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Gender and Social Inclusion Assessment



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Authorship and Acknowledgements

This report was prepared by Laterite, Ltd. in close collaboration USAID/Rwanda. The authors of this report are Serafina Buzby, Loes van der Velde, and Ellen van Himbergen. Data collection was supported by Dominique Kalisa and Ezron Mucyo.

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Abbreviations

ANC	Antenatal care
CBHI	Community-based health insurance
CHP	Community Health Programme
CHW	Community health worker
CSO	Civil society organization
DHS	Demographic and Health Survey
DPO	Disabled people organization
ECD	Early childhood development
EDPRS	Economic Development and Poverty Reduction Strategy
EICV 4	Fourth Integrated Household Living Conditions Survey
GBV	Gender-based violence
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
HMIS	Health management information system
HSRP	Health Sector Research Policy
HSSP IV	Health Sector Strategic Plan 2018-2024
LGBTI	Lesbian, gay, bisexual, transgender, or intersex
M&E	Monitoring and evaluation
MIGEPROF	Ministry of Gender and Family Promotion
MINALOC	Ministry of Local Government
MOH	Ministry of Health
MSM	Men who have sex with men
NCD	Non-communicable disease
NCPD	National Council of Persons with Disabilities
NGO	Non-governmental organization
NUDOR	National Union of Disability Organizations in Rwanda
PHC4	Fourth Population and Housing Census
RMNCAH	Reproductive, Maternal, Newborn, Child, Adolescent Health
RWAMREC	Rwanda Men's Resource Center
SGBV	Sexual and gender-based violence
WASH	Water, sanitation, and hygiene
USAID	United States Agency for International Development
UNCRPD	UN Convention on the Rights of Persons with Disabilities
VACYS	Violence against Children and Youth Survey
VUP	Vision 2020 Umurenge Program
WHO	World Health Organization

Chapter 1: Introduction

This report was commissioned by the USAID/Rwanda Health Office to assess the gender and social inclusion issues facing the Rwandan health, nutrition, and WASH sectors. The objective is to provide a comprehensive overview of the issues with a focus on identifying the main obstacles to inclusive health care and health program delivery and gaps between policy and implementation that can be targeted to improve access to and equity in health care, particularly for women, persons with disabilities and people who are lesbian, gay, bisexual, transgender, or intersex (LGBTI).

Background on Health, Gender, and Social Inclusion in Rwanda

According to Article 21 of the Constitution, all Rwandans have the right to good health. Furthermore, the Constitution affirms the state's commitment to: upholding the equality of all Rwandans before the law, equality between men and women, and the eradication of discrimination and divisionism based on ethnicity, region, or on any other ground.

During the past decade, the Government of Rwanda has made great strides in expanding the provision of health care services throughout the country to meet its commitments. Notably, the creation of community-based health insurance (CBHI, also known as Mutuelles de santé), the expansion of primary care centers, and the establishment of the volunteer-based Community Health Program (CHP) have contributed to improving reported access to health care (Abbott and Malunda, 2015).

The Government of Rwanda has also implemented homegrown solutions for social protection and poverty reduction. The Girinka Program gives one cow to poor families to reduce childhood malnutrition and increase household income through access to and sale of milk. The Vision 2020 Umurenge Program (VUP) improves the livelihoods of the poorest families by reestablishing the public works system to create off-farm employment, developing credit packages to address extreme poverty, and providing direct income support to households without a member eligible to work. These programs offer both direct and indirect health benefits including expanded access to sources of nutrition and financial resources to make health care-related decisions.

The overall vision for the Rwanda health system is outlined in the Health Sector Strategic Plan. Recently redrafted for 2018 through 2024, HSSP IV sets an overall objective of ensuring universal accessibility of equitable and affordable quality health services for all Rwandans. Specific priorities of HSSP IV include: increasing coverage of health interventions along the life course; scaling up coverage of essential services to combat communicable and non-communicable diseases; strengthening support systems; and building health security and resilient systems.

Through these strategies and programs, Rwanda has achieved notable progress towards meeting key global health indicators. According to the Demographic and Health Surveys (DHS), under-five mortality decreased from

196 deaths per 1,000 live births in 2000 to 50 deaths in 2015 exceeding the fourth Millennium Development Goal (MDG) target of a reduction by two thirds. Likewise, maternal mortality decreased from 1,071 maternal deaths per 100,000 live births in 2000 to 210 deaths in 2015 exceeding the fifth MDG target of a 75% reduction (DHS 2005, DHS 2015). Further supporting improved maternal health, deliveries at a health facility increased from 29.3% to 90.7% and nearly 100% of pregnant women attended at least one antenatal care visit with most accessing two or three ANC visits (Abbott et al., 2017).

Gaps, however, persist in equitable access to health care and health-related interventions. Gender norms, cultural biases and stigmatization, power imbalances, unequal control and prioritization of household resources, and gaps in institutional support all hinder access to health care and health programs and can have a detrimental effect on health outcomes.

Patriarchal social structures and culturally-held beliefs, in particular, continue to impact women's health.

In 2015, only 23% of women reported being empowered to make decisions for their own health care independently, and 16% reported that decisions were mainly made by their husbands (DHS 2015). Uptake of family planning interventions remains low and has shown minimal progress. In 2015, 48% of married women reported using modern contraceptive methods compared to 45% in 2010 (DHS 2015 and DHS 2010). Sexual and gender-based violence (SGBV) also poses serious health risks to women. In the 2015, 44% of women reported ever having experienced physical or sexual violence, and 36% reported having experienced injuries due to intimate partner violence in the past twelve months (DHS 2015). Despite progressive gender legislation and national attention to this issue, institutional constraints and patriarchal norms limit reporting of SGBV and consequently support for survivors. In 2015, only 12% of women who experienced SGBV reported having ever sought help from health centers, police, or social workers to stop violence (DHS 2015; Umubyeyi et al 2016).

