

Rwanda:

“Marked for Death”, rape survivors living with HIV/AIDS in Rwanda

“During the genocide, the militia at the barriers said they would protect me, but instead they kept me and raped me in their homes. One militia member would keep me for two or three days, and then another would choose me. If killers came to their house, the militia member would say I was his sister. I had to stay with these men because I would have been killed otherwise. The conditions were very favourable for HIV transmission. I managed to flee Kigali, and when I returned, I learned that my husband had been killed. My husband was a Hutu, and he had gotten a Hutu identity card for me because he hoped it would protect me. Because I had this card, I was denied assistance from IBUKA [support organization for genocide survivors] for my children or from the government fund for genocide survivors”.

-Francine, HIV-positive, Kigali

“In 1998, I was leaving for boarding school in Gisenyi. Just before reaching the town...we were ambushed by the abacengezi [insurgents]...The taxi rolled over, and as the passengers fled the vehicle, the abacengezi chopped them with machetes. I managed to hide under corpses but heard the rebels saying they would get fuel to burn the bodies. I cried out, and they stabbed me...and carried me into the forest...There were other women and girls there too, from different parts of the country who were kidnapped under similar circumstances. ... Members of the militia came each night to rape me, until one night a militia member announced that I was his, that he was my “husband”. I only thought of escaping to my family...We had to flee constantly because they were being chased by the Rwandese army. During a major offensive of the government military in Gishwati forest, I managed to flee when everyone else was dispersed...then returned home...A few years later, an RPF soldier came to my house and wanted to have sex with me. I tried to convince him that I was HIV-positive and couldn't have sex. It was like a rape. Because he was a soldier, I felt I couldn't shout. He wanted to marry me, and since he was a soldier I felt I had no choice. I made him get tested the day after the rape, and it turned out he was already HIV-positive. I married him against my will. My hopes have been dashed. I have finished my studies. I am very upset because my family pinned all their hopes on me, sacrificed to have me educated, but I fear I will soon be dead and my family members will not benefit from their sacrifice”.

Angèle, HIV positive, Kigali-Ngali

I. Introduction

In April 1994, Rwanda suffered one hundred days of violence, targeted at the Tutsi and moderate Hutu population. Ten years later, the consequences of the violence have not been dealt with adequately, neither by the international community nor by the Rwandan government. Survivors of violence still cry out for medical care; survivors and families of victims clamour for justice that is slow in coming. Women continue to die from diseases

related to HIV/AIDS, which some of them contracted as a result of rape during the 1994 genocide and armed conflict. Survivors of rape and their families face human rights violations that themselves lead to further and overlapping violations: survivors of sexual violence may have contracted HIV/AIDS, as a result of which they and their families often face stigma, which can in turn lead to loss of employment, difficulty in asserting property rights, and a loss of civil and political rights.

Although not all cases of HIV/AIDS among rape survivors can be traced to the sexual violence they survived, the mass rape during 1994 contributed significantly to the spread of the virus in Rwanda, particularly as rates of HIV transmission during sexual violence are believed to be high. The HIV/AIDS pandemic in Africa grows worse daily, though the international response has been lukewarm. It is in this context, ten years after the start of the Rwandan genocide and war and as part of its Stop Violence Against Women campaign, that Amnesty International is making an appeal to the Rwandan government and international community to expand access to healthcare and justice for survivors of rape and their families.

Violence against women and girls constituted a well-documented and tragically widespread component of the genocide and war strategy in 1994. In the 1998 Akayesu judgment at the UN International Criminal Tribunal for Rwanda (ICTR), prosecutors were successfully able to demonstrate that genocidal intent spurred extensive sexual violence during the genocide, as determined from individual testimonies regarding the stated intent of the perpetrators and the investigation of sexual violence occurring in a widespread fashion across the country. During the genocide, women and girls—predominantly but not exclusively Tutsi—survived or succumbed to extraordinary acts of violence. Many were raped at barriers erected by the *interahamwe* youth militia and/or held as sexual captives in exchange for temporary protection from *interahamwe* militia and the military. Their bodies and spirits were mutilated, humiliated and scarred.

The Rwandan Patriotic Army (RPA) was likewise responsible for sexual and other violence during its military advance, sometimes in reprisal against the Hutu population. The extent and nature of these crimes is less well-known, and very few of the suspected perpetrators have been brought to justice. While the impact of sexual violence perpetrated during the genocide and war constitutes the focus of this report, it is important to note that the phenomenon of rape neither began nor ended in 1994. Sexual violence and forced marriage continue to be perpetrated by members of the current Rwandese military (Rwandan Defence Forces or RDF), security forces and unpaid militias. These assaults are sometimes reported but are again seldom prosecuted. Gender-based violence has been a persistent feature of the human rights violations committed by Rwandese security forces in the Democratic Republic of Congo (DRC)/Zaire and in the post-war insurgencies in Rwanda.

For some women, the violence began during the 1990 conflict, or during spates of ethnic killing decades earlier.¹ Though no baseline studies exist from before the genocide and war, anecdotal evidence suggests that domestic and sexual violence have increased

¹ The Rwandan Patriotic Army invaded Rwanda in 1990. Following the invasion, local authorities, with government complicity, launched 17 large-scale attacks against Tutsi in 12 communities, killing an estimated 2,000 individuals according to a Foundation for Human Rights Initiative investigation.

significantly since then.² The economic and social vulnerability of women and girls, among other factors, has in the past and continues today to leave them exposed to sexual violence. The availability of small arms in the region increases the capacity of perpetrators to commit acts of sexual violence and other crimes. The overwhelming impunity of members of the armed forces, Local Defence Forces (an armed but unpaid local militia) and others in position of authority likewise hampers efforts to combat the problem.

For some of these women, the killing has yet to claim its last victims. AVEGA, an association for genocide widows, carried out a study in 2000 of 1125 women who survived rape during the genocide and found that 66.7% had HIV.³ AVEGA also estimates that 80.9% of survivors of violence during the genocide remained traumatized in 1999.⁴ According to a UN report, at least 250,000 women were raped during the genocide, a large number of whom were subsequently executed. Of the survivors, 70% are estimated to have been infected with HIV. AVEGA estimates that 200 of its members have died of AIDS since 2001, when the organization set up an HIV/AIDS support centre. AVEGA had 618 members living with HIV in January 2004, though this number represents only those members who had been tested for HIV in three of the 12 provinces in the country.⁵ As of March 2004, only 28 of these women were receiving life-prolonging anti-retroviral (ARV) treatment (22 from AVEGA, 6 from other sources), though the number is expected to increase this year. Other HIV-positive AVEGA members benefit from free antibiotics to control opportunistic infections.

Associations of people living with HIV/AIDS (PLWHA) in Rwanda routinely bury members, casualties of the long wait for the government and international community to respond to their needs. In some cases, survivors of rape have passed the infection on to their partners or children.

Policy advisors in Rwanda told Amnesty International delegates that the number of patients clinically in need of life-prolonging anti-retroviral (ARV) therapy is estimated at between 50,000 and 100,000. As of January 2004, only approximately 2,000 Rwandese were being treated with ARVs. Approximately 50,000 Rwandese per year die of AIDS⁶. By the end of 2004, an estimated 3,000 to 5,000 Rwandese will receive ARVs.

Of course, the state of health of a person living with HIV/AIDS depends on far more than access to medication: proper nutrition, psychological well-being, decent housing and personal and financial security can all have a dramatic impact on the physical health of such an individual. Average per capita annual GDP is \$US252, and, according to Rwandese

² Medical professionals, local leaders and social workers attest to a dramatic rise in rape in the years since the 1994 conflict, including of very young girls, and speculate that it is one of the outcomes of a traumatized, brutalized and increasingly fragmented society.

³ AVEGA «AGAHOZO», website, <http://www.avega.org/rw/englishhome.htm>, and interviews with AVEGA «AGAHOZO» staff, January 2004.

⁴ AVEGA «AGAHOZO», "Etude sur les violences faites aux femmes au Rwanda", Kigali, December 1999, p.24.

⁵ Interviews with staff of AVEGA-AGAHOZO, January 2004.

⁶ Government of Rwanda HIV/AIDS Treatment and Care Plan 2003-2007, Developed with the William J. Clinton Foundation, p. 12.

government documents, 60% of Rwandese are estimated to live below the poverty line.⁷ More than half of the population lacks access to clean water, and 40% of Rwandese are undernourished.⁸ Only an estimated 28% of Rwandese households affected by HIV/AIDS are able to afford even basic health care; many families borrow money, sell assets, including land, or decide to forego healthcare. Under these conditions, it is clear that a holistic approach is needed if ARV treatment is to be effective, including improving living conditions of PLWHA and reducing the burden on their families or those caring for them.

II. Context: discrimination against women

In recent years, the status of women in Rwanda and the importance of women's rights have been significantly elevated. Rwanda now boasts the highest percentage of woman parliamentarians in the world (48.8%), and legislation on land rights, marriage, child rape and violence against women has been amended to contribute to the protection of women's rights. Nevertheless, customary law, which often overrides written law, remains biased against women with regard to inheritance and land ownership, thus often placing the woman in a position of dependency. Many customary practices reinforce the patriarchal system in Rwanda. The level of education of women, and hence their access to information and means of empowerment, has generally been much lower than that of men, though this imbalance is changing.

II.1. Discrimination and sexual violence

The low status of women and difficulty in seeking redress leave many women and girls vulnerable to sexual violence. In some areas, relatives of a male who has died, been imprisoned or left the country will expect to be able to have sexual relations with his female partner.

Domestic workers are particularly vulnerable to rape, and often fear reporting sexual assault or harassment for fear of losing their jobs and disappointing their families. Other women find themselves vulnerable to soldiers, Local Defence Forces, neighbours and male relatives who demand sex or wish to exchange food or other goods for sex. Following rape survivors rarely bring their cases to the police, but rather families will find a financial solution to compensate for the abuse; the survivor may even be forced to marry the perpetrator in order to "normalize" relations between the families concerned.

Poverty and insecure living circumstances, including unprotected housing that fails to protect women from unwanted sexual advances from neighbours and passers-by, may ultimately result in unwanted pregnancies and sexually transmitted diseases. Children of both sexes have also been frequent victims of rape in recent years, a phenomenon fuelled by

⁷ <http://www.cnls.gov.rw/cadre.htm>. The figure they use for poverty level is not specified. The UNDP Human Development Index for 2003 records 86.4% of Rwandese living on less than \$2 per day from 1990-2001.

