Policy Brief: Human Rights Analysis of Rwanda's Draft Law Regulating Healthcare Services submitted by the following organizations

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Contents

TERMS USED.. 4

1. CEDAW – Convention on the Elimination of All Forms of Discrimination Against Women. 4
2. CRPD – Convention on the Rights of Persons with Disabilities 4
3. CRC – Convention on the Rights of the Child.. 4

Executive Summary 5

Background 7

Context and Purpose of the Draft Law.. 7

Scope of Analysis.. 7

Legal Framework.. 8

Domestic Constitutional Obligations.. 9

International Human Rights Treaties.. 9

Article-by-Article Analysis and Key Issues 10

1. General Provisions and Definitions..10
2. Non-Discrimination and Equality in Healthcare..12
3. Gender Equality and Reproductive Health Rights 13
4. Adolescent Health Rights and Consent Mechanisms 17

Recommendations to Address Consent for Adolescents and PWD...20

Adolescent-Friendly Services Beyond Consent 21

5. Rights of Persons with Disabilities in Healthcare..22

6. Mental Health Services and Patient Rights 23

7. Digital Health Services and Data Privacy...29

Conclusions and Recommendations...31

TERMS USED

1. CEDAW – Convention on the Elimination of All Forms of Discrimination Against Women

- **Signed:** 1 May 1980
- **Ratified:** 2 March 1981
- **Entry into Force:** 3 September 1981

Rwanda also ratified the **Optional Protocol to CEDAW** on **15 December 2008**, enhancing the enforcement of women's rights through individual complaints and inquiry procedures.

2. CRPD – Convention on the Rights of Persons with Disabilities

- **Acceded:** 15 December 2008
- **Entry into Force:** 14 January 2009

Rwanda's accession to the CRPD signifies its commitment to promoting and protecting the rights of persons with disabilities.

3. CRC – Convention on the Rights of the Child

- **Signed:** 26 January 1990
- **Ratified:** 24 January 1991
- **Entry into Force:** 23 February 1991

By ratifying the CRC, Rwanda has pledged to uphold the rights and welfare of children in all aspects of society.

Executive Summary

Rwanda's Draft Law Regulating Healthcare Services is a significant reform intended to modernize the health sector by replacing outdated laws and integrating scattered provisions (including reproductive health and professional liability laws) into a comprehensive framework. The draft law demonstrates commendable strengths – it seeks to ensure **accessible, high-quality, and patient-centered healthcare**, enumerates key health services (e.g. reproductive, digital, mental health services), and incorporates important protections such as the right to emergency care and data privacy in digital health. It also explicitly upholds equality in reproductive health rights, stating that all persons have equal rights to reproductive health **"without any form of discrimination"**. These are positive steps aligning with Rwanda's Constitution (which guarantees equality and the right to health) and international obligations under CEDAW, CRPD, and CRC.

However, a **human rights-based review** of the draft law identifies critical gaps and areas for improvement. While the law proclaims non-discrimination, some **definitions and provisions inadvertently perpetuate discrimination or omit vulnerable groups**. For example, defining a "couple" strictly as a man and woman legally married may exclude unmarried or same-sex partners from assisted reproduction services, raising concerns under CEDAW's mandate to eliminate discrimination based on marital statuslaw.umich.edu. Provisions on consent are also problematic: the draft requires that any patient under 18 or any adult with a mental or sensory disability have decisions made by a legal representative. This blanket substitution of consent conflicts with the CRPD's standards of **supported decision-making** and equal recognition before the law, which prohibit denying persons with disabilities their legal agencyatlas-of-torture.orgatlas-of-torture.org. Additionally, **adolescent health rights** are not sufficiently guaranteed – although drafters signaled intent to lower the age of consent for health services, the law retains the rule that only adults (18+) can consent to treatment. This may deprive mature adolescents of autonomous access to essential services like **contraception or mental health care**, contrary to CRC guidance that adolescents' evolving capacities be respected and that lack of confidentiality or parental consent requirements can deter them from seeking carelaw.umich.edu.

Gaps also exist in **reproductive health provisions**. The draft rightly lists comprehensive reproductive services (e.g. family planning, STI treatment, infertility care, prevention of gender-based violence), reflecting Rwanda's commitments under CEDAW and the Maputo Protocol. Yet it does not explicitly address **adolescent access** to these services or clarify consent mechanisms for adolescents – an omission at odds with the CRC and CEDAW, which urge States to ensure adolescents can obtain confidential reproductive health services without unnecessary barrierslaw.umich.eduohchr.org. The law also repeals the prior Reproductive Health Law (2016), which had allowed some access to safe abortion under specific conditions; **if equivalent guarantees are not fully incorporated in the new law**, there is a risk of regression in reproductive rights. Likewise, the draft's treatment of **mental health** raises human rights concerns. It provides procedures for involuntary psychiatric admission and treatment (e.g. initial 48-hour emergency hold and 30-day extension reviews) – a sign of progress in regulating mental healthcare – but does not clearly mandate judicial oversight or regular independent review of such detentions. The CRPD Committee has called for ending forced treatment and replacing it with measures based on free and informed consent and supportatlas-of-torture.orgohchr.org. Strengthening safeguards (periodic court review, patient advocacy, right to appeal) in the law would better align with

Rwanda's obligations under CRPD and the right to liberty and security of persons with psychosocial disabilities.

Finally, while the draft law addresses **digital health data privacy** admirably in Article 64, it should be implemented in harmony with Rwanda's 2021 data protection law and include explicit **confidentiality protections** for all patient records. The law should explicitly affirm that **healthcare providers must keep patient information confidential**, including for adolescent patients – as highlighted by the CRC, breach of confidentiality can deter minors (especially in sexual and reproductive health matters) from seeking care

Recommendations:

Rwandan health laws must acknowledge that certain groups face elevated risks of discrimination and stigma in healthcare. Key populations—such as sex workers, people who use drugs, people living with HIV, and other marginalized groups—as well as sexual minorities often encounter mistreatment, refusal of care, or hostility in health settings. These experiences undermine their right to health and lead to worse health outcomes, including higher rates of untreated illness and mental health challenges. The Draft Law's background should explicitly recognize these vulnerabilities and the need to protect the dignity and rights of all persons.

To ensure the law fulfills Rwanda's human rights commitments, this brief recommends specific amendments and clarifications, including: broadening definitions to be inclusive, adding a general non-discrimination clause covering **all** grounds (sex, disability, age, etc.), introducing a provision enabling adolescent consent for certain services in line with evolving capacities, removing or revising the blanket requirement of guardian consent for adults with disabilities (in favor of supported decision-making), and strengthening reproductive and mental health rights protections. These changes, detailed in the analysis below, will help ensure the law not only modernizes healthcare delivery but does so in a way that upholds **gender equality**, the **rights of persons with disabilities**, and **adolescents' health rights**, in harmony with Rwanda's Constitution and international treaties like CEDAW, CRPD, and CRC.

Definitions and General Provisions

The law's definitions and general provisions should be made explicitly inclusive. Key terms like **"healthcare provider"**, **"patient"**, **"couple"**, and **"family"** must be defined without heteronormative or marital biases. For example, *"couple"* and *"family"* should include unmarried partners and same-sex couples, as well as extended or non-traditional family structures. This prevents the law from implicitly limiting services to married, opposite-sex couples only. Similarly, definitions of **healthcare professional** should cover all cadres (doctors, nurses, midwives, community health workers, HIV counselors, etc.) to ensure inclusive regulation. All references to guardianship or marital status (e.g. in consent rules) should be broadened so as not to disadvantage single parents, non-traditional families, or sexual minorities. Ensuring inclusivity at the definitional level strengthens the law's non-discrimination framework and avoids loopholes that could marginalize key populations and sexual minorities.

The Draft Law should explicitly prohibit discrimination against all vulnerable groups in healthcare. **Key populations and sexual minorities should be named** as protected categories. For instance, the law should bar any provider or facility from denying or limiting care based on a patient's sex, gender identity, sexual orientation, HIV status, history of drug use, or occupation (such as sex work) Including sex workers, men who have sex with men (MSM), transgender persons, people who inject drugs, prisoners, and people living with HIV in the non-discrimination clause makes clear that these at-risk groups are entitled to equal treatment. The law should also forbid both direct and indirect discrimination (e.g. not only explicit refusals of care but also policies that have discriminatory effects).

- **Explicit Protections:** Incorporate language such as *"No one shall be denied healthcare services on the grounds of race, color, sex, gender, gender identity, sexual orientation, HIV status, disability, occupation, social or economic status, or any other status"*. This unified statement should appear early (e.g. in the general provisions) to set the tone. Healthcare ethics chapters should mirror this by requiring providers to treat all patients respectfully, without stigma or prejudice.
- **Accessible, Confidential Services:** Emphasize that all patients have the right to confidential, stigma-free care. For example, sexual minorities and adolescents should be assured that seeking HIV testing, sexual/reproductive health, or mental health services will be private, encouraging them to seek care without fear of exposure or punishment. Stigma remains a formidable barrier to engaging in care among key populations, so legal protections for confidentiality are essential.
- **Complaint and Enforcement:** Specify that discriminatory acts by health workers (such as refusing treatment or verbal abuse) carry disciplinary penalties or fines. Establish a mechanism (like a regulatory authority or patient ombudsman) to receive discrimination complaints and mandate regular reporting on non-discrimination compliance.

Example Revision: In Article 31 on Patients' Rights, add: "Every person has the right to respect and dignity in healthcare. Discrimination by healthcare providers or facilities based on any status—including key population status or sexual orientation/gender identity—is strictly prohibited. Any violation shall be subject to disciplinary action." This could be modeled on Article 66's principle of equal rights, extended to cover all care settings.

By integrating these changes, the Draft Law will better uphold *"leave no one behind"* and the full spectrum of human rights in healthcare. In addition to the specific additions above, stakeholders should consider the following overarching recommendations:

- **Explicitly mention key populations and sexual minority persons** as protected in the law's non-discrimination clauses.
- **Broaden family/couple definitions** and remove heteronormative assumptions in every applicable article (e.g. access to services, consent rules).
- **Guarantee confidentiality** for all patients, especially adolescents and sexual minorities seeking SRHR or mental health care.
- **Train health workers** in human rights and diversity, and enforce accountability for discriminatory conduct.
- **Cite Rwanda's treaty obligations** (African Charter and Maputo Protocol) in the law's preamble or explanatory notes to reinforce inclusive commitments.