Data is limited on other gender-related aspects of health in Rwanda, especially for men and boys. In HSSP IV, the Ministry of Health acknowledges that “women and men have specific health needs at all stages of life that are related to both physical differences and their societal roles.” The key gender issues highlighted in the policy, however, only include recommendations for sexual and reproductive health, SGBV, and nutrition for women and children. While the DHS shows that the mortality rate across all age groups is higher for men than women, further research is needed on health risks specific to men and boys in Rwanda.

Through VUP, expanded CBHI coverage, and other policies to make health care more accessible, the Government of Rwanda has prioritized support to persons with disabilities. Types of disabilities include limitations related to mobility, vision, hearing, speaking, learning, and psychosocial wellbeing. The need, however, is likely underreported. According to the Fourth Population and Housing Census (PCH4) in 2012, the disability prevalence rate in Rwanda was 5% (446,453 persons aged 5 and above,) though the WHO estimates that 15% of the global population is living with some form of disability with a higher disability prevalence in lower income countries (WHO/World Bank World

Report on Disability). Stigmatization, reliance on self-identification, and an unclear definition of disability have likely led to an under-identification of persons with disabilities in Rwanda (M'kumbuzi 2013).

Disability prevalence rates and causes of disability differ by gender and age. According to the PCH4 report, the disability prevalence rate among men aged five and above (5.2%) is similar to the rate among women (4.8%). Disabilities caused by disease and illness, however, are more prevalent among women than men (58% compared to 45%), which is partly the result of women's longer life expectancy and greater likelihood to be affected by illnesses related to old age. Men, meanwhile, have an increased prevalence of disabilities caused by an injuries and accidents (25% among men compared to 15% among women) and war or conflict (7% among men and 3% among women).

Persons with disabilities also face specific barriers in access to health care and health programs. In addition to stigmatization and discrimination, persons with disabilities face barriers derived from a lack of resources in the health system for inclusive infrastructure and treatment. Mobility obstacles characteristic of ableist contexts such as impassable roads, long commutes, and inaccessible facilities create can obstruct access to health care. Notably, 40% of persons with disabilities live more than one-hour walking distance from a health center (Njelesani et al. 2018). Among persons with disabilities identified in the census, 13% have vision-related limitations, and 8% and 4% have limitations related to hearing and speaking respectively (PCH4 2014). The absence of adequate assistive equipment and services create barriers to accessing health information and issues with communication impede quality care. Data on intellectual and psychosocial disabilities is limited, but the census reports estimate that 18% of persons with disabilities have limitations related to learning and concentration (PCH4 2014). The limited research also shows that depression, post-traumatic stress disorder, anxiety, suicidal attempts and other mental health are especially prevalent in Rwanda with no evidence of a decreasing trend across time (Rugema et al 2015). Persons with cognitive disabilities have the lowest labor force participation rate (43%) compared to all persons with disabilities (56%) and persons without disabilities (75%) (PCH4 2014). The lower labor force participation rate likely influences social inclusion, healthy livelihoods, and the financial resources available for health care.

Although not legally prosecuted, people who are LGBTI face systemic social oppression, including in the health system and health programs. Article 217 of the penal code regarding the imprisonment of "any persons who practices, encourages or sensitizes people of the same sex, to sexual relation or any sexual practice" was removed in 2009, thereby explicitly decriminalizing homosexual identities and behavior in Rwanda. Stigmatization and discrimination, however, are still frequently encountered by people who are openly lesbian, gay, bisexual, transgender, or intersex when attempting to access health care services. They have reported to receive behavioral interventions by untrained health workers and other suboptimal care (Irudukunda and Odoyo 2016). Fear of outing, discrimination, and expectations of rejection keep many people from disclosing their sexual orientation, which in turn poses challenges for their participation in health interventions particularly those targeted to the LGBTI community. A study found that only 20% of men who have sex with men (MSM) in Kigali had comprehensive knowledge of HIV (Binagwaho et al. 2009). These knowledge gaps can

lead to more risk-taking behavior, which is further exacerbated by lack of access to antiretrovirals for HIV/AIDS management, lubricants, and pre- and post-exposure prophylaxis (Iradukunda and Odoyo 2016; Binagwaho et al. 2009).

Gender is a cross-cutting factor which interplays with disability and LGBTI identities. A study conducted by Stern and Dunkle (2018) in twelve developing countries including Rwanda found that women with disabilities were two to four times more likely to experience SGBV than women without disabilities. They furthermore found that women with disabilities were more likely to be poorer, less educated, and at a greater societal disadvantage than men with disabilities or women without disabilities. The needs and concerns of women are also given less attention within the LGBTI community, where sexual health and HIV/AIDS programs target men who have sex with men and transgender women. As a result, lesbian and bisexual women and transgender men have a less visible presence and receive less consideration in programming and policy (Iradukunda and Odoyo 2016).

The Government of Rwanda, together with international donors, have been taking steps to address issues of gender and social inclusion in health systems and programs. The lack of data coupled with the challenges of identifying and reaching people who experience stigmatization, disenfranchisement, and disempowerment have resulted in slow progress. To bridge the gaps in access to health care and health programs for all Rwandans, greater efforts must be made to design and implement programs that address the gender and social inclusion dynamics at play and the barriers that create differential impacts.

This report uses evidence collected from key informants to explore the reasons for, consequences of, and interventions to address differential health access and participation. To inform future program strategy, this report describes the social and institutional context for inclusive health care, identifies successful and unsuccessful approaches for interventions, and make recommendations for advancing inclusive and equitable health care in Rwanda.