⁸ 2002 FAO State of Food Insecurity, <http://www.fao.org/docrep/005/y7352e/y7352e07.htm#>.

traditional healers' exhortations that having sex with a virgin will make the perpetrator wealthy or cure him of HIV/AIDS.

II.2. Stigmatisation of survivors of sexual violence

If the status of the average married Rwandese woman is often low, it is still higher than that of a widow or a rape survivor. Demeaning attitudes exhibited toward women who have been raped are not exclusive to men: several women told Amnesty International how they had been humiliated and tormented by female community members or even their own daughters following their rape.

The children of the genocide themselves can face severe discrimination, belittled as offspring of *interahamwe*, and are sometimes called the "*enfants mauvais souvenir*" or children of bad memories, even by their mothers. The mothers may also be humiliated and marginalized by the community as a result. Other women or girls are driven to infanticide; a majority of women and girls with whom Amnesty International delegates spoke in March 2003 in the former women's prison in Byumba were serving long prison sentences, including life imprisonment, for abortion or infanticide, though not necessarily from 1994.

II.3. Poverty, discrimination and loss of sexual autonomy

Discrimination against women in Rwanda extends to sexual health and family planning choices. Like women in many countries, women across Rwanda find it difficult to control their reproductive health and their sexuality, often because of extreme poverty, their economic dependence or social inferiority to their husbands and their lack of access to health care and contraception. Domestic violence is believed to be rampant, with a high percentage of women suffering routine battery and assaults, though the figures of a recent baseline survey carried out by International Rescue Committee have not yet been published. Domestic violence, or even the threat of violence, decreases a woman's ability to negotiate her sexual autonomy, making her more vulnerable to HIV infection.

Women's diminished access to radios, community meetings and written information sources lessens their access to information and education about sexual health and contraception.⁹ Abortion remains illegal in Rwanda and, for many women and medical personnel, contravenes religious beliefs. Women and girls must therefore either carry an unwanted pregnancy to term or attempt to end the pregnancy illegally, sometimes with serious, sometimes fatal, health consequences.

III. Rape as a tool of genocide

"Like so many others, my husband was killed during the war, and I was raped by two assailants. Most of my family died".

⁹ In Rwanda, as throughout much of Africa, radio is the electronic communications medium with the highest level of penetration. Television and print media reach only a small percentage of the population.

Jeanne Musabe, age 50, Nyamirambo (Kigali)

In a well-established pattern of systematized brutality and humiliation, Rwandese women and girls suffered a range of gender-specific violence such as rape, various forms of genital mutilation, hacking off of breasts, sexual slavery, forced abortion and forced marriage. The United Nations Special Rapporteur of the Commission on Human Rights, René Degni-Segui, estimated in 1996 that between 250,000 and 500,000 rapes were committed during the genocide. Women and girls were systematically subjected to rape, including gang rape¹⁰, inflicted even on pregnant women or women who had just given birth. Some were killed or seriously injured by having arrows, spears or other objects pushed into their vaginas or by being shot in the genitals. Tutsi women were given as rewards to men who “excelled” at killing Tutsi, and many were forced to submit to sex in exchange for temporary security, particularly at roadblocks. Degradation was integral to the physical violence, with some women being made to parade naked or perform various humiliating acts at the bidding of soldiers and militia. As reported in human rights literature and to Amnesty International delegates, the genitalia of Tutsi women were sometimes cut off and displayed, and some women reported seeing members of the militia or military rape corpses. Assailants sometimes mutilated or chopped off body parts deemed characteristic of Tutsi women, such as thin fingers or long noses.

While the violence was directed primarily at Tutsi women during the genocide, Hutu wives of Tutsi men sometimes suffered particular brutality. Moderate Hutu women, those who attempted to protect Tutsi, or Hutu women and girls who were thought to look like Tutsis were also raped and brutalized. Some perpetrators took advantage of the lawless atmosphere to rape Hutu women and girls. Both Hutu and Tutsi women were vulnerable to rape and other forms of aggression as they attempted to flee to safety or as they sought shelter in refugee camps. Hutu women were also raped during and after the Rwanda Patriotic Army (RPA) advance in the country, sometimes as a reprisal action directed against the Hutu population. Very few perpetrators of these rapes have been prosecuted.

Women and men alike were brutalized by torture, murder, grave injury and severe psychological trauma in their homes, in schools, hospitals, fields and churches. Survivors reported to Amnesty International that family members had been asked to kill their own relatives and were themselves killed, if they refused or even if they complied. Injured persons were often left to die, sometimes thrown into latrines. Some survivors felt particularly aggrieved that they were forced to flout custom by being prevented from burying the dead, and instead made to let their bodies rot in the street.

IV. Legacies of the conflict

“During the war, the militia came and would look for young men to kill and for girls to have sex. For one week, I had sex with a different one each night, and they threatened to kill me...Now I am the head of the household. Fortunately, my younger siblings have gotten assistance for their school fees, and I have been taking anti-retrovirals for nine months. I

¹⁰ In some instances, male relatives were forced to rape women, thus traumatizing both the woman and the man.

want to get married and find someone who will help take care of my brother and sister. Sometimes people ask to marry me, but I have to say no because I don't want to infect my potential husband. I feel different from other young people, who have their whole lives ahead of them". Clémentine, Kigali-Ngali, age 30.

IV.1. Psychological trauma, guilt and ostracization

During the genocide and war, women and girls suffered or witnessed acts of indescribable brutality, including the murder of family members and loved ones. Husbands, brothers and children were anguished by the physical and psychological assaults on their female family members. The violence has left many Rwandese profoundly traumatized, far beyond the capacity of support organizations to assist meaningfully in most cases. In a 1999 study, 80.9% of people surveyed reported symptoms of trauma.¹¹

Women and girls who suffered sexual violence during the genocide and war sometimes faced severe stigmatisation and marginalization if and when their assault became known. Many have kept silent about the horrors they had endured as a result. Some women said people in their communities who knew they had been raped assumed they had a sexually transmitted disease, particularly HIV. Several women said candidly that they combated feelings of guilt for having survived and having been raped, and said that community members told them that, if they had survived, they must have collaborated with perpetrators of the genocide. Some women had been affected by grave medical problems such as fistula that contributed further to their ostracization.¹² Some were unable to marry or were abandoned by their husbands. Many of the women interviewed by Amnesty International said they had not sought medical help immediately, even if it was available, because they wished to conceal the fact that they had been raped. Ten years later, the greatest medical issues many women face, particularly women affected by HIV/AIDS, are psychological problems. One woman, who had not only been raped but lost two children and her husband in 1994, said, "*I have gone to the hospital four times for psychiatric treatments... It is still very bad for me, and it is hard to find someone to talk to.*"

IV.2. Differential impact on women and girls

The after-effects of the violence have often impacted women with particular severity. Following the genocide and war, women constituted a majority of the population and were left with new burdens of generating income, caring for the injured, sick and disabled and taking in orphans. Women were left to cope with these difficult circumstances while grappling with their own illnesses, injuries, grief and trauma.

¹¹ AVEGA «AGAHOZO», Etude sur les violences faites aux femmes au Rwanda, Kigali, December 1999, p. 24.

¹² A fistula occurs when the wall between the vagina and the bladder or bowel is ruptured and women lose control of the bladder or bowel functions. They become isolated as a result of their incontinence. The problem can be resolved by surgery.

The genocide, war and ensuing instability in the region have created a complex series of ramifications for women and their families, often differentially affecting women. Women or girls may have been left as the only breadwinner in their families or pressured into “opportune” marriages. Some families lost their land, housing and assets during the genocide and war, thereby augmenting the strains on family resources and eroding social cohesion. Girls may have been left orphaned and are more likely to have been deprived of education, as they are often expected to take on childcare roles or find work as domestic servants. Young women may be forced to sell sex to provide for themselves and their siblings, sometimes being forced to live in the street. Survivors of rape may have been rejected by their partners, families or communities.

“My husband was imprisoned one week after the war, though nobody has come to accuse him...I suspect my brother-in-law of infecting me... After my husband was imprisoned, his brother started coming around and insisted that I had to have sex with him in order to confirm that I was still part of the family. Eventually I had to give in. ... I worry because I had extramarital relations and about what will happen when my husband returns from prison. I will be kicked out and my children will be maltreated by the new wife. I refuse to keep silent and contaminate him...All of this happened only because of the war. My husband was my confidante—he wouldn’t be in jail, and I wouldn’t be infected, if it weren’t for the war”.

Florence, Kigali-Ngali

Providers in the family may have been imprisoned, gone into exile or sent to fight, again leaving women (or indeed children) with the charge of providing food—including having to transport it to the prison—and becoming sole care-takers of the family. Malnutrition and other health problems are often the natural consequence of these stresses for many women and children. Women have been left to care for countless orphans, even as poverty in the country worsens, and some women care for children born to them as a result of rape. Family members may have been left with lasting health consequences or disability as a result of injuries sustained in 1994 and often rely on women and girls to tend to them.

IV.3. Land and inheritance issues

Some widows lost their land when it was reclaimed by their husband’s family or by Rwandese who returned in the months and years following the RPA victory, or during the “villagization” process that sometimes forcibly attempted to group dispersed rural inhabitants into villages. During a decade of refugee returns, displacement, “villagization” programs and seizures of land by powerful individuals, land has changed hands frequently; women’s claim to land, even if codified in law, has been particularly difficult to enforce.

IV.4. Legacies of the genocide and war that contribute to HIV transmission

Some girls and young women said they had been turned out of their homes when family incomes were deemed inadequate to provide for everyone. Widows and orphan girls were rendered particularly vulnerable to forced marriage, rape by neighbours or strangers, or sexual abuse by employers, particularly if they worked as domestic servants. Sex work seemed the only option for destitute and traumatized women and girls, some of whom had survived sexual violence. Economic problems force women into staying in abusive relationships or submitting to unwelcome sexual advances. Meanwhile the generalized trauma undoubtedly continues to exacerbate sexual and domestic violence, women's groups and medical professionals speculated to Amnesty International delegates. According to Rwandese government figures, an estimated 80% of sex workers are infected with HIV.¹³

While HIV transmission is obviously not the only problem facing women and girls, the after-effects of the genocide, war and ongoing regional conflict on women and girls contribute significantly to their risk of exposure to the virus. They may engage in "survival sex"—that is, sexual encounters entered into in exchange for food, shelter, school fees or other goods.¹⁴ Up to 400,000 children are missing one or both parents, whether to violence, AIDS or other causes. These children may be forced to wander the streets as vendors or may simply find themselves homeless, where they are vulnerable to rape or may engage in survival sex. Some women and girls engaged in survival sex or prostitution are themselves survivors of sexual violence and may suffer from serious trauma and depression.

