CENTER FOR REPRODUCTIVE RIGHTS

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

Submission to the United Nations Universal Periodic Review of

RWANDA

23rd Session of the UPR Working Group of the Human Rights Council

November 2-13, 2015

Report on Rwanda's Compliance with its Human Rights Obligations in the Area of Women's Reproductive and Sexual Health

Submitted by:

Center for Reproductive Rights

and

Great Lakes Initiatives on Human Rights and Development

March 23, 2015

In accordance with Human Rights Council Resolution 5/1 of June 18, 2007, the Center for Reproductive Rights (the Center)—a global non-governmental organization that uses the law to advance reproductive freedom as fundamental human rights—and Great Lakes Initiative on Human Rights and Development (GLIHD)—a Rwandan non-governmental organization that uses public interest litigation to advance human rights and provides legal aid services—submit this letter to supplement the report of the Government of Rwanda, scheduled for review by the Human Rights Council during its 23rd Session.

Rwanda is a party to multiple international human rights treaties that require states parties to ensure the sexual and reproductive rights of women and girls.[1] In addition, per Articles 189 and 190 of the Rwandan Constitution, these treaties immediately become part of Rwanda's national law upon their ratification and take precedence over Rwandan national laws.[2] Despite this, Rwandan women and girls experience serious violations of their reproductive rights. This letter highlights the following issues that the Center and GLIHD hope the Human Rights Council will take into consideration when reviewing Rwanda's compliance with its human rights obligations: (i) maternal mortality and morbidity, (ii) unsafe abortion and lack of post-abortion care, (iii) aggressive enforcement of laws prohibiting abortion and high incidence of imprisonment for abortion related charges, (iv) inadequate access to family planning services and information, and (v) discrimination and sexual and physical violence against women and girls

I. HIGH MATERNAL MORTALITY AND MORBIDITY

Maternal death is defined as any death that occurs during pregnancy, childbirth, or within 42 days of birth or termination of pregnancy or its management.[3] Treaty monitoring bodies have affirmed that states' failure to reduce maternal deaths violates a number of rights including the rights to health and life.[4] Since most maternal deaths are preventable,[5] the failure by governments to provide the services needed by women to survive childbirth constitutes a violation of their rights.[6] The Committee on Economic, Social and Cultural Rights (CESCR Committee), during its review of Rwanda in 2013, expressed concern regarding the high rate of maternal mortality and recommended that the state take measures to reduce the rate.[7]

The World Health Organization (WHO) indicates that Rwanda's maternal mortality ratio (MMR) is 320 deaths for every 100,000 live births.[8] This is a decline from the MMR of previous years when, for instance, the ratio was 1,000 per 100,000 live births in 2000.[9] While this trend is positive and Rwanda is on track to achieve the UN Millennium Development Goal of 75% reduction in MMR by the end of 2015,[10] more efforts are needed to address the ongoing problems in the health sector, discussed below, which continue to contribute to preventable maternal deaths and injuries if Rwanda is to meet its Vision 2020 goal of decreasing the MMR to 200 per 100,000 live births.[11]

Access to antenatal care, the timely intervention of skilled health professionals during childbirth, and post-natal care can significantly reduce the MMR.[12] However, there are significant barriers in Rwanda for women and girls to access these maternal health services. Approximately 23% of patients need to walk for an hour or more than five kilometers to reach the nearest health care facility.[13] While there has been an increase in health facility delivery from 45% in 2009 to 69% in 2011, 29% of women in Rwanda still deliver at home in unsanitary and sometimes dangerous conditions.[14] The WHO recommends at least four antenatal visits,[15] but as of 2010 less than 35% of Rwandan women received the recommended minimum according to the 2010 Rwanda Demographic Health Survey (RDHS)—which is the latest.[16] The WHO also recommends having a postnatal check-up during the first two days after delivery as many maternal deaths occur during

this time;[17] however, the RDHS found that only 18% of women and girls received this service.[18]

In its 2009 concluding observations, the Committee on the Elimination of Discrimination against Women (CEDAW Committee), the committee which monitors state compliance with the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), urged Rwanda to increase health care access, especially for rural and elderly women.[19] The CEDAW Committee also recommended that obstacles to accessing obstetric services be monitored and steps be taken to remove these barriers.[20] There remain, however, disparities in access to maternal health care services based on geography and socio-economic status. For instance, low-income women in Rwanda are eight times less likely than their wealthier counterparts to have access to skilled care.[21] Further, according to the latest available data, Rwanda has a total of 661 doctors working in private and public health facilities, amounting to approximately one doctor per 15,306 people.[22] Similarly, there is approximately a combination of 8,513 nurses and midwives nationwide, amounting to one midwife per 23,364 inhabitants and one nurse per 1,138 inhabitants.[23] Lack of access to these health professionals is exacerbated in rural areas, where distance to a health facility can be a barrier to health services.[24] According to the WHO, Rwanda has a critical shortage of health professionals and needs to increase its health workforce by about 140% in order to make a positive difference in the health and life expectancy of the population.[25] The Vision 2020 initiative aims to have 10 medical doctors, 20 nurses, and 5 lab assistants for every 100,000 inhabitants,[26] but these numbers will still need to be improved upon to make adequate impact.