Key Research Questions

The specific research questions guiding the assessment are:

- How are health interventions in Rwanda (key Government of Rwanda interventions/services, USAID activities, and other donor and partner activities) enabling or disabling women, men, persons with disabilities, and people who are LGBTI to receive quality health care and nutrition services?
 - What best practices were observed and should be scaled up?
 - What practices/approaches are not working or can be improved to enable more inclusive health care delivery and advance gender equality and social inclusion?
 - Which policy areas related to gender and social inclusion should be highlighted for advocacy by USAID?
- What socio-cultural norms and barriers in Rwanda are discouraging women, men, and persons with disabilities, and people who are LGBTI from using health and nutrition services?

- What are potential differential effects that health and nutrition programming could have on women, men, persons with disabilities, and people who are LGBTI and how could these effects be mitigated?
- What are key gaps or opportunities the Health Office should prioritize to continue to advance gender equality and social inclusion to produce better and sustained health outcomes?

Structure of the Report

The report consists of the following sections:

- **Chapter Two** summarizes the methodology used for this assessment;
- **Chapter Three** provides an overview of the key Government of Rwanda policy achievements related to health, gender, and social inclusion;
- **Chapter Four** describes the context for gender, health, and social inclusion in Rwanda based on data collected during key informant interviews and analyzed according to the Six Domains for Gender Analyses;
- **Chapter Five** considers the interventions that implementing partners, other donors, and NGOs and civil society organizations have used to promote inclusive health care, nutrition, and WASH services, including best practices and lessons learned; and
- **Chapter Six** concludes by identifying key gaps and opportunities and makes recommendations for the USAID Health Office to prioritize to advance gender equality and social inclusion to produce better and sustained health outcomes.

Chapter 2: Methodology

2.1 Framework for Analysis

This report uses the Six Domains for Inclusive Development Analysis to identify areas in which marginalized groups are disadvantaged or disempowered, opportunities for partnering with marginalized populations, and entry points for empowerment.

The Six Domains

- **Laws, policies, regulations, and institutional practices** and the extent to which they contain explicit biases (treating individuals differently by law or criminalizing individuals on the basis of their identity), implicit biases (different impacts of law as a result of different social arrangements or economic behavior), and the presence or absence of key gender-related legislation (non-discrimination, equality, SGBV, sexual harassment);
- **Cultural norms and beliefs**, including the perceived appropriate qualities, life goals, and aspirations (often supported or embedded in laws) and their influence on how men and women behave in different domains;
- **Roles, responsibilities, and time use** and the division of productive or market economic activity and reproductive or non-market activity and how these roles differ between men, women, persons with disabilities, and people who are LGBTI;
- **Access to and control over assets and resources**, including whether men and women own, have access to, or have the capacity to use productive resources, the information necessary to be a fully-active and productive participant in society, and society's level of acceptance of identity and its influence on ability to access and control resources;
- **Patterns of power and decision-making** and the ability of women and men to decide, influence, and control resources (material, financial, intellectual, and human) in their family, community, and country and the extent to which different groups are represented and have a voice in decision-making; and
- **Personal safety and security** and the ability of individuals to live a life free from discrimination, danger, and violence based on characteristics of personal identity.

2.2 Data Collection Strategy

Meaningful stakeholder engagement is critical to understanding the current landscape for the provision of health services and the challenges to inclusion and equity. Laterite conducted interviews with 52 key informants for an in-depth look at the health system, barriers to and facilitators of access, existing policies and programs, and potential policy levers or interventions to improve inclusive health outcomes.

Table 1: Key Informants and Objectives for Interviews

	Objectives
USAID/Rwanda	Current activities; objectives and desired outcomes of the assignment; stakeholders and partners to interview.
Government of Rwanda	Existing policies and programs related to gender, health, and social inclusion; processes of policymaking and priority setting; upcoming priorities.
Other Donors	Existing and planned programs; best practices and lessons learned; recommendations for coordination; upcoming priorities.
USAID Implementing Partners	Current activities, with a focus on considerations of gender and social inclusion and differential effects; approaches to promoting inclusive health care; challenges addressing gender and social inclusion within the health sector; possible areas for future focus.
Civil Society Organizations and NGOs	Current activities; approaches to promoting inclusive health care; challenges addressing gender and social inclusion within the health sector; advocacy for gender and social inclusion; potential opportunities for collaboration with USAID programming.
Local Government and Health Authorities	Local implementation of national policies for health care, gender engagement, and social inclusion; perceived successes and challenges of inclusive access to care and on-the-ground implementation of policies and programs.

A full list of key informants interviewed is included in Annex 1.

Key informants were selected through recommendations from USAID and snowball sampling to represent a diversity of opinions and experiences. The objective of interviews was not to reach saturation but instead to collect a wide range of information from experts with specialized knowledge on health, gender, and social inclusion in Rwanda.

2.3 Interview Guidelines

The key informant interviews were loosely structured to answer the assessment questions and to gather useful insights from each informant based on his or her area of expertise. The interview guides consisted of broad open-ended questions as well as specific focused questions and were customized to each informant and used to help steer the direction of the interview. The interviewer was also free to go into more depth on any topics about which the interviewee had a lot to discuss.

Themes that were explored during the key informant interview included:

1. Key issues affecting access to health, nutrition, or WASH services for women, persons with disabilities, or people who are LGBTI;
2. Efforts to address the specific health needs of women, persons with disabilities, or people who are LGBTI;
3. Different impacts of programs and policies on men, women, persons with disabilities, and people who are LGBTI;
4. Mechanisms for input in program design and implementation or policy discussions;

5. Specific expertise and experiences related to advocacy or health promotion for women, persons with disabilities, and people who are LGBTI;
6. Policy accomplishments or priorities; and
7. Recommendations for future USAID programming.

