



**Submission to the United Nations Third Universal Periodic Review of Democratic Republic of
Congo**

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**Report on Democratic Republic of Congo Compliance with its Human Rights Obligations on
Sexual and Reproductive Health and Rights**

Submitted by: Center for Reproductive Rights

4th October 2018

INTRODUCTION

Distinguished members of the Council:

In accordance with **Human Rights Council Resolution 5/1** of June 18, 2007, the Center for Reproductive Rights (the “**Center**”) submits this letter to supplement the report of the government of the Democratic Republic of Congo (the “**DRC**”), scheduled for review by the Human Rights Council during its 33rd session of the Universal Periodic Review (the “**UPR**”) Working Group (2019). The Center is a non-profit legal advocacy organization dedicated to promoting and defending reproductive rights worldwide. The Center uses the law at national, regional, and international level to advance reproductive freedom as a fundamental right that all governments are legally obligated to protect, respect and fulfill. The Center has strengthened reproductive health laws and policies across the globe by working with more than 100 organizations in 45 nations in Africa, Asia, Europe, Latin America, the Caribbean’s and the United States, and through in-depth engagement with UN and regional human rights bodies.

The DRC is a party to multiple international and regional human rights treaties that require state parties to ensure the sexual and reproductive rights of women and girls. These obligations are further reaffirmed in International Humanitarian Law (IHL). Current interpretation of these obligations encompasses protection from sexual violence as well as the need to ensure that women and girls in conflict receive medical treatment and adequate health services, including counseling. This letter highlights the various reproductive health and rights issues that the Center hopes the Human Rights Council will take into account during its review of the DRC: (i) violations of women’s and girls’ reproductive rights in situations of conflict; (ii) high maternal mortality and lack of access to maternal health care; (iii) lack of access to contraception and family planning information and services; (iv) sexual and gender-based violence against women and girls; and (v) high rate of unsafe abortions and lack of post-abortion care services.

I. **DRC’s failure to protect women’s and girls’ sexual and reproductive rights**

A. Violations of women’s and girls’ reproductive rights in situation of conflict

1. According to the, United Nations Security Council Report (UNSCR),¹ for decades the DRC has been the land of ‘widespread impunity’ for those committing rape and other sexual crimes against women and girls. Abduction of women and girls, rape, and sexual violence have been used as weapons of war.² In its last UPR, the DRC admitted that war was both a contributing and aggravating cause of **increased cases of sexual violence**.³ Several countries raised concern as to the increase in cases of sexual violence against women and girls in the DRC and made recommendations urging the DRC to intensify efforts to combat violence efficiently and prosecute perpetrators.⁴
2. Since the last review, progress has been made....⁵ **DRC’s Public Authorities** have intensified initiatives aimed at protecting and promoting women’s rights, especially in times of conflict. For instance, several ministries center their work separately on “*Gender, Child, and Family*”, “*Solidarity and humanitarian action*”, and “*Human rights*” in the case of *Jeune Afrique v. DRC & Bruno Tshibala v. DRC*.⁶ Additionally, specific human rights and criminal law instruments have been adopted at State level,⁷ and a special adviser in charge of the fight against sexual violence and the recruitment of children has been appointed.⁸ A Women’s month was organized at the DRC’s Presidency,⁹ and the country secured a membership on the UN’s Human Rights Council.¹⁰

