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Report on Rwanda's Compliance with its Human Rights Obligations on Sexual and Reproductive Health and Rights

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Introduction

Distinguished Council Members:

The Center for Reproductive Rights (the **Center**) and Health Development Initiative (**HDI**) jointly submit this letter as relevant stakeholders[1] to assist in the review of Rwanda during the 37th session of the UPR Working Group of the Human Rights Council.

The Center is a non-profit legal advocacy organisation dedicated to promoting and defending reproductive rights worldwide. The Center uses the law at the national, regional, and international levels to advance reproductive freedom as a fundamental right that all governments are legally obligated to protect, respect and fulfil. The Center has strengthened reproductive health laws and policies across the globe by working with more than 100 organisations in fifty nations in Africa, Asia, Europe, Latin American, the Caribbean, and the United States, and through in-depth engagement with UN and regional human rights bodies.

HDI is an independent, non-governmental, non-profit organisation based in Kigali and registered with the Rwandan government. HDI strives to improve both the quality and accessibility of healthcare for all Rwandans regardless of their socio-economic status. HDI was founded in 2006 by a dedicated group of Rwandan physicians with a vast experience in the health sector. This diverse group was united by a shared commitment to advance health and inclusive development for disadvantaged communities.

This letter highlights the following issues in Rwanda: maternal mortality and access to maternal healthcare, access to sexual and reproductive health services and information, including access to safe legal abortion and post-abortion care, and sexual and gender-based violence against women and girls.

A. Maternal mortality and access to maternal healthcare

1. In its last review in 2015, the Government of Rwanda received several recommendations from member states to reduce maternal mortality,[2] including undertaking the following actions: (a) take measures to reduce the high rate of maternal mortality and improve access to maternal health information and services, including antenatal, delivery and post-natal care;[3] (b) redouble efforts to facilitate access to urgent obstetrical care;[4] and, (c) reduce the high rate of maternal mortality and improve access to maternal health information and services.[5]

2. In June 2016, Rwanda passed Law No 21/2016 relating to reproductive health[6] which contains concerning provisions and omits critical reproductive health services. For instance, the law leaves out services such as antenatal and postnatal care and abortion services which are essential to preventing maternal mortality and morbidity. It also gives the right to decide on one's reproductive health only to persons who have attained the age of majority,[7]and does not account for adolescents who have not attained the age of majority.

3. General Comment No.22 by the Committee on Economic, Social and Cultural Rights (**CESCR Committee**) reminds States that adolescents face multiple discrimination while seeking sexual and reproductive health information and services and that States must put in place measures to guarantee non-discrimination and substantive equality.[8] Further, the General Comment reaffirms individuals including adolescents have "the right to evidence-based information on all aspects of sexual and reproductive health, including maternal health, contraceptives, family planning, sexually transmitted infections, HIV prevention, safe abortion and post-abortion care, infertility and fertility options, and reproductive

cancer".[9] Also, during its 2017 review of Rwanda, the Committee on the Elimination of Discrimination against Women (**CEDAW Committee**), recognized that although there had been a reduction in the country's maternal mortality rate, the rate remains relatively high, and recommended that "the State party continue its efforts to further reduce the high rate of maternal mortality, including by improving the quality, availability and accessibility of medical assistance throughout its territory."[10]

4. Indeed, the Maternal Mortality Ratio (**MMR**) in Rwanda dropped to 210 deaths per 100,000 live births in 2015,[11] due in part to the sensitisation of pregnant women to attend prenatal consultations and to deliver at health facilities; improvements in the referral system, notably the expansion of both basic and comprehensive emergency obstetric care capacity; and the work of ambulances to timely bring women in need of emergency care to the nearby hospitals.[12] However, Rwanda's MMR remains high compared to the goal of reducing the MMR to less than 70 per 100,000 live births under the Sustainable Development Goals.[13] Problems with accessing quality maternal health services also remain.