"I married in 1995. I heard that my husband might have HIV, but my father was dead and my mother was in prison. I had five brothers and sisters to take care of, and I had to get married so they would have money for school fees". HIV-positive woman, Kigali

"After the war, we saw that our family was decimated...My little sister for whom I care is a pseudo-prostitute because she has no money. She says that she will continue this lifestyle even if she becomes HIV-positive. She says she looks at my health degrading and insists that wants to taste life before she dies". HIV-positive woman from Kigali-Ngali

"Some of the street children are orphans from 1994...The Local Defence Forces tell [street] children that if they have sex with them, they will be protected. We hear of many cases of girls being raped...they call sex for protection umuswati, which is Kinyarwanda slang for the female genital organ". Joseph, from support organization for Rwandese street children

V. International legal framework

International human rights and humanitarian law provide comprehensive guarantees of the rights of women and girls to protection from sexual violence and abuse. International law requires states to address persistent violations of human rights and take measures to prevent their occurrence. With respect to violations of bodily integrity, states have a duty to prosecute

¹³ Cadre Stratégique de la lutte contre le VIH/SIDA 2002-2006, produced by the Commission National de Lutte contre le SIDA (CNLS), p. 37.

¹⁴ This is also known as "transactional sex", indicating that sex is being traded for financial or other considerations. Women "consent" because they see no alternative way of surviving.

abuse, whether an agent of the state or a private citizen commits the violation. For example, Article 2 of the International Covenant on Civil and Political Rights (ICCPR) to which Rwanda is a party requires governments to provide an effective remedy for abuses and to ensure the rights to life and security of the person of all individuals in their jurisdiction, without distinction of any kind including sex. When states routinely fail to respond to evidence of sexual violence and abuse of women and girls, they send the message that such attacks can be committed with impunity. In so doing, states fail to take the minimum steps necessary to protect the right of women and girls to physical integrity.

Perpetrators of sexual violence, including rape, can be held accountable under international law for acts of genocide, war crimes or crimes against humanity. Rape and other forms of sexual violence are explicitly condemned as war crimes, both in internal and international conflicts. Common article 3 of the 1949 Geneva Convention, to which Rwanda is a state party, is applicable to armed conflicts not of an international character and is binding on all parties to a conflict. It prohibits “[violence to life and person, in particular murder of all kinds, mutilation, cruel treatment and torture” and “outrages upon personal dignity, in particular, humiliating and degrading treatment”. The “fundamental guarantees” of Protocol II Additional to the Geneva Conventions, also applicable to non-international armed conflicts, protect civilians and requires that “they shall in all circumstances be treated humanely, without any adverse distinction. It is prohibited to order that there shall be no survivors.” Protocol II prohibits “violence to the life, health and physical or mental well-being of persons, in particular murder as well as cruel treatment such as torture, mutilation or any form of corporal punishment”, “outrages upon personal dignity, in particular humiliating and degrading treatment, rape, enforced prostitution and any form of indecent assault” and “slavery and the slave trade in all their forms”. Rwanda acceded to Protocol II in 1984.

The widespread or systematic commission of acts of sexual violence against a civilian population may be prosecuted as crimes against humanity, regardless of whether they took place in the context of war or peace. As recognized in the Rome Statute of the International Criminal Court, rape and other forms of sexual violence of comparable gravity may be considered crimes against humanity when they are committed as part of a widespread or systematic attack directed against any civilian population, with knowledge of the attack. The Rome Statute includes in its definition of rape, the invasion of “the body of a person by conduct resulting in penetration, however slight, of any part of the body of the victim or of the perpetrator with a sexual organ, or of the anal or genital opening of the victim with any object or any other part of the body.”

The 1948 Convention on the Prevention and Punishment of the Crime of Genocide (“the Genocide Convention”), to which Rwanda is a state party, defines genocides as “any of the following acts committed with the intent to destroy, in whole or in part, a national, ethnic, racial or religious group, as such:

- (a) Killing members of the group;
- (b) Causing serious bodily or mental harm to members of the group;
- (c) Deliberately inflicting on the group conditions of life calculated to bring about its physical destruction in whole or in part;
- (d) Imposing measures intended to prevent births within the group;
- (e) Forcibly transferring children of the group to another group.”

Sexual violence includes rape and attempted rape, and such acts as forcing a person to strip naked in public, forcing two victims to perform sexual acts on one another or harm one another in a sexual manner, mutilating a person's genitals or a woman's breasts, and sexual slavery. The appeals chamber judgment of the UN International Criminal Tribunal for the former Yugoslavia (ICTY) in the 2002 *Foca* case define rape as "[t]he sexual penetration, however slight: (a) of the vagina or anus of the victim by the penis of the perpetrator or any other object used by the perpetrator; or (b) [of] the mouth of the victim by the penis of the perpetrator; where such sexual penetration occurs without the consent of the victim. Consent for this purpose must be consent given voluntarily, as a result of the victim's free will, assessed in the context of the surrounding circumstances. The *mens rea* is the intention to effect this sexual penetration, and the knowledge that it occurs without the consent of the victim."¹⁵

The landmark 1998 Akayesu judgment at the ICTR articulates a broad definition of rape, including more than physical penetration or even sexual contact: "a physical invasion of a sexual nature, committed on a person under circumstances which are coercive. The Tribunal considers sexual violence, which includes rape, as any act of a sexual nature that is committed on a person under circumstances that are coercive. Sexual violence is not limited to physical invasion of the human body and may include acts which do not involve penetration or even physical contact... The Tribunal notes in this context that coercive circumstances need not be evidenced by a show of physical force. Threats, intimidation, extortion and other forms of duress which prey on fear or desperation may constitute coercion, and coercion may be inherent in certain circumstances, such as armed conflict or the military presence of *interahamwe* among refugee Tutsi women at the bureau communal."¹⁶ The Akayesu judgment for the first time noted that rape and sexual violence could be prosecuted as constitutive elements of genocide. The Akayesu decision further represents an important evolution from previously existing definitions of rape, including Article 27 of the Fourth Geneva Convention, which regards rape as an attack against a woman's honour or decency, rather than as a physical assault. The language of the Akayesu decision clearly describes rape as an assault on physical integrity, thus elevating rape to the status of other grave crimes, rather than reinforcing the pre-existing notion that it was a lesser or private crime.

The first convictions by the ICTY for rape as a crime against humanity came in the Kunarac, Kovac, and Vukovic decision of 22 February 2001, when the court found that the crimes of the accused comprised part of a systematic attack against Muslim civilians, intended to drive the Muslims out of the region. The defendants were also convicted of enslavement as a crime against humanity, thus setting a legal standard for sexual enslavement as a crime against humanity.

The Akayesu definition of rape is reinforced by the Kunarac decision, which rejects the notion that the victim need show resistance to force. Rather, under the ruling, force or

¹⁵ *Prosecutor v. Dragoljub Kunarac, Radomir Kovac and Zoran Vukovic (Foca case)*, Appeals Chamber Judgment, June 12, 2002, IT-96-23 and IT-96-23/1, paras. 127-133.

¹⁶ United Nations, International Criminal Tribunal for Rwanda, Chamber 1, Judge Laïty Kama, Presiding, Decision of 2 September 1998, *The Prosecutor versus Jean-Paul Akayesu*, Case No. ICTR-96-4-T.

threat of force provide sufficiently clear evidence of non-consent; coercive circumstances—without necessitating physical force—were deemed sufficient to determine the absence of consent.

Rwanda ratified the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) in 1981, but has not signed its Optional Protocol. CEDAW recognizes that many women's rights abuses emanate from society and culture, and compels governments to take appropriate measures to correct these abuses. CEDAW requires governments to "modify the social and cultural patterns of conduct of men and women, with a view to achieving the elimination of prejudices and customary and all other practices which are based on the idea of the inferiority or the superiority of either of the sexes or on stereotyped roles for men and women".¹⁷ The Committee on the Elimination of Discrimination against Women, which monitors application of CEDAW, issued in 1992 General Recommendation 19, which specifies that gender-based violence is a form of discrimination that gravely affects women's enjoyment of their human rights: "[g]ender-based violence, which impairs or nullifies the enjoyment by women of human rights and fundamental freedoms under general international law or under human rights conventions, is discrimination within the meaning of article 1 of the Convention". The Committee includes as examples of violence rape and other forms of sexual assault the denial of reproductive health services and battering. According to Article 2 of CEDAW, states must "pursue by all appropriate means and without delay a policy of eliminating discrimination against women" by taking "all appropriate measures to eliminate discrimination against women by any person, organization or enterprise". This obligation extends to violence against women in the context of armed conflict. In reference to the impact of violence against women, the Committee states that "wars, armed conflicts and the occupation of territories often lead to increased prostitution, trafficking in women and sexual assault of women, which requires specific protective and punitive measures".

The Recommendation 19 comment on Article 6 of CEDAW contains language that is especially relevant for women and girls left destitute following the genocide and war: "Poverty and unemployment force many women, including young girls, into prostitution. Sex workers are especially vulnerable to violence because their status, which may be unlawful, tends to marginalize them. They need the equal protection of laws against rape and other forms of violence." The Committee notes, in its comment on Articles 16 and 5, that the "lack of economic independence forces many women to stay in violent relationships. The abrogation of their family responsibilities by men can be a form of violence, and coercion. These forms of violence put women's health at risk and impair their ability to participate in family life and public life on a basis of equality." This comment is of particular importance for women with grave illnesses such as HIV/AIDS who may be neglected or abandoned by their husbands on the basis of their infection, their inability or unwillingness to reproduce or their incapacity to work.