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

The United Nations Special Rapporteur on the Right to Health has confirmed that the criminalization of abortion and other reproductive health services violates the right to health by imposing barriers that interfere with accessibility to safe health care services and with individual decision-making in health-related matters.[27] Such criminalization also perpetuates gender stereotypes, and marginalizes and disempowers women by forcing them to choose between making personal decisions about their health and well-being or facing criminal liabilities.[28] Similarly, several human rights bodies have found that both restrictive abortion laws and the failure to ensure access to abortion when it is legal are incompatible with international human rights obligations, amounting to violations of the rights to life and health, the right to be free from torture and cruel, inhuman and degrading treatment, and the right to be free from discrimination.[29] The CEDAW Committee and the UN Special Rapporteur on the Right to Health have specifically called on states to decriminalize abortion.[30]

Although in July 2012, Rwanda amended its Penal Code to allow abortion when performed to save the life of the woman, protect her health, or when the pregnancy is a result of rape, incest or forced marriage,[31] the new Penal Code simultaneously severely limits access to these legal services by adding significant hurdles in order to qualify for a safe and legal abortion. For example, Rwanda's abortion law requires a "competent Court" to certify that a woman has become pregnant as a result of rape, incest, or forced marriage before she can procure abortion.[32] This creates a barrier because stigma, fear, and family pressure prevent many women and girls from reporting incest or sexual violence and engaging with the justice system. In addition, those requiring the termination of a pregnancy have a limited window in which to obtain these services and court proceedings are often cumbersome and ineffective in these time-sensitive contexts. 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.[33]

In addition, the law requires that the procedure be performed by a medical doctor and the doctor performing the abortion must seek "advice from another doctor" when possible before proceeding with the abortion to avoid criminal liability.[34] This requirement for the involvement of multiple doctors is particularly onerous in a country such as Rwanda with a limited number of doctors, as previously noted.[35] Most contemporary legal and policy experts also agree that consultation requirements are inappropriate and delay access to services.[36] In addition, the WHO has made clear that mid-level providers, such as nurses or clinical officers, can safely and beneficially provide first-trimester abortion services.[37] Further, fulfilling these requirements can cost money, waste time that women may not have, and dangerously delay critical health care, creating additional significant barriers. During its review of Rwanda in 2013, the CESCR Committee expressed concern regarding "the general criminalization of, and the application of, severe punishment for recourse to abortions" and recommended that the state "revise its laws in order to reduce the scope and severity of the punishment for abortion" and to ensure that women and girls have access to medical services.[38]

In addition to these concerns, as of 2012, the Rwandan Parliament was considering a Reproductive Health Bill[39] 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."[40] Information about the current status of the Bill is not easily accessible; however, if passed, this Bill would be a severe setback to the efforts to expand access to safe and legal abortion and to reduce maternal mortality from unsafe abortion. Not only does the bill seek to greatly narrow legal abortion, it also seeks to enhance the procedural barriers to accessing legal services by requiring the authorization of *three* medical doctors. These restrictive provisions would not only contravene accepted medical practice and standards, as indicated above, they would also directly violate international human rights laws and standards concerning access to safe and legal abortion services.

Aggressive enforcement of the laws on abortion

The criminalization of abortion in Rwanda has great implications in Rwanda because the law is aggressively enforced and women and girls are routinely arrested, prosecuted, and imprisoned for procuring an unlawful abortion.[41] A study by Youth Action Movement Rwanda, which documented the testimonials these women and girls, found that some are serving sentences as long as ten years which were imposed when they were adolescents below the age of 18.[42] According to this study, in 2010, of the 114 women in Karubanda Prison—one of Rwanda's main prisons—one in five were in for procuring illegal abortions, and 90% were 25 years old or younger.[43] Many of these women were the victims of sexual violence and abuse.[44] For instance, Anne—who was 20 years old during the interview—was imprisoned in 2007 and is serving a nine-year sentence for terminating a pregnancy resulting from sexual abuse by her teacher when she was 17 years old.[45] She had to drop out of school because pregnancy is "against school regulations."[46] She decided to terminate the pregnancy and then was reported to the police by her elder brother.[47]

The study further showed that in a number of instances, those imprisoned were low-income girls and women,[48] and engaged in transactional sex for money to meet essential needs such as food, school fees, and accommodation.[49] 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."[50] Heavy bleeding stemming from a clandestine abortion compelled her to seek medical treatment in a hospital. She was taken to prison from the hospital.

Medical professionals who provide abortion services are also prosecuted and imprisoned. A 26 year

old medical doctor who was sentenced to ten years in prison for helping his sister to procure an abortion stated that their parents had died in the 1994 Genocide, leaving them all alone. He undertook to help her procure an abortion when the man who was responsible for her pregnancy abandoned her. She died during the unsafe abortion and he was subsequently reported to the police and imprisoned.[51]

Despite the review of the Penal Code which reduced the prison terms to be imposed, aggressive enforcement of the law and imprisonments continue. Consequently, Rwanda's criminalization of abortion through its Penal Code, and the fear of being imprisoned if found to have procured, provided, assisted with procuring, or had knowledge that an illegal abortion was procured continues to heavily stigmatize women seeking access to abortion-related services. One immediate consequence is that women are forced to seek clandestine abortion, often having to travel long distances and, as the statistics show, almost always exposing themselves to unsafe abortion. Many interviewees in one study on abortion in Rwanda noted that they traveled to the Democratic Republic of Congo or Uganda to access abortion.[52] 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.[53] This further heightens their sense of vulnerability and the stigma attached to abortion.

