed. This Ministerial order added more conditions for the provision of safe abortion services including:

1. A gestational term limit that prohibits women and girls from seeking an abortion after 22 weeks, unless the health of the mother or foetus is at risk;[31]
2. The requirement that abortion services can only be provided in a hospital or polyclinic;[32] and
3. Additional requirements where an abortion is sought to preserve the health of the mother or foetus, namely:[33]

i. the risk to health must be confirmed by 2 doctors one of whom must be a gynecologist.

ii. the woman must provide written consent or, if the person who is pregnant is below the age of 18, the girl's parent or guardian must provide written consent; and

iii. the doctor providing the service must issue a report.

Although it is argued that the intent of these criteria is to ensure the quality of care for women and girls seeking abortion services, the effect of these criteria is to deny access to safe abortion services. This is because there are insufficient medical personnel to provide abortion services or issue the required confirmations or reports. According to government estimates, in 2019, there were 1,492 doctors. This translates to a doctor to patient ratio of 0.12: 1,000[34] which is far below the World Health Organization ("**WHO**") recommended doctor to patient ratio of 1: 1000.[35] The ratio of gynecologists to women is even lower as the ratio of surgeons, anesthesiologists, obstetricians and gynecologists to patients is estimated at 0.042: 1,000.[36] There is also an insufficient number of hospitals and polyclinics in Rwanda. Reports from the Ministry of health confirm that there are approximately 180 hospitals and polyclinics in Rwanda,[37] which are supposed to serve a population of 12.38 million people, slightly more than 50% of whom are women and girls. More than 45% of all women and girls in Rwanda are of reproductive age.[38]

[31] Article 4, Ministerial Order N°002/MOH/2019 Of 08/04/2019 Determining Conditions to be Satisfied for a Medical Doctor to Perform an Abortion.
[32] Article 5, Ministerial Order N°002/MOH/2019 Of 08/04/2019 Determining Conditions to be Satisfied for a Medical Doctor to Perform an Abortion.
[33] Article 11, Ministerial Order N°002/MOH/2019 Of 08/04/2019 Determining Conditions to be Satisfied for a Medical Doctor to Perform an Abortion.
[34] Page 17, Rwanda Health Sector Performance Report 2017-2019, Ministry of Health, Republic of Rwanda (2020).
[35] Kumar R., Pal R., *India achieves WHO recommended doctor population ratio: A call for paradigm shift in public health discourse!* Journal of Family Medicine and Primary Care (2018). Accessed on 30th May 2022 Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6259525/
[36] Page 6, Rwanda Health Sector Performance Report 2017-2019, Ministry of Health, Republic of Rwanda (2020).
[37]Page 3, Rwanda Health Sector Performance Report 2017-2019, Ministry of Health, Republic of Rwanda (2020).
[38] Page 17, Rwanda Health Sector Performance Report 2017-2019, Ministry of Health, Republic of Rwanda (2020).

To paint a broader picture, more statistics and facts are telling. According to findings from a study report, an estimated 22 % of unintended pregnancies in Rwanda that end in induced abortion are carried out in unsafe methods due to legal restrictions and strong stigma surrounding abortion. The same study revealed that half of abortions in Rwanda are performed by untrained health providers.[39] In another Rapid Assessment conducted by GLIHD, findings indicate that 90% of health centers have at least a midwife who can perform Post Abortion Care (PAC) services after training and that health centers have enough nurses available in different levels A1 and A2 who can support in the provision of safe abortion services.[40]

Therefore, it is feasible to train and assign specifically trained mid-wives and nurses to handle safe abortion services at first level. WHO's safe abortion guidance recommends that abortion services be provided at the lowest appropriate level of the health-care system. It states that vacuum aspiration can be provided at primary-care level up to 12 completed weeks of pregnancy and medical abortion up to 9 completed weeks of pregnancy, and that mid-level health workers can be trained to provide safe, early abortion without compromising safety. It includes mid-level providers:midwives, nurse practitioners, clinical officers, physician assistants, and others. Training includes a bimanual pelvic examination to determine pregnancy and positioning of the uterus, uterine sounding, trans-cervical procedures, provision of abortion, and skills for recognition and management of complications.[41]The government of Rwanda submits that it has expanded the grounds for access to safe abortion through the adoption of law Nº68/2018 of 30/08/2018 determining offences and penalties in general and the Ministerial order n°002/MoH/2019 of 08/04/2019 determining conditions to be satisfied for a medical doctor to perform an abortion. However, the requirement for a doctor authorization for an abortion when the pregnancy is threatening the health of the woman[42] bearing in mind the limited number of available medical doctors based on the ratio of 1 doctor per 15,806 patients denies girls and women access to these critical services.