5. A recent study at the largest tertiary referral hospital in Rwanda indicated that although the most common causes of maternal near miss and maternal death were sepsis/severe systemic infection, postpartum hemorrhage and complications from eclampsia/severe preeclampsia, the most common *preventable* causes were medical errors, shortage of medical supplies, and lack of patient education/understanding of obstetric emergencies.[14] Rwanda's 2015 Demographic Health Survey (**2015 RDHS**) shows that more than half (50%) of women do not attend[15] the minimum four (4) antenatal care (**ANC**) visits as recommended by the World Health Organization (**WHO**).[16] Further, a recent study indicated that continuous training opportunities for ANC providers in Rwanda are still rare and the information being given to pregnant women attending ANC services is not enough; for example: (a) over 20% of the ANC providers did not advise pregnant women on how to seek care if there was a sign of danger or if a symptom needing prompt referral should arise; and, (b) over a third of the ANC providers did not discuss the place of delivery with pregnant women.[17]

6. Also, while 91% of women delivered with the assistance of a skilled provider, only 18% received this care from doctors.[18] Fifty-five percent (55%) did not attend postnatal checkup,[19] even though "a large proportion of maternal and neonatal deaths occur during the first 48 hours after delivery."[20] These numbers are indicative of the significant barriers Rwandan women and girls encounter in accessing services. Approximately 23% of patients need to walk for an hour or more than five kilometers to reach the nearest health care facility.[21] According to the latest available data from the National Institute of Statistics, Rwanda has a total of 742 doctors working in private and public health facilities, amounting to approximately one doctor per 15,479 people[22] and 49 obstetricians and gynecologists.[23] There are approximately only 8,895 nurses and midwives serving a population of approximately 12 million people.[24]

B. Access to sexual and reproductive health services and information

7. In its last UPR review in 2015, recommendations were made to the Government of Rwanda concerning access to sexual and reproductive health services including maternal health and abortion care.[25] The Government was also asked to continue to implement health policies that guarantee the right to health for all.[26] Likewise, during its 2017 review of Rwanda, the CEDAW Committee noted that access to modern forms of contraception is still inadequate and recommended that all women and girls be given

"adequate access to affordable, modern methods of contraception, including emergency contraception…."[27] Further, the CESCR Committee has stated that access to sexual and reproductive health information is key to preventing unintended teenage pregnancies.[28] The Committee on the Rights of the Child (**CRC Committee**) continues to urge governments to "ensure that sexual and reproductive health education is part of the mandatory school curriculum, and that it is developed with the involvement of adolescent girls and boys, with special attention paid to preventing early pregnancy."[29]

8. According to WHO and the United Nations Development Fund (**UNFPA**) adolescent girls run a disproportionate risk of dying during or after childbirth and are more vulnerable to pregnancy-related complications.[30] Children born to adolescent mothers are predisposed to higher risks of illness or death, and adolescent mothers are more likely to experience life-threatening complications during and after pregnancy.[31] Moreover, early entry into reproduction often denies young women the opportunity to pursue basic education and is detrimental to their prospects for good careers.[32] This is also confirmed by the 2015 RDHS, which notes that early childbearing constrains adolescent girls' ability to pursue educational opportunities,[33] thereby limiting their employment opportunities.

9. This is significant as approximately 29.5% of the entire population is between 10-19 years old[34] and the fertility rate for 15-19-year-olds is 44 per 1,000 according to the 2015 RDHS.[35] Approximately, 7% of girls aged 15-19 have begun child bearing—that is, they have either given birth or are pregnant.[36] At age 19, 21% have begun childbearing.[37] A strong inverse relationship exists between early childbearing and education. According to the 2015 RDHS, 13% of adolescents without formal education had started childbearing, compared to only 9% of adolescents with primary education and 4% of adolescents with secondary education.[38] Adolescent pregnancy also disproportionately affects low-income girls, who are more than twice as likely to start childbearing as their counterparts in the highest wealth quintile, 11% and 6% respectively.[39]