3. Despite these efforts, sexual and gender-based violence against women and girls in conflict-affected zones in the DRC remain high. Rape and sexual abuse in war zones are still common and perpetrators can be state agents as well as militia fighters reported in Convention on the Elimination of All Forms of Discrimination against Women (CEDAW).¹¹ The African Committee on the Rights and Welfare of the Child (ACEWRC),¹² noted that rape and other forms of sexual violence, including bodily mutilation, are still rampant in the DRC. Similar concerns have been raised by the Committee on the Rights of the Child (CRC),¹³ in its 2017 review, further highlighting that survivors of sexual violence received little access to healthcare, psychological support and compensation, and that **perpetrators were neither arrested nor prosecuted**. The CRC urged the DRC to ‘ensure prompt and effective investigation, prosecution and punishment of all perpetrators of sexual violence and abuse, sanctions commensurate to the gravity of their crimes, provision of legal aid and rehabilitation to victims’ as well as to ‘undertake a study of the extent and forms of sexual violence and abuse against children by both civilians and militias, and collect disaggregated data on gender-based violence against girls and on the number of complaints, prosecutions and convictions’.¹⁴
4. According to United Nations Organization Stabilization Mission in the Democratic Republic of the Congo (MONUSCO),¹⁵ victims of sexual violence in conflict affected zones in the DRC are often stigmatized and face multiple challenges when reintegrating into their communities. Prevention, security, and post-incident support to victims is limited, and is solely provided by Non-Governmental Organizations. Some of the victims abducted join militias in order to survive in areas where war has been rampant for decades.
5. Violence in areas such as the Kasai region precludes women from accessing maternal health services.¹⁶ Conflict has also affected birth registration due to the constant movement of people in affected areas.¹⁷ In North Kivu, maternal mortality ratio for the first half of 2018 was 790 deaths per 100,000 live births.¹⁸ Insecurity, poor healthcare infrastructure and delays in seeking, reaching, and receiving care are just some of the causes.¹⁹ The percentage of deliveries attended by skilled birth attendants in Kasai ranges from 42% to 62% of expected deliveries, and the percentage of women completing the four antenatal care visits recommended by the World Health Organization (the “WHO”) is under 20% in some areas.²⁰

B. Maternal Mortality and Access to Maternal Healthcare

6. The last UPR Review for the DRC urged the government to effectively implement a national strategy to reduce maternal mortality.²¹
7. In addition to the Constitution, which guarantees the right to health,²² some statutes contain specific measures to protect maternity, such as the right for a woman whose pregnancy severely impacts her health to suspend her work contract.²³ In 2015 the DRC passed a law guaranteeing every woman’s right to health care services at a reasonable cost and distance, while pregnant, and during and after childbirth.²⁴ In 2010, the country launched the National Strategy for the Fight against Newborn and Maternal Mortality. This allowed for the establishment of community relays and basic health structures such as health centers at a national level.²⁵ As a result, maternal mortality went from 1,289 for every 100,000 births in 2001²⁶ to 693 per 100,000 live births in 2015.²⁷
8. Albeit progress, the DRC continues to be recognized as one of the worst ten states for mothers to live in.²⁸ Implementation of national, regional and international law is still hampered by lack of information campaigns concerning legal instruments, persistence of stereotypes, and insufficient funds in the field of

equity and parity.²⁹ According to the 2014 Demographic Health Survey (the “DHS”), maternal mortality increased to 846 deaths per 100,000 live births (compared to 549 deaths per 100,000 live births in the 2007 report), and 35% of all female deaths in the DRC were attributed to maternal causes (up from 19% in the 2007 report).³⁰ A poor rate of qualified medical assistance during births,³¹ in a country with a majority of women and a high fertility rate, remain a barrier to quality maternal healthcare services.³² Lack of qualified medical assistance was indeed raised by the CRC in 2017. Mothers have no access to appropriate medical assistance during and after delivery of the baby.³³ Although a high proportion of women (88%) receive prenatal care from qualified medical personnel,³⁴ 48% of them have received no post-natal care whatsoever. This number reaches 60% for women with poor education, and 58% in rural areas.³⁵ Only 48% of women have gone to the four recommended visits by the WHO, and only 17% of them went to the first one before the 4th month of pregnancy.³⁶

9. For 69% of women, the main obstacle to accessing treatment is money.³⁷ In the province of Occidental Kasai, this number reaches 77.6%, versus 45.1% in that of Kinshasa.³⁸ Another 39% consider distance to be the number one reason,³⁹ especially in rural areas (44.3% in Occidental Kasai compared to 17.5% in Kinshasa⁴⁰).
10. For adolescents, restricted access to maternal health affects not only their health but also education. Pregnant girls are usually asked to leave school and to come back once the baby is born, despite international obligations to provide children with an education without discrimination, thus leaving such young girls poorly educated. Even though the DRC is among the 26 African countries that have adopted continuation or re-entry strategies – where a pregnant student should be allowed to remain in school or be re-admitted easily- policies explaining the process to be followed by schools and information concerning this procedure are still lacking.⁴¹