In 2021, in recognition of these realities, GLIHD with the support of the Center, instituted litigation challenging the constitutionality of the criteria requiring abortion services only be provided by doctors. Unfortunately, the Supreme Court declined to find that these requirements are restrictive and thus upheld a law that limits women's access to safe abortion services in contravention of Rwanda's obligations under international law, barring trained mid-level healthcare providers, such as nurses and midwives, who make up most of the country's healthcare professionals, from providing this essential health care service.

Criminalization of abortion is another legal barrier that hinders access to safe abortion services. Access to abortion in Rwanda is primarily provided for in the penal laws of the country. Failure to meet the legal criteria discussed above attracts a prison sentence of 1-3 years and a fine of FRW 100,000- 200,000 for the woman or girl.[43] Healthcare providers who provide abortion services in circumstances that do not

[39] Guttmacher Institute and School of Public Health of the
National University of Rwanda "Unintended pregnancies and
Induced abortions in Rwanda: Causes and Consequences". Available
at <<https://www.guttmacher.org/pubs/unintended-pregnancyRwanda.pdf>> Accessed on 18 August 2015.
[40] Rapid Assessment conducted by GLIHD, 2020
[41]https://iris.who.int/bitstream/handle/10665/349316/9789240039483-eng.pdf?sequence=1
[42] Article 166 of the Penal Code
[43] Article 123, Law N°68/2018 of 30/08/2018 Determining Offenses and Penalties in General

meet the legal criteria, are liable to a minimum prison sentence of 3 years and, depending on the existence of aggravating circumstances, a maximum sentence of life imprisonment.[44] These laws are frequently implemented as was found in a 2017 study conducted by HDI which found that 24% of women in prison in Rwanda were incarcerated as a result of abortion related charges.[45] Conversations with women leaders in a 2021 study, also conducted by HDI, that found that despite the President of Rwanda pardoning hundreds of women incarcerated for abortion related offences,[46] there are still estimated to be thousands of women serving abortion related sentences.[47]

The CEDAW Committee has reiterated that the criminalization of abortion is a form of SGBV against women, in line with general recommendation No. 35' and has connected it to the resulting high number of women and girls seeking unsafe abortions and preventable maternal mortality.[48]In line with its general recommendation No. 24 (1999), the Committee highlighted the obligation to ensure access to abortion and to remove the restrictions to access to safe abortion services, such as the requirement for mandatory counseling, medically unnecessary waiting periods and third-party authorization, in line with the recommendations of the World Health Organization.[49]

It is well established that legal barriers to health services, particularly those that are exclusively used by women such as abortion, undermine women's autonomy, right to equality, freedom from non-discrimination[50] and hinder access to safe services thus forcing women and girls to seek clandestine and unsafe services which jeopardizes their right to life and health.[51] These are all rights that are enshrined in the Constitution of Rwanda[52] as well as the Law N°49/2012 of 22/01/2013 Establishing Medical

[44] Article 124, Law N°68/2018 of 30/08/2018 Determining Offenses and Penalties in General

[45] Pg. 1, Barriers to Safe Abortion and Existing Legal Framework: Opinions of Women Leaders in Rwanda, Health Development Initiative (2021). Accessed on 30th May 2022. Available at: https://hdirwanda.org/wp-content/uploads/2021/04/Final-Barriers-to-Safe-Abortion-Opinion-of-Women-Leaders-27_10_2020.pdf

[46] Committee on the Elimination of Discrimination against Women, Tenth periodic report submitted by Rwanda under Article 18 of the Convention, due in 2021 (2021). Paragraph 220, U.N. Document CEDAW/C/RWA/10.