10. Additionally, in 2016, the Ministry of Gender and Family Promotion reported that Rwanda registered over 17,500 pregnant girls aged between 16 and 19.[40] In the first 6 months of 2018, approximately 9,172 teenage pregnancies were recorded in health facilities.[41] Research conducted by Collectif des Ligues et Associations de Défense des Droits de l'Homme au Rwanda (**CLADHO**) in 2016 revealed that most consequences and problems faced by adolescents after getting pregnant included becoming school dropouts (50%), poverty (19%), depression (11%) and other challenges such as discrimination (5%).[42] In addition, a baseline survey conducted by Imbuto Foundation revealed that only 34.2 % of first time young mothers (aged between 15 and 19 years) used contraceptive methods after delivery.[43]

11. Furthermore, health care facilities that are religiously affiliated do not offer contraception.[44] This is particularly problematic since over 40% of public health care facilities in Rwanda are religiously affiliated.[45] As a result, women living in the areas that these facilities serve may find it more difficult to obtain contraceptives. This has led to the rise of new mini "health posts" the government has set up within proximity to every Catholic hospital,[46] with the single purpose of giving out contraceptives. Reports indicate that there are approximately 88 of these, tethered to about 80 percent of the Catholic hospitals and clinics in the country.[47] Whilst this Government response is commended, it is difficult to assess the degree to which this measure is sufficiently addressing the needs of women and girls in accessing contraception.

C. Sexual and gender-based violence against women and girls

12. In its last review in 2015, several countries recommended to the Government of Rwanda to take measures to combat violence against women and girls which included: (a) ensuring justice for the victims;[48] (b) building institutional capacity for effectiveness in the prevention and response to gender-based violence (**GBV**);[49] and, (c) addressing resourcing issues through the redoubling of efforts to address prevention and response to GBV through enhancement,[50] and expansion of Isange One-Stop Centres.[51] A recommendation was also made to the Government to continue implementing the law on the prevention and punishment of GBV and encourage zero-tolerance among law enforcement agencies.[52]Several countries also made a set of recommendations to eradicate violence against girls and adolescents and, specifically, sexual violence perpetrated against children.[53] The majority of recommendations made in relation to combatting GBV in the last review were supported by the Government of Rwanda (and were at the time, recorded as implemented or implementation in process).

13. The CEDAW Committee had previously expressed concern regarding the "prevalence of different forms of violence against women, in particular sexual violence and domestic violence" and the lack of information on the extent of the problem in Rwanda.[54] The CEDAW Committee reiterated the same in 2017 highlighting that "the number of women who are victims of gender-based violence, including sexual violence, is particularly high in Rwanda."[55]

14. Whilst the Government of Rwanda has made progressive developments in its attempt to eliminate GBV, for instance by expanding the number of Isange One-Stop Centres (**IOSC**) from 7 in 2013 to 44 in 2017, [56] sexual and gender-based violence continues to be widespread and a prevalent danger for adolescent girls and women. The 2015 RDHS found that 10% of adolescent girls in Rwanda experienced sexual violence by age 18, and 16% experienced sexual violence by age 22.[57] Further, adolescent girls aged between 15 and 19 were less likely than older women aged between 40 and 49 to report ever having experienced sexual violence.[58] Between 2015 and 2018, over 49,000 victims of GBV were assisted through the various IOSCs in the country.[59] However, it was noted in a recent evaluation of the effectiveness of the IOSCs that in order to be more effective in the prevention of GBV it is "important that more cases are brought to justice and that more perpetrators are prosecuted successfully. The system of collection of evidence needs therefore to be further improved."[60]