Implementing these changes will help ensure that Rwanda's healthcare law truly advances equitable, stigma-free care for the most vulnerable—fulfilling both the letter and spirit of domestic and international human rights standards. In the words of the African Charter, the State must work to *"provide an environment that enhances the enjoyment of good health"* for every person, especially those facing the greatest barriers to care.

Background

Context and Purpose of the Draft Law

Rwanda's Draft Law Regulating Healthcare Services was developed to replace an outdated 1998 law on the practice of medicine and to consolidate various health-related statutes into a single, comprehensive Law. The impetus for this reform is both practical and progressive: the prior legal framework had become obsolete given rapid advances in medicine and technology, and relevant provisions were scattered across multiple laws (including a 2012 law on medical professional liability insurance and a 2016 law on human reproductive health). By **merging these areas into one law**, the drafters aimed to reduce fragmentation and fill gaps in the delivery of health services. Indeed, the draft law explicitly repeals those earlier laws, signaling an intent to **update and streamline health governance**.

The Government's explanatory notes highlight that this legislation comes "at a timely moment" to address unmet needs in healthcare provision and to attract investment in new health technologies. Notably, Rwanda has recently experienced growth in services such as **assisted reproductive technology (ART)** – IVF and related fertility treatments – which were not regulated under older laws. The draft law responds by including dedicated provisions on ART. It also addresses **digital health services** (like telemedicine and electronic records) and **mental health care**, both reflecting the evolving landscape of healthcare needs.

From a human rights perspective, this legal update is occurring in a country known for strong commitments to gender equality and social inclusion. Rwanda's Constitution enshrines principles of **non-discrimination and equal rights** (Articles 10, 16) and explicitly recognizes the **right to health** for all citizensrwandalii.org. Rwanda is party to all major human rights treaties relevant to health, including the **Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)**, the **Convention on the Rights of Persons with Disabilities (CRPD)**, and the **Convention on the Rights of the Child (CRC)rwandalii.orgrwandalii.org**. These instruments obligate Rwanda to ensure access to healthcare **without discrimination**, to provide particular protections for women, children, and persons with disabilities, and to respect principles like **informed consent, privacy, and the best interests of the child**. Additionally, at the regional level Rwanda has ratified the **Maputo Protocol (African Women's Rights Protocol)rwandalii.org**, which in Article 14 guarantees women's reproductive rights, and the **African Charter on the Rights and Welfare of the Child**, reinforcing adolescent health rights. This context sets a high bar: the new law should align with these commitments and advance the realization of the right to health for all, with special attention to eliminating longstanding barriers faced by women, adolescents, and people with disabilities.

Scope of Analysis

This policy brief focuses on key human rights dimensions in the draft law, with emphasis on **gender equality, disability rights, and adolescent health rights**. These areas are examined against Rwanda's international and constitutional obligations. The analysis covers:

- **Definitions and General Provisions:** whether key terms are defined clearly and inclusively, and how the law's purpose and scope align with human rights principles.
- **Non-Discrimination and Equality:** the extent to which the law ensures equal access to services and prohibits discrimination (de jure and de facto) on grounds such as gender, sexual orientation disability, age, etc.
- **Gender Equality & Reproductive Health:** content of provisions on reproductive health services, rights of women and girls (including survivors of gender-based violence, access to family planning, safe motherhood, and safe abortion where applicable), and any gaps in protecting these rights.
- **Adolescent Health Rights:** how the law addresses health services for minors – consent mechanisms, confidentiality, access to sexual and reproductive health (SRH) and mental health services – in light of CRC standards on evolving capacities and best interests of the child.
- **Rights of Persons with Disabilities:** provisions affecting persons with disabilities, including physical accessibility of healthcare, communication assistance, and especially legal capacity and consent to treatment (aligned with CRPD principles of autonomy and supported decision-making).
- **Mental Health Services:** specific analysis of the mental health section (involuntary admission, treatment safeguards, property management for patients unable to manage affairs, etc.), assessing compliance with human rights norms (e.g. CRPD, and protection against cruel, inhuman or degrading treatment).
- **Digital Health & Data Privacy:** evaluation of how the law protects patient privacy and data security in electronic health services, and whether it adequately safeguards sensitive information in line with the right to privacy.

Each section highlights **strengths** of the draft law and identifies **gaps or inconsistencies**. The brief then offers actionable recommendations for lawmakers and the Ministry of Health to strengthen the bill, ensuring it effectively protects human rights and addresses practical implementation challenges.

Legal Framework

Domestic Constitutional Obligations

The Constitution of the Republic of Rwanda (as revised in 2015) provides a strong foundation for the right to health and equality. Article 21 of the Constitution guarantees the **"right to good health"** for every Rwandan, obligating the State to take measures for health promotion and disease prevention. Article 16 enshrines equality before the law and **prohibits discrimination of any kind**, whether based on sex, race, ethnicity, religion, or other status, thereby covering discrimination on grounds of gender or disability in access to services. In addition, Article 14 commits the State to promoting the equality of women and men. These provisions mean that any healthcare law must ensure that women, persons with disabilities, children, and other groups enjoy equal access to quality health services **without discrimination**. The Constitution also requires Rwanda to comply with international treaties (Article 168), effectively integrating ratified human rights conventions into the national legal hierarchy.

International Human Rights Treaties

CEDAW (1979): CEDAW obligates Rwanda to eliminate discrimination against women in healthcare (Article 12). This includes ensuring women's equal access to healthcare services, **including those related to family planning**law.umich.edu, and guaranteeing appropriate services for pregnancy, childbirth and postnatal carelaw.umich.edu. The CEDAW Committee's General Recommendation No.24 on women and health underscores that "women" includes girls and adolescents, urging states to address their specific health needslaw.umich.edu. It calls out barriers such as requiring **third-party authorization** (by husbands, parents, or others) for women (including adolescent girls) to access health services as discriminatory practices that should be abolishedlaw.umich.edu. CEDAW also emphasizes the importance of confidentiality and informed consent, noting that lack of respect for women's privacy can deter them from seeking care (e.g. for STIs, contraception or gender-based violence)law.umich.edu. Under CEDAW, Rwanda must ensure the draft law provides women (of all ages and abilities) equal rights in health decision-making and removes any legal provisions that could indirectly discriminate (such as age or marital status limitations not applied to men).

CRPD (2006): The CRPD requires States to ensure persons with disabilities have equal access to the highest attainable standard of health without discrimination (Article 25). Notably, Article 25(d) mandates that health services be provided to persons with disabilities **on the basis of their free and informed consent**, and that States "require health professionals to provide care of the same quality to persons with disabilities as to others"ohchr.org. The CRPD enshrines the principle of **individual autonomy** (Article 3) and equal recognition before the law (Article 12). General Comment No.1 of the CRPD Committee clarifies that persons with disabilities have the right to make their own decisions and that **substitute decision-making regimes (guardianship) and forced treatment** contravene the treatyatlas-of-torture.orgatlas-of-torture.org. Instead, States should implement **supported decision-making** models, where assistance is provided but the person's will and preferences remain centralatlas-of-torture.org. For the draft law, compliance with CRPD means it should not automatically deny legal capacity to decide on healthcare based on disability status. It also means healthcare facilities must provide **reasonable accommodations** (e.g. sign language interpreters, information in accessible formats) to ensure persons with disabilities can give informed consent and access services equally.

CRC (1989): The CRC affirms every child's right to the enjoyment of the highest attainable standard of health (Article 24) and obliges States to ensure access to necessary medical services, with emphasis on abolishing traditional practices harmful to a child's health (e.g. early marriage, FGM). Cross-cutting, Article 2 guarantees rights without discrimination (including on the basis of age or disability), Article 3 requires the **best interests of the child** be a primary consideration in all actions concerning children (including law-making), and Article 12 gives children the right to be heard in matters affecting them, with due weight given to their age and maturity. Together, these mean that adolescents – as developing children – should be progressively empowered to make autonomous decisions about their health in line with their evolving capacities (Article 5). **General Comment No.4 (2003) on Adolescent Health** and **General Comment No.20 (2016) on Adolescence** Urge States to **provide adolescents with access to appropriate, youth-friendly health information and services –** especially sexual and reproductive health – without mandatory parental consent when that would act as a barrierfile-jmzh98rmpawhbxb7pqqhfefile-jmzh98rmpawhbxb7pqqhfe. The CRC Committee has stated that confidential counseling and advice must be available to adolescents, and information regarding their health should not be disclosed to parents without the adolescent's consent except in cases where an adult's confidentiality would also be overridden (e.g. immediate serious harm)ohchr.org. The CRC thus guides that Rwanda's law should balance parental involvement with adolescents' confidentiality and autonomy interests, ensuring that older adolescents can seek sensitive services (like contraception, STI treatment, mental health support) **confidentially and without fear**.

In addition to these core treaties, the **International Covenant on Economic, Social and Cultural Rights (ICESCR)** – which Rwanda has ratified – enshrines the right to health (Article 12) and requires non-discriminatory access to health facilities. The **African Charter on Human and Peoples' Rights** and its Protocol on Women's Rights (Maputo) further reinforce rights to health, including reproductive choice and medical privacy.

Implications for the Draft Law: Rwanda's legal commitments create a framework against which the draft health law must be measured. Any provisions that **directly or indirectly exclude or restrict women, persons with disabilities, or adolescents** could undermine these obligations. Conversely, incorporating explicit rights (e.g. the right to informed consent, right to confidentiality, freedom from discrimination in healthcare) will strengthen the law's legitimacy and effectiveness. The analysis below uses this legal framework to assess relevant articles of the draft law and recommends adjustments to ensure full compliance.

Article-by-Article Analysis and Key Issues

1. General Provisions and Definitions

Purpose (Article 1): The draft law's stated purpose is to "regulate healthcare services to make them accessible, high-quality and user-centered". This language aligns with the right to health's core elements of **accessibility and quality** (as defined by international standards). Emphasizing a "user-centered" approach is commendable, signaling that the system should be responsive to patients' needs and preferences (consistent with patient dignity and participation rights). This could be further bolstered by explicitly referencing principles of equity and non-discrimination in the purpose clause. For instance, acknowledging that services should be accessible *to all* without discrimination would mirror constitutional and treaty requirements. The current purpose clause implicitly covers this, but an explicit mention would strengthen interpretive clarity.