As a result, there is 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—were due to pregnancy or pregnancy related causes.[54] Approximately 26,000 women each year are treated for abortion complications, with about 17,000 of these complications likely resulting from induced abortions (65%).[55] Methods of unsafe abortion include ingesting drugs and herbs and inserting metal objects or other items into the vagina.[56]

Studies have shown that 47% of all pregnancies in Rwanda are unintended and that 22% of the country's unintended pregnancies result in induced abortions.[57] Many of the women and adolescent girls who make up these numbers seek out clandestine and unsafe abortion due to the restrictive abortion law.[58] Overall, half of all abortions in Rwanda are performed by untrained individuals and are considered to be very high risk, with poor rural women being the most likely to go to untrained providers or self-induce.[59] Consequently, approximately 40% of abortions in Rwanda result in complications and require medical treatment.[60] In 2012, alone, approximately 18,000 women were treated for complications resulting from unsafe abortion, costing an estimated USD 1.7 million.[61]

The restrictive laws on abortion has a disparate effect on women based on their age, level of income, and geographical location as they are more likely to seek unsafe abortion. For instance, this is reflected in the higher incident of abortion related complications that require treatment in health facilities among low-income women (54-55%) than those in a higher wealth quintile (20% among urban non-poor and 38% of rural non-poor).[62] The complication rates are highest for procedures carried out by the woman herself (67%) and by traditional healers (61%), the two forms of abortions that adolescents, low-income women, and those living in rural areas are most likely to undergo.[63]

Post-Abortion Care

Post-abortion care (PAC) encompasses a set of interventions to respond to the needs of women and girls who have miscarried or induced an abortion.[64] It has been recognized that PAC should be integrated with other available maternal health services.[65] However, the potential for prosecution deters Rwandan women and girls from seeking necessary post-abortion treatment after procuring

unsafe abortions.[66] About 30% of those who experience complications are ultimately unable to access PAC and treatment at health centers.[67]

For those that seek care, barriers to access to quality care include inadequate equipment and medical supplies in health care facilities and insufficient training of health care providers.[68] Moreover, very few providers employ techniques recommended by the WHO for treating uncomplicated post-abortion cases.[69] As of 2010, just 10% of all health facilities in Rwanda had the equipment for the recommended method and almost 40% of the health facilities lacked the trained staff to use the equipment, leaving only about 6% of all the country's facilities having both the equipment and trained staff to provide the service.[70]

In March 2012, Rwanda released its first National Comprehensive Treatment Protocol for PAC Services.[71] The protocol confirms that health care providers should only use the procedures recommended by the WHO to treat incomplete abortions.[72] Releasing this protocol for PAC indicates that the government recognizes and acknowledges the importance of PAC. However the lack of access to PAC, is particularly dismal given that 20%—almost a quarter—of women in Rwanda will, during their reproductive years, need medical care for abortion-related complications.[73]

The Rwandan Government's current report to the Council does not discuss abortion and PAC and the steps the government is taking to ensure women's access to these services.

III. INADEQUATE ACCESS TO FAMILY PLANNING INFORMATION AND SERVICES

Maternal deaths in Rwanda could be reduced by a third by addressing the unmet need for modern contraceptive methods,[74] and the government has taken some steps to ensure access. For instance, the Health Sector Strategic Plan 2012-2018 assessed the family planning program and made recommendations including scaling up community based family planning and expanding the distribution of condoms in both the public and private sectors.[75] The use of modern contraceptives among married women also increased between 2000 and 2010, going from 4% in 2000 to 45%.[76] Under the Family Planning Strategic Plan 2012-2016, the government aims to achieve a contraceptive prevalence rate of 70% by the end of 2015 and 90% by 2017.[77]

However, Rwanda still has one of the highest levels of unmet need for contraceptives in the world—35% of married women of child bearing age want to avoid or postpone their pregnancy but are not using contraceptives.[78] According to the 2010 DHS, 48% of unmarried women age 15-19 have an unsatisfied demand for modern methods.[79] Only 29% of women aged 15 to 49 use some form of contraceptive method and 25% use a modern contraceptive method.[80] Further, adolescent girls, low-income, and rural women often face additional obstacles to accessing family planning services. The 2010 RDHS found that 43% of women in the lowest wealth quintile used contraceptives, whereas usage is 57% for women in the highest wealth quintile.[81] Geographically, a significantly higher percentage of women use modern contraception in urban areas such as Kigali (28%), compared to a low of 4% in Gikoro, a rural region.[82]

This low contraceptive prevalence rate and the high level of unmet need can be attributed to the numerous barriers women encounter in accessing contraceptive information and services. In Rwanda, discussing family planning is considered taboo and most women rarely discuss the issue with their husbands.[83] In addition most health care facilities are religiously affiliated and do not offer contraception. [84] Specifically, 40% of health care facilities are religiously affiliated[85] and 60% of these facilities with religious affiliations do not offer contraception, which amounts to 25% of all

facilities.[86] As a result women living in the areas these facilities serve may find it more difficult to obtain contraceptives. Unmarried women who use contraceptives also experience stigma as they are often assumed to be promiscuous if they seek family planning services, which further deters use of contraceptives among unmarried sexually active women.[87] Due to this, nearly half of all the pregnancies in Rwanda are unintended, amounting to an estimated 276,000 pregnancies.[88] Concerned about the difficulties women encounter in accessing family planning services, particularly those living in rural areas, the CESCR Committee recommended that the government ensure access to family planning services, including contraceptives, to all women, and conduct "educational programmes on sexual and reproductive health."[89]