C. Access to sexual and reproductive health services and information

11. In 2014, following recommendations from the 2nd National Conference to Reposition Family Planning (Kinshasa), the General Secretary of the *Ministère de la Santé* of the DRC adopted the 2014-2020 National Strategic Plan for Family Planning. Its objectives are twofold: increase the modern contraceptive prevalence rate (the “mCPR”) for all women of reproductive age from 6.3% to at least 19.0% by 2020, and increase the number of users of modern contraception to 2.1 million by 2020.⁴²
12. Recently, the DRC also increased its financial commitments for the purchase of contraceptives,⁴³ with similar commitments being made at provincial level.⁴⁴ More recently, a number of laws and initiatives such as the *Loi n° 15/013 du 1 Août 2015 portant modalités d’application des droits de la femme et de la parité*, in relation to sexual and reproductive rights, as well as access to education, have been adopted or are in the process of being adopted.⁴⁵
13. Surveys conducted by independent agencies have shown an increase in the mCPR rate (from 18.5% to 26.7% among married women between 2013 and 2017).⁴⁶ The level of unmet needs however remain high. Whilst the number of charities promoting family planning in the DRC has increased in the past five years,⁴⁷ family planning remains mostly concentrated in the provinces of Kinshasa and Nord Kivu.⁴⁸ Disparities between urban and rural areas pose another challenge. The mCPR is high in urban areas with a 15% rate, against 5% in rural areas.⁴⁹ According to the 2014 DHS, only 20% of married women are using any method

of contraception, and only 8% are using a modern method.⁵⁰ The uptake also varies dramatically by level of education: 19% of women with more than a secondary education are using a modern method, compared to 4% of women with no education.⁵¹ A restrictive legal environment hinders access to information on family planning. Under criminal law, any information and/or distribution of contraception is still considered a felony.⁵² Funding remains a challenge and despite government committing to an annual budget of \$2.5 million of contraceptives, only \$1 million was disbursed in 2016.⁵³ Other factors include the influence of social cultural norms, such as the requirement that women seek permission from their husbands to use contraception,⁵⁴ the belief that large families are potential economic assets,⁵⁵ and the misconception that contraception encourages prostitution or causes infertility.⁵⁶

14. Limited access to family planning information continues to hinder access to family planning services. 13% of women were exposed to family planning messages on the radio, on television, in newspapers or magazines, and only 5% of non-users were visited by a field worker in the months prior to the DHS survey.⁵⁷
15. Awareness of Emergency Contraception (the “EC”) is low, and the method remains underused and poorly integrated in family planning programming.⁵⁸ In 2016, only 1.3% and 0.9% of married and unmarried women respectively aged 15 to 49 in Central Congo had access to the EC.⁵⁹ The unmet needs for families in conflict-affected zones in the DRC remain as high as 38%.⁶⁰

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

16. Existing DRC legislation and initiatives address sexual and gender-based violence against women and girls. Article 14 of DRC Constitution sets out that public authorities are tasked with the elimination of discrimination against women and their rights, as well as the protection and promotion of their rights.⁶¹ This involves taking measures to ‘fight all forms of violence against women in their public and private life.’ Moreover, article 15 targets ‘sexual violence used as an instrument in the destabilization and displacement of families specifically’, declaring it a crime against humanity punishable by law.⁶² The DRC also introduced amendments to the Criminal Code in order to criminalize several forms of sexual violence.⁶³ The intention was to prevent and reprimand infractions relating to sexual violence and to ensure systematic support for the victims of these crimes.
17. The DRC has made efforts in the past years to improve the situation. Some of the steps taken include:
 - (a) introducing public campaigns combatting violence, for example the 2015 “*Break the Silence*” Campaign launched by the Personal Representative of the Head of State on Sexual Violence and Child Recruitment; and the annual 16 days of activism against gender-based violence campaign which is held from mid-November to December;
 - (b) establishing special police units to protect women and children against sexual violence in the different provinces;
 - (c) adoption by the armed forces of an action plan to combat sexual and gender-based violence and a code of ethics and conduct specifically aimed at addressing sexual violence; and
 - (d) appointing a Personal Representative of the Head of State on Sexual Violence.⁶⁴