2.4 Limitations

While confidentiality and the anonymity of informants were assured before the start of interviews, the purpose of the assessment and its audience at USAID was introduced as well. As a result, key informants may not have considered the research team as entirely independent of USAID.

To date, Laterite yet to receive approval from the Rwanda National Ethics Committee to conduct focus group discussions so that aspect has been omitted from the methodology and analysis. Findings and recommendations are based on information shared by leaders of organizations who were asked to speak as experts in their respective fields. As a result, the information in this report does not capture personal experiences and represents the perspectives of people in positions of authority who may be better off or more empowered than the general public. With the exception of interviews with district officials and associations of community-based volunteers (noted in Annex 1), interviews were conducted in Kigali.

Chapter 3: Key Policies and Strategies for Inclusive Health

This research sits at the intersection of the health, gender, and social protection policy agendas. This chapter provides an overview of the key Government of Rwanda policies and strategies for inclusive health service provision with particular attention to women, persons with disabilities, and people who are LGBTI.

3.1 Policies and strategies providing overall guidance for the health sector

Rwanda's guiding Vision 2020 policy envisions a transformation of Rwanda into a middle-income nation in which Rwandans are healthier, educated, and generally more prosperous. Key objectives in the health sector include reducing the fertility and population growth rates—for which access to and use of family planning is crucial—and addressing malnutrition and non-communicable diseases. The strategy also puts forth addressing the shortage of specialized health personnel and improving the quality of health care while continuing the success of homegrown solutions like the community health worker model. According to the policy, health strategies need to be targeted at the poorest members of the population and should improve geographic and financial accessibility.

The Vision 2050 strategy takes the Vision 2020 one step further and envisions Rwanda's achieving upper middle-income status by 2035 and high-income status by 2050. Through these achievement Rwanda will ensure high standards of living for all Rwandans, including: sustained food security and better nutrition status; universal, sustainable, and reliable household access to improved water and sanitation; and universal access to quality health care and services.

The National Strategy for Transformation (2017-2024) provides the platform and pillars for accelerated transformation on the pathway to the prosperity sought by Vision 2050. One of the guiding principles for this seven-year government plan is to ensure inclusiveness for all to benefit and for no one to be left behind. The main health-related priorities include graduation from poverty and extreme poverty, eradication of malnutrition, and enhancing the demographic dividend by ensuring access to quality health to all.

The Economic Development and Poverty Reduction Strategy (EDPRS II) set out the government's efforts to transform the economy according to Vision 2020. Quality, demand and accessibility of primary health care were seen as one of the foundational issues to achieve targets, and the strategy identified gender and family, sensitization around HIV/AIDS and NCDs, and disability and social inclusion as cross-cutting issues that needed to be mainstreamed in all sector strategies and district plans. This Strategy has since been replaced by the National Strategy for Transformation.

The Rwandan Health Sector Policy (2015) outlines the Government of Rwanda’s overall vision for development in the health sector, as set out in Vision 2020 and EDPRS II. The policy gives general directions for the sector to guide key health programs and departments. Its overall objective is that the health sector ensures the universal accessibility, geographically and financially, of equitable and affordable quality health services. The guiding values and principles of the policy are people-centered, integrated, and sustainable health services, which will be achieved through: community inputs; equity and inclusion; decentralized services; involvement of private sector and civil society; and a health system that builds the capacity of people, communities and institutions.

The Fourth Health Sector Strategic Plan (HSSP IV, 2018-2024) sets out the national strategic direction for the health sector in order to improve health standards of Rwandans. It elaborates the strategic directions defined in the Health Sector Policy. The strategy recognizes that the specific health needs of women and men at all stages of life are related to both their physical differences and societal roles. It acknowledges that a gender-sensitive approach is needed not only for sexual and reproductive health but also for other key health programs. Among key gender issues, teenage pregnancies and related risks such as maternal mortality, fertility rates, gender disparities with regard to HIV/AIDS, nutritional disorders especially among children and women, and gender-based violence are specifically addressed. HSSP IV addresses people living with disabilities as a cross-cutting theme and endeavors to facilitate access to health services by removing physical and communication barriers. It also aims to improve the early identification and treatment of causes of preventable disabilities through its NCD and injuries strategy and increase access to specialized mental health services. The HSSP IV does not make any specific mention of LGBTI people or their health needs.

The Rwandan Community-Based Health Insurance (CBHI) is one of Rwanda’s flagship health financing policies to insure the population against financial risk and catastrophic payments in the event of illness, and therefore ensure universal and equitable access to quality health services. The main objectives of the policy are to promote CBHI membership, to strengthen the financial viability of the CBHI, strengthen management capacities of the CBHI system and to reinforce equity and fairness in the payment of contributions.

National Social Protection Strategy (2011) defines social protection across two domains: direct income support through cash transfers and means of ensuring access to public services – such as education and health – by enabling poor households to overcome financial barriers that they may face. Additionally, it outlines a number of social development initiatives and complementary activities to social protection that are focused on helping poor households graduate out of poverty. Among others, the vulnerable populations targeted in the policy include persons with disabilities.

The **National Gender Policy** (2010) aims to support programs in various sectors that are directly aimed at addressing gender inequalities and women’s rights. For the health sector, it puts in place health advisors throughout the country to mobilize and monitor the implementation of health programs in the community, the uptake of CBHI, the development of a reproductive health strategy, and the regularly-implemented demographic and health surveys and gender profiles produced at regular basis. The first Health Gender Profile was validated in November 2018.

3.2 Policies for health system strengthening

Health Financing Sustainability Policy. The goal of the Health Financing and Sustainability Policy (2015) is to strengthen current health financing systems and guide the development of new initiatives and strategies to improve financial accessibility and resourcing towards a sustainable Rwandan health sector. The policy acknowledges the protection of the most vulnerable, but does not directly address women, people living with disabilities or LGBTI people.