Emergency Contraception

Emergency contraception (EC) is a vital tool to prevent unplanned and unwanted pregnancies and is a critical component of care for survivors of sexual violence.[90] Rwanda recognizes that EC should be provided to survivors of sexual violence as soon as possible after the assault.[91] However, a survey of clinics showed EC was not readily available.[92] For instance, one study showed that only 16% of facilities surveyed have ever offered EC, noting that the day the survey was taken only 5% of the facilities had EC available.[93]

A further barrier to access to EC is knowledge of the option. According to the 2010 Demographic and Health Survey, only 23% of all women know about EC.[94] In a 2012 Rwanda Ministry of Health, National University of Rwanda School of Public Health and IntraHealth International study, only 5% of the health care providers that were participants reported regularly including EC as part of family planning discussions with patients and almost 40% of the providers said they never include the topic in their discussions.[95]

Adolescents' Access to Family Planning Information and Services

In addition to the general barriers to accessing reproductive and health services in Rwanda, adolescents and youths face particular challenges, including misconceptions, lack of youth-friendly services/providers, and social stigma associated with use of the services that are available.[96] This is significant as approximately 29.5% of the entire population is between 10-19 years old and, although the fertility rate for 15-19 year olds declined from 60 per 1,000 in 1992 to 41 per 1,000 in 2010, this population continues to suffer from a higher unmet need for health services than similarly situated populations.[97]

The interviews conducted by Youth Action Movement Rwanda, previously referenced, also document the role that the lack of information and education in respect to health services plays in the unintended pregnancies of adolescents.[98] The young women interviewed cite a variety of factors, ranging from a lack of knowledge of where to access reproductive health services to misconceptions about their ability to use contraceptive methods (e.g. the pill) themselves rather than relying on their male sexual partners to use condoms, as contributing to their unintended pregnancies.[99] Another assessment conducted in 2011 also found that adolescents and youth are often unable to discuss sexual issues freely with their parents, which further restricts their ability to access reproductive health services.[100]

Social stigma connected to adolescent sexual activity is also a barrier to adequate access for adolescents. This is evidenced by the fact that the unmet need for family planning in Rwanda is much higher for unmarried women age 15-19 compared to the other groups of the same age, such as married women. Forty-eight percent of unmarried women age 15-19 have an unsatisfied demand for modern methods.[101]

IV. DISCRIMINATION AND SEXUAL AND PHYSICAL VIOLENCE AGAINST WOMEN AND GIRLS

According to international and regional human rights standards, states are obligated to advance equality and discourage discrimination by means of the "elimination of prejudices, customary and all other practices that perpetuate the notion of inferiority or superiority of either of the sexes, and stereotyped roles for men and women."[102] The CEDAW Committee expressed concern in its 2009 Concluding Observations on Rwanda, regarding discriminatory laws and practices in the country.[103] The CEDAW Committee further expressed concern regarding "the persistence of deeply rooted, traditional patriarchal stereotypes regarding the role and responsibilities of women and men in the family and in the wider community which result in violence against women…."[104] The Committee Against Torture indicated the dearth of comprehensive data on domestic violence is a concern and further recommended women victims in Rwanda be provided with assistance and that Rwanda "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."[105] More recently, the CESCR Committee stated its concern regarding the high incidences of violence, including sexual violence, despite legislations and other measures adopted by the government, and the lack of information on investigations, prosecutions, convictions and penalties for perpetrators.[106]

However, according to a recent news report, Rwanda "continues to have one of the highest incidences of gender-based and domestic violence in Africa"[107] The 2010 RDHS reported that, nearly half of all women between the ages of 15 and 49 have experienced physical or sexual violence at least once in their lifetime.[108] About 41% of all women in Rwanda have experienced physical violence since reaching the age of 15.[109] 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.[110] The 2010 RDHS report also indicated that 22% of women had experienced sexual violence during their lifetime[111] and 51% of this group had been abused by a current or former husband, partner, or boyfriend.[112] Additionally, 13% of women ever married had experienced sexual violence in the twelve months preceding the survey.[113] 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.[114]

As the WHO recognizes, violence against women is a major public health problem and a violation of women's human rights.[115] Moreover, violence against women can result in physical, mental, sexual and reproductive, and maternal health problems.[116] Health practitioners recognize that the consequences of gender-based violence on women's lives include "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."[117]

Rwanda also suffers from a prevalence of sexual and physical violence against children. For instance, 9% of the students at the Gahanga Primary School—which was the subject of media reports due to sexual abuse—reported that they had been sexually abused at least once, according to a survey conducted by the school in 2007.[118] The Rwanda National Police report that between 2005 and 2008 there were 10,000 cases of child defilement.[119] In 2009 there were 1,570 cases of child rape recorded.[120] The Rwanda National Police also report that there were 863 cases of violence against children reported between January and July 2012.[121] It should be noted that these statistics do not give a comprehensive portrayal of the issue since gender-based violence, particularly sexual violence, tends to be under-reported.[122]

Sexual violence and other discriminatory practices in Rwandan schools also significantly interfere

with access to education for girls. A June 2011 survey conducted by the State Minister in charge of Primary and Secondary Education found that over 600 children were sexually, physically, and psychologically abused in the previous two years across the country.[123] Those incidents resulted in at least 110 pregnancies.[124] The Minister concluded the abuse was committed by relatives, teachers, and other community members, explaining that "[m]ale teachers in most primary schools take advantage of their positions to abuse pupils who fear and respect them."[125]