[47] Pg. 10, Barriers to Safe Abortion and Existing Legal Framework: Opinions of Women Leaders in Rwanda, Health Development Initiative (2021). Accessed on 30th May 2022. Available at: https://hdirwanda.org/wp-content/uploads/2021/04/Final-Barriers-to-Safe-Abortion-Opinion-of-Women-Leaders-27_10_2020.pdf

[48] CESCR Committee, Concluding observations on the sixth periodic report of El Salvador, UN Doc. E/C.12/SLV/CO/6 (November 9, 2022), para. 58-59; CEDAW Committee, Concluding observations on the combined fifth to ninth periodic reports of Saint Kitts and Nevis CEDAW/C/KNA/CO/5-9 (November 5, 2022), paras. 32-33; CEDAW Committee, Concluding observations on the ninth periodic report of Honduras, UN Doc. CEDAW/C/HND/CO/9 (November 1, 2022), para. 38.

[49] World Health Org., *Abortion Care Guideline* 26 (2022), https://www.who.int/publications/i/item/9789240039483 ; See also Committee on the Elimination of Discrimination against Women Concluding observations on the seventh periodic report of Slovakia, UN Doc. CEDAW/C/SVK/CO/7, para 37 May 31, 2023, 37 a,b,c; CEDAW Committee, Concluding observations on the combined fourth and fifth periodic reports of Djibouti, UN Doc. CEDAW/C/DJI/CO/4-5 (February 26, 2024), para. 36(c); CEDAW Committee, Concluding observations on the sixth periodic report of Turkmenistan, UN Doc. CEDAW/C/TKM/CO/6 (February 20, 2024), para. 46(a); CEDAW Committee, Concluding observations on the sixth periodic report of the Central African Republic, UN Doc. CEDAW/C/CAF/CO/6 (February 20, 2024), para. 42(c);

[50] Pg. 24-25, Abortion Care Guideline, World Health Organization (2022).

[51] Pg. 24-25, Abortion Care Guideline, World Health Organization (2022).

[52] Chapter IV, Constitution of the Republic of Rwanda

Professional Liability Insurance,[53] which is the main law that provides for health rights. These rights are also recognized in international instruments which are binding on Rwanda such as the CEDAW Convention and the Maputo Protocol.

4. Mandatory HIV Testing

According to a Rwanda Population Based HIV Impact Assessment, as at 2019, the Prevalence of HIV among adults in Rwanda was 3.0%. This corresponded to approximately 210,200 adults living with HIV in Rwanda with more women (3.7%) than men (2.2%) living with HIV. The prevalence of HIV among young adolescents (those aged 10-14 years) was 0.4%, corresponding to approximately 5,900 young adolescents living with HIV in Rwanda, for a total of 216,000 people living with HIV among those aged 10-64 years.[54]

According to the 2020 Rwanda Demographic Health Survey, approximately 94% of pregnant women in Rwanda have tested for HIV during their pregnancy.[55]Such high rates of testingdemonstrate the government's commitment to combat HIV/AIDS. Further, the Rwandan government, through the Ministry of Health (MoH), has adopted strategies to promote HIV testing services among pregnant women by adopting the National Strategic Plan (NSP) of July 2013-June 2018, including mandatory HIV testing during antenatal care (ANC), community-based testing, self-testing, and door-to-door testing.[56]

Some concerns emanate from the above. According to Article 10 (20) of N° 21/05/2016 of 20/05/2016 Law Relating to Human Reproductive Health: "*No person shall undergo unconsented HIV/AIDS testing. However, mandatory testing may be required upon request by competent organs in accordance with the law."* There is a lacuna in this law as the definition "competent organs" is not clearly offered. The law also fails to define under which circumstances the "competent organs" can compel an individual to undergo mandatory HIV Testing. Under these circumstances, mandatory HIV testing in Rwanda infringes and/or has the potential toinfringe on the rights to autonomy, privacy, and to offer informed consent, as these rights relate to the right to health; and as they are provided for in both regional and global human rights instruments.

5. Disparity in geographic distribution of health human resources

The government of Rwanda submits that as part of its strategies to improve and expand health services particularly to women and girls it has deployed *"over 58,000 CHWs in Rwanda (about 4 CHWs per village). One CHW, named AssistanteMaternelle de Santé (ASM), is in charge of maternal and new-born health, one in charge of health promotion whereas the other two CHWs, known as Binôme (a pair of one male and one female), are multi-disciplinary health agents. The package of services offered by CHWs*

