Gender Analysis
for USAID/Rwanda
Strengthening Capacity of Health Sector to Deliver Quality Health Services in Rwanda (SCHS) Project
July 2014

EXTERNAL VERSION

Introduction

The SCHS project interventions contribute to improvement of health outcomes for all Rwandans. Gender considerations need to be built-in into the following most critical elements that are required to come together, interact, and work effectively to contribute to the achievement of the SCHS project objective: effective leadership, political will, advocacy, and policy; a robust financing mechanism; a well-trained and adequately paid workforce; reliable information on which to base decisions and policies; well-maintained facilities and logistics to deliver quality medicines and technologies; results-based Monitoring and Evaluation (M&E); and a culture of knowledge-based learning. It is therefore crucial for the project activities to address gender gaps and other hindrances tied to social and cultural norms and perceptions, which prevent women and men from fully participating and benefiting from the development outcomes. Furthermore, health-related gender inequalities at the central and decentralized levels relevant to the SCHS project activities should be tackled, especially building on the host country's experience in working with the community through community health workers and health facilities to identify and respond to their health care needs.

The gender analysis team examined gender considerations relevant to each of the five gender analysis framework domains (laws, policies, regulations; cultural norms and beliefs; gender roles/responsibilities and time use; access to and control over assets and resources; patterns of power and decision-making) and project outputs (see pages 19-32) and explored ways to promote gender equality and women's empowerment in health systems strengthening interventions. The gender analysis report comprises several parts, but it mainly reflects two major sections: a) section 1 entails background information, existing gender assessments that informed this report, stakeholder consultations, and main findings by each domain of the gender analysis framework; b) section 2 depicts the project sub-purposes, identified gender constraints, and finally proposed solutions or recommendations that the project interventions should take into account to address these issues and strengthen health systems.

The critical gender issues that emerged from this analysis include:

- Slow implementation of gender policies in public and private spheres;
- Stigma and discrimination associated with access to health care and health service delivery;

- Limited awareness/sensitization of the community about patients' rights and protective gender laws and policies;
- Unequal social power and decision-making for women and girls;
- Poor household division of labor;
- Limited women's mobility;
- Women's economic dependency;
- Illiteracy and limited knowledge about reproductive health for rural adults and youth in general;
- Negative effect of gender norms that drive health behavior, health decision making, and the provision and utilization of health care, to name a few.

Additionally, the findings from the gender analysis include the following constraints, which can negatively impact the project implementation if not well addressed:

- Poor customer service;
- Lack of appropriate/special health care based on the differential gender and vulnerability needs;
- Limited gender-responsive planning, budgeting, and reporting;
- Lack of/limited gender integration capacity in core health system functions and gender skills to fully develop and maintain a strong and sustainable health system;
- Infancy of the private sector in health care, limited gender engagement, and its accessibility to urban elites only.

USAID/Rwanda will use the SCHS Project activities to strengthen the health system and promote host country ownership by increasing capacity to manage a variety of systems operations. This should be done, for example, through incorporating gender perspectives into technical assistance in procurement of health commodities, improvements in service delivery and availability, further development of information systems, identifying and piloting innovative solutions for mobilizing additional domestic resources for health.

The gender analysis team strongly recommends that the Health Office staff, especially the SCHS project design team integrate the findings in the project documents so that subsequent activities/interventions and implementing mechanisms will address these gender issues in a strategic manner based on programmatic recommendations provided in detail in the matrix, which is part of this analysis report.

Project description

Through SCHS project, USAID/Rwanda will transition to a new model of assistance, by gradually increasing the Ministry of Health's (MOH) capacity to manage USAID-supported health activities. This is a critical step in the longer-term goal of both the GOR and USAID to

increase the efficiency of the health sector and to gradually decrease the country's dependence on foreign aid.

Under this project, activities will support five sub-purposes that will contribute to the achievement of the project purpose and goal: sub purpose 1: Delivery of Health services improved; sub purpose 2: Accurate and timely data use for decision-making institutionalized; sub purpose 3: Essential medical products available and accessible at service delivery points; sub purpose 4: Increased domestic resources for the health sector used equitably and efficiently; sub purpose 5: Leadership and governance of health system at central and local levels strengthened.

The project includes a number of existing activities—including the Rwanda Family Health Project (RFHP), USAID|DELIVER, Supply Chain Management System (SCMS), the Rwanda Integrated Health System Strengthening Project (IHSSP), and the African Indoor Residual Spraying (AIRS) Project, as well as planned follow-on and new activities. A key new component of this project will be the Reproductive, Maternal, Newborn and Child Health Program (RMNCH), that will focus on contributing to achieving a goal of Ending Preventable Maternal and Child Deaths (EPMCD), through supporting Rwanda's health sector to increase coverage and utilization of evidence- based high quality RMNCH interventions at the household, community and health facility level and reducing the burden of malaria. In order to help the GOR prepare for assuming more independence in the financing and management of the country's health system, USAID's investments in health systems strengthening will contribute directly to the goals of the HSSP III to:

- Achieve the universal and sustainable availability of quality drugs and consumables. USAID resources and technical expertise will be directed to the MPPD of the Rwanda Biomedical Center (RBC) to build the Rwandan health supply chain into a more efficient and sustainable institution.
- Improve and sustain universal access to high quality health services. This activity will support the decentralization of health management through the incremental transition of district health services to the GOR, planned to begin with six districts in the first year of the agreement.
- Transform the institutional capacity of targeted health sector institutions by building strong systems for health care management, administrative leadership, and sound financial management.

To maintain the gains achieved in the delivery of services nationwide, USAID will provide financial and technical support to all levels of the health system with a holistic, integrated approach to system strengthening and capacity building. Support will be provided to district authorities to plan, manage, monitor, and sustain both integrated service delivery and progress toward improved health outcomes. At the facility and community level, USAID will support health providers to deliver essential health interventions in a timely manner and in compliance

with quality standards of care. Support at the central level will include management skills, strengthening integrated supervision and the promotion of integrated training for health care workers in both pre-service and in-service settings that benefit the Rwandan health system as a whole. Some of the planned interventions will also aim to identify and pilot innovative health financing solutions to generate additional domestic resources for health, as well as create opportunities and enabling environment for the private health care sector to grow.

Background

The Gender Analysis for the USAID/Rwanda SCHS project was conducted in October 2013 and updated in July 2014 and is intended to inform the design of this project, subsequent activities, and relevant implementing mechanisms. This Gender Analysis is one of the three required analyses and the findings need to be integrated into the activity design and implementation.