Definitions (Article 2): Proper definitions are crucial as they set the scope for who and what is covered. Some definitions in the draft raise human rights concerns:

- **"Couple"** is defined as "a man and woman who are legally married". This heteronormative definition is narrow. It excludes unmarried partnerships and same-sex couples. While Rwandan law does not recognize same-sex marriages, defining couple strictly in these terms for the purposes of healthcare (notably in the context of assisted reproduction) may unintentionally discriminate against, for example, an unmarried woman seeking fertility services or a man and woman in a long-term union not formally married. It could also preclude single women from certain services like IVF unless they qualify under another category (the draft does allow individuals to use ART to preserve fertility, but not necessarily to have a child).

Recommendation:

- **Broaden the definition of "couple" or avoid a gender-specific definition** in the healthcare context. For instance, use "couple means two persons in a conjugal union as recognized under the law" – this would accommodate legal changes and avoid embedding gender discrimination. CEDAW prohibits discrimination based on marital status and family status, so the law should not privilege only married heterosexual couples for health services. If the intent was to restrict ART to legally married opposite-sex couples for cultural reasons, policymakers should weigh this against women's rights to found a family and to equality; perhaps allowing exceptions (such as single women who cannot marry but wish to have a child) or at minimum documenting the justification for such a restriction
- **Terms related to reproductive technology:** The draft provides technical definitions for assisted reproduction. For example, it defines the process of in vitro fertilization in Kinyarwanda (literally "combining male and female gametes in a laboratory"). These definitions seem scientifically sound and ensure clarity about what procedures are governed. A potential gap is the absence of a definition for **"surrogacy"** or **"genetic material"**, given that Article 71 deals with prohibited practices in ART (like sex selection and modifying human genetic material). If surrogacy is intended to be addressed or banned (as is common in some jurisdictions), it should be defined. Not defining it could lead to confusion in enforcement.
- **"Incapable person" / Consent-related terms:** Unlike the 2016 Reproductive Health Law which explicitly defined an "incapable person" as a child or a person with mental disability, the draft law doesn't define this term but effectively uses the concept in Article 24 on consent. It might be clearer to include a definition of a "minor" (child under 18) and perhaps "legal representative" in Article 2. The law should avoid terms like "mental incapacity" without definition, as they can be stigmatizing and inconsistent.

Recommendation:

- **Define "child"** as any person under 18 (the draft does use "under the majority age" which is the same thing).
- **Define "legal representative"** in the health context (likely parent or guardian for a minor, or a court-appointed guardian for an adult who has been declared legally incapacitated). The law should **not** define persons with disabilities as categorically incapable of consent – instead, it could define who is authorized to consent on behalf of a patient unable to consent **in fact** (e.g. unconscious or lacks decision-making ability), using objective criteria and aligning with CRPD by emphasizing this is a last resort measure with safeguards.

- **“Healthcare services/professional/facility”:** The draft likely defines these or at least uses them consistently (Article 3 onward in Chapter II likely categorizes health professionals). While we did not excerpt those definitions here, it’s important they be inclusive. For example, “healthcare professional” should include not just doctors and nurses but also midwives, lab technicians, mental health professionals, etc., as appropriate. If any cadre is omitted, it might create regulatory gaps. The law does list professional categories in Chapter II (e.g. doctors, nurses, midwives, etc.) – ensuring none are defined in a way that restricts women or PWD from practicing is also a consideration (though more a labor issue than patient rights).

In summary, definitions should be **inclusive, precise, and consistent** with human rights norms. Where definitions inadvertently entrench biases (like the “couple” example), revisions are needed. Clarity in terms like “informed consent,” “emergency treatment,” and “disability” (if used) would also help. The law currently does not define “disability,” which may be wise to leave to the existing Law on the Protection of Persons with Disabilities (which likely has a definition aligned with CRPD). If needed, a cross-reference could be added (e.g. “person with a disability has the meaning given in [disability law]”).

2. Non-Discrimination and Equality in Healthcare

A fundamental measure of the draft law is how it ensures **no one is left behind** in accessing health services. Positively, the draft contains explicit non-discrimination clauses in specific contexts. Most notably, **Article 66** (in the reproductive health chapter) states: “All persons, without any form of discrimination, have equal rights in relation to human reproductive health and well-being.” Furthermore, it adds that no person shall be denied these rights based on any form of discrimination. This replicates the principle from the prior 2016 law and is a strong statement, directly reflecting CEDAW and CRC requirements for equality in health. It covers grounds implicitly (“any form” suggests broad coverage: sex, age, marital status, disability, ethnicity, etc.). **This is a strength**: it will provide a legal basis to challenge any discriminatory practices in reproductive health service delivery (for instance, refusing services to a woman because she is unmarried or to an adolescent because of age, or poor treatment of a patient due to HIV status).

Additionally, in **Article 31(e)**, which outlines responsibilities of healthcare facilities, the law requires facilities “to provide healthcare services to all healthcare service users **without discrimination of any kind**”. This is an excellent general provision, operationalizing the duty of non-discrimination at the point of service. It aligns with ICESCR and constitutional mandates, and would cover cases such as a hospital denying treatment to someone due to inability to pay or because of stigma (e.g. refusing to treat a person with a disability or a sex worker, etc., which unfortunately are real issues in many contexts). By embedding nondiscrimination in facility obligations, the law makes it clear that equal service is not optional but required.

However, there are areas to strengthen:

- **General Non-Discrimination Clause:** The law could benefit from a general clause in Chapter I or Chapter IV (rights and obligations) stating that *“Every person has the right to access healthcare services without discrimination on any ground, and all forms of* *discrimination in the provision of healthcare are prohibited."* While Article 31 and Article 66 cover this in specific ways, a unified statement early in the law would set the tone. It would also help in covering areas beyond reproductive health and facility duties – for example, professional conduct (Chapter III on ethics) could reference non-discrimination by providers toward patients (e.g. a doctor cannot refuse to treat someone on a prohibited ground). Perhaps the medical ethics chapter already implies a duty to treat all patients respectfully, but making it explicit would be in line with Rwanda's obligations.

- **Specific Grounds:** Neither Article 31 nor 66 enumerates grounds of discrimination. While "of any kind" is laudably broad, sometimes listing key protected grounds can be instructive (sex, gender, age, disability, sexual orientation, social origin, etc.). Particularly, to ensure **gender equality**, "sex, pregnancy and marital status" should be understood as protected grounds – important for preventing any bias against pregnant adolescents or unmarried women in accessing services. To ensure **disability inclusion**, "physical, mental or sensory disability" should be considered under discrimination – e.g. a clinic failing to provide sign language interpretation might be seen as discriminatory. Clarifying that failing to accommodate can constitute discrimination would align with CRPD's concept of discrimination (which includes denial of reasonable accommodation as discrimination).
- **Training and Enforcement:** The presence of non-discrimination clauses is only as good as their implementation. The law might authorize the Ministry to issue regulations or codes of conduct that detail this (for instance, requiring all health professionals to undergo training on ethics and non-discriminationlaw.umich.edu, and establishing complaint mechanisms for patients who experience bias). Including reference to **accountability mechanisms** – such as patients' right to complain or seek redress – would operationalize equality. Perhaps Chapter VIII on offenses and penalties covers discriminatory practices (e.g. sanctioning a provider or facility that discriminates). If not, it could be considered.

In sum, the draft law's text demonstrates a **commitment to equality**, especially in reproductive health and service provision. The task for lawmakers is to ensure this commitment is comprehensive and not undermined by other sections. One area of concern is the **consent framework in Article 24**, which, as discussed below, discriminates on the basis of age and disability in decision-making. This is a form of legal discrimination that should be reconciled with the law's equality guarantees. CEDAW's directive is clear that women (including adolescents) should not be denied health services **"based on any form of discrimination"**, and specifically calls out age as an improper basis to withhold reproductive health services. The CRC also forbids arbitrary age discrimination if it is not a reasonable differentiation in the child's best interests. Thus, reconciling the consent rules with nondiscrimination principles is essential (explored under adolescent rights below).

3. Gender Equality and Reproductive Health Rights

The draft law devotes an entire **Section (Section 4 of Chapter VI)** to human reproductive health services, signaling the priority of this issue. This is in line with Rwanda's policy commitments to family planning, maternal health, and combating gender-based violence. Key provisions include:

- **Article 65: Essential Reproductive Healthcare Services.** This article lists a comprehensive package of reproductive health services, which is a major strength. It includes:
    - **Safe delivery and newborn care** – ensuring skilled birth attendance and postnatal care.
    - **Family planning** – access to contraception and fertility information.
    - **Prevention and treatment of STIs** (including HIV).
    - **Prevention and treatment of other conditions affecting reproductive health** (this could cover cervical cancer, for example).
    - **Prevention and treatment of infertility**.
    - **Prevention of gender-based violence (GBV) and care for survivors**.
    - **Awareness-raising to change attitudes on reproductive health**.

This broadly corresponds with international recommendations (the 2016 law had a similar list: safe motherhood, family planning, STIs including HIV, infertility, GBV, and reproductive health educationrwandalii.org). Including GBV response is particularly laudable – it situates care for rape or abuse survivors as an essential health service (meaning facilities should have capacities for emergency contraception, post-exposure prophylaxis for HIV, psychosocial support, etc.). It also implements CEDAW General Recommendation 35 (which links GBV to gender discrimination) by ensuring survivors' health needs are met.

Observation: The list does **not explicitly mention safe abortion or post-abortion care.** In many countries, safe abortion (within legal grounds) and post-abortion care (treatment of complications from miscarriage or unsafe abortion) are considered part of comprehensive reproductive health services. The former Law No.21/2016 had a provision on the "Right to decide" on reproduction but limited it to those 18 and above, and it referenced that abortion is permitted under certain conditions set by penal law. The repeal of that law means those provisions should be reflected here or at least not contradicted. The draft law is **silent on abortion**, which might be intentional (leaving it solely to the Penal Code provisions). However, given Rwanda's recent progressive moves (e.g. a 2018/2019 reform easing some abortion restrictions and pardoning women jailed for abortion), the health law could have recognized at least the right to **post-abortion care** for all women (even if terminating pregnancy is only legal under specific circumstances).

Recommendation:

Add a clause that "Every woman has the right to access quality post-abortion care and management of abortion complications, regardless of the circumstances, and healthcare providers must not withhold such care." This would save lives and align with WHO guidance and CEDAW's position that post-abortion care is a human right. On safe abortion, if the law cannot expand beyond current legal grounds, it should at least ensure that where abortion is legal (rape, incest, forced marriage, risk to health, or fetal anomaly under current Rwandan law), it is treated as part of reproductive health services and not unduly restricted by healthcare providers. The **Maputo Protocol** (Article 14(2)(c)), which Rwanda has ratified, actually calls for states to authorize medical abortion in cases of sexual assault, rape, incest, or danger to health of mother or fetus. Incorporating that spirit would strengthen the law's gender-responsiveness.