15. Other areas that require improvement include addressing the effectiveness of avenues for recourse for victims of GBV, who continue to face significant barriers when accessing justice. Indeed, accessing justice, as a means of strengthening responses to GBV, was a prevailing theme in the set of recommendations made in the last review. In Rwanda, a commonly reported issue that impacts access is the long waiting time for a case to be prosecuted as the National Public Prosecution Authority (**NPPA**) navigates impediments to obtaining the required evidence to successfully bring cases to court. One of the cited reasons is gaps in obtaining evidence in a timely manner by the Rwanda Investigation Bureau, which in turn impacts the NPPA's ability to proceed with prosecuting reported cases.[61] Statistics from the office of the NPPA show that out of 3,001 rape cases reported in 2017/2018, 1,096 cases were dismissed, out of 538 defilement cases, 273 cases were dismissed and out of 1,093 domestic violence cases reported, 301 cases were dismissed due to insufficient evidence.[62] Additionally, an evaluation report by the United Nations shows that access to the full range of legal services by victims of sexual violence remains a great challenge and this includes access to legal aid, which, again, impedes access to justice.[63]

D. Access to safe legal abortion and post-abortion care

16. At the last UPR review, recommendations were given to the Government of Rwanda to: (a) review national legislation to reduce the high levels of maternal mortality caused by illegal abortion in the country, as well as the imprisonment of women for this reason;[64] (b) ensure access to safe abortion services and remove punitive provisions imposed on women who undergo abortions;[65] (c) simplify the procedures for abortions envisaged by the penal code;[66] (d) continue to implement the law on prevention and punishment of GBV and encourage zero-tolerance among law enforcement agencies for GBV; (e) eliminate, as a first step, the judicial and administrative barriers that prevent women from accessing safe and legal abortions; and, (f) protect women from being reported and arrested or going to jail for unsafe abortion as well as review the penal code in order to decriminalise abortion.[67]

17. The government of Rwanda has taken some steps to implement these recommendations. For instance, in September 2018, the government revised its penal code, which had previously required a "competent court" to certify that a woman had become pregnant as a result of rape, incest, or forced marriage before she could access a legal abortion. This effectively created a barrier because the legal process to obtain such authorisation was often long, cumbersome and confusing. Under the current penal code, women and girls are no longer required to obtain a court authorization. Whilst the person requesting abortion is no longer required to provide evidence, if she is subsequently found to have provided false information so that an abortion can be performed, she will be liable in accordance with the law.[68] Also, abortion is now allowed where the pregnant person is a minor, in addition to the other previously existing legal grounds.[69] The Government of Rwanda's removal of the court authorisation requirement and the addition of a new ground for a legal abortion demonstrates the country's continued commitment to ensure compliance with international human rights standards and implement some of the recommendations made in the last UPR review in 2015. However, abortion is yet to be decriminalised as was recommended.

18. In addition, doctors alone are permitted by the penal code to provide abortions, which is not in line with recommendations by the WHO allowing for mid-level healthcare providers such as nurses and mid-wives to provide abortion services. Further, anyone who requests an abortion on the ground of the risk of health to the person or the foetus will be required to submit a confirmation which is signed by two medical doctors, one being a specialist in the area of obstetrics and gynaecology.[70] This requirement for the involvement of multiple doctors is onerous in a country such as Rwanda which, as earlier discussed, has a limited number of doctors, including specialists, and serves as a continuing barrier to access safe and legal abortion. This is particularly the case where in 2016, for instance, Rwanda had an average of one (1) doctor per 12,000 people compared to the recommended WHO standards of one doctor (1)per 1000 people.[71] Further, this requirement disproportionately affects low income women and girls and those living in rural areas.