Reports from the USAID Interagency Gender Working Group (IGWG) and other donors, such as the World Health Organization, revealed that growing evidence supports the theory that gender is an important aspect of development programming, including health systems and health related interventions. The IGWG emphasizes the adoption of the "Gender Transformative" approaches, which actively strive to examine, question, and change rigid gender norms and imbalances of power as a means of achieving health objectives, as well as gender equality objectives. This is achieved through critical awareness among men and women of gender roles and norms; promotion of the position of women and girls in the community and society; challenging the unequal distribution of resources and allocation of duties between men and women; and/or addressing the power relationships between women and men and others in the community, such as service providers or local leaders. The ability of women to make decisions that affect their personal circumstances, such as their own health care, is essential for their empowerment and serves as an important factor in national development[1]. However, women who do not have a voice in intra-household major decisions, often encounter difficulties to exercise their full potential, claim for their rights, and promote overall family wellbeing; hence, they fail to respond to their own and family health care needs.

Gender inequality damages the health of millions of girls and women across the globe and it can also be harmful to men's health despite the many tangible benefits it gives men through resources, power, authority and control[2]. These benefits to men do not come without a cost to their own emotional and psychological health, often translated into risky and unhealthy behaviors, and reduced longevity. Briefly, the above referenced report by Sen, G et al. points out that health issues and needs can be significantly different for men and women; medical poverty may not trap women and men to the same extent or in the same way, and poor and or

[1] 2010 Rwanda Demographic and Health Survey

[2] Sen, G, Ostlin P, George A. (2007) Unequal, Unfair, Ineffective, Inefficient Gender Inequity in Health: Why it exists and how we can change it. Women and Gender Equity Knowledge Network.

marginalized populations are often worse off in terms of both health access and health outcomes than those who are economically better off. The Health Sector Strategic Plan III (HSSP 2012-2018) has the overall vision and goal for the Rwandan Health Sector to continually improve the health of the people of Rwanda, through coordinated interventions by all stakeholders at all levels, thereby enhancing the general well-being of the population and contributing to the reduction of poverty. The total fertility rate in Rwanda has declined over the past two decades. According to the DHS 2010, women have an average of 4.6 children, down from 6.1 in DHS 2005. Though the maternal mortality ratio remains high in Rwanda – 487 deaths per 100,000 live births, the rate has declined considerably in the past 10 years from 1,071 deaths per 100,000 live births to 750 deaths per 100,000 live births in RDHS 2000 and 2005, respectively. Childhood mortality levels have been decreasing, and the current infant mortality is 50 deaths per 1,000 live births, compared with 73 deaths for the last five-to-nine year period before the DHS 2010 survey.

Data from several research documents show that women and men interact differently with health systems, partly as a consequence of differences in reproductive health needs, partly because women and men differ in their responsibilities, with more women providing care for others, and partly because men and women vary in their knowledge about health, their recognition of symptoms and their willingness to consult[3]. In addition, the various social determinants of health, including socioeconomic status, paid and unpaid work and culture, vary between men and women. Women and men have different exposures to the following risks: in almost all countries women are more likely than men to be financially insecure, for example, and have a lower social status, while men are more often employed in occupations with specific threats to health – including for example construction work where there are increased risks of accidental injury[4]. However, there are also important differences among women, and among men, reflecting socioeconomic status for example, which further affect their risk of poor health and problems concerning access to services and experience of health systems.

However, health systems in many countries, including Rwanda have been unable to deliver adequately on basic health or on health equity in general and gender equity in health in particular. One reason is that many health care systems pay insufficient attention to the differential needs of women and men in planning and providing health services. Another reason is that equitable utilization of health care is strongly affected by gender inequalities in society that determine whether women's health needs and problems are properly acknowledged, and whether families are ready to invest equally in the health of girls and women. It is also affected by unequal restrictions on physical mobility, unequal control over financial resources, and

[3] Payne S. (2009) Policy Brief 12: How can gender equity be addressed through health systems? World Health Organization on behalf of the European Observatory on Health Systems and Policies.
[4] Courtenay Will H. (2000) Constructions of masculinity and their influence on men's well-being: A theory of gender and Health. Elsevier Science Ltd.

unequal decision making. Health services may also be unsuited to meeting the health needs of men: for example, reproductive health services are often not set up so as to encourage male involvement. Gender equality is recognized as essential to the success of national health programs and a central pillar of the GHI strategy for Rwanda, cutting across all health interventions.

Promotion of gender equality and female's empowerment for improved services delivery includes encouraging increased male involvement in maternal, child, and reproductive health, and nutrition programs, as well as linking low-income women and child- or women-headed households to income-generating activities and social welfare programs. This project focuses on strengthening the capacity of health sector, leading to better services for both male and female adults, youth, children, and vulnerable or marginalized populations. Women stand to benefit greatly, though indirectly, from the SCHS Project as the overall system is improved. SCHS investments will deliberately target women taking a proactive position in ensuring the integration of gender equality into health programs aimed at improving the quality of health services and responding to specific health needs for men and women populations at both health facility and community levels. To ensure that the planned SCHS activities through this project benefit all Rwandans, it is important to understand the gender situation and its implications for USAID/Rwanda's interventions in strengthening health systems in Rwanda.

This gender analysis will try to respond to the following questions with the aim of promoting equality throughout the SCHS project activities:

1) Where are the key entry points for inclusive health programming at the local level?
2) How do traditional and cultural norms "gender roles" affect health needs and outcomes for female and male populations?
3) How do different Government of Rwanda's policies, strategies, and health care delivery systems create different levels of health seeking behaviors (risk-prone and risk-averse) for populations to access better quality of health services for all?
4) What are major gender gaps in health system that the SCHS project activities should seek to address?

This analysis considers the above listed questions and their implications for programming, so that the planned interventions will help to strengthen health systems, particularly creating enabling environment to systematically improve both the demand and supply sides of health systems through which male and female health services seekers and care providers fulfill their responsibilities and satisfy their specific needs.

Existing Gender Assessments

This analysis takes into consideration findings from existing general and health sector-specific gender assessments and reports that have been conducted by other interveners in the health sector in and outside Rwanda, and many of these materials have been referenced in this report.

Stakeholder Consultations

This gender analysis for the SCHS project was conducted by USAID/Rwanda and Washington staff. The gender analysis team completed the literature review, which was supplemented by focus group discussions and meetings/consultations with the following people: Mission staff in the Health Office; members of the Mission Gender Team; other stakeholders, such as government counterparts, NGOs, civil society organizations, community-based organizations, community representatives, and some of the Mission's implementing partners. A complete list of institutions and individuals consulted is attached to this report as Annex A.

Main findings by domain

1. Laws, Policies, Regulations, and Institutional Context

Nationally, gender responsive laws and policies, including the National Reproductive Health Policy (2003), the Law on the Prevention and Punishment of Gender Based Violence (GBV) (2008), the National Accelerated Plan for Women, Girls, Gender Equality and HIV (2010-2014), the National Gender Policy (2010), and the Adolescent Sexual and Reproductive Health and Rights Policy (2011) have been enacted. Relevant bodies/agencies have been set up at national and decentralized levels to advance, coordinate and advocate on gender issues, women's empowerment and the fight against GBV. All Ministries are aware of these policies. Representatives from the Ministry of Health were adamant that the law required equal treatment for all people regardless of gender and that is how they were delivering their services. However, many people reported feeling stigmatized based on various criteria including economic – those using health insurance were made to wait much longer than those paying cash, marital status – particularly when trying to access contraceptives, and homosexuality.