- **Article 66: Equal Rights in Reproductive Health.** As noted, it guarantees equal rights to reproductive health and forbids discrimination. It's worth highlighting this again under gender: it ensures women's health services cannot be denied or inferior due to gender biases. For example, it can be read to prohibit health workers from withholding family planning from unmarried women (a known issue in some contexts) or refusing to treat a woman because of her ethnicity or disability. This article is essentially the CEDAW Article 12 mandate put into national law – a very positive element.

- **Article 67: Protection from Harmful Practices.** From the content we extracted, Article 67 appears to grant every person the right to be free from practices that harm their reproductive health or capabilities, and imposes an obligation on everyone to avoid harming their own or others' reproductive health. This likely targets thing like female genital mutilation (FGM) or forced sterilization, and also maybe emphasizes public health duties (e.g. not knowingly spreading STIs). It references physical, psychological, social, and environmental factors, which is comprehensive. This resonates with CEDAW and CRC provisions against harmful traditional practices and with general public health principles. It's a progressive inclusion – few health laws explicitly mention protection from GBV or FGM, etc., so Rwanda is being forward-thinking here.

- **Article 68-71: Assisted Reproductive Technology (ART).** Recognizing infertility care as essential (Article 65(f)) is progressive, and Articles 68-71 flesh it out:
    - Article 68 establishes the **"right to assisted reproductive technology"**, meaning making fertility services accessible to those who need them. This shows Rwanda's intent to facilitate modern family-building methods domestically (important, as the explanatory note mentioned Rwandans used to pay abroad for these services. It's a women's rights issue too, as infertility often unfairly burdens women socially.
    - Article 69 limits ART use to **infertile couples or individuals preserving fertility** and calls for a Ministerial Order to set up a supervisory committee. The limit to infertile **married** couples is implied by "couples" (as defined as married) – which we flagged as potentially discriminatory. For gender equality, one might question why a single woman who isn't infertile (but lacks a partner) couldn't access donor insemination – but that touches cultural sensitivities. From a rights perspective, excluding single women or requiring marriage could violate the principle of non-discrimination on the basis of marital status (CEDAW) unless justified by a best interest of the child argument or resource constraint. Policymakers should consider if that restriction is necessary.
    - Article 70 requires ART services to be provided by qualified specialists (e.g. reproductive endocrinologists or OB/GYNs with ART training). This is a safety and quality measure – consistent with ensuring high-quality care.

- Article 71 lists **prohibited practices** in ART: no experimental procedures aimed at human cloning or sex selection for non-medical reasons, and a prohibition on placing anything but a human embryo in a woman's womb, among possibly others (the snippet suggests also banning creating human-animal hybrids or genetically modified embryos). These prohibitions are aligned with ethical norms and avoid violations of human dignity. They also implicitly protect women from being subjects of unethical experiments (e.g. a rogue scientist attempting gene editing on embryos, etc.). This is consistent with CEDAW's call for states to ensure women are not subjected to non-consensual medical experimentationohchr.org and with general bioethics.

Overall, the reproductive health section is robust and largely aligned with human rights standards, with the exception of the **age of consent issue**. The glaring issue is that Article 7 of the old law (which restricted decision-making to those 18+) may have been dropped, but Article 24(3) of the draft still effectively implements it by requiring a legal representative's consent for minors. This contradicts the notion of adolescents' reproductive autonomy. For example, **access to contraception**: The law says reproductive health services are for "all persons" without discrimination, and presumably that includes teenagers. But if a 16-year-old girl cannot get contraceptives without a parent's signature, that right is illusory. Empirical evidence (including Rwanda's teen pregnancy rates) underscores that requiring parental consent often leads adolescents to avoid seeking safe services, resulting in higher rates of unintended pregnancy and unsafe abortion. The draft's own explanatory note acknowledged this problem in the old law – stating it "clearly discriminates against adolescents" and leads to high rates of unintended pregnancy. It even claimed the new law lowers the age of consent. **Yet the actual draft text has not introduced a clear exception for adolescent consent.** This discrepancy needs urgent attention:

Recommendation:

Incorporate a provision in the reproductive health section (or general consent rules) allowing minors above a certain age (e.g. 15 or 16) to consent to specified services – such as contraceptive services, testing and treatment for STIs, and prenatal care – **without parental consent**, where the healthcare provider deems the minor mature enough, or if seeking parent's consent is not in the minor's best interests. This would be consistent with CRC General Comment 20, which encourages evolving capacity-based access for adolescents to preventive and sexual health careohchr.org. Additionally, an explicit confidentiality guarantee for adolescent patients seeking reproductive health info and care could be included (e.g. "Information provided by an adolescent in receiving reproductive health services shall remain confidential and only be disclosed pursuant to the adolescent's consent or by order of a competent authority in exceptional circumstances"ohchr.org).

- **Maternal Health and Maternity Care:** The draft ensures safe motherhood (delivery without adverse outcomes) and the care of newborns It does not explicitly mention **maternal mortality surveillance or emergency obstetric care** – but those could be considered implicit in "safe delivery" and quality services. CEDAW Article 12(2) and ICESCR General Comment 14 emphasize that states must provide appropriate services for pregnancy and childbirth including emergency obstetric care. The law might not delve into that detail, which is fine as long as regulations and health system policies cover it. What could be added is a provision on **maternal and paternal rights** – for instance, workplace protections or requiring health facilities to offer respectful maternity care. However, those may be beyond the scope of this law (which is more regulatory). At minimum, the law's nondiscrimination promise covers pregnant women (no woman should be denied care or treated poorly because she's pregnant, even if e.g. she's a teen or unmarried).

- **Gender-Based Violence (GBV):** By including GBV prevention and survivor care as essential, the law implicitly mandates that health facilities must be prepared to handle such cases. It could be strengthened by cross-referencing Rwanda's laws on GBV (like the law on prevention and punishment of GBV) and by specifying components: e.g. "Care for victims of gender-based violence shall include medical examination, treatment of injuries, psychological support, forensic evidence collection, and referral to legal authorities as per applicable law." This would make it actionable for hospitals to set up GBV desks or trained personnel. Given Rwanda's strong stance on GBV, such detail would be welcome.

In summary, the reproductive health provisions of the draft law are a **major strength**, reflecting a rights-based approach by enumerating services everyone is entitled to. To fully comply with human rights standards: (a) **ensure adolescent girls can actually access those services** by modifying consent requirements; (b) **ensure no regressive step on abortion** – at least maintain what was allowed under previous law and ensure post-abortion care; (c) possibly add clarity on sensitive issues (surrogacy, etc.) if relevant. If these tweaks are made, Rwanda's law could serve as a model for integrating gender equality into health legislation – a realization of CEDAW's mandate that women have equal say in reproductive choices and equal access to healthcare.

4. Adolescent Health Rights and Consent Mechanisms

One of the most critical human rights issues in healthcare legislation is how it deals with minors. Adolescents (generally ages 10-19) are in a transitional stage with evolving capacity: they have specific health needs (for example, puberty-related care, sexual and reproductive health, mental health), yet often face legal barriers in accessing care independently. The CRC emphasizes guiding adolescents with respect for their autonomy as it developslaw.umich.edu. This draft law shows intent to improve adolescent health access in some respects, but as currently written it retains **strict requirements for parental or guardian consent that could undermine adolescent rights**.

Consent Rule (Article 24): Article 24 of the draft covers the "Right to informed consent." It affirms that before any medical act, a healthcare user must give consent – a fundamental principle of medical ethics aligned with the right to bodily integrity. It even provides a solution for illiterate patients (using a fingerprint on the consent form after it's read to them), which is a nice inclusion to ensure comprehension and consent for those who cannot read. However, Article 24(3) then states: *"if a healthcare service user is a person under the majority age or an adult with mental disability, hearing or hearing and vision impairment, the consent form is read for his or her legal representative and signed by him or her."*

This single sentence is problematic on multiple levels:

- For **minors (under 18)**: It mandates parental (or guardian) consent for any health service. This is a blanket rule with no exception for adolescents seeking, say, contraceptives, STI tests, or mental health counseling. Such a blanket approach conflicts with the concept of evolving capacity under CRC Article 5 and the principle that in health matters, a mature minor should be able to seek care in their best interest, especially if involving parents is a barrier. The *CRC Committee's General Comment No.4* explicitly encourages states to establish lower age of consent for counseling and health services *"without parental consent"* to ensure that adolescents can get the care they need. Many countries have adopted specific lower ages for certain services (e.g. 16 for consent to general medical care, 12-15 for contraceptives depending on maturity, etc.) – or use a "Gillick competence" approach (capacity assessment rather than age threshold). Rwanda's draft law does not yet incorporate any such flexibility.

- For **adults with certain disabilities**: It is startling that the law automatically diverts consent to a legal representative not only for those with "mental disability" but also for those with "hearing or hearing and vision impairment". This treats *all* deaf or deaf-blind individuals as incapable of informed consent, which is a gross overreach. Deafness in no way implies incapacity to understand medical information – it simply requires accommodation (sign language interpretation). Similarly, many persons with mental disabilities (a broad term that could include intellectual or psychosocial disabilities) are capable of informed consent if information is presented appropriately or if support is provided. By lumping sensory impairments under this clause, the draft law is actually discriminating on the basis of disability, contrary to CRPD Article 12 and 25, and even contrary to its own non-discrimination principles. **CRPD Article 25(d)** requires health care to be on the basis of free and informed consent of the person with disabilityohchr.org. This draft clause would allow, say, a doctor to insist a deaf patient's family member sign consent, rather than simply communicating with the patient via an interpreter. This is neither necessary nor acceptable. It contradicts the earlier clause (24(2)) which already provided a means for someone who cannot read/write to consent via fingerprint after an explanation – a deaf patient who cannot hear could likewise be explained to via sign language, or a deaf-blind person through tactile signing or Braille, etc., rather than bypassing them.