Services to victims of sexual violence and gender-based violence are available through "Isange One Stop Centers."[126] These centers provide "comprehensive services such as: medical care, psycho-social support, police and legal support, and the collection of legal evidence."[127] According to a 2013 evaluation report, there is only one such Center, which is located in Kacyiru Police Hospital in Kigali. [128] The evaluation also found that from 2009-2012, 4725 gender-based violence victims sought treatment from this Center, and, although the rate of convictions was not available, 2327 out of these cases were prosecuted.[129] Action has been recently taken to expand the number of Isange One Stop Centers, but the situation will have to be monitored to verify whether the expanded access improves the overall climate for women and girls who are victims of gender-based violence.[130]

6. QUESTIONS

We hope that the Human Rights Council will consider addressing the following questions to the government of Rwanda:

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

b) Beyond Vision 2020, what immediate steps is the government taking to ensure the adequate recruitment, training, and retention of health workers, and sufficient equipping of health care facilities to reduce injuries and deaths due to pregnancy and childbirth-related complications, particularly given the current severe shortage of doctors and midwives in the country?

c) What measures has the government undertaken to address unsafe abortion, which is one of the leading causes of maternal morbidity in Rwanda? Specifically, what efforts has the government undertaken to ensure that its laws on abortion are in line with international and regional human rights treaties, including by removing the third party authorization requirements stipulated in the Penal Code before women and girls can access abortion?

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

e) What steps are being taken to ensure access to a wide range of family planning services and information, including emergency contraception, and to address the disparities in access? What measures has the government taken to ensure the recruitment, training, and retention of youth-friendly health workers, and access to sexuality education for adolescents?

f) What measures is the government taking to address the high physical and sexual violence against women and girls and to eliminate impunity for perpetrators? What steps is the

government taking to ensure that victims of violence have access to comprehensive legal, medical, and pyscho-social services, including by expanding the Isange One Stop Centers?

7. RECOMMENDATIONS

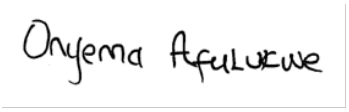
We hope that the Council will consider making the following recommendations to the Government of Rwanda:

1. The government should take measures to reduce the high rate of maternal mortality and improve access to maternal health information and services including ante-natal, delivery, and post-natal care. Such measures should include increasing the number of health care facilities equipped and staffed to handle basic and emergency obstetric care, especially in low-income and rural areas, and increasing the number of skilled health care providers able to offer quality and convenient antenatal care 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 ensure that women and girls have access to safe abortion services, and that its abortion law is in line with its obligations under international and regional treaties, including by revising the law to remove the third party authorization requirements to access abortion. It should set up a mechanism for reviewing the long sentences already imposed on some women for illegal abortion to commute their sentences or grant them pardons.
3. It should also review the sentences of those who were imprisoned on abortion-related charges that are no longer offenses under the revised 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. It should further ensure that health care facilities are well equipped and heath care professionals are trained to provide PAC services.
4. The government should take concrete steps to ensure an adequate and consistent supply of contraceptives, including emergency contraception, 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.
5. The Government should take immediate steps to ensure that the health care professionals and police treat women who report sexual or physical violence with respect, and provide them with the necessary medical and legal services. It should also take all steps necessary to prevent, investigate, and prosecute incidents of physical and sexual violence against women and girls.

We hope this information is useful during the Universal Period Review of the Rwandan Government's compliance with its human rights obligations. If you have any questions, or would like further information, please do not hesitate to contact the undersigned.

Evelyne Opondo
Regional Director
Africa Program
Center for Reproductive Rights

Tom Mulisa
Executive Director
Great Lakes Initiative for
Human Rights Development



Onyema Afulukwe
Senior Legal Advisor
Africa Program
Center for Reproductive Rights

---

[1] International Covenant on Economic, Social and Cultural Rights, G.A. Res. 2200A (XXI), U.N. GAOR, Supp. No. 16, U.N. Doc. A/6316 (1966), (entered into force Jan. 3, 1976); African Charter on Human and Peoples' Rights, June 27, 1981, 1520 U.N.T.S. 217; Convention on the Elimination of All Forms of Discrimination against Women, Dec. 18, 1979, 1249 U.N.T.S. 13; Convention on the Rights of the Child, Nov. 20, 1989, 1577 U.N.T.S. 3; International Convention on the Protection and Promotion of the Rights and Dignity of Persons with Disabilities, G.A. Res. 61/106, Annex I, U.N. GAOR, 61st Sess., Supp. No. 49, U.N. Doc. A/61/49, at 65 (Dec. 13, 2006); International Covenant on Civil and Political Rights, Dec. 16, 1966, S. Treaty Doc. 95-20, 6 I.L.M. 368 (1967), 999 U.N.T.S. 171; Universal Declaration of Human Rights, Dec. 10, 1948, G.A. Res. 217 (III) A, U.N. Doc. A/RES/217(III), at 71 (1948).

[2] ITEGEKO NSHINGA RYA REPUBLIKA Y'U RWANDA [CONSTITUTION], Title X, art. 189-90 (2003).

[3] WORLD HEALTH ORGANIZATION (WHO) ET AL., TRENDS IN MATERNAL MORTALITY: 1990-2013 4 (2013), *available at* http://apps.who.int/iris/bitstream/10665/112682/2/9789241507226_eng.pdf?ua=1 [hereinafter TRENDS IN MATERNAL MORTALITY].