Although homosexuality is not criminalized in Rwanda, Lesbian, Gay, Bisexual, Transgender, and Intersex (LGBTI) populations continue to face stigma and discrimination in the society. Traditional gender norms promote heterosexual relationships and do not condone homosexuality. The Gender Assessment of Rwanda's National HIV Response conducted in 2013[5] pointed out that **stigma and discrimination** keep LGBTI hidden and as a result they are less likely to be reached by HIV prevention services or have access to the necessary HIV prevention tools. These populations report facing discrimination from health care providers and 28 percent state that they

[5] UNAIDS. (2013) Gender Assessment of Rwanda's National HIV Response. Kigali, Rwanda

would not disclose their sexuality to a health care provider if explicitly asked during a medical consultation. The high degree of felt stigma among these populations has implications for health service delivery for them.

The Government of Rwanda is aware of the many challenges and gaps facing the promotion of gender equality and the fight against discrimination and GBV. It has therefore articulated **the need for continued integration of gender equality into the development sector strategies, programs, and actions** to address them in line with Vision 2020 and key strategies, such as EDPRS II 2013-2018. EDPRS II focuses on strategies that address the needs of all groups to realize rapid economic growth. It will mainstream gender and family in planning and budgeting and in all development programs/projects at national and local levels. Sector strategies and district plans will focus on interventions that reduce poverty levels among men and women, and reduce gender based violence, malnutrition and other related conflicts at both family and community level. The Ministry of Gender and Family Promotion has the mandate to assure the oversight of the implementation of gender-related laws and policies, whereas the Gender Monitoring Office has the responsibility to ensure proper monitoring and evaluation of programs and activities across development sectors in order to provide evidence-based data on gender issues for advocacy and decision-making purposes.

While Rwanda is making progress through interventions by both public and private institutions in integrating gender equality into strategies, programs, projects, and activities to promote gender equality and empower women, **the transformative potential of various gender equality policies is limited by the lack of adequate gender mainstreaming and integration trainings at central and decentralized levels and the deep-rooted social norms and practices within which, gender inequalities are embedded.** At the institutional, organizational, and community levels, key areas of concern include: coordination; sustainable reproductive health funding; access of adolescents to sexual and reproductive health services, including family planning education; expansion of family planning access; reproductive health services integration; ensuring confidential provision of reproductive health services; resistance from certain religious groups; cultural beliefs; limited male involvement; fear of side effects; and capacity of human resources to provide services[6]., However, a significant number of gender discriminatory laws have been revised; new policies and strategies have been put in place, although not exhaustively; and community education and dissemination of protective gender laws and policies have been carried out to the extent possible to challenge societal perceptions and norms. More efforts are still needed, though, and this creates an opportunity for USAID/Rwanda to support the implementation of local gender-related policies and strategies through design and implementation of gender-sensitive development programs and projects.

[6] Government of Rwanda (2012) Family Planning Policy – Strategic Plan to Accelerate Progress towards Reducing Maternal and Neonatal Morbidity and Mortality, 2009-2012. Ministry of Health, Maternal and Child Health.

2. Cultural Norms and Beliefs

Rwandan society is characterized by a patriarchal social structure that underlies the **unequal social power relations between males and females**. This has translated into **men's dominance and women's subordination**. Even though women in Rwanda represent 52% of the population, they do not participate fully and equally in socio-economic and political spheres of life. Over centuries, gender inequalities have not been seen as unjust, but as respected social normality[7]. It is important to note that the issue of **gender inequality is embedded in patriarchy as a system that accords more powers to men than women**. Thus, boys have been attributed more values than girls. It is therefore crucial to address health-related gender imbalances in Rwandan society if the SCHS project goal to improve health and nutritional status of Rwandans was to be effectively and efficiently achieved.

According to the recent assessment[8] gender roles and norms interact with other factors (e.g. poverty, illiteracy, economic vulnerability/dependence) to produce particular manifestations of attitudes and behaviors among women and men, which can reduce their ability to access critical health care services, take informed and timely health related decisions, and negotiate safer sex and mitigate domestic/sexual based violence. These behaviors and practices also influence who is more affected by ill-health and HIV risk and vulnerability for women/girls, men/boys, and marginalized and other vulnerable groups in Rwanda and can consequently affect their life expectancy and increase the risk of death and disease. This assessment also revealed **that gender norms that promote an image of a strong and powerful man are likely to restrict men and boys' health-seeking behavior**, as these norms are at odds with care seeking. In Rwanda, men are much more likely than women not to seek care from health facilities. For example, only 35 per cent of men with sexually transmitted infections reported seeking care from a health care professional – compared to 54 percent of women. According to the DHS 2010, the HIV prevalence is 3.7 percent for women and 2.2 percent for men; and the prevalence is three times as high in urban areas (7.1 percent) as in rural areas (2.3 percent).Those living in poverty are also most intensely affected by HIV and vulnerable to the socio-economic impacts of the epidemic. This is evident in different overarching issues, including poverty, which is felt more acutely by women than men in Rwanda; lack of institutionalization of gender accompanied by unequal participation of men and women in most social, cultural, economic and political spheres, and unequal access to services.

Societal perceptions, expectations, and marginalization often tend to neglect socio-economic differences, including sexual and reproductive health needs of the following categories of vulnerable groups: widows/widowers, elders, youth, sex workers, orphans and other vulnerable children, people living with HIV/AIDS and/or disability, and the LGBTI

[7] Government of Rwanda (2010) National Gender Policy. Ministry of Gender and Family Promotion. Kigali, Rwanda
[8] UNAIDS. (2013) Gender Assessment of Rwanda's National HIV Response. Kigali, Rwanda

community. These categories have vulnerability as a common denominator but women are generally more vulnerable than men in these groups. It is critical that programs and activities across all development sectors take into consideration special and unique needs of these groups for inclusive and sustainable development. **The HIV National Strategic Plan 2009-2012[9] acknowledged that prioritization of marginalized groups in national strategies does not always result in prioritization on the ground. This plan noted that marginalized groups require specially adapted services that respond to their needs, and consequently, emphasized the need for special training for health care providers to ensure that these groups receive adequate, regardless of the prejudices service providers may have towards them.**

The UNFPA Policy Recommendations for the International Conference on Population and Development Beyond 2014: Sexual and Reproductive Health and Rights for All articulated that equity and equality in access to health services cannot be ensured unless sexual and reproductive health is also prioritized in the primary health care system. There is a need to provide adequate geographic distribution and availability of services and information in both urban and rural areas, make services free or affordable, including through universal health care coverage and insurance schemes with particular attention to reaching women, young people, and the most impoverished sectors of the society for whom costs are a significant barrier to seeking the health care they need. Despite significant progress in improving sexual and reproductive health in Rwanda, the RDHS 2010 (NISR et al 2012) reports a number of challenges in the areas of sexual and reproductive health, including an unmet target for the use of modern methods of contraception and an unmet need of 17 per cent, insufficient youth-friendly centres, lack of reduction in the HIV infection rate, low rates of condom use by adolescents when engaging in risky sex, high levels of stigma against people living with HIV/AIDS, and high levels of domestic violence and tolerance of violence against women.