In effect, Article 24(3) denies legal capacity to entire categories of people (all minors and all persons with the listed disabilities) without any individualized assessment. This is a **critical gap and conflict with human rights law**:

- Under **CRC**, while parents generally have responsibilities to make decisions in children's best interests, children have a right to be heard and progressively take responsibility for decisions. The CRC Committee has urged that health laws *"should not require parental consent for access to services such as … sexual and reproductive health services, where such requirement would deter adolescents from seeking them"*. The blanket requirement in Article 24(3) is exactly the type of provision that deters adolescents. It is at odds with observed reality: many Rwandan adolescents may be sexually active or need contraception below 18; requiring parental consent might mean they choose to forgo safe services out of fear or embarrassment, potentially resulting in harm (e.g. unintended pregnancy or STIs). This ultimately undermines the right to health (Article 24 CRC) and can violate the principle of evolving capacities and best interests (Article 3 CRC – is it truly in a 17-year-old's best interest to be denied contraception because a parent refuses consent? Likely not, from a health perspective).

- Under **CRPD**, Article 12 requires that persons with disabilities "enjoy legal capacity on an equal basis with others in all aspects of life." Substituted decision-making (like automatically deferring to a guardian) is something the CRPD Committee has asked states to abolish, or at least restrict severelyatlas-of-torture.orgatlas-of-torture.org. At a minimum, **supported decision-making** should be tried: for example, if an adult has an intellectual disability, a supporter can help them understand the decision and express their will, rather than the decision being taken out of their hands. The draft law's approach is old-fashioned paternalism. It might come from a good intention – to protect patients who might not understand – but it's overly broad and not consistent with human rights standards.

Recommendations to Address Consent for Adolescents and PWD:

1. **Introduce an exception or lower age for adolescent consent:** The law can specify that for certain categories of care, or above a certain age (e.g. 16), adolescents can consent on their own. Some options:
    - A general statement like: "Notwithstanding Article 24(3), a minor who is at least 15 years of age (or has attained an age to be specified) may consent to sexual and reproductive health services and mental health services without the need for parental consent, if in the opinion of the healthcare provider the minor has sufficient maturity to understand the service and its implications." This approach bases it on maturity for specific sensitive services.
    - A tiered approach: e.g. "Minors aged 16 and 17 are deemed capable of consenting to health services as if they were adults, except for interventions of a serious nature as defined by an Order of the Minister (which could list surgeries, etc.). Minors below 16 require consent, except in cases of medical emergency or prevention services as defined…" etc. This can get complex, but many jurisdictions allow mature minors to consent to at least some treatments.
    - At the very least, include a *confidentiality and best interest* clause: "Healthcare providers may, in exceptional situations where obtaining parental consent is not feasible or not in the best interests of the adolescent, provide necessary health services to a minor without parental consent." This could cover, for example, an adolescent who comes with an STI or seeking contraception, where involving a parent might lead to abuse or the adolescent simply wouldn't come if forced to involve a parent.

The rationale for any of these should be documented: it's to prevent the harm of adolescents avoiding care. In the explanatory materials that accompanied the draft, it was noted that the legislation was silent on how adolescents can access info and services despite affirming everyone's right, and recognized that led to high unintended pregnancy rates. The drafters *agreed* by saying "in this new law we have lowered the age of consent" so the intention was there – it simply needs to be explicitly reflected in the text.

2. **Revise the disability consent clause:** This is urgent. The law should **never** assume someone with a hearing impairment cannot consent. The correct approach: mandate the provision of interpreters or assistive measures. For persons with intellectual or psychosocial disabilities, the law could say: *"If a healthcare service user is unable to understand and appreciate the nature and consequences of the medical decision even with appropriate explanations and support, and thus cannot give informed consent, then the consent of a legal representative may be sought in accordance with the law. The healthcare professional must still involve the service user as much as possible in the decision, and the decision must be made in the user's best interests, taking into account their will and preferences to the greatest extent ascertainable."* This aligns with CRPD to some extent by requiring trying support first and honoring will/preferencesatlas-of-torture.org. It also limits surrogate consent to cases of actual incapacity (e.g. someone in a coma, or an adult with advanced dementia who truly cannot decide). As written, Article 24(3) covers even a mild intellectual disability or any deaf person, which is discriminatory.

   Specifically, delete "hearing or hearing and vision impairment" from that clause – those are communication issues, not decision-making issues. For "mental disability," one could change it to "a healthcare user who is **legally declared** incapacitated due to mental condition" (meaning a court has established guardianship). But CRPD ideal is to move away from that system entirely. If Rwanda's laws still allow declaring someone of "unsound mind" and assigning a guardian, then at least limit it to those cases rather than all with mental disability. And even then, incorporate supported decision language. This will protect many persons with disabilities from being needlessly stripped of agency in health matters. It will also avoid violating CRPD Article 25 which calls for health care based on the person's own consentohchr.org.

Adolescent-Friendly Services Beyond Consent:

Beyond the consent law, adolescent health rights involve:

- **Privacy/Confidentiality:** Does the draft law ensure that adolescents can seek care confidentially? There is no explicit patient privacy clause excerpted, except the digital privacy article (Article 64) which applies to all. A general medical confidentiality obligation likely exists in the ethics chapter or patients' rights (it might be in Article 23 or 26 which we haven't seen, but often health laws include confidentiality). If not, it should. Particularly, it should discourage healthcare workers from disclosing an adolescent's health information to others (including parents) without consent, unless necessary. CRC GC4 noted that adolescents' confidentiality should be respected on par with adults'ohchr.org. This could mean, for example, if a 17-year-old is treated for an STI, the provider should not automatically inform the parents if the teen doesn't want that, unless not informing would seriously harm the teen or others. Many jurisdictions allow confidentiality for mature minors in sexual health, recognizing that if confidentiality isn't guaranteed, minors just avoid clinics.

- **Age of medical consent vs. age of sexual consent:** In Rwanda, the age of sexual consent is 18 by law (sex with a person under 18 can be statutory rape). This creates a tension: allowing sub-18 access to contraceptives might seem to condone underage sex. However, public health perspective and human rights favor allowing it because it prevents worse outcomes (pregnancy, HIV) and recognizes reality. The law could finesse this by not explicitly mentioning sexual activity but just focusing on health needs. Also, it should be clear that providing an adolescent health service is not a legal endorsement of underage sex but a protective measure. Policymakers might worry about parental backlash; hence at least a lower age like 16 could be a compromise.
- **Mental Health services for adolescents:** The draft's mental health provisions (Articles 56-61, discussed in next section) likely apply to adolescents as well. In many countries, minors can be admitted for psychiatric care without consent (parents' consent on their behalf). That can be tricky – older adolescents might disagree with being institutionalized. International standards (CRC, and new CRPD approaches) would argue for adolescent involvement in such decisions, and using the least restrictive measures. While the law outlines judicial and medical review for involuntary admission (which would include minors), it might not separately consider when a minor can consent to outpatient counseling or refuse treatment. Ideally, by 16 or so, a teenager should have a say in mental health treatment plans. The law could allow mature minors to consent to therapy or refuse certain medications, but again, that's a nuanced area requiring guidelines. For now, focusing on enabling them to seek help (e.g. a depressed 15-year-old seeing a therapist without needing parent's signature) is crucial. Hurdles like requiring parental consent for any mental health consult often result in teens not getting counseling for issues like depression or substance use. Given Rwanda's youth suicide prevention efforts, easing access to mental health support for adolescents is important.

Summary on Adolescents: The draft law's progressive promise ("lowered the age of consent" in concept) must translate into practice. Without adjustments, the law risks perpetuating the status quo where adolescents are effectively denied autonomous access to the very services the law enumerates as their right. This contradiction could undermine Rwanda's goals of reducing teen pregnancies, HIV infections, and other public health concerns among youth. By amending the consent framework and emphasizing confidentiality, Rwanda would fulfill its CRC obligations and likely see improved health outcomes. Lawmakers should consult with pediatric and adolescent health specialists, and potentially with adolescents themselves (CRC Article 12 says their views should be considered in matters affecting them – including this law). The resulting law would balance protecting youth with empowering them, aligning with international best practices.

5. Rights of Persons with Disabilities in Healthcare

Persons with disabilities often face physical, communication, and attitudinal barriers in accessing healthcare. The CRPD requires **inclusive healthcare** – meaning services must be as accessible and of equal quality for PWD as for othersohchr.org. The draft law touches on disability issues in several places, some positive and some needing improvement:

Non-Discrimination and Equal Access:

As noted, Article 31(e) obliges facilities to serve all without discrimination. This includes non-discrimination on disability. In practice, this means a hospital cannot refuse a patient because they have a disability (sadly, in some places, women with disabilities have been denied reproductive care or people with intellectual disabilities turned away from clinics – this clause forbids that). It also implies an obligation to **provide reasonable accommodations** so that PWD can actually benefit equally. For example, a blind patient should get information verbally, a deaf patient in sign, wheelchair users should have ramps, etc. The draft does not spell out these accommodations explicitly. Perhaps a regulation under infrastructure or ethics will cover it. It would strengthen the law to add: *“Healthcare facilities must adapt services to the needs of persons with disabilities, in line with national disability law and international standards, including by removing physical barriers and providing information in accessible formats.”* This direct reference to accessibility would operationalize Article 9 of CRPD (accessibility) in the health context.

Informed Consent and Legal Capacity: As extensively discussed, Article 24(3) is a concerning provision for disability rights. By equating certain disabilities with inability to consent, it violates the CRPD principle of equal legal capacityatlas-of-torture.org. The law should pivot from substitute consent to **support mechanisms**. For instance, if an adult with an intellectual disability needs to undergo a procedure, the default approach should be to explain it simply, maybe involve a trusted support person of their choice for help, and attempt to get the patient’s own consent. Only if that fails should a guardian’s consent be invoked, and even then the patient’s will should guide the decision. The current text doesn’t reflect that nuance. **Positive step:** Recognizing incapacity is not necessarily permanent or universal – a person with a psychosocial disability may be perfectly capable of deciding on a dental filling, but perhaps not during an acute psychotic episode for a major surgery. The law could allow flexibility: consent from a legal representative only “when the patient is unable to give consent and this inability is formally certified as per medical and legal standards.”