[4] 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), *reprinted in* COMPILATION OF GENERAL COMMENTS AND GENERAL RECOMMENDATIONS ADOPTED BY HUMAN RIGHTS TREATY BODIES, 91, para. 52, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. I) (2008); *See, e.g.*, *CEDAW Committee Concluding Observations*: *Belize*, para. 56 (1999), U.N. Doc. A/54/38; *Colombia*, para. 393 (1999), U.N, Doc A/54/38; *Dominican Republic*, para. 337 (1998) U.N. Doc A/53/38; *Madagascar* para. 244 (1994) U.N. Doc A/49/38.

[5] WHO, *Maternal Mortality, Fact Sheet No. 348*, http://www.who.int/mediacentre/factsheets/fs348/en/s/fs348/en/index.html (last updated May 2014) [hereinafter WHO, *Maternal Mortality*].

[6] *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.

[7] CESCR Committee, *Concluding Observations: Rwanda* para.26 (2013) UN Doc E/C.12/RWA/CO/2-4

[8] WHO et al., *Maternal mortality in 1990-2013, Rwanda* (2014), *available at* http://www.who.int/gho/maternal_health/countries/rwa.pdf?ua=1.

[9] TRENDS IN MATERNAL MORTALITY, *supra* note 3 at 41.

[10] *Id.*

[11] DEPARTMENT FOR INTERNATIONAL DEVELOPMENT (DFID), THE WHITE RIBBON ALLIANCE FOR SAFE MOTHERHOOD, RWANDA STRATEGIC PLAN 2010-2013 AND ONE YEAR OPERATIONAL PLAN 10 (2010), *available at* http://hdrc.dfid.gov.uk/wp-content/uploads/2012/05/275007_RW-Consultancy-to-Finalise-the-Strategic-Plan-for-

White-Ribbon-Alliance-Rwanda-2010-2013_Strategic-Plad.n.pdf [hereinafter DFID, RWANDA STRATEGIC PLAN 2010-2013].
[12] *See* WHO, *Maternal Mortality*, *supra* note 5.
[13] *See* DFID, RWANDA STRATEGIC PLAN 2010-2013, *supra* note 11 at 9.
[14] 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; NATIONAL BUREAU OF STATISTICS (RWANDA), RWANDA DEMOGRAPHIC AND HEALTH SURVEY 2010, 115 (2011), *available at* http://www.measuredhs.com/pubs/pdf/FR259/FR259.pdf [hereinafter 2010 RDHS].
[15] 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 March 11, 2015).
[16] 2010 RDHS, *supra* note 14, at 111.
[17] *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/oanfullreport.pdf.
[18] 2010 RDHS, *supra* note 14, at 118.
[19] Committee on the Elimination of Discrimination against Women, *Concluding Observations*: *Rwanda*, para. 36, U.N. Doc. CEDAW/C/RWA/CO/6 (2009).
[20] *Id*.
[21] 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*].
[22] MINISTRY OF HEALTH RWANDA, *Human Resources for Health Strategic Plan, 2011-2016* 13 (2011), *available a*t http://medicine.yale.edu/intmed/globalhealthscholars/sites/323_158432_HRH%20Strategic%20Plan%20March%202011.pdf.
[23] *Id*.
[24] *Id*.
[25] AFRICAN HEALTH WORKFORCE OBSERVATORY (AHWO) & WHO, HUMAN RESOURCES FOR HEALTH COUNTRY PROFILE: RWANDA 8, 23 (2009), *available at* http://www.hrh-observatory.afro.who.int/images/Document_Centre/rwanda_hrh_country_profile.pdf.
[26] REPUBLIC OF RWANDA, RWANDA VISION 2020 25 (2000), *available at* http://www.gesci.org/assets/files/Rwanda_Vision_2020.pdf.
[27] Anand Grover, *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. 21 & 25, U.N. Doc. A/66/254 (Aug. 3, 2011) , [hereinafter SRRH, *Interim rep*. (2011)] (citing WHO, *Safe Abortion: Technical and Policy Guidance for Health Systems* (Geneva, 2003), para. 86).
[28] *Id*. para. 17.
[29] 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* 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* Committee on the Elimination of Discrimination against Women (CEDAW Committee), *General Recommendation No. 24: Article 12 of the Convention (women and health)*, (20th Sess., 1999), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, 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).
[30] CEDAW Committee, *Gen. Recommendation No. 24, supra* note 29, para. 31(c); SRRH, *Interim rep*. (2011), *supra* note 27, para. 65(h).
[31] The Penal Code (2012), GOVERNMENT GAZETTE [REPUBLIC OF RWANDA], arts. 165-166.
[32] *Id*. art. 165.
[33] For example, when Ethiopia liberalized it's 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).
[34] The Penal Code (2012), GOVERNMENT GAZETTE [REPUBLIC OF RWANDA], art. 166.
[35] Fred Ndoli, *Number of doctors to double by 2017*, THE NEW TIMES (Mar. 19, 2011), http://www.newtimes.co.rw/section/article/2011-03-19/29442/.
[36] 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." House of Commons Science and Technology Committee, *Scientific Developments Relating to the Abortion Act 1967*, 12th Rep. of Sess. 2006-7 (vol. 1), , at 35, para. 99 (to be published Nov. 6, 2007), *available at* http://www.publications.parliament.uk/pa/cm200607/cmselect/cmsctech/1045/1045i.pdf.
[37] *See* Marge Berer, *Provision of Abortion by Mid-Level Providers: International Policy, Practice and Perspectives*, 87BULLETIN OF THE WHO 58-63 (2009). *Available at* www.who.int/bulletin/volumes/87/1/07-050138/en.
[38] CESCR Committee, *Concluding Observations: Rwanda* para.26 (2013) UN Doc E/C.12/RWA/CO/2-4.
[39] 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/section/article/2012-08-17/56294/.
[40] 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.
[41] *See*, *e.g.*, Association Rwandaise pour le Bien-Être Familial (ARBEF), ABORTION AND YOUNG PEOPLE IN RWANDA (2012) (unpublished research) (on file with the Center for Reproductive Rights) [hereinafter ABORTION IN RWANDA].
[42] *Id*.
[43] *Id*. at 9.
[44] ABORTION IN RWANDA, *supra* note 41.
[45] *Id*.
[46] *Id*.
[47] *Id*.
[48] *Id*.
[49] *Id*.
[50] *Id*. at 9.
[51] ABORTION IN RWANDA, *supra* note 41.
[52] *Id*. at 9.
[53] *See* ABORTION IN RWANDA, *supra* note 41.
[54] 2010 RDHS, *supra* note 14, at 238.
[55] Basinga et al, UNINTENDED PREGNANCY AND INDUCED ABORTION IN RWANDA 5 (2012) hereinafter [UNINTENDED PREGNANCY].
[56] Basinga et al., *Abortion Incidence and Postabortion Care in Rwanda*, *43* STUDIES IN FAMILY PLANNING 11, 16 (2012) [hereinafter *Abortion Incidence and Postabortion Care in Rwanda*].
[57] BASINGA ET AL, UNINTENDED PREGNANCY, *supra* note 55, at 21.
[58] *See*, *e.g.*, ABORTION IN RWANDA, *supra* note 41.
[59] *Fact Sheet: Abortion in Rwanda* GUTTMACHER INSTITUTE, (Apr. 2013), www.guttmacher.org/pubs/FB-Abortion-in-Rwanda.html [hereinafter Guttmacher Fact Sheet].
[60] *Id*.
[61] Guttmacher Institute, *In Rwanda, Treating Complications from Unsafe Abortion Drains Scarce Health Resources* (2014), *available at* https://guttmacher.org/media/nr/2014/05/30/index.html.
[62] UNINTENDED PREGNANCY, *supra* note 55, at 17.
[63] Guttmacher Fact Sheet, *supra* note 59.
[64] Sneha Barot, *Implementing Postabortion Care Programs in the Developing World: Ongoing Challenges* 17 GUTTMACHER POLICY REVIEW 1 (2014), *available at* http://www.guttmacher.org/pubs/gpr/17/1/gpr170122.html.
[65] UNINTENDED PREGNANCY, *supra* note 55, at 24.