In addition, there is a high rate of adolescent pregnancies at schools as revealed by the Gender Monitoring Office in their report on GBV in Primary and Secondary Schools in Rwanda[10]. This had also been pointed out by the Ministry of Education based on an assessment on primary and secondary schools conducted in 2011, which revealed that 61 percent of students expressed gender based violence and unwanted pregnancies as the main causes of school dropout. It involves verbal abuse, physical attacks/punishment, humiliation and assault, including rape. Consequences include unwanted pregnancy and young people, especially girls dropping out of school. **Lack of education on sexual and reproductive health; limited or lack of communication; peer pressure; coercion - especially by teachers; poverty driving**

[9] CNLS. (2009) National Strategic Plan on HIV and AIDS 2009-2012. Kigali, Rwanda. National AIDS Control Commission (CNLS) (NSP 2009-2012).

[10] GMO. (2013) A research on GBV in primary and secondary schools. Online article accessed on June 24, 2014 at http://www.gmo.gov.rw/index.php?id=31&no_cache=1&tx_ttnews%5Btt_news%5D=63

acceptance of materials etc. in exchange for sex from sugar daddies and mummies, and the cultural practice of informal dispute resolution are all contributory factors.

3. Gender Roles, Responsibilities and Time Use

Cultural factors play a significant role in determining men's and women's roles and responsibilities, and time allocation in handling both productive and reproductive work in the household and community. In order to contribute to the country's pro-active political leadership and legal framework, development programs have to take advantage of the enabling gender environment in Rwanda, and address existing and potential gender issues that hamper development. **Traditional gender norms in Rwanda promote the perception that domestic work, caring for children, sick people and elderly are predominantly women's tasks**. This places the disproportionate burden of domestic work and unpaid caregiving role on women and girls, which more often, goes unrecognized and unremunerated. A 2010 study[11] on masculinity found that 73 per cent of men and 82 per cent of women totally agree that a woman's most important role is to take care of her home, whereas 44 per cent of men and 78 percent of women agree that changing diapers, giving kids a bath, feeding the kids are mother's responsibilities. It therefore appears that a large number of women strongly agree with these traditional gender norms than men.

The domestic role includes tasks (for example: cleaning the house, washing clothes, taking care of animals, cooking, and taking care of kids, etc.) **that are often arduous, time-intensive, and energy-consuming, which affects health outcomes for women and girls and often prevents them from seeking timely and high quality health care services**. Gender norms, relations, and inequities affect health outcomes for everyone. **It is crucial to understanding the unique needs of men and women, boys and girls from different settings and other gender identities, such as LGBTI in order to efficiently respond to specific needs of target populations and dedicate resources where they are most needed**. Ignoring gender-related barriers, such as societal and cultural norms and expectations and community's perceptions of gender-based violence can negatively affect access to service, utilization, treatment adherence, and health outcomes for everyone. Gender-informed health systems at the decentralized level will strengthen the response to unique identified needs of men and boys, women and girls, and other gender identities. It will also improve program outcomes, living conditions of the populations, and enhance sustainability.

4. Access to and Control over Assets and Resources

Data from the Third Integrated Household Living Conditions Survey (EICV 3) and DHS 2010 explain **that socio-cultural norms precipitate economic and political realities that contribute**

[11]RWAMREC. (2010) Masculinity and Gender-Based Violence in Rwanda: Experiences and perceptions of men and women. Kigali, Rwanda: Rwanda Men's Resource Center.

to gender inequalities in different domains, including HIV transmission. Men in Rwanda are more often gainfully employed, earn more, and are more likely to be employed in fields outside of agriculture, such as semi-skilled occupations, than their female counterparts. **Men have also traditionally benefited from greater access to education than women**. These factors contribute to men's greater access to financial resources and decision-making power in their relationships. **The lower economic status for women and power imbalances reduce their ability to access/use productive resources, decide/negotiate or take best choices for their own lives, including reproductive health, and can lead to greater levels of domestic violence, unmet health care needs, and contribute to a high degree of ill-health for women and girls**. The equal right to health is affirmed in the Universal Declaration of Human Rights. However, due to women's subordinate position and economic dependency in the Rwandan's society**, the burden of health inequality is not shared among different members of poor households**. Often, medical poverty does not equally affect women/girls and men/boys, widows/widowers, OVCs, people living with disability and HIV, and LGBTI groups.

5. Patterns of Power and Decision Making

Gender roles in traditional Rwanda were structured around a **household division of labor that allowed women substantial autonomy in their roles as child bearers and food producers but preserved male authority over other family affairs**. While couples will often say that sexual behaviour, contraception and family size are discussed between husband and wife, **decision-making is still culturally a male preserve** and a recent survey by Hageman et al 2009[12] indicates large areas of disagreement in the reports of what is going on in the family. Other studies indicate that parents do not tell their children about reproductive health, HIV and the sexual transmission of diseases, but some children learn about sex at school, and unprotected sex is common among young people. There is also **misconception about use of condoms by couples** - men feel they cannot use condoms with their wives; condom use suggests promiscuity or at least the intent to be unfaithful, and the major use of condoms by men is said to be when they stray outside the marriage relationship. For women abstinence messages based on religious beliefs have reinforced the perception that using a condom is a 'sin'. Per the Rwandan Constitution 2003, as amended to date, **men are heads of the family**. **This means that men in Rwanda have a right and religiously/politically endorsed role as protectors and head of the family**. Women have to be submissive and accept their female roles, hence GBV is accepted as part of everyday life and is used to warn and or punish wives who do not conform to cultural expectations.

In addition, based on the data in the DHS 2010, **women's autonomy and decision-making power in their relationships are often linked to their earning power and educational attainment**. The majority of women who are married and earned cash for their work in the last 12 months report that they decided jointly with their husbands on how to spend their earnings –

[12]Kathy M Hageman M. K. et al (2009) What the better half is thinking: A comparison of men's and women's responses and agreement between spouses regarding reported sexual and reproductive behaviors in Rwanda. Published online on March 10, 2009. Accessed on July 7, 2014 at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3218770

66 per cent, with the majority also deciding jointly on how their husband's earnings are spent. This means that the women with no education were the least likely to decide jointly how to spend their earnings – 60 per cent, while women with a secondary education or higher are more likely to decide jointly – 70 per cent. Moreover, a woman's financial independence and earning power is also key to her participation in decisions regarding her own health care, major household purchases, and whether she visits family or relatives.