In General Recommendation 24, the Committee affirms that access to health care, including reproductive health is a basic right under the Convention. Furthermore, it requires states to eliminate discrimination against women in their access to healthcare services

¹⁷ Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), art. 5(a).

throughout the life cycle, particularly in the areas of family planning, pregnancy, confinement and during the post-natal period. Article 12 of CEDAW calls on states to provide “equal access to health care services...including family planning”.

The Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa, which Rwanda signed on 19 December 2003, requires governments to eliminate violence against women as well as gender discrimination. The Protocol is far-reaching and innovative in its definitions and substantive provisions. Its provisions include equal access to justice and equal protection before the law; the right to adequate food and drinking water; the right to equal access to education and other economic, social and cultural rights. Article 14 concerns women's reproductive rights and health. It includes the right to contraception and “the right to self protection and to be protected against sexually transmitted infections, including HIV/AIDS” and “the right to be informed on one's health status and on the health status of one's partner, particularly if affected with sexually transmitted infections, including HIV/AIDS, in accordance with internationally recognised standards and best practices.”

Article 14.2 also requires that “States Parties shall take all appropriate measures to:

- a) provide adequate, affordable and accessible health services, including information, education and communication programmes to women especially those in rural areas;
- b) establish and strengthen existing pre-natal, delivery and post-natal health and nutritional services for women during pregnancy and while they are breast-feeding;
- c) protect the reproductive rights of women by authorising medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the foetus.”

For the first time in international law, the Protocol guarantees the right to abortion in case, *inter alia*, of sexual assault, rape and when the pregnancy endangers the mental or physical health of the mother. The Protocol also guarantees the rights of widows, including the right to be free from inhuman, humiliating or degrading treatment, to automatically become the guardian of her children after the death of her husband, and to have an equitable share in the inheritance. States are directed to reduce their military expenditures "significantly" and to use the funds instead for social development, especially with regards to women.

Under the International Covenant on Civil and Political Rights (ICCPR), to which Rwanda is a state party, states parties are required to refrain from human rights violations against women and to protect women from abuses by other actors, whether in peacetime or war. The Human Rights Committee has specifically mentioned the risk posed to women in times of conflict and informed states that they must report to the Committee “all the measures taken to protect women from rape, abduction and other gender-based forms of violence”. Children are additionally protected by provisions of the UN Convention on the Rights of the Child, to which Rwanda is a state party, which sets forth standards for the protection of girls from sexual violence and exploitation. State parties must undertake to protect children “from

all forms of sexual exploitation and sexual abuse,” and in particular take all appropriate measures to prevent “the inducement or coercion of a child to engage in any unlawful sexual activity” and “the exploitative use of children in prostitution or other unlawful sexual practices”.¹⁸ States must take all appropriate measures to promote physical and psychological recovery and social integration of a child victim of any form of neglect, exploitation, or abuse; torture of any other form of cruel, inhuman, or degrading treatment or punishment; or armed conflicts.¹⁹

The International Covenant on Economic, Social and Cultural Rights (ICESCR), to which Rwanda is also a state party, guarantees enjoyment of its substantive rights without discrimination of any kind. Women, on an equal basis to men, therefore have the right to the highest attainable standard of health and to education.

VI. Domestic legal framework

Rape and attacks on decency are the subject of articles 358 to 362 in the Rwandese Penal Code, which prohibit rape. Under Rwandese law, rape requires sexual penetration of the sexual organs, anus or mouth, by a male sexual organ or in some cases by another object. Under article 360, rape can be perpetrated by violent means or by means of threats, deception or by taking advantage of a person who is not in full possession of their faculties due to illness or any other cause, making the individual incapable of giving consent. Article 33 describes child rape, and articles 47 to 50 relate to the forced or early marriage of children under the age of 18. Article 360 states that rapes that result in the death of the victim are subject to capital punishment, and Article 361 states that if the act causes grave health problems to the victim, the sentence will double. Similarly, child rape resulting in the death of the child or infection with an incurable illness carries the death sentence. Amnesty International is opposed to the death penalty under all circumstances, as it constitutes a violation to the right to life, and considers it the ultimate form of cruel and inhuman punishment. Under article 361, circumstances are aggravated and the sentence doubled if religious ministers, public sector employees, doctors and other healthcare workers, teachers, and individuals in positions of authority commit the assault.

Organic Law No. 08/96 of August 30, 1996 on the Organization of Prosecutions for Offences constituting the Crime of Genocide or Crimes against Humanity committed since October 1, 1990 (“the Genocide Law”) categorizes crimes according to their severity. Those in “category 1”, for the most serious offences, include “persons who committed acts of sexual torture”, for which they may be sentenced to capital punishment and which do not carry the option of reduced sentences. Domestic law inflicts capital punishment for sexual violence only when victims die as a result (art. 359 al.3 and art.360 al.4 of the Penal Code, cfr. n° 25); in order not to violate the principle of retroactivity, sexual violence perpetrated during the genocide is generally classed in Category 1 only if it constituted grave sexual torture, which

¹⁸ Convention on the Rights of the Child, G.A. res. 44/25, U.N. Doc. A/44/49 (1989), entered into force Sept. 2, 1990, article 34.

¹⁹ Convention on the Rights of the Child, article 39.

can include repeated rape or mutilation. This interpretation harmonizes with Article 316 of the Penal Code, which likens the use of torture for the execution of a crime to assassination.²⁰

Provisions have been made for women to testify in special courtrooms and to maintain their privacy. The Genocide Law stipulates that victims are entitled to the payment of damages or compensation. Article 30 requires that “convicted persons whose acts place them within Category 1 under Article 2 shall be held jointly [sic] and severally liable for all damages caused in the country by their acts of criminal participation, regardless of where the offences were committed”, and those in Categories 2, 3 and 4 shall likewise be held liable for damages. Article 32 states that “damages awarded to victims who have not yet been identified shall be deposited in a victims Compensation Fund, whose creation and operation shall be determined by a separate law. Prior to the adoption of the law creating the fund, damages awarded shall be deposited in an account at the National Bank of Rwanda opened for this purpose by the Minister responsible for Social Affairs and the Fund shall be used only after the adoption of the law.”

Organic Law N. 40/2000 of 26/01/2001 Setting Up “Gacaca Jurisdictions” And Organizing Prosecutions For Offences Constituting The Crime Of Genocide Or Crimes Against Humanity Committed Between October 1, 1990 And December 31, 1994 contains provisions for damages to be paid. Article 90 stipulates that the gacaca judgments are to be forwarded to the Compensation Fund for Victims of the Genocide and Crimes Against Humanity, which will then fix “the modalities for granting compensation”. Article 91 notes that “any civil action lodged against the State before the ordinary jurisdictions or before ‘Gacaca jurisdictions’ shall be declared inadmissible on account of its having acknowledged its role in the genocide and that in compensation it pays each year a percentage of its annual budget to the Compensation Fund. This percentage is set by financial law.”

Paragraph 9 of the preamble to the 2003 Constitution reaffirm Rwanda’s “adherence to the principles of human rights enshrined in the United Nations Charter of 26 June 1945, the Convention on the Prevention and Punishment of the crime of Genocide of 9 December 1948, the Universal Declaration of Human Rights of 10 December 1948, the International Convention on the Elimination of All Forms of Racial Discrimination of 21 December 1965, the International Covenant on Civil and Political Rights of 19 December 1966, the International Covenant on Economic, Social and Cultural Rights of 19 December 1966, the Convention on the Elimination of All Forms of Discrimination against Women of 1 May 1980, the African Charter of Human and Peoples’ Rights of 27 June 1981 and the Convention on the Rights of the Child of 20 November 1989”. Paragraph 10 of the preamble records Rwanda’s commitment “to ensuring equal rights between Rwandese and between women and men without prejudice to the principles of gender equality and complementarity in national development”.

Article 11 of the Constitution affirms that “discrimination of whatever kind based on, inter alia, ethnic origin, tribe, clan, colour, sex, region, social origin, religion or faith, opinion,

²⁰ *Avocats Sans Frontières, Titre Premier de la Loi Organique et de ses disposition pénales*, Daniel de Beer: Brussels, 1996.

economic status, culture, language, social status, physical or mental disability or any other form of discrimination is prohibited and punishable by law.”

VII. Justice, impunity and redress

Ten years after the genocide, justice is slow in coming for many women. The women’s rights organization Haguruka, in an interview with Amnesty International in March 2004, estimated that significantly less than one hundred women have seen rape cases from 1994 through the ordinary courts. According to Haguruka, of the twenty or so defendants who were found guilty, most were sentenced to death, but appealed their sentences. The organization notes that women have little interest in bringing such cases, as testifying—even behind closed doors—is traumatic and increases the chances that community members will find out about the rape. Cases of grave sexual violence are all meant to be transferred to the ordinary jurisdictions. If such cases were being discussed in the *gacaca* (or community-based) jurisdictions, no perpetrator would yet have been sentenced, as *gacaca* has yet to try a single case.²¹ *Gacaca* is still in the phases of categorizing suspects according to the severity of the crime, a process that is expected to take until the end of 2005, before the trial phase can begin countrywide. The Rwandese government, according to some representatives of bilateral cooperations working on *gacaca* and members of Rwandese civil society, seems to have lost interest in the process. The *gacaca* process was frozen during the months leading up to the presidential and parliamentary elections of August and September 2003, and had, at the time of writing in 2004, not yet recommenced.

Women who suffered at the hands of RPA or RPF soldiers face an even more difficult struggle for justice. Survivors of sexual violence who accuse soldiers face reprisals and are unlikely to see the case advance. Journalists note that discussion of crimes committed by the RPA and RPF are still taboo in Rwanda. Only a few isolated cases have been brought to court, though the Rwandese government maintains that all RPA soldiers suspected of having committed rape have been brought to justice. Amnesty International has repeatedly asked for statistical evidence and names regarding RPA/RPF perpetrators brought to justice; the Rwandese government has on several occasions promised to produce figures, but these have never been forthcoming.