[66] *Id*.
[67] *Id*. at 5.
[68] *Abortion Incidence and Postabortion Care in Rwanda*, *supra* note 56, at 17-18.
[69] *Id*. at 18.
[70] UNINTENDED PREGNANCY, *supra* note 55, at 18.
[71] *Id*. at 25.
[72] *Id*.
[73] *Abortion Incidence and Postabortion Care in Rwanda*, *supra* note 56, at 13 (2012).
[74] *Health Providers Trained on Family Planning*, UNFPA RWANDA, (May 26, 2012). countryoffice.unfpa.org/rwanda/2012/05/26/5061/health_providers_trained_on_family_planning/.
[75] Republic of Rwanda Ministry of Health, *Family Planning Strategic Plan 2012-2016*, 7 (Dec. 2012), *available at* http://www.moh.gov.rw/fileadmin/templates/Docs/Rwanda-Family-Planning-Strategic-2012-2013.pdf.
[76] *Id*.
[77] *Id*.
[78] Dieudonné Muhoza Ndaruhuye et al., *Demand and Unmet Need for Means of Family Limitation in Rwanda*, 35(3) INT'L PERSPECTIVES ON SEXUAL & REPRODUCTIVE HEALTH 122 (Sept. 2009) [hereinafter *Demand and Unmet Needs*].
[79] 2010 RDHS, *supra* note 14, at 95-96. The chart also indicates that women in this age group have only a 0.9% unmet need, this is because the demand for family planning is also low for the group, 2%. In other words only 0.9% of all the women in this age group surveyed have an unmet need, because most do not have a demand for family planning.
[80] *Id*. at 87.
[81] *Id*. at 95-96.
[82] WHO, *Rwanda: Country Profile*, *supra* note 21, at 10.
[83] *Demand and Unmet Needs*, *supra* note 78.
[84] *Id*. at 96
[85] JULIE SOLO, INTRAHEALTH INTERNATIONAL,FAMILY PLANNING IN RWANDA: HOW A TABOO TOPIC BECAME PRIORITY NUMBER ONE 22 (2008), *available at* http://www.intrahealth.org/files/media/5/fp_in_Rwanda.pdf.
[86] *Demand and Unmet Need, supra* note 78.
[87] *Abortion Incidence and Postabortion Care in Rwanda*, *supra* note 56, at 2.
[88] UNINTENDED PREGNANCY, *supra* note 55, at 19.
[89] CESCR Committee, *Concluding Observations: Rwanda* para.26 (2013) UN Doc E/C.12/RWA/CO/2.
[90] WHO, *Emergency Contraception Fact Sheet No. 244* (Nov. 2012), *http://www.who.int/mediacentre/factsheets/fs244/en/*.
[91] Jill Thompson et al., *Access to Emergency Contraception and Safe Abortion Services for Survivors of Rape: A Review of Policies, Programmes and Country Experiences in Sub-Saharan Africa,Step Up Research Report* 12 (Sept. 2014), *available at* http://www.popcouncil.org/uploads/pdfs/2014STEPUP_EC-SA_Report.pdf.
[92] International Consortium for Emergency Contraception, *Counting What Counts: Tracking Access to Emergency Contraception in Rwanda* (Jan. 2015), www.cecinfo.org/custom-content/uploads/2015/01/ICEC_Rwanda-factsheet_2015.pdf [Hereinafter *Counting What Counts*].
[93] *Id*.
[94] 2010 RDHS, *supra* note 14, at 86.
[95] *Counting What Counts, supra* note 92.
[96] REPUBLIC OF RWANDA MINISTRY OF HEALTH, FAMILY PLANNING STRATEGIC PLAN 2012-2016 6-7 (Dec. 2012), *available at* http://www.moh.gov.rw/fileadmin/templates/Docs/Rwanda-Family-Planning-Strategic-2012-2013.pdf [hereinafter FAMILY PLANNING STRATEGIC PLAN].
[97] *Id*. at 18.
[98] *See generally* ABORTION IN RWANDA, *supra* note 41.
[99] *See generally id*.
[100] MINISTRY OF HEALTH, RAPID ASSESSMENT OF ADOLESCENT SEXUAL REPRODUCTIVE HEALTH PROGRAMS, SERVICES AND POLICY ISSUES IN RWANDA (2011).
[101] NATIONAL BUREAU OF STATISTICS (RWANDA), RWANDA DEMOGRAPHIC AND HEALTH SURVEY 2010, 238 (2011), *available a*t http://www.measuredhs.com/pubs/pdf/FR259/FR259.pdf [hereinafter 2010 RDHS].
[102] *See* 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).
[103] CEDAW Committee, *Concluding Observations*: *Rwanda*, U.N. Doc. CEDAW/C/RWA/CO/6 (2009).
[104] *Id*. para. 21.
[105] CAT Committee, *Concluding Observations*: *Rwanda*, para. 16, U.N. Doc. CAT/C/RWA/CO/1 (2012).