Furthermore, Rwanda Men's Resource Center (RWAMREC) study conducted in 2010 on gender-based violence revealed that women with higher income are more likely to be exposed to violence, **suggesting that issues of women's economic dependency and conflict over control of household resources are more likely to trigger domestic violence than the lack of resources altogether**. In addition, the DHS 2005 survey makes the point that spousal violence is frequently associated with certain dominating behaviors used by the husband/partner to control various aspects of a woman's life. Such behaviors, it argues, can be precursors to acts of violence. **Controlling behavior by men in their capacity as heads of the household, as discussed above, affects the ability of women to make autonomous decisions**, or to participate equally in family decision-making in a number of areas, such as health, governance, education, and agriculture. Data from the DHS 2010 showed that 56 per cent of ever-married women have suffered from partner abuse (physical and/or sexual) at some point in time, with one in five women having experienced sexual violence. Furthermore, the DHS findings revealed that over 55 per cent of women of all ages answered affirmatively when asked a question of whether it is justified for men to beat their wives.

The above mentioned statistic is in stark comparison to the percentage of men, ranging from 15.3 per cent in the older men range, and 34.6 per cent in the youngest age range (15-19) who agreed with the question. **This is also an indication that women generally and culturally accept the right of a man to control his wife's behavior even by means of violence**. These statistics were particularly shocking as the DHS survey showed improvement for both health and economic statistics in almost all other areas. Although more analysis would be necessary to truly understand these numbers, it's quite clear that attitudes about gender based violence, particularly from the perspective of women and younger men, are justifying physical abuse against women. The vast majority of the women surveyed - 59 per cent live in rural areas and are in a lower income bracket. The SCHS interventions are therefore expected to improve health systems and respond to youth related health care issues, while supporting young generations to have healthy relationships, understand human sexuality and puberty, prevent and delay pregnancies, prevent or reduce risk of HIV and other sexually transmitted infections, prevent sexual coercion, sexual violence, and transactional sex.

Analysis of issues and recommendations by sub-purpose and output

Project Problem Statement:

In Rwanda, a country that has exceeded expectations regarding its performance in the health sector, the accolades run deep. Few if any countries on the African continent have managed to affect mortality rates and other key indicators in such a short period. Infant mortality declined from 86 deaths per 1,000 live births in 2005 to 50 in 2010.[13]Similarly, child mortality declined from 72 deaths per 1,000 live births to 27.[14]Malaria incidence is declining steadily. Almost all pregnant women attending antenatal care (ANC) are counseled and tested for HIV, with PMTCT services reaching 94%. More than 100,000 patients are on ARV, representing 94% of expected patients. Family planning commodities are being procured and distributed. Enrollment of the population in the innovative Community Based Health Insurance (CBHI) scheme, covering essential package of services, reached 91%.[15]Several new district hospitals and maternity wards have been constructed and rehabilitated, or are in the process. These accomplishments would be remarkable for many countries, but Rwanda stands out in large part due to its post-crisis history. Globally, Rwanda is recognized for its executive level commitment to health - a commitment that is paying dividends. These gains, among numerous others, reflect the high rate of adoption of effective health practices by Rwandans, and focused strategic investment by politically dedicated executive level government officials.

Despite impressive gains, Rwanda remains a poor country. Domestic investment in health ranks substantially below the Abuja Declaration target of 15% of Gross Domestic Product (GDP). It is widely known that the country's success is largely built upon external donor support, a fact that Rwanda's national development strategy, Vision 2020, aims to change. A major constraint to maintaining the successes and further improving the health of the nation is the lack of domestically generated resources and capacity to fully develop and maintain a strong and sustainable health system. Private sector in health care is still nascent and accessible to urban elites only. USAID sees important opportunities to assist Rwanda in its economic transformation, thus strengthening the health care system that can sustainably deliver positive health outcomes. Therefore, USAID stands on firm technical and strategic ground in proposing a state-of-the-art SCHS Project.

To achieve many of the advances to date, donors (including USAID) have relied on high levels of international technical assistance and direct financing of recurrent costs (including staff) to operate an expanded health system. Institutional and human capacity building took a backseat to delivering services and expanding service outlets. The system is now stronger, and health status is improving. Both the donor community and the GOR agree that it is time to tackle the problem of sustainability by strengthening the institutional capacity of the sector and building financing mechanisms that can be maintained into the future. The GOR has asked the United States Government (USG), through USAID, to continue assistance in the further development of the country's health management systems.

USAID/Rwanda will use the SCHS Project to strengthen the Rwandan health system and promote host country ownership by increasing capacity to manage a variety of systems

[13]*Rwanda Demographic and Health Survey (DHS) 2010*, National Institute of Statistics of Rwanda, Ministry of Health Rwanda and MEASURE DHS, Calverton, Maryland , February 2012, p.103.
[14] Ibid.
[15] The Republic of Rwanda Ministry of Health Annual Report 2011-2012.

operations. This includes assistance in procurement of health commodities, improvements in service delivery and availability, further development of information systems, identifying and piloting innovative solutions for mobilizing additional domestic resources for health, gradually transferring responsibility over system's recurrent costs, and overall, strengthening the system in an integrated way. In addition to standard implementing mechanisms that provide technical assistance, the investments in local capacity development will be continued, adding a learn-by-doing component to managing health funds and activities.

Project Goal: To improve the health and nutritional status of Rwandans

Project Purpose: To strengthen capacity of health sector to deliver high quality services

Project Theory of Change:

By maintaining and improving availability of quality health services; ensuring that accurate and timely health data is available and used for decision making; guaranteeing access and availability of medical products at service delivery points through strengthening and supporting the Rwandan commodity procurement and distribution systems; promoting rational use of medicines; supporting GOR in its aspiration to increase domestic resources for health sector and use it equitably and efficiently; sustaining, broadening and deepening access and affordability of essential health services, and strengthening leadership and governance of the health sector both at central and local levels and coordination between those, USAID expects to **achieve the purpose of the project**: to strengthen the capacity of health sector in Rwanda to deliver affordable, responsive and high quality health services. This, in turn, will **significantly contribute** to improvement of health status of Rwandans, as demonstrated by achievement of high level health targets in line with GOR HSSP III.