Human Resource for Health Policy. This policy has as overarching goal to improve service delivery to the population through sufficient and qualified human resources. It aims to improve the production of human resources by strengthening education and training in order to address challenges such as maternal and child death, infectious diseases and NCDs, improve equitable recruitment and deployment in order to reduce urban/rural disparity in health services provision, and to strengthen attraction, motivation and retention of available professionals.

Health Sector Research Policy. This policy aims to promote research which improves the availability of high quality information and its effective use in decision making in order for Rwanda to improve the health status of its population. The Ministry of Health seeks to ensure the protection of vulnerable or marginalized populations in the implementation of research programs in Rwanda.

3.3 Policies related to interventions in the health sector

Sexual and Reproductive Health. The recent National Integrated Reproductive, Maternal, Newborn, Child, Adolescent Health (RMNCAH) policy aims to advance the implementation of the Maternal, Newborn, and Child Health and Family Planning and Sexual and Reproductive Health strategic plans. The overall goal of the policy is to eliminate preventable maternal, neonatal and child deaths and promote the wellbeing of women, men, children, and adolescents using a multi-sectoral approach to ensure healthy development and ageing. The policy identifies a need to educate the population about RMNCAH and encourage health-seeking behavior. The focus is on women, newborns, children and adolescents and their universal access to sustainable quality health care delivered in a continuum of care across the life course and moves away from disease- and condition-specific approaches.

The policy calls for all data in the health management information system (HMIS) to be disaggregated by disability, age, and socioeconomic status to inform implementation and the targeting of interventions. The policy acknowledges the need to use innovative client-friendly mechanisms to reach young people, hard to reach groups, and persons living with disabilities to increase community knowledge and promote health seeking behavior. The policy does not describe what is meant by “client-friendly mechanisms” or who is included in “hard-to-reach groups” though other documents from the Ministry of Health, like the National HIV/AIDS Strategic Plan, use similar language to refer to MSM and female sex workers. The policy mentions MSM as a key population at risk for HIV transmission.

Nutrition. The National Food and Nutrition Policy outlines as its most important priority addressing the high level of chronic malnutrition in children under two years through multisector support and coordination at the national, district, and community levels. The policy seeks to strengthen existing community-based activities for child growth monitoring and improve the prevention and management of malnutrition. The policy supports expanding services and practices for household food security, improving the link between household food security and the health and nutrition of women and children, and strengthening of nutrition education in schools. The policy acknowledges the links between nutrition and HIV/AIDS, hygiene and sanitation, and nutrition-related non-communicable diseases. Pregnant women, lactating mothers, and young children are central in this policy. The policy does not directly address people with disabilities or LGBTI.

The HSSP IV specifically emphasizes community education and awareness of dietary and complementary feeding practices, using early childhood development and specifically nutrition as an entry point for health interventions, prevention and management of acute and chronic malnutrition, and the improvement of multisectoral collaboration.

Community Health. The National Community Health Policy aims to promote and sustain community health services that reduce child, infant, and maternal mortality rates and improve the general health of the population. Its objectives include: strengthening decentralized health systems to improve community health service delivery; increasing participation of community members in community health activities; improving monitoring and evaluation systems and the coordination of community health services at different levels of administration; and motivating CHWs to improve health service delivery and access in the community.

The HSSP IV specifically emphasizes capacity building support to CHWs, sustainability of the CHW program, and the availability of commodities and materials for the program.

Sexual and Gender-based Violence. The National Policy against Gender-Based Violence (2011) aims to progressively eliminate gender-based violence through the development of a preventive, protective, supportive, and transformative environment in which SGBV is not tolerated. The policy also aims to identify and reduce the vulnerability of groups most at risk, provide comprehensive services for victims, improve accountability and eliminate impunity, and build better M&E systems and expand the data available on SGBV.

According to the National Gender Policy (2010), in addition to the enactment of gender-sensitive laws, institutional anti-SGBV achievements include the establishments of: Isange One-Stop Centers; anti-SGBV and child protection committees from grassroots to national level; gender desks within the Rwanda National Police, Rwanda Defense Force and National Public Prosecution Authority; free hotlines; the Rwanda Men's Resource Center, a men's association that fosters gender equality through the promotion of non-violent and healthy masculine behaviors, support to families, and the eradication of SGBV.

The HSSP IV specifically emphasizes the scaling up of management of SGBV cases at health center and supporting the social reintegration of SGBV cases.

HIV/AIDS. The National HIV/AIDS Strategic Plan (2013-2018) identifies female sex workers, MSM, and sero-discordant couples as groups at increased risk of HIV transmission. The strategy does not directly address other groups within the LGBTI community. The strategy considers persons with disabilities as a vulnerable population but also states that there is no data showing that HIV prevalence is higher than in the general populations in Rwanda. In the strategic plan, the main policy challenge acknowledged for persons with disabilities is ensuring access to services. Likewise, the strategy considers MSM as a hard-to-reach group, and the preferred method of outreach is through peer educators. The strategy lists several interventions for MSM, including: development and distribution of specific guidelines for HIV prevention and clinical follow-up; an intensive package of services including provision of condoms and lubricants; outreach programs; advocacy with law enforcement and local authorities to improve protection of MSM; and increased MSM participation in policy development and program implementation. The strategy also identifies an opportunity to integrate HIV interventions into sexual and reproductive health, nutrition and mental health programs.

Malaria. Through the HSSP IV, the Government of Rwanda reinforces its commitment to malaria prevention and control, especially among under five children and pregnant women who are considered especially vulnerable.