[53] Chapter II: Fundamental Rights of a Patient and Other Health Service Users, Law N°49/2012 of 22/01/2013 Establishing Medical Professional Liability Insurance.
[54]Rwanda Population Based HIV Impact Assessment, RPHIA-Summary-Sheet_Oct-2019.pdf (columbia.edu)
[55] https://journals.plos.org/globalpublichealth/article?id=10.1371/journal.pgph.0002728
[56]
https://journals.plos.org/globalpublichealth/article?id=10.1371/journal.pgph.0002728#pgph.0002728.ref020

includes health promotion, prevention and curative services."[57] Further, the government of Rwanda submits that it has done massive construction of Health Facilities which have contributed to the reduction of the average time used by a Rwandan citizen to reach a health facility.[58]

However, the geographic distribution of health human resources in Rwanda showcases significant disparities, with a concentration of healthcare professionals in urban areas and a critical shortage of such professionals in rural regions. Data from 2018 revealed that out of 567 physician specialists in the country, a substantial number worked in just four districts—Gasabo, Huye, Kicukiro, and Nyarugenge—while several districts had no specialists at all or only one each. This urban-centric distribution leaves rural areas, where most of the Rwanda's population resides, with inadequate access to specialized healthcare services.[59]In connection with foregoing information on inadequate access o maternal health, women, and girls in rural areas in Rwanda face significant health challenges, particularly concerning maternal health. The latest findings from the 2019-2020 Rwanda Demographic and Health Survey (RDHS) reveal that only 47% of women are accessing the recommended four or more antenatal care (ANC) contacts during pregnancy, which is far below the global recommendations set by the WHO. This is concerning as proper ANC is crucial for monitoring and maintaining the health of both the mother and the fetus, and for preventing complications during pregnancy and childbirth.

The health system in Rwanda, while extensive, might not be fully accessible in rural areas despite a broad network of community health workers and health insurance programs intended to improve access to care for all citizens. The lack of sufficient ANC contacts suggests a gap in specialized maternal healthcare services needed in rural regions, such as comprehensive ANC that includes essential screenings and treatments to prevent complications.[60]

Another related major challenge identified is the retention of adequately trained health professionals. The HRH (Human Resources for Health) Strategic Plan aimed to address this by increasing the number of skilled, motivated, and equitably distributed healthcare workers. However, high turnover rates, low salaries, and lack of opportunities for career advancement and further training have been persistent hurdles. These factors not only lead to attrition from the public to the private sector but also contribute to the migration of healthcare workers abroad, seeking better opportunities.[61]

Proposed Recommendations for Rwanda

In light of the information provided in this submission, the Center, GLIHD and HDI hope that the Committee will consider adoptingthe following recommendations for Rwanda. The Government of Rwanda should:

(i) Increase and monitor the effectiveness of awareness campaigns on comprehensive sexual are reproductive health and rights, including the importance on maternal health care, contraception, and how to access safe abortion.

[57]Tenth periodic report submitted by Rwanda under article 18 of the Convention, due in 2021, parag.216
[58] Tenth periodic report submitted by Rwanda under article 18 of the Convention, due in 2021, parag.217
[59] https://nap.nationalacademies.org/read/25687/chapter/8
[60] https://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/s12884-022-05109-9
[61] https://nap.nationalacademies.org/read/25687/chapter/8

(ii) Urgently address preventable maternal mortality in Rwanda by accelerating its efforts to ensure access to skilled care, including ante-natal care, delivery and postnatal care by all women and girls, including those in rural areas. One of the ways in which the government should do this, is by reducing disparities in geographic distribution of human resources in the health sector, and by working towards retention of health human resources in Rwanda

(iii) Consider and adopt the law that seeks to reduce age of consent to access to contraception for adolescents to 15 years, and ensure that the law also provides for considerations on evolving capacity and support that must be offered to adolescents to enable them to offer their informed consent to sexual and reproductive health information and services.

(iv) Related to the above, review its laws, including the sexual reproductive and health rights law and medical liability law to allow minors to seek healthcare services without prior consent of their parents or legal representatives, with support of health service providers and based on evolving capacity.

(v) Initiate appropriate legal and policy reforms in order toensure that mid-level healthcare professionals, including nurses and midwives are permitted to provide safe abortion services in both law and practice. The Government should be guided by and seek to provide access to safe abortion without risk of criminalization in line with the 2022 WHO abortion guidelines.

(vi) In the context of the presidential pardons granted for abortion-related offences, release women and girls who are still imprisoned for abortion-related offences.

(vii) Review the Law Relating to Human Reproductive Health and define therein, the "competent organs" and the circumstances under which competent organs may compel one to undergo mandatory HIV testing, in Rwanda.