Potential Gender Issues	Recommendations
Sub purpose 1: Delivery of Health Services Improved	
• Adult women perceive health services provided at community and facility as insufficient. Women do not feel comfortable to talk freely about their health issues (in relation to reproductive health, gynecology) to young health professions. These behaviors are mainly due to cultural and social norms, issues of confidentiality/privacy, and may significantly affect the demand side of health services[16] • Adults and youth experience poor customer care at the health facility, due to negligence, particularly by some female health providers and appearance of being rude and arrogant toward patients. They prefer getting health services from male health professionals. Health services cannot be effectively improved if service providers do not behave in a professional manner. • Patients with special health needs and those from marginalized groups (people with disability, people with HIV/AIDS, LGBTI) experience poor customer care, poor and inefficient health services, stigma, and discrimination at the facility and community. This is due to poor understanding of their specific needs by health professionals, lack of adequate trainings, cultural and societal beliefs coupled with insufficient number of staff at the facilities. • Co-pay factor and non-covered medications under the CBHI are challenges for poor female and male	• Project interventions should provide basic gender training sessions for health service providers at the facilities and in the community to challenge social stigma/discrimination and cultural beliefs that would affect the demand side based on different levels of vulnerabilities, including biological and physiological differences. • Adequate and specific trainings for community and health service providers should be provided so as to enhance their skills to improve customer care and respond to special and particular needs of different categories of patients, including more disadvantages and marginalized groups in order to give them satisfactory health services. • Negotiate with the Ministry of Health to provide an adequate number of staff at the facilities and make sure to offer same sex providers when needed by patients. In addition, health facilities should consider offering integrated mobile health services, if possible, to females with restricted mobility, people with disability, and accommodating male migratory or work patterns • Conduct outreach and sensitization activities targeting men in the community to educate and encourage them to seek health care services. • Project interventions should conduct and strengthen sensitization and outreach activities, especially targeting men in the community and if possible at their workplaces to educate and encourage them to seek health care services

[16] Testimony from cooperative members from the USAID-support FXB activity

households and they constrain sick people to access adequate health services and products. • The time needed to go the clinic and long waits for medical consultations due to inadequate staffing and customer care discourage patients to seek health care services, especially women who often have other competing priorities related to domestic chores. • There is inefficient and poor use of health care services by men, which is often related to cultural and societal beliefs and expectations. If not addressed, this may widen gender disparities in health and affect health outcomes for male populations.	
• Some specialized health services and products may not always be available at the facilities (health centers) and community due to inadequate medical infrastructure and equipment, which can lead to less-efficient use of services offered. For example youth and single women are not given priority for accessing family planning services and products due to societal expectations that only couples should seek these services[17] • The Ministry of Health's capacity to plan and manage health services at the facilities and community is limited and health services offered are not necessary based on knowledge of local gender-related behavior and perceptions. • Failure to tackle gender inequalities can lead to poorer morale among health professionals. According to the	• Interventions should strengthen the health care provider-recipients' relationship and interactions in addition to educating the community on the importance of accessing and utilizing health care services. • Work with the Ministry of Health to build capacity of health professionals and service providers to plan and manage health services, deliver quality health services in target facilities and communities in a professional manner and meet patients' needs and expectations. • Work with the Ministry of Health to encourage and strengthen the use of customers/clients' satisfaction survey at health facilities and use the information to improve and maintain better health services both at the facilities and in the community • Negotiate with the Ministry of Health to put in place a safe service in charge of receiving grievances and injustice cases

[17] Testimony from consultation held on June 19th, 2014 with the Rwanda Men's Resource Centre

report findings by the Transparency International in Rwanda[18], women and girls in general are the main victims of gender based corruption in search of employment and in work places, while men in decision making position are the main perpetrators both in public and private institutions. For example, gender inequalities affecting women at the level of the workforce include poorer employment conditions, poor work environment and discrimination with regard to opportunities for promotion that can result in poor attitudes and higher attrition among female staff and the loss of trained and valuable employees. • Community Health Workers (CHWs) who are predominantly women have been successful assisting the community through provision of preventive and primary health care services. The fact is that they experience a huge workload/burden with ever greater responsibilities without adequate support or remuneration.	related to gender based corruption, violence, and discrimination in the work place. For example, the employee satisfaction survey should be used and findings taken into consideration. In addition, the Human Resource department should integrate the dimension of gender-based corruption in the action plan and staff management policies at central and decentralized levels, and require private health service providers to comply. • Negotiate with the Ministry of Health to enhance support to the cooperatives of CHWs in order to improve the living conditions of CHWs, especially women; increase performance-based bonuses to health providers; and offer different types of incentives to health care seekers. This was proven to help raise the quality and use of some services.
• In health care, private sector is not well developed, existing private service providers are not accessible to rural population, and gender equality not well considered, particularly in private spheres[19]. This needs to be addressed in order to create an enabling environment that promotes private health care services. • Private health care service providers need specific trainings so that they can offer more targeted, gender sensitive services to both men and women.	• Work with the Ministry of Health to ensure that regulations under which private health providers operate include safeguards for gender equality in human resources and employment, non-discrimination practices and care to patients. • Work with the Ministry of Health in capacity building interventions for private health workers and professionals to acquire key skills in caring for populations with specific and special needs

[18] Transparency International (2013) Gender Based Corruption in workplaces in Rwanda. Kigali, Rwanda

[19] Information obtained from the consultation that took place on June 19th, 2014 between USAID/Rwanda Team and the Gender Monitoring Office.

Sub purpose 2: Data use for decision-making institutionalized	
• Data collection, analysis, and utilization are still problematic in Rwanda. The lack/limited data in numbers, especially sex-disaggregated data, gender-sensitive health indicators, and the know-how to manage data[20] might negatively affect this output if not addressed. • Data dissemination appears also to be an issue, which can affect this outcome. This is due to the lack of effective communication strategies by both public and private institutions in order to influence decision-making and support the advocacy efforts.	• Project interventions should strengthen the capacity of health professionals at all level of the health system to plan, implement, access, analyze, disseminate, and use quality data to make informed management • Negotiate with the Ministry of Health to ensure adequate collection and analysis of sex-disaggregated data within the Health Information Management System (HIMS) and emphasize adequate dissemination of the results to male and female information users to inform the selection or development of gender-transformative interventions. • In coordination with the Ministry of Health, enhance good informational approaches that will focus on well-functioning HIMS and Logistics Management Information System. Once sex-disaggregated data becomes routinely available, trends can be observed that help make the case for proper gender-related budgeting necessary to address health disparities between males and females in terms of their use of specific health services
• Data quality, validity, reliability and feedback based on the current HIMS are still weak. Even if the data might be available, there are issues of getting sufficient quantitative and qualitative gender related data; issues of who communicates, when, what, and to whom to make sure that relevant stakeholders have the necessary and reliable information to take appropriate actions in due course.	• Specific project interventions should support regular data audits and review collection of sex-disaggregated and gender qualitative data as well as indicators sensitive to the specific issues of project beneficiaries
• Management and use of patient data aimed at increasing	• Interventions should promote the customization of electronic