Non-communicable Diseases. The National NCD Policy (2015) aims to alleviate the burden of NCDs and their risk factors and protect against premature morbidity and mortality related to NCDs. To achieve this goal, it will: promote healthy environments and community actions to reduce exposure to injuries and modifiable NCD risk factors; strengthen and mainstream NCD prevention, diagnosis, care, treatment, and rehabilitation programs within the national health system; and document national trends and determinants of NCDs through M&E and research for evidence-based interventions.

Mental Health. The National Mental Health Policy (2011) strives to promote quality health care that aims at reducing morbidity in mental health, appropriate to the Rwandan context and accessible within the community. HSSP IV foresees mental health services at the community-level to be available at each level by 2024. According to informants, the draft mental health bill is yet to be presented to Parliament for debate and no legislation specifically addresses mental health.

Early Childhood Development. The National Early Childhood Development Policy and Strategic Plan (2016) emphasizes that interventions in the early years have the potential to provide young children with more opportunities and better outcomes in terms of access to education, quality of learning, physical growth and health, and productivity. Among other objectives, the policy promotes positive parenting, reducing malnutrition and stunting, reducing under five and maternal mortality rates, and equal access by children with disabilities to services under the ECD program.

Chapter 4: Context

This chapter, we describe the context for health gender, and social inclusion in Rwanda based on data collected from key informants and analyzed according to the Six Domains for Gender Analyses.

4.1 Laws, Policies, and Institutional Practices

According to informants, Rwanda's numerous laws and policies promoting access to health care for all Rwandans are characterized by implementation gaps. Institutional constraints that affect the delivery of gender-sensitive and socially-inclusive health care include:

- **Dissemination of laws and policies at the local level.** Local authorities, community health workers (CHWs), and the public are often not informed of new policies. Likewise policies are not communicated effectively and in a way that can be understood to the specific populations they concern.
- **Infrastructure and equipment.** Informants reported that health facilities and program locations are not always accessible environments for persons with disabilities. They cited examples of entrances without ramps, beds that cannot be easily mounted, latrines in public places without, and inaccessible program venues. While the building code requires the construction of ramps to the entrances of health clinics and public buildings, informants noted that not all ramps follow standards for wheelchair use.
- **Financial resources** to build additional health facilities, improve the physical accessibility of existing buildings and equipment, or train health personnel. Informants report that few public services have guides for people who are blind or sign language interpreters for people who are deaf.
- **Supply of skilled human resources in the health sector.**
 - CHWs play a major role in providing services to the general population but are working on a volunteer basis. They are overburdened with many responsibilities and have limited time to implement services beyond basic care.
 - The scarce supply of specialized health professionals and equipment cannot meet the health needs of the population. An informant provided the example of only six psychiatric doctors practicing in Rwanda.
 - Informants reported that health professionals have inadequate knowledge of different types of disabilities and how to communicate with and care for persons with disabilities. These knowledge gaps

result in lower quality of service to persons with disabilities, including omitting consultations, treating the wrong assumed conditions, and prescribing unnecessary or erroneous medication.

- **Diagnostic services** for hearing, vision, development delays, and other disabilities are only available at the central level of the health system.

Laws and policies facilitating access to health for persons with disabilities

Rwanda ratified the UN Convention on the Rights of Persons with Disabilities in 2008, including its Optional Protocol, through which Rwanda has made commendable achievements. These achievements include laws protecting the rights of persons with disabilities, ensuring quotas for representation in decision-making bodies, establishing the National Council of Persons with Disabilities (NCPD) and its local structures, revising laws to make them disability inclusive, organizing advocacy meetings in all districts, and revising the building code for more inclusive infrastructure. The Initial Report of Rwanda on the implementation of the Convention on the Rights of Persons with Disabilities (2015) charges the Minister of Health with establishing the degree of disability for all persons (category 1: >90% extent of limitation; category 2: 70-79%; category 3: 50-69%; and category 4: 10-49%). The categorization supports the implementation of laws granting specific rights to persons with physical or mental disabilities in categories 1 and 2, such as subsidized health care and the provision of assistive devices. These achievements demonstrate the willingness of the Government of Rwanda to meet the needs of persons with disabilities. Disability organizations, however, said that the existing legislation is lacking effective enforcement and mechanisms to report cases of discrimination, and most policies mainly address the needs of persons with physical disabilities. Key informants noted a lack of knowledge and awareness among policymakers about other types of disability, specifically psychosocial and intellectual disabilities like autism and Down syndrome.

Upcoming policy priorities demonstrate the Government of Rwanda's commitment to build a health system inclusive of persons with disabilities. Informants shared that upcoming policy priorities include:

- Ratifying the African Union protocol to the African Charter on Human and Peoples' Rights on the Rights of Persons with Disabilities in Africa;
- Signing the East African Community Persons with Disability Bill;
- Issuing the upcoming new National Policy on Disability and Inclusion;
- Revising the National Disability Law and aligning the official definition of disability with the UN Convention on the Rights of Persons with Disabilities and the WHO International Classification of Disability Functioning and Health;
- Initiating an annual budget tracking process to assess local government spending on disability interventions; and
- Providing training on roles, rights, and advocacy to all 13,000 cell and sector NCPD executive committee members, including guidance to mainstream disability within homegrown solutions such as Umuganda, Ubudehe, Itorero, Kuremera, and Parents' Forums.

Laws and policies facilitating access to health for people who are LGBTI

Though same-sex sexual orientations and behavior are not criminalized, there is an absence of laws that protect the rights of people who are LGBTI. With the exception of the National HIV/AIDS Strategic Plan which identifies men who have sex with men as a high-risk group, informants noted that existing health policies do not specifically consider the needs of people who are LGBTI. The Government of Rwanda has, however, signed the 2015 Joint UN statement on ending violence and discrimination against lesbian, gay, bisexual, transgender and intersex people.

Community-based health insurance

Community based health insurance supports universal health coverage and covers all primary health care.