VII.1. Compensation fund

One of the recurrent requests of rape survivors from the 1994 period with whom Amnesty International delegates spoke was the establishment of a compensation fund for victims, particularly victims of the genocide. It is very difficult for victims to recover effective remedies from suspected perpetrators, as they are usually very poor, particularly if they have spent most of the past decade in prison. There is a high risk of persons sentenced to be made

²¹ *Gacaca* is a community-based form of justice traditionally used to try lesser crimes in Rwanda. In 2001, the Government of Rwanda introduced a system, based on *gacaca*, to try the tens of thousands of detainees held for suspected participation in the genocide who could otherwise not be tried in a timely fashion by the ordinary jurisdictions.

bankrupt, and no decision on damages has reportedly been enforced through court action. Although an old version of the compensation law for victims of the genocide was drafted and discussed by the Council of Ministers in August 2002, it has yet to be put to a vote in the National Assembly. A new version of the bill putting into place the *Fonds d'Indemnisation* (FIND), or Indemnity Funds, is apparently being circulated. The new version will reportedly limit the total funds distributed by compensating a fixed amount to genocide survivors.²² Up until this point, the Rwandese government has been providing services via the *Fonds des Rescapés du Génocide* (FARG) or Genocide Survivors Fund, in the form of approximately 5% of the state's internal revenue spent on housing, medical and educational assistance, which may be increased under the new draft bill. Many genocide survivors complain that the funds are insufficient and can be difficult to access. In theory, FARG is meant to assist both Hutu and Tutsi victims of the genocide. However, some Hutu survivors with whom Amnesty International spoke said they been denied assistance and suspect their ethnicity to be the cause of the denial.

VIII. Access to healthcare

“The truly indigent are luckier than the mid-level poor, as they are likely to get some medicine for free, while the moderately poor can neither afford medicine themselves nor benefit from government assistance”.

Olive Gatesi, President of the national network of people living with HIV/AIDS

VIII.1. Poverty and access to healthcare

The majority of the population in Rwanda faces difficulty in accessing basic healthcare, much less coping with the extremely high costs of AIDS treatments, tests and hospitalisations. According to UNAIDS, only an estimated 28% of Rwandese households affected by HIV are able to afford even basic health care; many families borrow money, sell assets, including land, or decide to forego healthcare.²³ The Rwandese healthcare system operates on a cost recovery policy, which was re-instituted soon after the genocide, though the government and international donors are trying to encourage people to participate in community health insurance schemes. The World Health Organization Commission on Macroeconomics and Health noted in 2001, “Experience has taught repeatedly that user fees end up excluding the poor from essential health services, while at the same time recovering only a tiny fraction of costs.”²⁴

Rwandese living in extreme poverty are sometimes able to procure cards that attest to their indigence and allow them to access free services, including medical care and education

²² Penal Reform International (PRI), “Research on the *Gacaca*—PRI, Report V”, September 2003, p. 13.

²³ UNAIDS, “Paying for HIV/AIDS Services: Lessons from National Health Accounts and community-based health insurance in Rwanda, 1988-1999”, September 2001, p. 7.

²⁴ Commission on Macroeconomics and Health. *Macroeconomics and Health: Investing in Health for Economic Development*, Geneva, WHO, 2001, p.61.

for their children. However, the beneficiaries of this program are sometimes too poor even to afford the transportation to the appropriate medical centre. The process for procuring the indigence card is tedious, and some destitute people with whom Amnesty International delegates spoke had not pursued the option. Other women accessed free medical services thanks to the FARG assistance for genocide survivors, though these did not cover some HIV-related services, including ARV treatments. Human rights activists also noted that the FARG and indigence system were open to corruption, and that high political officials, including members of parliament, benefited from FARG assistance, which is supposed to be directed to the most vulnerable people in Rwanda.

Individuals who do not find assistance under these categories find the burden of living with HIV/AIDS onerous. Transportation fees, consultation fees, medicines and tests are well beyond the means of most Rwandese. Those few who do access free ARVs are still required to pay for hospitalisation and consultation fees. Many find themselves deciding between paying for medical expenses or buying food and wondering how to apportion the little food there is between family members. The majority of Rwandese who are not eligible for free medical care are often unable to afford basic treatments; women have reportedly been held prisoner in health centres after giving birth and being unable to pay for medical expenses. Their families sometimes sell a piece of their land in order to find the money to secure her release. Women are now reportedly required by some healthcare providers to bring a guarantee from a government authority at the cell-level (smallest administrative unit in Rwanda) reassuring the healthcare provider that she will pay for services rendered.

“Services are increasing, but we can’t help everyone...Sometimes women are afraid of having their children tested because it is simply too painful for them to know, when they don’t have the means to care for the child”.

Dr. Fabienne Shumbuso, HIV/AIDS specialist, Gitarama hospital

VIII.2. Prevalence of HIV/AIDS

HIV prevalence in Rwanda is itself a contentious issue. UNAIDS estimated adult prevalence at 8.9% in 2002, or 495,000 people living with HIV/AIDS, including 65,000 babies and children, out of a population of 8,162,715.²⁵ Rwandese government figures describe a national prevalence of between 11 and 13%²⁶. All parties do agree that prevalence is rising and that it is far higher in the capital, Kigali—with the most commonly cited figure being 17%—than elsewhere in the country. A 2002 sentinel surveillance of women visiting antenatal clinics around the country showed urban HIV prevalence varying between 3.7% and 13.0% in sites tested with a median site-specific prevalence of 6.9%, and rural prevalence between 1.2% and

²⁵ UNAIDS/WHO Epidemiological Fact Sheet on HIV/AIDS and Sexually Transmitted Diseases, Rwanda, 2002 Update.

²⁶ Cadre Stratégique de la lutte contre le VIH/SIDA 2002-2006, produced by the Commission National de Lutte contre le SIDA (CNLS), p. 9.

5.1%, with a median site-specific prevalence of 3.0%²⁷. Based on this survey, the United States Centre for Disease Control estimates prevalence at 4.9%.

VIII.3. Availability of ARVs and the international response

The availability of medical care for PLWHA has increased significantly in the past few years, but does not begin to meet the needs of the population, including survivors of sexual violence. Voluntary counselling and testing (VCT) programs are expanding and administered free of charge. Experts in Rwanda estimate the number of patients clinically in need of life-prolonging anti-retroviral (ARV) therapy at between 50,000 and 100,000. Rwanda is currently in a period of rapid scale-up of ARV delivery, but as of January 2004, only about 2,000 Rwandese were being treated with ARVs, including approximately 800 hundred who paid for their own supply of medicine. A month of ARV treatment, without additional tests, cost about 33,000 Rwandese francs, about 59 US dollars, in January 2004. 3,000 to 5,000 patients are projected to be receiving treatment by the end of 2004, depending on arrival of funds, logistical considerations and capacity of overburdened healthcare workers to follow their patients. Many more patients are benefiting from antibiotics and treatment of opportunistic infections (such as tuberculosis) to stave off serious illness and death. Donors such as the Global Fund to Fight AIDS, Tuberculosis and Malaria, The World Bank and bilateral donations pay for these initiatives.

Some doctors and policy advisors expressed concerns to Amnesty International that treatment programs in Rwanda have during the past year received as much money as they can absorb. They cite the limited capacity within the health sector for adequate medical follow-up of large numbers of HIV/AIDS patients. Other doctors hotly contested this notion and believe that it would be possible to scale up ARV delivery significantly. These medical professionals do concede that ARV scale-up poses logistical problems, for instance that hospital and clinic management needs to be reconfigured with every new influx of money and services that is made available. In either case, many gaps remain in ameliorating the daily living conditions and addressing basic needs of PLWHA, such as food assistance and nutritional programs, school fees, housing and psychosocial support.

VIII.4. Government-coordinated responses to HIV/AIDS

The National Commission to Fight Against AIDS (CNLS) was established in 1986, and a first plan for monitoring and preventing HIV/AIDS put in place in 1988. Since then, the government of Rwanda, multilateral and bilateral donors and non-governmental organizations (NGOs) have made strides to expand prevention, care and treatment services available in the country. President Kagame and First Lady Janet Kagame have both committed considerable effort to domestic advocacy and international lobbying. Donors are generally satisfied with the Rwandese government response, planning and implementation and note progress in

²⁷ Treatment and Research AIDS Center (TRAC), "HIV Sentinel Surveillance Among Pregnant Women Attending Antenatal Clinics", Republic of Rwanda Ministry of Health/CDC, Rwanda 2002, p. 15.

coordination and procurement procedures.²⁸ However, the same sources acknowledge that a weak healthcare system, management problems, stigma surrounding HIV/AIDS (exacerbated by some healthcare personnel), difficulties in changing behaviours and capacity limitations all pose substantial challenges to combating the disease. Donor contributions of money and technical support have sometimes been uncoordinated, resulting in glaring gaps in services, occasional duplication of efforts and a high concentration of service provision in urban areas.

The Rwandese government has developed a national strategic framework and multi-sectoral plan for the 2002-2006 period that continue prevention, monitoring and VCT efforts, prepare for scale-up of treatment programs and step up the presently rather weak community and home-based care systems to support PLWHA. Government ministries, private businesses, NGOs, religious groups and other civil society organizations are all requested to participate in curbing the spread of the virus and mitigating its consequences. Some private businesses in Rwanda have particularly strong programs to offer ARV treatment to employees and have acknowledged that it makes business sense to do so.

VIII.5. Access to ARVs for survivors of sexual violence

Most women survivors of sexual violence who do benefit from free ARVs at government or private clinics entered treatment programs following their participation in prevention of mother-to-child transmission (PMTCT) programs. Survivors of rape are not accorded special privileges in government ARV treatment plans, though there are very limited privately implemented programs that offer free treatment, in particular for genocide widows with HIV/AIDS and their children. The government does acknowledge that rape, including child rape, is a significant factor in HIV transmission in addition to constituting a grave violation of the individual's rights. In March 2003, the Minister of Health and State Minister for HIV/AIDS both confirmed to Amnesty International delegates their intention to put in place post-exposure prophylaxis (PEP) for survivors of violence to reduce the likelihood of HIV transmission²⁹. However, no implementing partner, government official or donor with whom Amnesty International spoke in 2004 had seen any concrete plans to realize this stated government intention.

Genocide survivors living with HIV often complain publicly that defendants awaiting or undergoing trial at the International Criminal Tribunal in Tanzania, accused of high-level participation in the genocide, receive ARVs and high quality medical treatment while in prison. Meanwhile, women who were survivors of atrocities lack access to medical treatment and a basic standard of well-being. Many women have expressed a sense of profound injustice at this differential treatment.