[20] Information obtained from the consultation that took place on June 19th, 2014 between USAID/Rwanda Team and the Gender Monitoring Office

integration of services across all service points for optimal care is limited and consolidated individual level patient data to take clinical decisions is often unavailable. This issue also affects male and female patients who might feel frustrated when their respective clinical information is rather scattered and difficult to be retrieved when needed.	medical records system so that all patients' health services across service points in the facility can be integrated to ease follow-up and referrals based on specific and unique clinical needs of each male and female patient.
Sub-purpose 3: Essential medical products available and accessible at service delivery points	
• Assuring the availability of medical products for clients at points of consumption is very crucial. Procurement agents/authorities still need to enhance their capabilities to manage all aspects of the selection of specific commodities for procurement and the supply of critical health commodities and drugs based on the general and particular needs from the demand side, which comprises female and male populations with socio-economic disparities, different gender identities, and different levels of vulnerabilities. • Due to some of the societal perceptions and insufficient community and patients' education and sensitization, the use of some health products, such as Maternal and Child Health, malaria, and HIV products may be very limited, thus affecting adequate procurement plans and supply side based on the assumptions that that there will not be sufficient clients for any given products.	• Interventions should promote gender equality in logistics and supply chain management through strengthening the capabilities for procurement agents to analyze and determine health commodities mostly used by males and females populations, including marginalized groups and by age categories so that the procurement plan should take into account different needs of health products for men and women. For example, some contraceptives may be very popular and used at a high rate, whereas others may not; likewise just a few men may mostly prefer to use condoms as a family planning method than choosing vasectomy • Interventions should also provide technical support to health leaders to effectively integrate gender awareness in both needs assessments and purchasing decisions to ensure that the supply chain effectively responds to clients' gender-related needs. This will be done through incorporating clients' perspectives and voices into health products' needs assessments in order to help bridge the purchasing gaps. • Interventions should strengthen education and sensitization of adults and young males and females, marginalized and vulnerable groups on the importance, use, and location of health commodities to promote and expand their access to medical

	products and their utilization
• Further technical assistance to strengthen and streamline the operations of the procurement unit and in-country distribution system is still needed to improve procurement and distribution management processes. There is a need to enhance capacity and understanding of the procurement unit and distribution system to integrate gender equality into their core operations. • In some circumstances, men, women, youth, and marginalized groups encounter gender-related obstacles to access medical products due to inability to articulate their health needs, cultural norms, inability to travel to the distribution points, limited time, and lack of financial means to pay for a product. Female clients including youth and marginalized groups face these challenges more than males.	• Interventions should continue to strengthen and streamline procurement processes taking into account gender related needs that should inform the development of medical procurement plans. • The supply chain managers should be trained on gender and customer service and the distribution system should be sensitive to the specific health facilities' needs, which in turn will reflect particular needs of health commodities for men, women, and youth at any identified geographical location. Attention will be taken to cultural or other types of barriers preventing men, women, youth, and vulnerable populations from accessing and/or using those commodities. Supply chain managers should be trained to be sensitive to gender differences in distribution decisions in order to support gender-equitable access to medical commodities.
Sub-purpose 4: Increased domestic resources for the health sector used equitably and efficiently	
• The Government of Rwanda, through the Ministry of Health has been successful in promoting the use of performance-based financing approach and community-based health insurance to incentivize both men and women to use services offered health providers and address health care challenges by the rural poor, respectively. However, based on consultations with stakeholders, it appears that the poorest of the poor remained excluded, and often that includes women, youth (boys and girls), rural clients, and marginalized groups. The causes include poverty, that some people are financially unable to buy the "mutuelles de santé"	• Support the Ministry of Health to restructure the revenues and expenditures using a gender lens through improvement of the health sector resource allocation taking into account that financial and risk protection has to be increased so that the most vulnerable of health system users are not further impoverished by health service access and utilization. • Negotiate with the Government of Rwanda to eliminate barriers to accessing health care services, through provision of financial assistance in the form of exemptions (example the user fees), savings and income-generating activities, and free services to the populations who lack adequate resources to pay for health care and communicate these benefits to clients and communities

and others have difficulties paying the user fees • Promoting fairness and equality in health financing for universal health coverage should closely look at household and individual revenues and their access/control over assets/resources. However, the approaches envisaged by the Health Sector Strategic Plan III might affect the quality of health care if more efforts are put into achieving high coverage of vital interventions without a sufficient number of health providers; health service fees and penalties to health care seekers may go up; and concerns that emphasis might be put on high dollar services and neglect cheaper services needed by vulnerable populations. • Men in Rwanda are household heads and primary decision-makers, and bread winners in many low-income households. This creates challenges to women and girls from these households who often have more limited access than men to cash, which impacts their capacity to enroll in the community health insurance plans in order to access health services	• Negotiate with the Ministry of Health and support the creation of network of decision-makers and civil society and faith-based organizations represented by women, men, youth, and marginalized groups that should be consulted on health financing issues, particularly with the aim of advocating for most vulnerable and disadvantaged groups to reduce gender disparities in health access, utilization, and status.
• Gender-responsive budgeting and gender-budgeting statement approached have been adopted, but not quite well functioning in Rwanda across ministries, including the Ministry of Health. There is still lack of knowledge and skills[21] for staff at both central and decentralized levels to fully implement these efforts • Transparent processes, guidelines, adequate financial and human resources, inter-sectoral collaboration, good quality and regularly produced gender-disaggregated	• Interventions should help build capacity of health program planners and financing decision-makers in gender-responsive budgeting and development of gender-budgeting statements at the central, district, and facility levels to make sure that gender gaps are clearly identified and strategies to address gender issues are put in place with the appropriate budget and monitoring and evaluation measures to increase accountability • Interventions should, to the extent possible, emphasize continued efforts to conduct gender-responsive budgeting in health systems

[21] Information obtained from the consultation that took place on June 19th, 2014 between USAID/Rwanda Team and the Gender Monitoring Office

data at the right level of details are still needed to inform gender-budgeting work	planning cycles to make sure that gender perspectives are adequately integrated in all health systems components as appropriate. This will contribute to improvement of quality, efficiency, and responsiveness of health systems and its components to the differential needs of men, women, girls, boys, and disadvantaged populations.
• Despite Government of Rwanda's strong political commitment and good stewardship to promote gender equality in public and private institutions, there is still lack of common gender equality understanding, knowledge, and skills among many public and private stakeholders (mostly private institutions and civil society organizations) in order contribute to the government's engagement through planning and implementing gender-responsive programs. • Coordination and collaboration between the GoR institutions and Development Partners need to be harmonized and strengthened through planning, budgeting, and evaluation of gender interventions to avoid duplication of efforts so that health resources needed for gender integration can be dedicated where they are mostly needed	• Work with the Ministry of Health to ensure that capacity building efforts for central, district and facility staff, including health service providers are trained in gender integration into health programs' planning, budgeting, and reporting. This will help to assure that health system financing are well-gender informed and functioning • Interventions should also include capacity building for members of the Joint Action Development Forum to acquire gender-focused skills and knowledge to efficiently and effectively contribute to the district health interventions aimed at addressing both national and local health development needs. • Support and strengthen the Government of Rwanda's political commitment and good stewardship through working with the Gender Monitoring Office and Ministry of Gender to enhance their gender equality and women's empowerment knowledge and skills. This will enable them to continuously and actively support public and private institutions in complying with the National Gender Policy through improved gender-sensitive planning, budgeting, and monitoring and evaluation strategies.
Sub-purpose 5: Leadership and governance strengthened	
• The District Health Management Team (DHMT) members are expected to contribute to the improvement of management and organizational aspects of the district	• Interventions should build capacity for the DHMT members to acquire specific gender knowledge and skills as an integral and critical part of their core functions to facilitate gender integration