19. Notwithstanding that abortion has been legalised for minors, they will still be required to be accompanied by a parent or legal guardian and present a birth certificate.[72] This is problematic for several reasons; there is intense social stigma around adolescents' sexuality which is intricately and comprehensively woven into Rwanda's social fabric and can prevent adolescents from discussing their pregnancy with their parents. For instance, a recent study showed that "rape, in particular, is surrounded by a culture of silence and girls are often too scared to report this as they feel that they will not be

believed or will even be accused of provoking the perpetrator."[73] Therefore, even where an adolescent has been a victim of sexual violence and as such satisfies one of the grounds for access to legal abortion, she may not access this due to the stigma that surrounds sexual violence.

20. One immediate consequence for those unable to access safe abortion is exposure to unsafe abortion. Complication rates are highest for procedures that are induced by women themselves (67%) or are performed by traditional healers (61%), the kinds of procedures that low-income rural women are more likely than other women to have.[74] Anyone who self-induces an abortion will also be subject to criminal liability.[75]

21. Human rights bodies such as the CRC Committee have consistently reminded states to decriminalise abortion. Nevertheless, adolescent girls and women in Rwanda continue to be incarcerated for obtaining an abortion. While the President of Rwanda has taken the initiative since December 2016 to grant pardons to some of the women and girls who have been imprisoned due to abortion-related offences, [76] this is a piece-meal approach which still fails to address the root causes.[77]

22. 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. There is limited data and information available that is specific to PAC and related services in Rwanda within the period of 2015 to 2020. It is therefore difficult to assess the level of progress, if any, that has been made by the Government in increasing access to PAC. It has been recognised that PAC should be integrated with other available maternal health services.[78] However, the potential for prosecution deters Rwandan women and girls from seeking necessary post-abortion treatment after procuring unsafe abortions.[79] About 30% of those who experience complications are ultimately unable to access PAC and treatment at health centres.[80] 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.[81] Moreover, very few providers employ techniques recommended by the WHO for treating uncomplicated post-abortion cases.[82]

23. The large demand for PAC services in Rwanda results in significant costs for individuals and the Rwandan health system as a whole. A 2014 study estimated that the annual average cost of PAC per person in Rwanda is USD 93, while the annual national cost is USD 1.7 million.[83] The study states that "[s]atisfying all demands for PAC would raise the national cost to USD 2.5 million per year," adding that "PAC comprises a significant share of total expenditure in reproductive health in Rwanda."[84] Improving access to safe abortions would reduce the need for PAC and enhance Rwanda's ability to provide sufficient access to PAC services.

24. In March 2012, Rwanda released its first National Comprehensive Treatment Protocol for PAC services[85] which indicates that the government recognises and acknowledges the importance of PAC. However, the ongoing lack of adequate access to the service is particularly dismal given that 20% of women in Rwanda will, during their reproductive years, need medical care for abortion-related complications.[86]

E. Questions for the Government of Rwanda

I. What amount of its budget is the Government of Rwanda allocating to providing maternal health and related services? How does the Government plan to expand access to health care facilities with adequately trained health workers and equipment? How does it plan to improve access to quality health care throughout the duration of a woman's pregnancy, from antenatal, delivery, to postnatal care, including for low-income and rural women?

II. What measures are being taken by the Government of Rwanda to demonstrate the effectiveness of investigations and prosecution of perpetrators of sexual and gender-based violence, including effective mechanisms for accountability and redress? What information is available on the penalties imposed on perpetrators and on redress and compensation afforded to the victims? What is being done to enhance the effectiveness of ISOCs based on the outcome of the recent evaluations?

III. How are the delays arising from the time that the Rwanda Investigation Bureau investigates the commission of an offence of sexual and gender-based violence to the time the NPPA prosecutes being managed to ensure justice for victims?

IV. What is the Government doing to address the burdensome authorization requirement by two doctors and to ensure that mid-level healthcare providers are permitted to perform abortions?

V. What effort is the Government of Rwanda making to ensure that third party authorisation/parental consent and need for a birth certificate, as provided in the Law determining Offences and Penalties of 2018, do not hinder adolescents' access to safe abortion services?