Mental Health Rights: Many persons with psychosocial disabilities interact with health law through mental health provisions (see next section for details). The CRPD’s stance is to move away from forced psychiatric hospitalization and toward community care with consent. The draft law still allows involuntary admission (with safeguards). For disability rights, it’s key that those safeguards are strong (due process, regular review, right to challenge). Does the law allow a person with mental illness to refuse treatment if they are not an immediate danger? The text we have suggests once admitted involuntarily, treatment goes ahead based on evaluations. CRPD would argue that even those with mental disabilities have the right to refuse medication/treatment (a contentious area since it pits autonomy vs. protection). At minimum, the law should ensure humane treatment and forbid practices that violate integrity (like unmodified ECT or forced sterilization). **We notice Article 59 and 60** deal with forensic patients and property management, respectively:

- Article 59: Forensic patients (those in custody) transferred for treatment must be evaluated by 3 doctors and report to judicial authorities, and treated according to evaluation results. This introduces oversight – a good thing. The presence of multiple doctors and reporting to justice helps check abuses (e.g. ensuring someone isn’t kept in a mental ward by law enforcement without medical justification).
- Article 60: If a healthcare professional has a “mentally incapacitated person” under care, they must protect that patient’s personal property and interests like a guardian would. This

is a compassionate provision aimed at preventing exploitation or loss of patients' belongings when they are vulnerable (e.g. if a patient with dementia is hospitalized, staff should ensure their money or keys are kept safe). It's aligned with respecting the rights of PWD to own property (CRPD Art 12.5). However, the term "mentally incapacitated" again is broad – hopefully it implies those adjudicated as such or in a coma, etc., not simply anyone with a mental disability. Regardless, it imposes a duty of care on health professionals beyond medical treatment, which is a positive recognition of holistic responsibility.

Accessibility of Information: The draft's digital health segment could greatly aid PWD if harnessed (telemedicine can help those with mobility impairments, digital records in accessible formats can help those with sensory impairments). But technology can also exclude if not accessible (e.g. a telehealth app not screen-reader compatible). Article 64(3) mandates compliance with personal data protection laws for technologies, but doesn't mention accessibility standards. Perhaps in regulations, the Minister's Order on digital health norms could include a requirement that digital health platforms meet accessibility standards (like providing captions on tele-consultations for the deaf, etc.). This is an often overlooked but important aspect for disability inclusion.

Training of Health Workers: An underlying issue is attitudes. CEDAW GR24 mentions training on disabled women's health needslaw.umich.edu. CRPD also asks that health workers receive disability awareness traininge-inclusion.unescwa.org. The draft law doesn't explicitly mention training obligations or curriculum. But perhaps under Chapter III (Ethics) or in an implementation section, the Ministry might be tasked to ensure continuing training. It would be beneficial for the Ministry of Health to develop guidelines on providing care to patients with disabilities – e.g. how to obtain consent, how to communicate, etc., in line with this law. We might suggest adding in the law or as a recommendation that **all healthcare professionals receive training in disability competence and inclusive communication**.

Women with Disabilities: It's worth noting that globally, women and girls with disabilities face double discrimination in healthcare (e.g. higher risk of forced contraception, or being deemed unfit for motherhood by biased providers). The draft law doesn't specifically address this intersection. However, the general provisions (non-discrimination, equal reproductive rights) apply to them. An example scenario: a deaf woman needing maternal health information – under this law, the facility must serve her without discrimination, but if no sign language interpreter is provided, in effect she's not getting equal quality service. This is where an explicit duty to accommodate would fill the gap. Also, protection from harmful practices (Article 67) should cover forced sterilization of women with disabilities (a known abuse). That may be implicitly covered by "practices that negatively affect reproductive capabilities". Indeed, if a doctor sterilized a woman with a disability without consent "for her own good," that violates Article 67(1) guaranteeing the right not to undergo such practices. It would be useful if the law's commentary or regulations clarify that.

In summary for disability rights:

The draft law shows **intention to include and protect PWD** (through broad nondiscrimination clauses and some novel duties like property protection). Yet, it inadvertently undermines their autonomy via the consent provisions. To align with CRPD:

- Remove blanket substitute consent for disability, institute case-by-case supported decision-making.
- Mandate accessibility and reasonable accommodations in healthcare settings.
- Prohibit disability-based discrimination in clear terms (maybe in definitions or an added article).
- Preserve rights during psychiatric care (no arbitrary detention; ensure due process and right to appeal involuntary admission).
- Ensure all mainstream health programs (immunization, HIV, etc.) actively reach PWD (this might be more policy than law, but law could say “the Ministry shall take measures to facilitate access to healthcare for vulnerable groups including persons with disabilities, those in remote areas, etc.” – a kind of affirmative action clause).

By making these adjustments, Rwanda would strongly comply with CRPD and set an example in the region for disability-inclusive health law. It would move from a paternalistic paradigm to an empowerment paradigm for PWD, truly ensuring **“healthcare for all”**.

6. Mental Health Services and Patient Rights

The draft law dedicates **Section 2 of Chapter VI** to mental health services (Articles 56-61). Mental health is a critical component of the right to health, and historically mental healthcare laws were separate (often framed in colonial “mental health acts” focusing on detention). Integrating mental health into a general healthcare law is a positive step, reflecting the modern view that mental health is part of health. The provisions in the draft aim to regulate **involuntary psychiatric admissions** and treatment, balancing individual rights with public safety. Key points:

- **Criteria for Involuntary Admission (Article 56):** This article specifies when a psychiatric patient can be admitted involuntarily (without their consent) to a mental health facility, and limits it to **48 hours initially, for emergency evaluation only**file-jmzh98rmpawhbxb7pqqhfefile-jmzh98rmpawhbxb7pqqhfe. The criteria include:
    - The patient is brought by security or judicial authorities to the facility, or
    - A mental health professional believes that: (i) the patient is in a manifest (acute) phase of mental illness; (ii) the patient lacks capacity to make treatment decisions (due to the illness); and (iii) no less restrictive option is available except immediate involuntary hospitalization.

  This is quite aligned with international standards: many countries require similar elements – an acute mental disorder, impaired judgment about the need for treatment, and dangerousness or necessity due to lack of alternatives – to justify emergency detention. The inclusion of **“no less restrictive means”** (point iii) is very important. It ensures involuntary admission is a last resort, respecting the principle of least restriction (from

CRPD and earlier mental health principles). 48 hours for evaluation is also a limited period, which is good (some jurisdictions allow up to 72 hours or a week; 48 hours is relatively short, which favors liberty).

However, one criterion commonly seen is *"danger to self or others"*. The text we saw doesn't explicitly mention danger, just manifest illness and incapacity. It might be implicitly considered under "no less restrictive means" (if they are not dangerous, maybe outpatient care would suffice?). If not mentioned, it could be a gap – potentially allowing involuntary admission of someone who is ill and lacks capacity but not actually posing any risk (e.g. a quiet psychotic patient who isn't harming anyone). CRPD would argue even risk to self isn't a justification to deprive liberty solely because of disability. But most laws do allow it for prevention of serious harm. Perhaps Rwandan law intentionally omitted "danger" to focus on incapacity; or maybe it's mentioned in a portion we didn't see.

Recommendation:

Consider explicitly requiring that the person's condition poses a serious likelihood of harm to self or others or of rapid deterioration if not hospitalized. Otherwise, you involuntarily treat someone "for their own good" without immediate risk, which is paternalistic and against CRPD's direction (the CRPD stance is no forced treatment at all based on disability; but given most states haven't fully implemented that, at least limiting it to high- risk scenarios is standard).

- **Extension of Hospitalization (Article 57):** After the initial 48-hour hold, Article 57 outlines how involuntary admission can be extended beyond that, presumably turning it into a longer inpatient stay. We have parts of it:
    - It requires a **legal and medical evaluation** to decide if the patient's condition necessitates continued involuntary hospitalization.
    - It allows extending the hospitalization in increments of **30 days, renewable every 30 days**, provided certain conditions are met. The text likely continues with criteria similar to initial admission or perhaps requiring a court order.

This is a procedural safeguard: rather than locking someone indefinitely, you need to review their case monthly. Ideally, one of those evaluations should be by an independent judicial or quasi-judicial body (e.g. a review tribunal or a judge) – the snippet suggests a "legal evaluation" is involved, implying perhaps a judge or a legal medical board. That aligns with CRPD guidance to have periodic review of any deprivation of liberty. It also aligns with the **MI Principles (UN Principles for Protection of Persons with Mental Illness, 1991)** which, although superseded by CRPD in some respects, also advocated for regular review of involuntary patients.

We would need clarity on who conducts the legal evaluation – likely a judge or prosecutor must authorize continued holding. If it's just an internal hospital decision, that's weaker. Hopefully, regulations or the code of criminal procedure cover that.

Patient’s rights during this period: Not explicitly in snippet, but important ones include right to be informed of their rights, right to communicate with family or a lawyer, right to appeal the decision to a court, and right to humane treatment. The law doesn’t explicitly list these (as far as we see). Perhaps in an ethics chapter or elsewhere it says patients retain their civil rights except as needed. If not, Rwanda should ensure such rights (these come from CRPD and other human rights standards). For instance, CRPD Article 14 says disability alone cannot justify deprivation of liberty and if persons are detained, they have right to guarantees equal to others (due process).

- **Management of Forensic Patients (Article 59):** This deals with offenders with mental illness (forensic patients). It requires:
  - At least three doctors to evaluate the patient and produce a report within a legally set timeframe, which is given to judicial authorities.
  - The patient to be cared for according to the results of that assessment.

  This provision acknowledges that persons who commit offenses but also have mental disorders need specialized handling (often they are sent to a psychiatric facility for evaluation of fitness to stand trial or for treatment). The requirement of a medical report and involvement of judicial authorities provides oversight so that people aren’t lost in asylums without legal follow-up. It’s positive and aligns with due process rights (the person is in criminal justice system so they get evaluations that inform their legal case). Possibly the law or related criminal laws describe what happens after – e.g. if found not responsible by reason of insanity, how long they can be kept, etc. For the law at hand, it ensures coordination between health and justice.

- **Rights during Inpatient Psychiatric Care:** The draft’s Article 61 covers “Discharge of an inpatient. Though we didn’t see the content, it likely sets conditions for discharging someone from psychiatric hospitalization (voluntary or involuntary). Possibly requiring a doctor’s assessment that the person is stable or community care is arranged. We saw a snippet in Kinyarwanda version about discharge needing to be based on an assessment showing the patient’s condition has improved such that services have helped stabilize them. That is reasonable to ensure people aren’t kicked out prematurely, but also that they aren’t kept longer than necessary.

  We should hope the law also gives patients the right to request discharge (a common feature: an involuntary patient can petition for release or a voluntary patient can leave unless converted to involuntary if unsafe). Without the full text, we assume basic rights are in place, but if not, a recommendation is to allow patients or their families to trigger a review or appeal of continued hospitalization. Often, mental health laws have an independent review board to handle appeals – not sure if Rwanda will implement that or just use courts.