18. The United Nations has welcomed the increased number of prosecutions and convictions for sexual violence. For example, in December 2017, the South Kivu Military Court sentenced 12 people, including local Member of Parliament Frederic Batumike, to life imprisonment for crime against humanity for the rape and murder of 38 children.⁶⁵
19. In spite of these efforts, sexual and gender-based violence remains high. In the months prior to the 2013-2014 DHS survey, 52% of women reported having experienced physical violence since the age of 15.⁶⁶ Occidental Kasai, a conflict-affected region, has a 62% rate of physical, sexual and spouse violence.⁶⁷
20. Despite strongly stated commitments from senior DRC officials, obstacles continue to prevent victims of sexual violence from gaining full access to justice. The limited efforts of some Congolese authorities to prosecute sexual violence cases, cases of corruption within the judicial system and the lack of resources and capacity all contribute to impunity for perpetrators of sexual violence.⁶⁸
21. Difficulties in acquiring accurate statistics about sexual and gender-based violence remain as a large number of victims do not report cases for fear of being stigmatized and rejected by their families and communities. Many also lack access to justice because they cannot afford legal fees, medical fees, and travel costs associated with formal legal proceedings.⁶⁹

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

22. The domestication of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (hereinafter the "**Maputo Protocol**") in March 2018 should be applauded, as it constitutes a significant step towards the legalization of abortion in cases of rape and incest.
23. However, existing restrictive abortion laws continue to deny women access to safe abortions and post-abortion care services. To date, many of the provisions of the DRC's Criminal Code⁷⁰ prohibit abortion in most cases. In its report to CEDAW, the government of DRC admitted that abortion is yet to be 'decriminalized given the sanctity of human life from the moment of conception'.⁷¹ The DRC's Criminal Code punishes anyone who performs an abortion,⁷² women who undergo an abortion,⁷³ and more generally, any person who promotes, by way of distributing or selling informational material, ways in which to obtain an abortion.⁷⁴ There are no exceptions in cases of pregnancies resulting from rape. On a very exceptional basis, an abortion may be possible in order to save the life of the pregnant woman.⁷⁵ The preservation of physical or mental health is, however, not taken into account.⁷⁶ It should be noted that doctors have the right, under certain conditions, to consciously object to undertaking the abortion on grounds of personal beliefs.⁷⁷
24. As a result, many women resort to clandestine abortions. An estimated 146,713 abortions took place in Kinshasa in 2016 for women aged 15 to 49.⁷⁸ Clandestine abortions are usually unsafe, and are considered to be one of the leading causes of maternal mortality in Sub-Saharan Africa.⁷⁹ In 2016, around 11,500 abortions resulting in complications did not receive medical attention.⁸⁰ In Kinshasa, the overall majority of complications resulting from abortion are treated in lower-level facilities (private or NGO affiliated health centers), with only 4% being treated in public health centers.⁸¹
25. In 2013, only 20% of health structures had established a post-abortion care protocol or had handbooks on the matter.⁸² From 2011 to 2015, CARE⁸³ launched a Supporting Access to Family Planning and Post-Abortion Care (the "SAF-PAC") programme in the DRC.⁸⁴ The strategy was based on a close collaboration

with local government health facilities and provided post-abortion counseling to women and clinical skills to providers.⁸⁵ Information pertaining to measures taken by the DRC concerning post-abortion care is scarce.

II. Questions

26. We hope that the Human Rights Council shall consider addressing the following questions to the DRC:

- (a) What measures are being taken to ensure that women and girls in conflict-affected areas have access to sexual and reproductive health services and information, quality maternal health care and safe abortion services?
- (b) What measures are being taken to investigate and prosecute perpetrators of sexual and gender-based violations against women and girls affected by conflict, including effective mechanisms for accountability and redress?
- (c) What steps are being taken to allocate resources necessary to improve maternal healthcare services through ensuring that healthcare facilities are adequately equipped and, to increase the number of skilled healthcare providers in hard-to-reach populations, specifically women and girls in conflict-affected areas?
- (d) What measures are being taken to clarify the laws on abortion and ensure that women have access to legal and safe abortion and post-abortion care services?
- (e) What measures are being taken to remove the barriers women and girls face when accessing contraception, especially on the matter of comprehensive reproductive health information and services? Specifically, what measures are being taken to ensure access to sexual and reproductive health services by adolescents, women and girls in rural areas in conflict-affected zones?