²⁸ The World Bank notes, for instance, "The project is likely to be sustained to the extent that there is strong ownership, participation and commitment. Likewise, a major effort is being made to strengthen implementation capacities at all levels". From The World Bank, "Project Appraisal Document on a Proposed Grant in the Amount of SDR 22.2 Million (US \$30.5 Million Equivalent) to the Republic of Rwanda for a Multi-Sectoral HIV/AIDS Project", March 11, 2003, Report No. 24992-RW, p. 36.

²⁹ ARV drugs, taken within 48 or 72 hours of rape, and taken for a month are believed to reduce the chances of the woman becoming infected with HIV.

VIII.6. Privileged access to ARVs

Some of the people whom the Rwandese government sponsors for free ARV treatment are reportedly military officers. The Ministry of Defence pays for their ARV treatment, but not for the treatment of ordinary soldiers who, like many others in the population, cannot afford to pay for ARV therapy. High-level civilian authorities also reportedly benefit from free ARV treatment, in spite of their relatively high incomes. Human rights sources have told Amnesty International that the RPF government have sometimes used ARV treatment as a bargaining chip and have threatened these civilian authorities with revoking treatment if they did not support RPF policies.

IX. Eligibility and access to ARVs

Some donors and implementing partners are worried that the phase of selecting patients for limited ARV treatments will prove problematic and open to manipulation, in spite of agreed protocols for deciding on patient eligibility. The World Bank assessment paper warns of “(i) pressures to select participants, as the number of people requiring treatment will exceed financial and institutional capacities; (ii) risk of leaving behind the most needy who have limited negotiating skills and low levels of education; and (iii) concerns over financial sustainability, particularly in light of the large pool of infected persons and the high cost of drugs for this chronic illness”.³⁰

A Ministerial Instruction was issued in 2003 “determining the conditions and modalities for health care delivery to persons living with HIV/AIDS”. This instruction makes provisions for Technical Committees for Patient Selection, which includes representatives from the health care provider, heads of psychosocial teams designated by the head of the health care delivery institution and “two representatives of associations of PLWHA located within the geographical area served by the health institution designated by the network of persons living with HIV”. The ministerial instruction has been hailed as a fair document that sets out logical criteria for eligibility for access to treatment and financial requirements based on medical considerations, proximity to treatment site and acceptance of behaviour that minimizes risk of further HIV transmission. Refugees living in Rwanda are not explicitly excluded from receiving treatment. However, the requirement that patients must have a fixed address for six months prior to treatment – a requirement intended to facilitate delivery and encourage continuity – means that refugees (and others without a fixed address) are less likely to be eligible for treatment.

³⁰ The World Bank, “Project Appraisal Document on a Proposed Grant in the Amount of SDR 22.2 Million (US \$30.5 Million Equivalent) to the Republic of Rwanda for a Multi-Sectoral HIV/AIDS Project”, March 11, 2003, Report No. 24992-RW.

IX.1. Access to HIV/AIDS-related services and the critical role of associations of PLWHA

The rationale of grouping as many people living with HIV/AIDS into associations as possible is to have a clear means of organizing and delivering services to the population, for associations to provide moral and psychological support to PLWHA and to educate and assist people who have just learned their HIV status following voluntary testing. The associations typically have weekly meetings and serve as focal points for HIV/AIDS education, any delivery of aid or assistance, and distribution of information about healthcare opportunities. For most PLWHA, particularly in rural areas, associations will be their point of contact for whatever information and assistance is made available. Membership in an association of PLWHA is not a precondition or requirement for people to access ARVs. However, local authorities have sent strong signals that people with HIV/AIDS had to join associations if they were to have a chance of receiving ARVs and other treatments and services. Some people with whom Amnesty International delegates spoke acknowledged that they recently joined associations in hopes of benefiting from projected ARV scale-ups and other services. Those who are perceived to be, or regard themselves as being, in opposition to the government are afraid that they will face discrimination within the association when services are made available—or indeed, can already attest to such discrimination. Some NGOs fear that government statements transmitted via associations might raise expectations of access to healthcare and other services that are impossible to fulfil, further frustrating the hopes of suffering individuals.

In some cases, association leadership appears to be working against the best interests of PLWHA. Even high-profile associations of genocide survivors or PLWHA with international reputations are routinely criticized for diverting funds and for being highly politicised. Several journalists and PLWHA cited associations that were run by individuals who did not have HIV, but were using the associations as a means of collecting money for themselves personally. Other PLWHA spoke of their exclusion from associations because of conflicts they may have had with local politicians. In other cases, the president and vice-president of an association might have benefited from services, while the membership was left with little or nothing. Often the management issues highlighted the gap in education and money between leadership and members. Some association members said they did not dare to speak out publicly against the poor leadership for fear they would be entirely denied access to services. One activist for PLWHA said, “Here, farmers aren’t free to ask for what they want, even to make suggestions. They are afraid of prison or maltreatment, so they say nothing.” In one case, the HIV-negative leadership of an association excluded some PLWHA from the association because they had asked about opaque financial transactions of the association. Because the association president was politically well-connected, she was able to prevent the excluded individuals from registering a new association.

“Sometimes people who are HIV-positive are excluded from associations because they have problems with politicians; sometimes you find associations whose president doesn’t even have HIV”. Woman living with HIV/AIDS, Kigali

“In many associations, you find that the only people receiving ARV treatment are the president and vice-president. Sometimes this may be because they are educated and so are the

only ones wealthy enough to afford to buy drugs every month. But it may be that they are using the association to ensure that they will have access to medicine. There are many problems with transparency in the association, but people may not speak out because they are afraid to lose any hope of accessing medicine". Journalist, Kigali

The leaders of these organizations are literally being given the power of life and death over membership, as they are often empowered to accord or deny services or donations to membership. Adequate measures should be put in place to ensure that they are operating transparently, that members have a means of filing grievances without suffering retribution and that PLWHA have access to services through means other than associations. Additionally, associations tend to cease functioning if members of leadership become sick; efforts to democratise associations would help ensure that they represent the best interests of their constituents and help to prevent associations from being rendered dysfunctional by the illness of leaders.

IX.2. Access to HIV/AIDS-related services and national associations of PLWHA

At higher levels, the National Network of PLWHA (Réseau National), a network of some 250 associations of PLWHA, has been criticized for being a government mouthpiece rather than representing the interests of its membership. Information reportedly tends to flow from the top down rather than from the grassroots up to the policy makers.

The National Association to Support People Living with AIDS (ANSP), under the Ministry of Local Government (MINALOC), has itself been twice sanctioned for embezzlement and mismanagement. More seriously, some PLWHA say they or people they know have been manipulated by ANSP. They cited instances when individuals were called upon to declare their HIV status publicly, sometimes in a crowded stadium, with the promise of being given ARV treatments. Reportedly, the individuals who declared their serological status publicly received nothing in exchange, in spite of the promises ANSP had made, but did suffer the predictable stigma that followed the event. At least one young man who testified has since died of an AIDS-related illness. One journalist told Amnesty International, "There are Rwandese government officials whom everyone suspects of having HIV, and yet they do not speak out about their situation to help destigmatise the disease, because they already can pay for ARVs; and yet the government expects the poor people to do just that."

X. Freedom of expression and access to HIV/AIDS-related services

Articles 19 and 20 of the Universal Declaration of Human Rights protect the rights to freedom of expression and assembly respectively. Article 19 protects the "freedom to hold opinions without interference and to seek, receive and impart information and ideas through any media and regardless of frontiers". PLWHA should have the right to receive information regarding their disease as well as to participate in representative mechanisms to advocate for provisions

that ameliorate their access to health³¹. Amnesty International is concerned that a climate of fear exists that curtails people's willingness to exercise their right to freedom of expression. PLWHA with whom Amnesty International delegates spoke reported problems expressing themselves within the context of their associations, particularly if they commented on the financial management or equitable distribution of services to association members. The Government of Rwanda should give meaningful assurances that PLWHA who do peacefully exercise their right to freedom of expression will not be subject to expulsion, denial of services or discrimination in receiving services or treatments, and other forms of intimidation. One association head commented, "You never see demonstrations in Rwanda. People living with HIV are very frustrated when they see their health deteriorate and there are many promises but no services, but they are too scared to demonstrate."

One exiled journalist cited the case of the former president of the ANSP who was the subject of a 2002 newspaper article in *Umuseso*, an independent newspaper. The article pointed out that she did not have HIV and accused her of embezzling money from the association. In response, the ANSP president organized a public demonstration at the *Umuseso* offices and reportedly urged the members of her association to raid the office and destroy their equipment, however the *Umuseso* staff frustrated their attempts.

Another limitation on the freedom of expression of PLWHA is the generalized atmosphere of silence that lies heavily over Rwanda. Detention, death threats and exile are a common fate for independent journalists in the country. Journalists told Amnesty International that certain health issues were essentially off-limits to the media, if the media workers did not wish to incur threats and reprisals. Several journalists interviewed by Amnesty International said they were aware of corruption by government and NGO programs related to HIV/AIDS, but were afraid to report extensively on the issue for fear that the government or organizations might take retaliatory action. These journalists cited the government Genocide Survivors' Fund, prominent NGOs that support genocide survivors and associations of PLWHA as organizations whose leadership and/or personnel were allegedly engaging in corruption. Journalists told Amnesty International that they hesitated for the same reasons to report on the free ARV treatment that military officers and high-level civilian authorities received, in spite of the fact that most of these beneficiaries were in a high-income bracket and could afford to pay for their own treatment. Journalists could also cite cases of individuals who had been fired reportedly because their employer learned of their serological status, but the journalists said they would be unlikely to broadcast such stories for fear of reprisals by the employer against the journalist or his or her sources.

XI. Stigma and discrimination related to HIV status

"When my husband learned I had AIDS, he left me and our three-month-old baby immediately. I stayed home until the landlord forced me out of the house. Then I returned to my family home in Gitarama. There I was almost kept in quarantine because I was symptomatic. They belittled me constantly in my family and in the village".

Christine, from Gitarama

³¹ Footnote: Guidelines on HIV and human rights – will send you the details].

As in many countries, HIV infection in Rwanda remains associated in many people's minds with behaviour—particularly with sexual practices—considered immoral. Predictably, taboos surround the discussion of the disease and impact on individuals' ability to access appropriate health care and other basic rights. While some women could cite neighbours or colleagues who had been supportive during their illness, nearly all reported incidents of intolerance, persistent teasing and denigration that they or their families had suffered once they were suspected of having HIV.