As of the 2014 EICV 4, 72% of Rwandans have some form of health insurance though only 60% in the poorest quintile. Fees to enroll in CBHI vary by Ubudehe category, the economic classification system in Rwanda, and are free for Ubudehe 1 households and persons with severe disabilities (categorized at 70% disability and above). The one-month waiting time for enrollment has been waived for these groups.

The broadening of service coverage is a key topic of advocacy. Coverage has recently been expanded to include more services for persons with disabilities, like medication for psychosocial health, consultation fees at Ndera psychiatric hospital, and orthopedic services and crutches. Nonetheless, the scheme is still financially fragile and cannot cover all out-of-pocket health costs for all Rwandans. Informants, however, cited sunscreen for persons with albinism and prostheses for persons with physical disabilities as examples of critical unmet need.

People who are not registered in the national census, and consequently not appointed within a Ubudehe category, typically lack health insurance. Informants discussed that those missing from census registration often include children with disabilities, new households, and households formed by people who are LGBTI or teenage mothers who have been chased away by their families. Additionally, several key informants reported that some households are not aware of their Ubudehe and what their specific rights are within the category.

Referral process

Within the Rwandan health system, some services are only available at district or central hospitals and require referrals. The referral process starts in a local health center and can be bureaucratically challenging, time-consuming, and costly to navigate. As discussed in later sections, these institutional obstacles are more difficult to surmount for people with many other time commitments or people who are disenfranchised and disempowered. The diagnosis of disability does not always include referral for assistive services or interventions, and these processes must be navigated independently.

4.2 Cultural norms and beliefs

Views on men and women

According to traditional gender roles, men are breadwinners and women are responsible for unpaid care work and subsistence farming. Within the patriarchal social structure, men are considered the heads of household and

typically control financial resources while women financially depend on the men in their households. Key informants noted that lower prioritization for household resources and cultural norms can affect women's health outcomes. For example, men must be strong to fulfill their productive roles and thus take priority for food consumption especially when meat is available. Respondents also reported that in some households spousal rape is tolerated with both men and women believing that wives are obligated to submit to the sexual demands of their husbands. If they do not submit, women may fear for their physical security if their partners are prone to violence or their financial and social standing if their partners were to leave.

The cultural expectations of masculinity also negatively impacts men's health. Informants reported that seeking health care can be viewed as a sign of weakness, and men will generally visit providers only for serious health issues or circumcision for HIV risk reduction. Sexual health issues such as impotence are highly taboo, and women are usually blamed for failing to conceive or birthing a child with a disability. Habits that are culturally associated with masculinity, such as alcohol and tobacco use, are risks factors for disease while having multiple sexual partners is associated with an increased risk of HIV infection.

Views on persons with disabilities

While the Government of Rwanda has made concerted efforts to create a disability-inclusive society, stigma and discrimination against persons with disabilities persist. Discrimination may exclude persons with disabilities from participating in community forums, health programs, or economic activities. The severity of stigmatization varies according to gender identity and type of disability. According to informants, the stigmatization is worse for women with disabilities and persons with mental or psychosocial disabilities. Advocates reported that women with disabilities are often excluded from and their needs ignored by both the gender and the disability movements. Stemming from a witchcraft belief that having sexual intercourse with a woman with a disability can cure HIV, women with disabilities may be at increased risk of sexual violence and coercion. Discrimination against men with disabilities most often occurs when men do not marry, cannot have children, or cannot join public forums since these men are not conforming to societal norms of masculinity.

Informants report that stigmatization is both a public and private issue and can extend to the immediate family members, especially mothers, of persons with disabilities. Key informants provided examples of husbands and families blaming the mothers of children with disabilities, chasing them away from the house, or filing for divorce. Key informants also highlighted that discrimination within families differs if a child is born with a disability or becomes disabled later as a result of an accident or disease. While families may be ashamed of children born with disabilities, they are usually more supportive when someone becomes disabled later in life when the cause is apparent.

Health care providers' lack of knowledge about different types of disabilities contributes to stigma and impacts the health outcomes of persons with disabilities. Many informants refuted the misconception that persons with disabilities are not sexually active. They explained that this belief, common among health care providers, prevented access to sexual and reproductive health services for persons with disabilities. Persons with psychosocial disabilities have experienced being treated like toddlers and are often not asked about their medical history or consulted about treatment

options. Caregivers of children with autism have been discouraged from seeking health care or other services because their children were unable to cope with long queues in facilities, and their children's behavior was regarded badly by other patients and providers. Advocates argued that health care providers maintain a pessimistic outlook, fed by a lack of knowledge, about the futures of children with intellectual disabilities like Down syndrome and autism. Since health care workers are viewed as authorities, family members of persons with disabilities may copy their attitudes and perspectives.

View on people who are LGBTI

People who are LGBTI are not widely accepted in Rwandan society. Key informants explained that non-heterosexual orientations or behavior are believed not be part of African culture and are not accepted by the prevailing Christian beliefs. Notably, when asked about acceptance of lesbian women, an informant from an umbrella organization supporting women relayed that LGBTI behavior was not within the values of their organization. Another informant shared that the majority of the Rwandan public considers people who are LGBTI to be sick or abnormal. When outed, people who are LGBTI are often chased away by their families. Limited familial support coupled with discrimination can lead to school dropout, limited access to assets and resources, and exclusion from economic opportunities. Some people who are LGBTI participate in sex work, which exposes them to increased risks of HIV and SGBV. Stigma is especially severe for women and men who are transgender.