III. Recommendations

27. We hope the Council will consider the following recommendations:

- a) The DRC should take steps to increase access to sexual and reproductive health services for women and girls in conflict-affected zones including access to quality maternal health care, and guarantee access to safe abortion services, as well as provide appropriate redress to victims of sexual and gender-based violence.
- b) The DRC should take measures to reintegrate and rehabilitate victims of sexual violence in conflict affected zones.
- c) The DRC should decriminalize abortion in line with international human rights standards.
- d) The DRC should take steps to remove barriers that women and adolescent girls face in accessing family planning and contraceptive information and services including undertaking measures to ensure that sufficient supplies of contraceptives, including emergency contraceptives, are available,

accessible and affordable, and that women and girls are provided with comprehensive and accurate information about contraceptives and family planning. This should include amending the provisions of the Criminal code which penalizes dissemination of information on contraception.

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

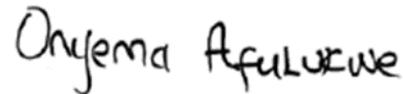
Sincerely,



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Onyema Afulukwe

Senior Counsel for Africa

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¹ UN, Security Counsel, Report on its mission in DRC, 2010; Final Report from the Expert Group on DRC, 2014 ; Final Report from the Expert Group on DRC, 2015; Report from the Secretary General on the UN Mission for the stabilization of DRC, 2016; Report from the Secretary General on the UN Mission for the stabilization of DRC; BCNUDH note on the main trends concerning violations of Human Rights in January 2018; BCNUDH note on the main trends concerning violations of Human Rights in May 2018

² RFI Afrique, *Une militante du droit des femmes en RDC primée à Genève*, 20 February 2018, <http://www.rfi.fr/afrique/20180220-rdc-droit-femmes-julienne-lusenge-primee-sofepadi>; Report of the Secretary General on Conflict -Affected Sexual Violence s/2018/250 (16 April 2018) available at <<https://www.un.org/sexualviolenceinconflict/wp-content/uploads/reports/sg-reports/SG-REPORT-2017-CRSV-SPREAD.pdf>>

³ UN UPR Review for the DRC, Report of the Working Group

⁴ Id.

⁵ UN Organization Stabilization Mission in the DR Congo (hereinafter “MONUSCO”), “Some progress in the fight against impunity but rape still widespread and largely unpunished”, 9 April 2014.

⁶ Jeune Afrique, *RDC : Bruno Tshibala dévoile la liste de son gouvernement*, 9 mai 2017, available at <http://www.jeuneafrique.com/434633/politique/rdc-bruno-tshibala-devoile-liste-de-gouvernement/>.

⁷ Loi n°15/023 du 31 décembre 2015 modifiant la Loi n°024-2002 du 18 novembre 2002 portant Code pénal militaire; Loi n°15/022 du 31 décembre 2015 modifiant et complétant le Décret du 30 janvier 1940 portant Code pénal; Loi n°15/013 du 1er août 2015 portant modalités d'application des droits de la femme et de la partie ; Loi n°11/008 du 0 juillet 2011 portant criminalisation de la torture ; Loi n°06/018 du 20 juillet 2006 modifiant et complétant le Décret du 30 janvier 1940 portant Code pénal congolais.

⁸ Digital Congo, *La loi condamne l'auteur du viol peu importe son rang social, soutient Me Césaire Divioka*, 28 August 2018, <https://www.digitalcongo.net/article/5b7ed4cc3bbb9b00041570cc/>; (last visited Sep 27, 2018) Décret n°09/38 du 10 octobre 2009 portant création, organisation et fonctionnement de l'Agence nationale de lutte contre les violences faites à la Femme et à la Jeune et Petite Fille.

⁹ Le Cabinet du Président de la République, *La clôture du mois de la femme célébrée à la Présidence de la République*, 3 April 2018, <http://www.presidentrdc.cd/iconsult.php?article657> (last visited Sep 27, 2018)

¹⁰ Deutsche Welle, “DR Congo controversially elected to UN Human Rights Council”, 16 October 2017, available at <https://www.dw.com/en/dr-congo-controversially-elected-to-un-human-rights-council/a-40978339>.

¹¹ DRC report to the Committee on Elimination of All Forms of Discrimination Against Women (hereinafter « **CEDAW** »), 2017, at 5.