- **Prohibition of certain practices:** The draft doesn’t explicitly mention, but we would suggest it should ban **forced irreversible treatments** like psychosurgery or sterilization without consent, and **inhuman treatments** like chaining or solitary confinement beyond medical necessity. Given Rwanda’s generally human-rights-forward stance, it may not have an issue with chaining (common in some countries, but Rwanda has modern facilities). Still, international standards call to explicitly forbid cruel treatments. Possibly, internal hospital regulations cover that.

- **Community Mental Health:** The law is very focused on hospital admission. It doesn't mention outpatient services, or the duty to develop community-based care. CRPD emphasizes moving away from institutionalization and towards community support. It might be good if the law or policy includes promotion of community mental health services (e.g. counseling in primary care, integration of mental health into general health services). The law does mention rehabilitation services in Article 59 context and likely implicitly covers mental health under general provisions. If not in law, at least in policy.
- **Stigma and Reintegration:** Mental health laws sometimes have provisions to combat stigma (like confidentiality of psychiatric records, protecting patients from discrimination). The draft doesn't explicitly say, but one could argue Article 31's nondiscrimination covers psychiatric patients too. It may be worth adding: e.g. "No patient shall be denied any civil right or be discriminated against solely due to past or present mental illness." This could help protect recovered patients in employment etc., though that might be more suitable to labor or disability laws.

Alignment with Human Rights:

- The procedures for involuntary admission show Rwanda trying to meet both the patient's rights and public safety. However, **full alignment with CRPD** would require moving towards no involuntary admission based on disability. CRPD Committee often says that mental health laws should not permit forced treatment, and instead consent and autonomy should be paramount. Rwanda might not be ready to abolish involuntary treatment – very few countries are at that stage. But by including strong safeguards (time limits, reviews, legal oversight, and clearly defined criteria), the law mitigates potential abuses and aligns with **"minimum" human rights standards (like ICCPR Article 9 on liberty and security, requiring lawful procedures).
- If well-implemented, these provisions can prevent arbitrary detention in psychiatric wards (a known problem historically). For example, requiring judicial review every 30 days prevents a scenario where someone is locked up for years without recourse. Also, the involvement of multiple doctors reduces risk of one doctor's bias. It's also in line with African regional standards like the draft AU Protocol on Mental Health (if any) or best practices.

Recommendations for mental health section:

1. Ensure **judicial oversight** is clearly mandated for extended involuntary hospitalization (i.e. a court order or review board approval after the initial 48h, and each 30-day extension).
2. Guarantee the patient's **right to legal representation** – persons involuntarily admitted should have access to a lawyer or advocate, and be informed of that right.
3. Add a provision securing the patient's **right to communication** (they should be allowed to contact family or a person of trust, except in very exceptional cases where it might cause serious harm).

4. Emphasize **voluntary treatment** whenever possible. The law might encourage that if a person is willing to stay as a voluntary patient, that's preferable.
5. Include **rehabilitation and reintegration**: after discharge, connect patients with community resources (could be in policy more than law).
6. Data systems: maybe mandate that all involuntary admissions are reported to the Ministry or a monitoring body, to track numbers and ensure compliance.
7. Training of police and justice officials about these provisions, since they are involved in bringing patients and reviewing cases – to avoid misusing the law (e.g. using psychiatric detention to silence someone, which in some countries happened; but multiple doctor's requirement acts as a safeguard against that).

Overall, Rwanda's approach to mental health in this law appears careful and rooted in contemporary mental health law principles of necessity, proportionality, and regular review. With the above tweaks and close monitoring, it can protect both patients' rights and public safety.

7. Digital Health Services and Data Privacy

The draft law recognizes the growing importance of technology in healthcare by including **Section 3 of Chapter VI** on digital health services (Articles 62-64). Embracing e-health can expand access (especially for remote populations) and efficiency, but also raises privacy and data protection concerns. Article 64 specifically addresses **security and confidentiality in digital health services**, which is very forward-looking:

- **Article 64: Security and Confidentiality in Digital Health:** This article sets out principles to protect sensitive patient information in digital health platforms:
    1. It affirms that **security and confidentiality must be ensured** to protect sensitive patient info and maintain trust in the healthcare system. This establishes a general duty.
    2. It **requires strong encryption protocols** for data in transit (when sent over networks) and at rest (stored in databases). This is a concrete technical mandate aligned with global best practices (e.g. HIPAA in the US also requires encryption for health data). It's important because health data is highly sensitive personal data, and breaches can harm patients (exposing HIV status, etc.).
    3. It states that technologies used must **comply with personal data protection regulations** (i.e. Rwanda's data privacy law of 2021). This is key – Rwanda's Personal Data Protection Law No. 058/2021 is a comprehensive framework (with consent requirements for data processing, rights of data subjects, etc.). By referencing it, the health law ensures consistency and gives patients recourse under that law too if their data is mishandled. Health data is usually classified as sensitive personal data that merits higher protection, and likely the data law has stricter rules for it. This clause basically ties digital health to those standards, which is commendable.
    4. It provides that a Ministerial Order will determine **norms and rules governing digital health services**. This allows for detailed regulation (which is wise, since tech evolves quickly). The Order could cover specifics like certification of telemedicine platforms, interoperability standards, etc. We recommend that such

norms include **accessibility** (as mentioned, ensure digital platforms are usable by people with disabilities) and **ethical guidelines** (like if AI is used in healthcare, how to ensure it's ethical).

By embedding these points, Article 64 aligns with the **right to privacy** (ICCPR Article 17 and analogous in Constitution) and newer concept of **health information autonomy**. It also addresses one of the biggest challenges in digital health: ensuring patient trust. Many countries are grappling with telehealth privacy; Rwanda is proactively legislating it.

- **Article 62: Digital Health Services (definition)** – though not shown, likely defines what digital health services mean (telemedicine, mobile health, etc.). It presumably legitimizes providing healthcare via electronic means. That's important in law – previously, a question might be if prescribing medicine via phone is legal. Now it likely will be, once standards are set.
- **Article 63: License for Digital Health Services** – likely requires that any provider of digital health (especially if independent of a traditional facility) must obtain a license or authorization. This helps ensure only vetted platforms operate, protecting patients from unqualified telemedicine outfits or data thieves posing as health apps. The licensing would evaluate if they meet criteria (security, qualified staff, etc.). It's a good governance measure.

From a human rights perspective:

- **Privacy:** The law's focus on encryption and compliance with the data law is directly aimed at privacy. Under the data protection law, patients should have rights like knowing who has their data, being able to correct it, maybe even to have it erased (though health records usually are kept). The health law reinforcing confidentiality is critical because trust is the bedrock of patient-provider relationships. If patients fear that their sensitive info (mental health status, HIV, etc.) will leak on the internet, they might avoid care. This law mitigates that risk.
- **Informed Consent in Digital Context:** One thing not explicitly stated is obtaining patient consent for digital services. The data law likely requires consent for processing personal data. In healthcare, typically patient consent to treatment covers some data processing, but when using digital tools, explicit consent to share data electronically might be considered. Possibly the Ministerial Order will cover that (for example, if using a telemedicine app, maybe the patient must be informed that their data will be stored on a cloud server and consent to that). Given reference to data law, which centers on consent, it's probably inherently required.
- **Cybersecurity and Breach Response:** Article 64 focuses on encryption, but perhaps also need policies for breach notification (data law might cover that). Hospitals should have to notify patients if their digital records are compromised. Also training staff in cybersecurity hygiene is implied.
- **Digital Divide:** A human rights view also asks: will digital services be accessible to all? Rural or older patients might not use apps. The law itself can't fix internet access, but policymakers should ensure e-health complements, not replaces, traditional services, so as

not to exclude those without smartphones or literacy. Maybe mention in the Order the need for user-friendly design and alternatives for those who cannot use digital means.

- **Ethical use of data:** If big data or AI is used (like predictive analytics on patient data), guidelines should prevent misuse or discrimination (e.g. insurance companies shouldn't get hold of personal health data to deny coverage). Rwanda's data law plus this law's nondiscrimination should help.

In sum, the digital health section is progressive:

It shows Rwanda is integrating the **right to privacy** and **data security** into health governance, which is increasingly part of the right to health (the notion of "health information privacy" is recognized in many rights frameworks as part of patient dignity). Few countries explicitly require encryption in health laws – Rwanda will be among leaders in that. As long as enforcement is strong (the Ministry will need to audit systems, etc.), this can prevent incidents like those seen elsewhere (e.g. patients' HIV status leaked online – which can lead to stigma or harm).

Recommendation for digital health:

- When drafting the Minister's Order, consult with cybersecurity experts, patient rights groups, and IT companies to ensure the rules are robust but also practical. Include **penalties for data breaches** to incentivize compliance (maybe already under data law).
- Clarify responsibilities: if a hospital outsources data storage to a cloud provider, the hospital still carries responsibility for confidentiality (cannot just blame the IT firm).
- Consider cross-border issues: if data is stored or telemedicine provided from outside Rwanda, ensure those providers are bound by equivalent standards or require local data storage for sensitive info – the data law probably addresses cross-border data transfer.
- Promote awareness among patients about their data rights and among providers about secure practices (like not sharing records on WhatsApp without encryption, etc. – though WhatsApp is encrypted, but you get the idea).

Finally, note that **digital health can improve access to adolescent-friendly or disability-friendly care** (e.g. an embarrassed teen might prefer an anonymous online consultation). But privacy must be airtight to use those advantages safely.

Conclusions and Recommendations

In its current form, Rwanda's Draft Law Regulating Healthcare Services is a **forward-looking and comprehensive bill** that strongly incorporates human rights principles in many areas. It affirms equality in health access, delineates essential health services (including often-neglected areas like reproductive health, mental health, and digital health), and updates legal standards to contemporary needs. The law's strengths – such as explicit non-discrimination clauses privacy protections, and safeguards in mental health procedures– provide a solid foundation to build a rights-respecting healthcare system.