VI. What concrete measures is the Government of Rwanda taking to develop clear guidelines for health care providers to improve the accessibility and availability of sexual and reproductive health services, including safe abortion services, to adolescents in line with the Law determining Offences and Penalties of 2018?

VII. What steps is the Government of Rwanda taking to ensure that women and adolescents have access to the full range of family planning and contraceptive services and information? What amount of its budget is the Government allocating to providing these services?

VIII. What steps is the Government taking to protect the right of adolescents to make decisions about their reproductive health and provide them with access to information that would enable them to make informed decisions?

F. Recommendations for the Government of Rwanda

I. The Government of Rwanda should further address preventable maternal mortality by implementing measures that 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 postnatal care, as well as skilled assistance during childbirth.

II. The Government should continue to implement measures to address the high rates of GBV and provide victims with the necessary medical, psychosocial and legal services. It should also take all steps necessary to prevent, investigate, and prosecute incidents of violence against women and girls. Further, the government should gather data on the issue, in order to be able to monitor, evaluate and improve the effectiveness of the different initiatives it is implementing.

III. It should ensure that more cases reported at the IOSCs are brought to justice and that more perpetrators are prosecuted successfully. The Government should further ensure that the system of collection of evidence at the IOSCs is improved.

IV. The Government of Rwanda should initiate civic education campaigns to ensure sufficient and non-discriminatory access to family planning information and develop comprehensive guidelines obligating health care facilities to provide accurate and comprehensive family planning information, without discrimination. The Government should take concrete steps to ensure adequate, consistent and non-discriminatory access to quality and affordable contraceptive services, for all persons including adolescents and those with low income and those living in rural areas.

V. The Government should remove all procedural barriers that impede access safe abortion services including allowing mid-level providers to provide abortion, removing the requirement of certification from two doctors for an abortion, and ensuring parental consent or birth certificate requirements do not prevent adolescents from accessing needed services.

We hope that this information is useful during the Council's review of Rwanda. If you would like further information, please do not hesitate to contact the undersigned.

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[1] In accordance with paragraph 3(m) of the Annex to the Human Rights Council resolution 5/1 of 18 June 2007.

[2] Rwanda National Report, Human Rights Council Working Group on the Universal Periodic Review Twenty-third session 2-13 November 2015 National Report submitted in accordance with paragraph 5 of the annex to Human Rights Council resolution 16/21[herein the Rwanda National Report].
[3] Rwanda National Report, second cycle, recommendation 135.66 (South Africa).
[4] Rwanda National Report, second cycle, recommendation 133.42 (Djibouti).
[5] Rwanda National Report, second cycle, recommendation 135.67 (Albania).
[6] Law N° 21/2016 of 20/05/2016 (Rwanda).
[7] Law Nº32/2016 of 28/08/2016 (Rwanda).
[8] Committee on Economic and Social Cultural Rights (CESCR), *General Comment No. 22 (2016) on the Right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights),* at 8 Para 30 E/C.12/GC/22 (hereinafter, CESCR General Comment No.22).
[9] *Id* Para 18.
[10] CEDAW Committee, *Concluding Observations: Rwanda*, para. 38(a) U.N. Doc. CEDAW/C/RWA/CO/7-9 (2017).
[11] National Institute of Statistics of Rwanda, *Rwanda Demographic Health Survey 2014-2015*, (2016) available at http://dhsprogram.com/pubs/pdf/FR316/FR316.pdf [herein 2015 RDHS].
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[18] 2015 RDHS *supra* note 18, at 121.
[19] *Id,* at 122.
[20] *Id,* at 122.
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[25] See the sections of this report discussing maternal health and abortion care.
[26] Rwanda National Report, second cycle, recommendation 134.78 (Mauritius).
[27] CEDAW Committee, *Concluding Observations: Rwanda*, paras. 38(c), 39 (d) U.N. Doc. CEDAW/C/RWA/CO/7-9 (2017).
[28] See for instance, CESCR Committee, *Concluding observations to the initial report of Mali,* para 49(c) E/C.12/MLI/CO/1 (2018); ESCR Committee *Concluding observations on the initial report of South Africa*, para. 66 (c), E/C.12/ZAF/CO/1 (2018).
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[35] 2015 RDHS, at 66-67.