¹² African Committee of Experts on the Rights and Welfare of the Child (hereinafter “**ACERWC**”), Continental Study on the Impact of Conflict and Crises on Children in Africa, 2016

¹³ CEDAW Committee, Concluding Observations on the combined third to fifth periodic reports of the DRC, 2017

¹⁴ Id. para. 2.4

¹⁵ MONUSCO, *La MONUSCO satisfaite de l’avancée de son projet d’assistance aux victimes d’exploitation et abus sexuels à Sake*; World Health Organization (hereinafter “**WHO**”), *Région des Kasai (centre de la RDC) : comment définir les priorités et renforcer la programmation des soins de santé de la reproduction*, 24 August 2018; ICRC, “Searching for snails as hunger stalks Tanganikya”, 14 March 2018; Arte TV, *RDC : les femmes résistent*, 2018, <https://www.arte.tv/fr/videos/084142-000-A/rdc-les-femmes-resistent/>; (last visited Sep 27, 2018) The Guardian, « Girls who leave militias get rejected: helping child soldiers go home », 15 August 2018, <https://www.theguardian.com/global-development/audio/2018/aug/15/girls-who-leave-militias-get-rejected-helping-child-soldiers-go-home-podcast>; (last visited Sep 27, 2018) ICRC, « DR Congo: Consequences of stigmatization of sexual violence victims », 13 January 2016 ; ICRC, « Sexual violence in the Democratic Republic of the Congo: Telling the story and overcoming the trauma », 4 June 2014.

¹⁶ UNFPA, “Violence and fear limit access to pregnancy care in Democratic Republic of Congo’s Kasai area, 1 September 2017, available at <https://www.unfpa.org/news/violence-fear-limit-access-pregnancy-care-democratic-republic-congos-kasai-area>.

¹⁷ CEDAW Committee, *supra* note 13.

¹⁸ State of the world’s mothers’ index (ICRC), 2014

¹⁹ “Using a quality improvement approach to improve maternal and neonatal care in North Kivu, DRC, Michelle Hynes et al, 2017, Reproductive Health Matter

²⁰ International Medical Corps, North Kivu assessment report, 2014

²¹ UN UPR Review for the DRC, Report of the Working Group, Recommendations 134, 143 and 144.

²² The Constitution of DRC, 2011, art. 47

²³ Article 129 of the DRC Labor Code.

²⁴ Loi n°15/013 du 1er août 2015 portant modalités d’application des droits de la femme et de la partie.

²⁵ DRC report to the CEDAW, 2017

²⁶ Id. para. 1.7.

²⁷ CIA World Factbook

²⁸ State of the world’s mothers’ index (ICRC), 2015

²⁹ African Commission for Human and Peoples’ Rights (hereinafter “**ACHPR**”), Periodic Report for 2005-2015 for the DRC to the African Commission for Human Rights.

³⁰ The Demographic and Health Surveys (hereinafter “**DHS**”), Demographic and Health Survey for the DRC for 2013-2014.

³¹ Less than six out of 10 births are assisted by qualified personnel, with only 7% by doctors, 38% by nurses and 3% by midwives. This number can vary from 74% in rural areas to 94% in the cities. In the regions of Equator and Oriental Province, 72% of women have problems accessing healthcare services in general, as opposed to 45,1% in Kinshasa (see DHS Survey for the DRC 2013-2014)

³² Six children per woman in 2015 according to the UN, Population Division, World Population Prospects.

³³ CEDAW Committee, *supra* note 13.

³⁴ DHS, Demographic and Health Survey for the DRC for 2013-2014.

³⁵ Id. para. 3.4.

³⁶ Id. para. 1.6.

³⁷ Country Gender Profile for the DRC, Final Report, 2017.

³⁸ Id. para. 2.4.

³⁹ Id. para. 1.6.

⁴⁰ Id. para. 1.3.

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⁴¹ “Leave No Girl Behind in Africa”, Human Rights Watch, 2018, <https://www.hrw.org/report/2018/06/14/leave-no-girl-behind-africa/discrimination-education-against-pregnant-girls-and> (last visited Sep 27, 2018)

⁴² Engagement of Mr. Kwete Dieudonné – advisor of the Prime minister of DRC – in the name of the government of DRC at the International Conference on family planning on November 15th, 2018.

⁴³ The DRC recently earmarked an annual budget for family planning and reproductive health of \$2.5 million for the purchase of contraceptives, *supra* note 3, para. 3.