However, to fully realize its intent and meet Rwanda's obligations under the Constitution and international treaties (CEDAW, CRPD, CRC), several **critical gaps must be addressed**. Lawmakers should consider the following key recommendations:

1. Strengthen and Clarify Non-Discrimination Provisions:

- **General Equality Clause:** Add a general statement in the law's early articles affirming that *"Every person has the right to access healthcare services without discrimination on any ground, and all forms of discrimination in the provision of healthcare are prohibited."* This will reinforce Article 31(e) and apply it across all contexts. List protected grounds explicitly (at least sex, age, disability, sexual orientation) to guide interpretation, ensuring, for example, that discrimination due to marital status or disability is unequivocally forbidden in healthcarelaw.umich.edu.
- **Reasonable Accommodation Duty:** Incorporate a requirement that healthcare providers and facilities make reasonable accommodations for persons with disabilities and others with special needs. For instance: *"Healthcare facilities must take appropriate measures to ensure accessibility for persons with disabilities, including physical access, communication assistance (e.g. sign language, Braille, plain language), and other accommodations, in line with the Law on Protection of Persons with Disabilities and Article 9 of the CRPD."* This gives practical effect to non-discrimination by leveling the playing fielde-inclusion.unescwa.org.
- **Accountability:** Ensure the law provides or references mechanisms for patients to report discrimination or mistreatment (e.g. hospital ombudsperson or complaints commission), and that sanctions are available for violators. This could be added in the Offenses chapter: e.g. a health worker proven to deny care or behave in a discriminatory manner faces disciplinary action or a fine.

2. Empower Adolescents in Healthcare Decisions:

- **Adolescent Consent:** Amend Article 24(3) to allow mature minors to consent to health services without a legal representative in defined situations. For example: *"A minor aged 16 or above shall have the right to consent independently to recommended healthcare services if, in the judgment of the healthcare professional, the minor possesses sufficient maturity to understand the nature and consequences of the treatment. In particular, minors may seek and consent to sexual and reproductive health services and mental health counseling without parental consent, in order to safeguard their health and well-being."*

Such a provision, consistent with CRC guidance, would reduce barriers for adolescents. Alternatively, include a blanket exception for "preventive or confidential services" with a maturity assessment.

- **Confidentiality for Adolescents:** Include an article or clause guaranteeing that information regarding an adolescent's use of health services will be kept confidential and not disclosed to parents/guardians without the adolescent's consent, **except** when nondisclosure would seriously jeopardize the adolescent's health or is otherwise required by law (e.g. in case of sexual abuse, where mandatory reporting might apply). This aligns with best practices that encourage adolescents to seek care knowing their privacy will be respectedohchr.org.
- **Best Interests & Guidance:** Emphasize that in any health decision for a person under 18, the best interests of the child is a primary consideration (echoing CRC Article 3). And that adolescents should be involved in decision-making to the degree of their maturity (echoing CRC Article 12). This can be a general principle in the rights chapter.

3. Uphold Autonomy and Legal Capacity of Persons with Disabilities:

- **Revise Substitute Consent for PWD:** Remove or rewrite the part of Article 24(3) that automatically assigns consent to a legal representative for adults with disabilities. The law should instead require healthcare providers to communicate with patients with disabilities using appropriate methods and seek the patient's own consent. Only if the patient is demonstrably unable to understand or communicate consent, even with support and accommodations, should a legal representative's consent be invokedatlas-of-torture.org. A suggested redraft: *"If a healthcare service user is unable to give informed consent due to an emergency or lack of decision-making capacity (after all appropriate support has been provided), consent may be given by the user's legal representative as provided by law. The healthcare provider shall still involve the user in decision-making as far as possible and respect the user's will and preferences."* This focuses on capacity rather than disability label, and requires trying support first.
- **Remove Discriminatory Language:** Eliminate references to hearing or visual impairment as a trigger for third-party consent-. Instead, mandate provision of interpretation or assistance. For example: *"If the healthcare service user has a communication disability (such as deafness or speech impairment), the healthcare provider must ensure effective communication (through interpreters, assistive devices, etc.) so that the user can exercise the right to informed consent."* This turns a previously discriminatory clause into an empowering one, consistent with CRPD.
- **Guardianship and Oversight:** If in some cases guardians do consent for persons with mental disabilities, integrate safeguards: require a second medical opinion or ethics committee approval for major procedures on a person who hasn't consented themselves, to avoid abuse. And affirm that such decisions must be made in the person's best interests and consistent with their known wishesatlas-of-torture.org.
- **Training and Awareness:** The Ministry of Health should, under the law's implementation mandate, develop guidelines for health workers on supported decision-making and disability etiquette, in partnership with disability organizations. While not a legislative change, this is an actionable recommendation to accompany the law.

4. Reinforce Reproductive Health Rights:

- **Safe Abortion and Post-Abortion Care:** To avoid any regression from prior law, explicitly acknowledge the legal conditions for abortion and ensure access under those conditions. E.g.: *"Every woman has the right to receive safe termination of pregnancy services in accordance with conditions provided under the Penal Code and other applicable laws, and to receive post-abortion care in all circumstances without discrimination or delay."* This ensures the health system will actually provide the services that are legally permitted (Rwanda's penal code allows abortion for rape, incest, forced marriage, fetal impairment, or risk to health, upon certain approvals – those conditions should be facilitated by the health law, not ignored). Including this also ties into CEDAW and Maputo Protocol compliance on women's reproductive choicerwandalii.orgrwandalii.org.
- **Broader Range of Services:** Ensure that *"reproductive health services"* explicitly include adolescent-friendly services, menstrual hygiene management, and safe abortion/post-abortion care as above. Possibly add a clause to Article 65 or as new Article: *"Every individual has the right to accurate, comprehensive education and information on sexual and reproductive health."* Education could be considered out of scope, but health facilities should at least provide information (this aligns with CRC Article 24 and CEDAW obligations on health education).
- **GBV Survivor Support:** Strengthen Article 65(g) by operationalizing it: consider an article under healthcare facilities requiring them to establish protocols for handling GBV cases (e.g. having rape kits, linking with Isange One Stop Centers which Rwanda already has, etc.). Mention that GBV victims shall be treated urgently and free of charge (Rwanda already has a policy of free care for GBV victims, which could be codified).
- **Maternal Health:** You might add: *"A pregnant woman, a woman who has given birth, and a newborn have the right to special care and assistance so as to ensure their well-being"*, echoing Article 6 of the 2016 lawrwandalii.org. This can reaffirm obligations like respectful maternity care and postnatal follow-up.

5. Ensure Robust Mental Health Safeguards:

- **Judicial Review and Appeal:** Explicitly require that involuntary admissions beyond the initial 48 hours be authorized by a competent court or independent review body. Article 57 should specify that the "legal evaluation" entails either a judge's order or a Mental Health Review Board's decision. And add: *"The patient or their representative has the right to appeal any decision of involuntary hospitalization to a court of law."* This provides a clear legal remedy, fulfilling due process.
- **Consent to Treatment:** Clarify that involuntary admission does not automatically mean forcible treatment without consent. Except in emergencies, patients should still be informed and consulted about treatment plans. Consider: *"Even during involuntary admission, healthcare providers should seek the patient's informed consent for treatments where possible. Treatments shall, as far as possible, be given with the patient's agreement. If a patient refuses a certain treatment, that refusal should be respected unless the treatment is immediately necessary to prevent harm to the patient or others as certified by the treating psychiatrist."* This is a nuanced area, but it protects patient autonomy to some degree (for

example, a patient might be held for safety but could decline a specific medication and request an alternative).

- **Rights of Inpatients:** Insert a provision listing rights of mental health inpatients: the right to humane and dignified treatment, to be free from abuse, to communicate with family, to privacy in personal matters, to continued general healthcare, etc. A model could be drawn from international standards or Rwanda's own patient charter. For instance: *"Any person admitted for mental healthcare has the right to be treated with humanity and respect, to privacy and confidentiality, to receive visitors and communicate (with reasonable restrictions only as necessary for treatment or safety), to continue practicing their religion, and to be free from torture or cruel, inhuman or degrading treatment. Restraints or seclusion, if used, shall be only as a last resort and in accordance with strict medical guidelines."* Such language would cement protections and align with CRPD's ethos of dignity and freedom from ill-treatmentpmc.ncbi.nlm.nih.gov.
- **Community Care:** Perhaps mandate that the Ministry develop community-based mental health services to reduce the need for hospitalization, though that might be a policy directive more than a law. Even a statement like *"Mental healthcare shall be provided at the primary care level to the extent possible, and families and communities shall be involved in supporting persons with mental health conditions"* could encourage systemic change.

6. Implementation Mechanisms and Oversight:

- **Ministerial Orders and Guidelines:** The draft already foresees several Ministerial Orders (for ART supervision, for digital health norms, possibly for professional ethics, etc.). It is crucial these regulations be developed promptly and with stakeholder consultation (including women's organizations, youth groups, and organizations of persons with disabilities). The Parliament in its report can urge the Ministry to prioritize these and perhaps set timelines.
- **Health Professional Training:** Include a provision that *"The Ministry of Health shall ensure continuous training of healthcare professionals on the rights and obligations established by this law, including patient rights, informed consent, non-discrimination and confidentiality."* This will help operationalize new concepts (like adolescent consent or supported decision-making for PWD) which might be unfamiliar to some practitioners. For example, a doctor used to paternalistic norms might need orientation to respect a 17-year-old's decision or to work with sign language interpreters for deaf patients.
- **Public Awareness:** The law could instruct that *"The rights of health service users under this law shall be made widely known to the public."* The Ministry could be tasked to disseminate user-friendly materials (like posters in clinics listing patient rights, including the new ones for adolescents and PWD). Empowering patients with knowledge of their rights is part of ensuring the law has practical effectlaw.umich.edu.
- **Monitoring and Evaluation:** Possibly establish a Health Services Regulatory Authority or strengthen the existing inspection system to monitor compliance. The law might not create a new body, but it can mandate annual reporting on implementation (e.g. number of involuntary admissions, status of ART committee, data breaches reported, etc.) to identify issues early.

By adopting these recommendations, Rwandan lawmakers will **bridge the gap between policy intent and practice**, creating a law that not only looks good on paper but truly upholds human dignity and rights in every hospital ward and health center. This will ensure that **women (including young women), persons with disabilities, and adolescents** are not just passive recipients of care, but active rights-holders whose needs and choices are respected in the health system.

As Rwanda's Parliament finalizes this law, there is an opportunity to set a leading example in the region – a law that integrates international human rights treaty standards into the domestic reality of healthcare. The Ministry of Health and other stakeholders, including civil society, should collaborate in implementing the law through regulations, training, and oversight so that its promises are realized on the ground. With these enhancements, the Draft Law Regulating Healthcare Services will strongly promote the health and human rights of all people in Rwanda, leaving no one behind in the pursuit of good health and well-being.

Sources:

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