health system through planning and management, coordination, participation, financing and resource allocation, and the regulation of norms and standards. However, the reality is that the DHMT often has limited/lack of gender related knowledge and skills to promote gender-sensitive health leadership and governance as part of their daily core duties and responsibilities. • Gender equality and women's empowerment are promoted in policies and strategies at national levels, but often lack clear and specific gender-informed approaches and mechanisms to translate high level gender equality commitment into tangible and transformative actions to maximize health outcomes at decentralized level, which in turn impact results at central level.	in health system components within their technical and administrative mentoring programs for efficient and effective management and coordination of the health sector at decentralized levels. • Interventions should enhance gender knowledge and skills for central level planners and managers to allow them to improve the development of gender-focused guidelines for the DHMT to optimize their efficacy and ability to respond to gender disparities within the district health system. For example, this will enable decentralized structures, protocols, personnel, competencies, financial resources, and operating hours to be designed in the best way to address the needs of women/men, boys/girls, and marginalized or vulnerable populations. • Interventions should build capacity in gender integration for the DHMT in monitoring and evaluation to assess gender differences in the impact of interventions and strategies in an explicit way, such as use sex-disaggregated data rather than aggregated data within district health system. This will help share best practices in implementing gender interventions and outcomes will inform further planning and programming.
• The coordination function between the central and decentralized levels is currently weak in terms of planning, management, budgeting and reporting, information, and monitoring and evaluation. These critical issues go along with limited/lack of technical knowledge and understanding of how gender should be part and parcel of these functions to ensure inclusive health systems and quality health service delivery.	• Technical assistance interventions to the GOR in operationalizing these structures should take a strong position to include gender perspectives into these structures and empower the GOR to explicitly require gender integration into their functions and provide clear support mechanisms both at central and decentralized levels to assure accountability. • Interventions planned for capacity building and mentoring in administrative and technical matters for district structures should enhance their understanding of gender issues in district health system and their ability to identify and implement gender-transformative health policies, programs, and projects

• Development of standardized procedures from the central level to decentralized level is slow because the policy and planning unit is short staffed compared to the work at hand. This issue is additionally coupled with the lack of adequate technical expertise on specialized topics. This has an impact on gender considerations into these functions because if gender is not taken into account in planning and budgeting, it will never be captured in reporting or monitoring and evaluations[22].	• The project interventions should facilitate the identification of training needs in specific technical areas, including gender considerations • Focused technical capacity building activities for central and decentralized levels will need to include gender considerations that should be taken into account at different levels of planning, reporting and monitoring and evaluation in order to improve quality, efficiency, and responsiveness of a health system to the differential health needs of men/women, boys/girls, and vulnerable populations. • Support the Ministry of Health to institutionalize basic and advanced technical training courses, including gender courses to meet the needs of new staff members both at central and decentralized levels and support changes in policy.

[22]Information obtained from the consultation that took place on June 19th, 2014 between USAID/Rwanda Team and the Gender Monitoring Office

Additional Recommendations and Opportunities for Mission Consideration

- The project interventions should encourage or support the Ministry of Health to initiate a health research agenda, which should include special quantitative and qualitative studies on gender and health as they relate to the building blocks of the health system. Both men and women professionals should be included as health systems researchers.
- The Ministry of Health's past experience coordinating and collaborating with civil society organizations on a range of policy matters, such as Community-Based Health Insurance, Community Health Workers, Performance-Based Financing, etc. should be strengthened. The aim of this will be to actively engage relevant civil society organizations, including women's, marginalized/vulnerable and human rights groups, and both public and private organizations in program design, implementation, and monitoring and evaluation to achieve gender equality outcomes.
- Encourage the Ministry of Health to assess the extent to which gender has been taken into account in the development, administration, and delivery of health services at central and decentralized level. This will enable them to identify gaps and take appropriate corrective measures to ensure the integration of gender equality and female empowerment in health system components in Rwanda.
- Negotiate with the Ministry of Health to monitor the use of the community-based health insurance looking at sex-, age-, and social/economic status data to track who is being covered under this scheme and who is not and key reasons preventing those people from enrolling in the CBHI. Developing protocols to identify the groups of people who are eligible for exemptions and other financial assistance options will help to actively transform gender relations and put vulnerable and marginalized populations on an equal playing field to receive high quality health services in an efficient and effective manner.
- Interventions should promote and strengthen men and boys' engagement in the community consultations, including parents' evening dialogues (initiated by the Ministry of Gender and Family Promotion), intra-household gender equality discussions, and health financing decisions so that they can actively support the transformation of gender relations and women's empowerment initiatives.
- All SCHS project activities should take into account gender gaps and disparities identified in this document and play an important role to respond to differential needs of men, women, boys, girls, and vulnerable populations throughout the health system and its components. If the scope of any planned activities changes significantly, an update to this analysis is recommended.
- The Mission has a comparative advantage to promote and support gender equality and women's empowerment through strengthening health systems in Rwanda due to the Agency's reputation as a leader in development and its high level commitment to gender equality globally. This project serves a great opportunity for the Mission to strengthen a

strategic partnership with the GoR for implementation of national gender policies and strategies in the health sector

- The SCHS project can have linkages with the new Youth Workforce Development (Education Office) project to provide critical life skills education for girls and boys, including youth from the disabled and LGBT communities to encourage critical thinking about gender relationships, risk taking behaviors and health
- Gender equality and women's empowerment should also be efficiently and effectively integrated in the activities of the Human and Institutional Capacity Development (Democracy and Governance Office) project under implementation to enhance gender skills of target public and civil society organizations working in the health sector so that they can include gender dimensions in their health service delivery
- The SCHS project has the potential to build on best practices, successes achieved, and constraints encountered by existing Mission's projects, such as the Rwanda Integrated Health System Strengthening and Family Health projects in working with the Ministry of Health, health facilities, and other stakeholders to better inform the implementation of this project.

Annex A: List of stakeholders consulted

Organizations
Rwanda Men Resource Centre
Gender Monitoring Office
Never Again Rwanda/USAID supported activity
Lesbian, Gay, Transgender, Bisexual associations
Health Development Initiative
Ministry of Health
USAID- funded Rwanda Pyrethrum Program
Ruhengeri Hospital
Handicap International
USAID-funded Society For Health activity
USAID-funded Family Health Program
USAID-funded Integrated

Health Systems Strengthening activity
USAID-funded Higa Ubeho activity
USAID-funded Ubaka Ejo activity
USAID-funded FXB Rwanda
USAID/Rwanda
USAID/E3/Washington
USAID/Georgia