⁴⁴ The Lualaba province committed to allocate \$109,000 for the purchase of contraceptives, *supra* note 2, para. 3.

⁴⁵ Loi n° 15/013 du 1 Août 2015 portant modalités d’application des droits de la femme et de la parité: article 13 provides that “*L’homme et la femme sont partenaires égaux dans la santé de la reproduction (alinéa 1). Ils choisissent de commun accord une méthode de planification familiale qui tient compte de leurs santé respectives.*”; Article 15 provides that: « L’Etat est le premier responsable de la lutte contre le VIH/Sida. Il définit la politique, trace les grandes orientations et élabore les programmes en matière de prévention, de prise en charge, d’atténuation de l’impact négatif et de la recherche (alinéa 1). La femme et l’homme séropositifs bénéficient de toutes les dispositions mises en place par l’Etat dans le cadre de la politique nationale de santé de la reproduction. (alinéa 2).” On 1 June 2018, the National Assembly of DRC approved a bill relating to healthcare. The next step is the passing of this bill “article by article” (Family Planning 2020, RDC Questionnaire Mise à Jour des Engagements 2018, available at <http://ec2-54-210-230-186.compute-1.amazonaws.com/wp-content/uploads/2018/07/RDC-questionnaire-mise-a-jour-des-engagements-2018.pdf>; (last visited Sep 27, 2018) Article 12-36 of the Eighth report submitted by the DRC (CEDAW) provides that DRC must make sure that early pregnancy is covered in school curricula, particularly in the life skills course. Also, reproductive health programmes must address methods of family planning and adolescent health.

⁴⁶ CEDAW, *supra* note 11, art. 12 – 38 the rate of HIV/AIDS has decreased from 4 per cent in 2006 to 2.57 per cent in 2011 and to 1.1 per cent from 2012 to 2015. Among other reasons, this is due to the fact that the national multisectoral programme to combat AIDS is far-reaching, and the number of HIV/AIDS-related services has increased significantly; Radio Okapi, *Sida : la RDC réalise des progrès en matière de traitement et de prévention*: about 50% of people living with HIV / AIDS (PVV) in the DRC have access to antiretroviral therapy compared to 10% in 2010 and 70% have access to methods of prevention of mother-to-child transmission against 8% seven years ago, 1 December 2017, available at <https://www.radiookapi.net/2017/12/01/actualite/sante/sida-la-rdc-realise-des-progres-en-matiere-de-traitement-et-de-prevention>; ONU Sida, *La République démocratique du Congo sur la bonne voie avec son plan de rattrapage pour le VIH*, 22 Mai 2017, available at http://www.unaids.org/fr/resources/presscentre/featurestories/2017/may/20170522_drc; ONU Sida, Country Factsheets, DRC, 2018: According to a study conducted by ONUSIDA, the number of people living with HIV has decrease from 420.000 in 2014 to 390.000 in 2017, available at <http://www.unaids.org/fr/regionscountries/countries/democraticrepublicofthecongo>. (last visited Sep 27, 2018)

⁴⁷ “Family Planning in the Democratic Republic of the Congo: Encouraging Momentum, Formidable Challenges”, Dieudonné Kwete et al, 2018, PMC.

⁴⁸ *Id.* at 3.

⁴⁹ “Barriers to modern contraceptive use in rural areas in DRC”, Mbadu Fidèle Muanda et al, Culture Health & Sexuality

⁵⁰ DHS, *supra* note 34.

⁵¹ *Id.*

⁵² Article 178 de la Loi n° 06/018 du 20 juillet 2006 modifiant et complétant le Décret du 30 janvier 1940 portant Code pénal congolais.

⁵³ Family Planning 2020, RDC Questionnaire Mise à Jour des Engagements 2018, <<http://ec2-54-210-230-186.compute-1.amazonaws.com/wp-content/uploads/2018/07/RDC-questionnaire-mise-a-jour-des-engagements-2018.pdf>> (last visited Sep 27, 2018)

⁵⁴ “In DRC, Married Women Receive Preferential Access to Birth Control”, Global Press Journal, 2018

⁵⁵ Mbadu, *supra* note 49.

⁵⁶ Kwete, *supra* note 47.

⁵⁷ DHS, *supra* note 34.