[106] CESCR Committee, *Concluding Observations: Rwanda* para.26 (2013) UN Doc E/C.12/RWA/CO/2-4
[107] Nishtha Chugh, *A Drive to Beat Rwanda's Gender-Based Violence*, THE GUARDIAN (Nov. 22, 2013), http://www.theguardian.com/global-development-professionals-network/2013/nov/22/rwanda-gender-based-violence.
[108] 2010 RDHS, *supra* note 14, at 246.
[109] *Id*. at 241.
[110] *Id*. at 243.
[111] *Id*.
[112] *Id*. at 245.
[113]*Id*. at 246.
[114] Joseph Kamugisha, *Gender based violence should be society's big health concern*, THE NEW TIMES (Mar. 10, 2009), http://www.newtimes.co.rw/section/article/2009-03-09/7519/ [hereinafter Kamugisha].
[115] WHO, *Violence against Women Factsheet No*. *239* (Nov. 2012) *available at* http://www.who.int/mediacentre/factsheets/fs239/en/.
[116] *Id*.
[117] Rashida Manjoo, *Report of the Special Rapporteur on Violence against Women, Its Causes and Consequences,* para. 46, U.N. Doc. A/HRC/17/26 (May 2, 2011) (citing Allan Rosenfield, et al., *Global Women's Health and Human Rights: an Introduction*, *in* WOMEN'S GLOBAL HEALTH AND HUMAN RIGHTS 3-4 (Padmini Murthy et al. ed., 2010).
[118] Eugene Mutara, *Grim Defilement Stats at City Primary School*, THE NEW TIMES (Sept. 3, 2007), http://www.newtimes.co.rw/section/article/2007-09-03/1071/.
[119] Kamugisha, *supra* note 114.
[120] CAT Committee, *Concluding Observations*: *Rwanda*, para. 16, U.N. Doc. CAT/C/RWA/CO/1 (2012).
[121] 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).
[122] *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).
[123] Stephen Rwembeho, *Minister Cautions against Child Abuse in Schools*, THE NEW TIMES (Aug. 24, 2011), http://www.newtimes.co.rw/section/article/2011-08-23/34264/; Bosco R. Asiimwe, *Survey Exposes Abuse in Schools,* THE NEW TIMES (Aug. 21, 2011), http://www.newtimes.co.rw/section/article/2011-08-21/34181/.
[124] *Id*.
[125] *Id*.
[126] *See ISANGE One Stop Center for Gender Based Violence*, IMBUTO FOUNDATION, *available at* http://www.imbutofoundation.org/what-we-do/health-projects/family-package/one-stop-center-for-gender-based/article/the-first-lady-mrs-jeannette (last visited March 12, 2015).
[127] *Id*.
[128] Tania Bernath et al., FINAL EVALUATION OF RWANDAN GOVERNMENT AND ONE UN ISANGE ONE STOP CENTRE FINAL REPORT 6 (2013).
[129] *Id* at 23, 24.
[130] Press Release, The World Bank, Rwandan Government and WBG Sign Agreement to Help Survivors of Sexual and Gender-Based Violence in Rwanda (Aug. 6, 2014) (on file with author), *available at* http://www.worldbank.org/en/news/press-release/2014/08/06/rwandan-government-and-wbg-sign-agreement-to-help-survivors-of-sexual-and-gender-based-violence-in-rwanda (announcing the World Bank's Commitment to provide loans of $15 million "to provide community and health services for survivors of sexual and gender-based violence (SGBV) by expanding the *Isange One Stop Centers* while promoting gender equality, behavioral change and violence prevention in Rwanda").