In addition to the stigma of having been raped, rape survivors living with HIV/AIDS are also marginalized, insulted or belittled because of their infection. Some women with HIV/AIDS have reported being belittled for having been raped, even if they did not contract HIV/AIDS as a result of rape; their tormentors assumed the women had been raped because sexual violence was such a widespread component of the genocide and war.

XI.1. Stigma within the family

Women who admit to having HIV risk social exclusion or abandonment, which they may already have suffered as a result of sexual violence. Several women interviewed by Amnesty International delegates were particularly distraught that their relationships with their partners had deteriorated or ended since they had revealed their serological status. While there has been a substantial push in Rwanda to encourage couples to get tested for HIV together, in some cases women learn their HIV status only when they seek prenatal care and are made aware of prevention of mother-to-child transmission of HIV (PMTCT) programs. They may then be reluctant to inform their partners of their status for fear of being abandoned—even if they are certain they were infected by their current partners.

“I was raped during the war by five interahamwe, even though I am Hutu. I was a virgin, so maybe the rape was the cause of my sterility. When I got tested for HIV in 2000, my husband tore up the test results. He can't accept that I'm in an association for people living with AIDS, and that I'm sterile... I haven't gotten food from him for five months... I don't get assistance from the government programs because I am of the wrong ethnicity”.

Rape survivor, HIV-positive, from Gitarama.

Numerous women whom Amnesty International interviewed reported that their male partners had abandoned them and their children, without leaving provisions to support them. In most cases, the men reportedly blamed their female partner for bringing AIDS into the relationship and considered them worthless or a burden, as being marked for death. Other male partners reportedly denied their partners and children food, stole donated rations and/or refused material goods such as clothing.

“I was in Nyanza during the war, and my husband was killed. The militia raped me and my sisters-in-law. Those who talked back were killed. I was shy, so I survived...I was already pregnant at the time, now my child is ten years old...My second husband is out of his mind, and I have gotten sicker because of the worries he gives me. He abandoned me when he learned I had HIV, which is why I am crying so much now. He denigrated me in front of the

neighbourhood, so now my neighbours also make fun of me. Maybe my husband is healthy, so that's why he did it. He refuses to get tested. I am worried because I have no property, no money for food for the children, and we live badly. I am always sick and we are too poor...I don't get help from the government because I didn't lose enough people during the genocide".
Rape survivor, Kigali

Some women spoke of the difficulties of getting food from their partners, children or family members since their infection had been discovered. One woman in Kigali-Ngali confronts a painful situation with her daughter, "My child has no more respect—she takes my rations and sells them to keep the money for herself, and says I am just a candidate for death anyway." Stigmatisation of this nature is not only traumatizing but can reduce the mental and physical capacity of the person to cope with the disease and the hardships it imposes. The Rwandese Association for Trauma Counsellors (ARCT) reports that it has noticed a marked increase in the number of people coming in for counselling for HIV-related trauma and stigmatisation.

XI.2. Government response and stigmatisation

The Rwandese government and local and international NGOs have made great strides in sensitising the population to the risks of HIV infection. By most accounts, stigmatisation is gradually decreasing as the efforts of medical personnel, government, business and NGO begin to bear fruit. Nonetheless, stigmatisation remains one of the most painful elements of HIV infection for many Rwandese. The nature and formulation of the messages distributed during HIV prevention campaigns have reportedly contributed to increased stigmatisation of some PLWHA. For instance, gatherings of people may be informed about certain risk behaviours and the consequences and symptoms of HIV infection, without receiving messages about how to care for PLWHA and their families or assurances that they cannot contract HIV through casual contact. An apparently common consequence is that people living with HIV/AIDS often find that they suffer most right after HIV prevention campaigns, such as the one on national AIDS day on 1 December 2003:

"My children were tormented on December 1st after the AIDS day activities. My older children are aware of my condition and are courageous, but the little ones can't accept that their mother is infected. The little ones shout back at those who tease them and say they don't believe their mother is sick". Woman living with HIV, Kigali-Ngali

As mentioned above, people who belong to associations of PLWHA often face discrimination because they are easily identifiable.

"People know that we come to these meetings on the weekend, so they assume that we have AIDS. Sometimes our children are tormented as a result, and then may come to confront us. They treat the whole family as if it is infected, and many people still seem to believe that you might get HIV just from greeting someone. You risk being treated as a second-class citizen; people think of you as someone about to die and don't pay much attention to you. Some family members may think it's not worth spending money on you since you will die anyway".

Member of PLWHA association, Umutara

This policy of grouping people into associations, supported by the Rwandese government and some foreign technical consultants, may in the long run facilitate service delivery and help to combat stigma. However, in the short term, it has in many cases contributed to an increase in stigmatisation and diminution of the rights of PLWHA and their families; meanwhile service delivery remains scant to non-existent. While PLWHA usually recognize that they are grateful for the moral support and discussion forum the association provides, their membership can contribute to social, educational and economic marginalization for themselves and their families. Educated or professional Rwandese are unwilling to participate in associations because they either fear being identified as having HIV and consequently fired from their jobs or simply do not identify with the others in the association.

XI.3. HIV/AIDS-related stigmatisation and socio-economic rights

Journalists, government officials, local and national NGOs and policy advisors could all cite cases of individuals having been dismissed from their work because their employer suspected their HIV infection. The employer is likely to invent an excuse other than the employee's health status for making him or her redundant, but may then hire an inferior replacement presumed to be HIV-negative.

Théodette, age 34 with three children, cleaned and did errands at the Kigali office of an international network of audit firms. She contracted HIV after being raped during the genocide. Her youngest daughter was herself raped and contracted HIV; her daughter's rapist is now in Gikongoro prison. Théodette has sole responsibility for her children. On 14 January 2004, her employer reportedly cut her salary because he said that he would have to hire another employee, who would be paid from her salary, to supplement her work because of her problems with illness. In fact, she has been taking anti-retrovirals since July 2003, had not yet manifested symptoms of AIDS and is still strong. Her employer had initially paid for her ARV treatment, but then ceased, reportedly to encourage her to quit. He also reportedly threatened her, repeatedly saying, "Théodette, tomorrow you and your daughter will die, why are working here?" On 16 February, her employer wrote a letter of resignation, which he alleged Théodette had written herself, and forced her to leave work. She subsequently went to see her trade union, a human rights organization, several highly-placed persons in the National Commission to Fight HIV/AIDS (CNLS) and someone from the Genocide Survivors Fund, who have offered her advice on how to confront her former employer. Théodette has not worked since 16 February, and is having increasing problems finding money for food and rent. She has some money saved to buy ARVs, but does not know what she will do when that runs out.

Although the new constitution forbids discrimination, no cases are known to have been prosecuted for employment discrimination based on HIV status. "Instead of being treated, you get kicked out of your job, then they hire someone much worse than you—it hurts the development of the country," said one government official in Kigali. Doctors reported that

their patients often did everything in their power to prevent their employer from learning about their illness and would invent excuses to be allowed to go to the hospital for treatment.

Many of the people living with HIV/AIDS whom Amnesty International interviewed in March 2004 reported that they had difficulty accessing micro-credit or bank loans, at a time when they were particularly vulnerable economically. "It is difficult to get micro-credit loans at the Banque Populaire because the management is worried that I will die before I pay back the loan. Because my status is known in the community, I am being stigmatised," says Bernadette from Kigali-Ngali. PLWHA also reported priests refusing to perform marriage rites between HIV-positive individuals, difficulty in accessing insurance or refusal of clients to continue buying from them. One woman described her attempt to pay a kind of insurance for her child's school fees now that she is healthy and earning money, in the event of her inability to pay once she becomes symptomatic; however, the school refused. Government authorities have reportedly urged insurance companies by radio broadcast not to deny insurance to PLWHA.

"My husband's family is waiting for my death to recuperate the property...I am very much stigmatised by my family. My mother still loves me, but she is old and can't really help. My family and others in the community think they can be infected even by greeting me. I didn't suspect I was HIV-positive initially. I was the first wife of a polygamous man. He and the other wives died of AIDS. He rarely stayed with me—he had practically abandoned me—so I thought I was safe from HIV. I started to have symptoms and learned I was infected, so I went to the hospital and also got traditional medicines, but neither helped".
Perpétue, Kigali-Ngali.

XI.4. Health consequences of stigmatisation of PLWHA

Although sensitisation programs have been undertaken, the stigma attached to HIV and discriminatory attitudes prevailing in Rwandese society often still encourage PLWHA to remain silent about their status. This silence can have very real health consequences, such as discouraging women from seeking medical advice and treatment or facilitating the transmission of the disease to partners or children when the infected person is unwilling to discuss her illness. Pregnant women who learn they are HIV positive are advised to feed their infants formula milk, rather than to breast-feed, to reduce the likelihood of infection. As in many countries, women are reluctant to choose alternatives to breast-feeding not only because of the additional cost but also, in a culture where breastfeeding is a nearly universal practice, because they fear their families, neighbours and community will identify them as HIV-positive and shun them.

XII. Children of people living with HIV/AIDS

"I was raped by militia. I was in the Zone Turquoise in the south... My husband left when he learned I had HIV and he didn't. He divorced me and left me with three children. Now I have problems paying for rent, school and food... As it is, I live thanks to my friends and

neighbours. My six-year-old also has many health problems, and never seems to get better. She should be on ARVs, but I can't get them for her, and she is allergic to antibiotics. We eat badly...My greatest worry is for my children. What will happen to them if I die? I am trying to get them sponsors abroad, so at least I will be able to die in peace." Tharcissie, age 29, Kigali

"My youngest child is HIV-positive; he is five years old and always sick. I learned I had HIV when I was pregnant with him. My husband is also sick. He used to work as a cook, but now he can't work like he used to. Finding school fees, clothes and medicine for the kids is already almost impossible. What will happen to them when I die?" Zawadi, age 37, from Gikongoro.

"I have four children, the second- and third-born have HIV, though they should get ARVs soon. My landlords don't know I have HIV, and I won't tell them otherwise they will know I am incapable of paying the rent and chase me away... We live with famine constantly, and I worry because I don't even have a piece of property to give to my children. If I died, I would be more at ease if I knew my children had a small house".

Béatrice, age 36, from Butare

"I am afraid because I am no longer strong enough to take care of myself and my children. I feel my health deteriorating. I have told my children of my HIV status, and they were sad, but can't do anything about it".