⁵⁸ “Awareness and Perceptions of Emergency Contraceptive Pills Among Women in Kinshasa, Democratic Republic of the Congo”, Julie Hernandez et al, 2017, Guttmacher Institute.

⁵⁹ PMA2020/DRC, Family Planning Brief, Performance Monitoring & Accountability 2020, Kongo Central, 2017.

⁶⁰ Ministère du Plan et Suivi de la Mise en œuvre de la Révolution de la Modernité, Ministère de la Santé Publique ; ICF International, République Démocratique du Congo; DHS, Demographic and Health Survey for the DRC for 2013-2014.

⁶¹ The Constitution of DRC, 2011, art. 14, “*Les pouvoirs publics veillent à l’élimination de toute forme de discrimination à l’égard de la femme et assurent la protection et la promotion de ses droits.*”

⁶² Id. art 15, “*Les pouvoirs publics veillent à l’élimination des violences sexuelles.*

Sans préjudice des traités et accords internationaux, toute violence sexuelle faite sur toute personne, dans l’intention de déstabiliser, de disloquer une famille et de faire disparaître tout un peuple est érigée en crime contre l’humanité puni par la loi.”

⁶³ Lois n°06/018 du 20 juillet 2006 modifiant et complétant le Décret du 30 janvier 1940 portant Code penal congolais et n°06/019 du 20 juillet 2006 modifiant et complétant le Décret du 6 août 1959 portant Code de Procédure Pénale Congolais; Reliefweb, “MONUC and the Congolese government launch the strategy against gender based violence”, 25 November 2009, available at <<https://reliefweb.int/report/democratic-republic-congo/monuc-and-congolese-government-launch-strategy-against-gender-based>> ; Refworld, DRC: Domestic and sexual violence, including legislation, state protection and services available to victims, 2012, <<http://www.refworld.org/docid/4f9e5e532.html>> . (last visited Sep 27, 2018)

⁶⁴ CEDAW, *supra* note 11.

⁶⁵ MUNSCO, *supra* note 5, para. 3.

⁶⁶ DHS, *supra* note 34.

⁶⁷ Id.

⁶⁸ MUNSCO, *supra* note 5, at 3.

⁶⁹ Id. at 5.

⁷⁰ Criminal Code of the Democratic Republic of Congo, 2004

⁷¹ Eighth Periodic Report submitted by the DRC to CEDAW, 2017

⁷² DRC’s Criminal Code, 2004, art. 165: “*Celui qui, par aliments, breuvages, médicaments, violences ou par tout autre moyen aura fait avorter une femme, sera puni d’une servitude pénale de cinq à quinze ans.*”

⁷³ Id. art 166.

⁷⁴ Id. art 178.

⁷⁵ Ordonnance 70-158 du 30 avril 1970 déterminant les règles de la déontologie médicale, *supra* note 2, para. 4.

⁷⁶ Guttmacher Institute (Chae et al), “*The incidence of induced abortion in Kinshasa, Democratic Republic of Congo*” (2016)

⁷⁷ *Supra* note 75, “*Dans des cas exceptionnels, lorsque la vie de la mère est gravement menacée et que l’avortement thérapeutique paraît le seul moyen de la sauver, la légitimité de cette intervention reste en discussion. [...]*

Si le médecin, en raison de ses convictions, estime qu’il lui est interdit de conseiller ou de pratiquer l’avortement thérapeutique, il peut se retirer et cesser ses soins dans les conditions prévues par l’article 22.

S’il est convaincu que l’avortement thérapeutique s’impose, il devra, avant d’y procéder, obtenir un avis conforme de la part de deux confrères dont l’autorité est notoire.” ; This right is recognized by the UN Human Rights Committee (Article 18 of the International Convention on Civil and Political Rights).

⁷⁸ Guttmacher, *supra* note 76.

⁷⁹ Id.

⁸⁰ Id.

⁸¹ Id.

⁸² UNFPA, *Soins Après Avortement dans les pays d’Afrique de l’Ouest*, (2013).

⁸³ Cooperative for Assistance and Relief Everywhere, nonsectarian, impartial and non-governmental organisation.

⁸⁴ CARE, Supporting Access to Family Planning and Post-Abortion Care, Fact Sheet, http://www.care.org/sites/default/files/documents/SAFPAC_Final.pdf. (last visited Sep 27, 2018)

⁸⁵ Id.

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