[36] *Id*., at 10.

[37] 2015 RDHS, at 73.

[38] *Id*. at 76.

[39] *Id*.

[40] Théophile Niyitegeka, *Over 17,000 premature unwanted pregnancies recorded in 2016* (May 2017) available at http://www.en.igihe.com/news/over-17-000-premature-unwanted-pregnancies.html

[41] Lydia Atieno, *Adolescents and contraception: What is the way forward?* (October 2019) available at <https://www.newtimes.co.rw/lifestyle/adolescents-and-contraception-what-way-forward.

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[47] *Id.*

[48] Rwanda National Report, second cycle, recommendation 133.24 (Singapore).

[49] Rwanda National Report, second cycle, recommendation 133.25 (Uganda).

[50] Rwanda National Report, second cycle, recommendation 134.43 (Republic of Korea).

[51] Rwanda National Report, second cycle, recommendation 134.44 (Cuba).

[52] Rwanda National Report, second cycle, recommendation 134.45 (Sweden).

[53] Rwanda National Report, second cycle, recommendation 133.23 (Nicaragua), recommendation 135.32 (Sierra Leone) and recommendation 134.41 (Portugal).

[54] CEDAW Committee, *Concluding Observations: Rwanda*, para 25, U.N. Doc CEDAW/C/RWA/CO/6 (2009).

[55] CEDAW Committee, *Concluding Observations: Rwanda,* para 22, U.N. Doc. CEDAW/C/RWA/CO/7-9 (2017).

[56] CROC, Rwanda National Report.

[57] 2015 RDHS at 275.

[58] *Id*, RDHS at 275. At the time of submitting this letter, the Demographic and Health Survey for Rwanda for the period November 2019 – May 2020, which will include domestic violence as a survey characteristic, was in progress.

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[60] Republic of Rwanda and United Nations, *Report on the Final Evaluation of the project for the national scale up of the Isange One-Stop Centre Model in Rwanda,* at page 41, (2016).

[61] Rwanda Today, *No Justice for gender-based violence victims* (21 May 2019) available at http://rwandatoday.africa/news/No-justice-for-gender-based-violence-victims/4383214-5124672-whs36a/index.html.

[62]See also https://nppa.gov.rw/fileadmin/user_upload/NPPA%20GENERAL%20ASSEMBLY%202012/IBYAGEZWEHO_N_UBUSHINJACYAHA_BUKURU_MU_MWAKA_WA_2018-2019.pdf

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[64] Rwanda National Report, second cycle, recommendation 135.16 (Uruguay).
[65] Rwanda National Report, second cycle,-recommendation 134.79 (Slovenia).
[66] Rwanda National Report, second cycle, recommendation 134.80.
[67] Rwanda National Report, second cycle, recommendation 134.45.
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[69] Article 4, Ministerial Order No 002/MoH.2019 of 8 April 2019 determining conditions to be satisfied for a medical doctor to perform an abortion (herein the Ministerial Order).
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[80] *Id,* at page 5.
[81] Basinga P et al., *Abortion incidence and post abortion care in Rwanda, 43 studies in family planning*, 11, 17-18 (2012) [herein Abortion incidence and post abortion care in Rwanda].
[82] *Id,* at 18.
[83] Michael Vlassoff et. al., *The health system cost of post-abortion care in Rwanda*, Oxford Journals 1-11 (2014).
[84] *Id.*
[85] Unintended Pregnancy and Induced Abortion in Rwanda at page 25.
[86] Basinga P et al., Abortion incidence and post abortion care in Rwanda, supra note 70 at page 13.