Jeanne, age 50, rape survivor taking care of three of her own children and two of her deceased brother's children, Kigali.

"My child just finished sixth grade, but now there is no money to pay, so he just sits at home now. I have no family or neighbours, so my child helps me. We don't have enough food". Immaculée, age 45, Butare.

As the quotes above demonstrate, the fate of their children is the primary concern of many women living with AIDS. Within days of their sole parent's death, children may find themselves forced to fend for themselves, although often they are too young to provide for themselves and their siblings. Inevitably, a percentage of these children end up on the street, where their health deteriorates, their nutrition is poor, and they are vulnerable to all manner of abuses. A study by Johns Hopkins University reported that 93% of a cohort of girls living on the street reported having been sexually abused.³²

Those who are able to find a home, whether by inheriting, squatting an abandoned house or constructing a makeshift shelter, are nearly as vulnerable. Individuals living in child-headed households are particularly vulnerable to physical aggression including sexual assault, or may be encouraged to trade sex for food and material goods. Some children see no

³²"Rwanda: Sexual Activity among Street Children in Kigali", U.N. Integrated Regional Information Network, March 13, 2002.

alternative to prostitution for providing for themselves and their siblings. A percentage of orphans will inevitably abandon their education either for lack of school fees or to find food, and they may not know how to access support services that may be available to them. Child-headed households are frequently isolated from the community and have no obvious structure or authority to assist them; some children are very young and completely lack the skills required to look after children even younger than themselves and to provide for their basic needs.

Some of the children suffer from the trauma of having lost a parent and family structure; some are themselves infected with HIV. Hospital staff points out that it is nearly impossible to administer ARVs to street children or children living alone because they cannot ensure that the child will take the drug consistently, besides which the child may have no home, food or other care, and will look to the health centre to provide emergency assistance.

The non-governmental organization CARE has a project in Gitarama to support child-headed households, and says that the problem needs the urgent dedication of resources to develop a network of assistance and support for these households. The project implementers note that there is scant understanding or acceptance of children's rights in Rwanda, and that human rights education needs to be integrated into any solution. One project director at CARE emphasized the need for support organizations to be proactive: "It is essential to get assistance to women living with AIDS, to prepare the terrain for the legal and logistical aspects to be taken care of before the children become orphans. If the inheritance is dealt with, if there is trauma counselling and psychological preparation, and a community structure is in place automatically to support the children, it would help a great deal." CARE advocates a community mentoring program to provide adult guidance to the child-headed households. Of the households that CARE assists in Gitarama, 80% of the children's parents have died of illness, while 20% died during the genocide and war. Not only would such assistance prove invaluable to the children, it would also be a great relief to ailing mothers, some of whom suffer severe depression as their health worsens, due to daily concern for their children.

XIII. RECOMMENDATIONS

XIII.1. TO THE GOVERNMENT OF RWANDA

Healthcare and economic and social rights

The Government should, with the help of UN agencies, bilateral donors and other experts as appropriate, equitably enhance the provision of medical care to survivors of sexual violence. Programs should be constructed in such a way as to ensure equal access for both rural and urban populations.

The Government should ensure that women and girls who have been victims of sexual violence have access on a voluntary basis to counselling and testing for HIV/AIDS and other sexually transmitted diseases, post-exposure prophylactic drugs to prevent HIV infection and other measures to protect the health of the woman.

The Government, with the assistance of international donors, should expand psychological counselling programs for rape survivors and ensure that these constitute an integral part of the health care system.

The Government must ensure that all decisions and policies concerning the provision of health care are consistent with its obligations under the International Covenant on Economic, Social and Cultural Rights, to which it is a state party. It should seek international assistance as necessary so as to be able to provide health care without discrimination of any kind.

The government should ensure that its resources are efficiently and fairly allocated to PLWHA in need of assistance, without discrimination of any kind. The needs and views of PLWHA should be consulted and taken into account in the formulation of government programs and strategies, at both national and local level.

The government should continue and should strengthen education programs aimed at the general public, law enforcement officials and the judiciary concerning existing legislation on inheritance, marriage and land, that protect the rights of women.

In meeting its obligations under the ICESCR to respect, protect and fulfil the right to food, the government should ensure that the particular needs of families living with HIV/AIDS are taken into account. Such needs include the additional burden on resources faced by such families, in addition to specific health needs. The government should seek international assistance and co-operation in this regard and international donors should provide appropriate support.

The Government should implement and enforce anti-discrimination provisions in the Constitution and other legislation by taking action against employers who discriminate against PLWHA by refusing to hire them, by requiring HIV tests prior to hiring or by firing them once they learn the employee's HIV status. The Government should likewise prevent banks and credit agencies from discriminating against people because of their serological status, or government and religious officials from refusing to marry individuals with HIV/AIDS.

The Government, with the assistance of international donors, should make provisions for the children of PLWHA—before the children are left orphan—to ensure the protection of children's rights, including the right to adequate food, clothing, housing, education and the highest attainable standard of health. The government should also provide assistance in claiming inheritance and other rights, and reliable adult support in managing the household if needed. Children already living on the street or in precarious conditions should benefit from special assistance to ensure the enjoyment of the above.

Immediate prevention and legal redress

The Government must continue public education campaigns regarding the rights of women and the rights of children and encourage the public to bring cases of sexual violence to the police, including sexual violence committed against domestic workers, street children and sex

workers, and to continue educating police and the judiciary on how to respond and create an environment where individuals feel comfortable reporting such cases.

The Government should continue investing in long-term and in-depth training of the members of all security personnel, including the armed forces and Local Defence Forces, in all ranks including those in positions of authority over others to ensure that they do not commit, condone or acquiesce in rape and other crimes of sexual violence.

The Government, with the financial assistance of international donors, should pass without delay a law compensating survivors of violence during the genocide and war for the abuses they suffered. This law should compensate victims of all ethnic groups for abuses in a non-discriminatory manner.

The Government should continue to press forward with the investigation and prosecution of reported cases of sexual violence, whether committed in the context of the genocide or by the Rwandan Patriotic Army, as well as recent and future cases of sexual violence.

The Government should invest the necessary energy and resources into the *gacaca* tribunals to ensure that they are able to try cases in a timely and fair manner.

The Government should continue full cooperation with the International Criminal Tribunal for Rwanda.

The Government should build the capacity of the security forces and judiciary to ensure that allegations of rape and other crimes of sexual violence are promptly investigated and where founded, the alleged perpetrators are brought to justice. Measures should include:

- issuing clear guidelines to law enforcement agencies insisting on the duties of law enforcement officials to investigate acts of violence against women, whoever the perpetrator;
- the continued provision of specific training to all law enforcement officials and the judiciary in relevant areas of international human rights law to enhance the understanding of violence against women from a human rights perspective, and to ensure the judiciary's effectiveness in the prosecution of acts of violence against women;
- the provision of training to law enforcement officials and judicial and medical personnel on the investigation and prosecution of cases of sexual violence including on the use of medical and forensic evidence and national and international legal and human rights standards; women police officers and women members of the judiciary should be recruited and trained in sufficient numbers to counter a culture of discrimination and to allow specialization on cases of violence against women;
- investigating past and future allegations of rape by its own forces, and ensuring cooperation with investigations and compliance with all investigations whether by national or international courts or commissions into allegations of human rights violations by members of its security forces and militia;
- transferring the jurisdiction for human rights violations committed by military personnel on active duty, particularly against civilians, to ordinary civilian courts;

- signing and ratifying the Rome Statute of the International Criminal Court immediately without an Article 124 declaration and enact effective implementing legislation, as spelled out in Amnesty International's *Checklist for Effective Implementation* (AI Index: IOR 40/11/2000, 1 August 2000);
- ratifying and fully implementing the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, the African Union Convention on Preventing and Combating Corruption, and the Optional Protocol to the Convention on the Elimination of All Forms of Discrimination Against Women;
- establishing communication and cooperation between civil society organizations and law enforcement agencies at the local level in the interests of protecting survivors of violence and increasing women's trust in the criminal justice system.

Ending general discrimination against women and PLWHA

The Government of Rwanda must give greater priority and resources to developing, supporting and promoting education programs for the public and community leaders on the importance of not stigmatising women survivors of violence or women living with HIV/AIDS and allowing them to speak openly about their situation and to seek help. These programs should include a particular focus on male partners and family members of women living with HIV/AIDS. Such programs should be carried out in consultation with international organizations, national non-governmental organizations, associations of PLWHA, religious communities and independent media. Journalists and civil society must be allowed to communicate freely with the public.

The Government must continue to take a strong public stance on gender-based violence by sending a clear message that it is neither inevitable nor acceptable and that those responsible will be brought to justice. To this end, the Government should compile statistics, conduct research on violence against women and permit other organizations working in Rwanda to document and publicize the results of their research.

The Government must ensure that material is available informing people of their rights, what health care is available and how to proceed if they or members of their families are survivors of sexual violence.

The Government must ensure that legal reforms that support women's rights are not undermined by customary law and practice.

XIII.2. TO THE INTERNATIONAL COMMUNITY

The international community should continue providing funding and technical support to measures that contribute to the protection and fulfilment of the rights to health, food and education of PLWHA and their families, including by supporting programs that provide assistance to children who are orphaned by HIV/AIDS or who are at risk of being orphaned.

Amnesty International urges the international community to ensure that all decisions and policies concerning the provision of health care are consistent with Rwanda's obligations under the International Covenant on Economic, Social and Cultural Rights, to which Rwanda

is a state party. The international community should provide assistance to ensure that the Government of Rwanda is able to provide health care without discrimination of any kind.

The international community must assist the government of Rwanda in establishing a systematic and comprehensive program of care for survivors of sexual violence.

The international community should devise support and promote education programs targeting the public and community leaders on the importance of not stigmatising women survivors of violence and allowing them to speak out and seek help. The international community should support independent media, in particular radio, as a vehicle for human rights awareness.

The international community should urge and support the Government of Rwanda in bringing perpetrators of sexual violence to justice through ordinary jurisdictions, and strongly encourage the Government to press forward with the work of *gacaca* jurisdictions without delay and with the necessary financial and political commitment.

The international community should assist and support the Government of Rwanda in establishing a compensation fund for victims of human rights abuses during the genocide and war.