Stigmatization prevents people who are LGBTI from accessing adequate health services. This issue is especially relevant for sexual health services, where appropriate care should involve an open discussion of sexual activity. In principle, people who are LGBTI should not experience differential barriers when accessing primary health care; however, according to LGBTI organizations, people who are LGBTI have little confidence in service providers and see health facilities as unsafe environments. Advocates reported that people who are LGBTI have experienced shaming or preaching in health facilities, have had their confidentiality violated by facility personnel, or have not received a thorough exam or proper diagnosis because health workers were uncomfortable. These issues can lead to people who are LGBTI to delay or avoid seeking health care when needed. For sexual health issues in particular, delayed care can result in the spread of infection in the community or the advancing of diseases that are easily treated or managed at earlier stages.

Social and cultural norms affecting access to specific health services

Nutrition. Large family sizes, especially among households living in poverty, can impact health and nutrition outcomes. According to the 2015 DHS, the fertility rate is 4.2 births per woman and the prevalence of stunting in children under five years is 38%. Since malnutrition and micronutrient deficiency during pregnancy and early childhood can lead to physical and development disabilities, addressing food security and dietary diversity is important for disability prevention.

Sexual Health and Family Planning. The 2015 DHS identifies an unmet need for family planning of 19%. Access to and use of modern family planning methods is complicated by gender roles. Women may need their partners' assent to use certain methods, and men are not motivated to use male forms of birth control. The expectation that young unmarried people, especially young women, should have no need for sexual health services deters them from approaching CHWs, who are typically respected members of their communities, for family planning. Access to and acceptance of family

planning is further complicated by religious beliefs that oppose modern methods of contraception. This opposition creates barriers to access especially in some rural locations where health centers are run by faith-based organizations that refuse to stock family planning commodities. As mentioned above, providers also lack a nuanced understanding of or do not acknowledge the sexual health needs of persons with disabilities and people who are LGBTI.

Antenatal and maternal health. Uptake of antenatal and maternal health care is improving with 99% of women completing at least one out of the recommended four antenatal care (ANC) visits to a skilled provider; however, only 44% of women attend all four visits (DHS 2015). Women who have birthed six or more children and those with no education are most likely to have received no antenatal care (DHS 2015). Deliveries in facilities are also increasing with 90.7% of women delivering at a health center or hospital (DHS 2015). According to informants, cultural norms that deter women from attending all four ANC visits or delivering at a facility include a taboo of talking about a pregnancy before the second trimester, a preference to deliver at home as their mothers and grandmothers did, and public shame when women do not have clothes for a newborn after a facility delivery.

Mental health. Since 1994, mental health issues have a strong cultural association with trauma from the genocide against the Tutsi. Informants hypothesized that individuals do not want to appear weak in a society that publicly promotes resilience or do not consider their issues serious in comparison to genocide-related trauma so tend not to seek health care for ongoing mental health issues like depression. According to informants, persons with disabilities, their caregivers, and people who are LGBTI may experience higher rates of depression resulting from discrimination and isolation.

Sexual and gender-based violence is not always seen as a crime by the community, victims, and perpetrators and is therefore not consistently reported. Informants explained that perpetrators of SGBV are often a family member, so reporting can affect the family's reputation and, consequently, their social status and economic wellbeing. Informants also shared that SGBV is considered a private matter with a culture of silence surrounding it. According to the 2016 Violence against Children and Youth Survey, young people, especially girls, believe women should tolerate violence to keep families together. This mindset can lead to underreporting and not seeking medical care.

4.3 Roles, responsibilities and time use

As a result of unequal gender roles in the household, women have double or even triple the responsibility of men. While men typically work outside the home, women care for children and sick relatives and perform household chores in addition to subsistence farming. Unequal gender roles are considered common by most men and women and are introduced at early age. Key informants provided examples of young girls being expected to help their mothers with household tasks while boys are given more opportunities to play, attend school, or study. Female-headed households are at a particularly disadvantage since they must fulfill their household responsibilities in addition to earning income to support their families.

The time burden of responsibilities both inside and outside the home can prevent women from accessing health services. They do not have time for long waits in health centers, traveling to distant facilities, or navigating the different steps in the referral process. Informants reported that women usually do not take the time to look after their own health until they are very sick. Additionally, judgement from community members when men perform tasks culturally attributed to women deter men from assuming household responsibilities when women are ill or occupied at health facilities. Unequal gender roles also affect reporting of SGBV since women fear for their families' wellbeing if men, the main income earners, are condemned.

4.4 Patterns of power and decision making

Women's empowerment

Many women are not empowered within their households and need permission from men to access health care. In 2015, only 23% of women reported being able to make decisions independently about their own health, and 16% reported that decisions were made mainly by their husbands (DHS 2015). Informants explained that women are also not always involved in household decision-making and depend financially on their partners. As a result, they must ask their partners for money for health care-related decisions like transport to health facilities, CBHI premiums, or copayments and service fees.

Umbrella organizations and advocacy groups are one avenue to promote empowerment. The National Women's Council provides a formal structure to give voice to women and through which women can raise ideas and concerns to inform policy. It works from the grassroots to national levels and includes all women at village level; however, the bottom-up information flow is challenged by lack of resources for these lower structures.

Empowerment of persons with disabilities

While persons with disabilities may have the knowledge to make their own health care decisions, they often lack the resources or power to do so. According to disability organizations, persons with a physical disabilities in particular have the necessary knowledge to make informed decisions about their health. Financial and physical barriers as well as stigmatization though can prevent them from accessing the health care they would ideally choose. Women with disabilities too experience the same empowerment issues as women without disabilities. Disability organizations raised concerns that women with intellectual or psychosocial disabilities are forced into family planning decisions—including sterilization—to avoid pregnancy. Informants also reported that health care providers will make decisions for their patients without consent or counselling. For example, when giving birth, women with disabilities are forced to deliver via cesarean section without the option to deliver vaginally. Advocates suggested that health care providers make these choices either because they do not know how to communicate with patients, do not understand their patients' capabilities, or believe that their alternative will be easier

Persons with disabilities participate in policy through a Parliamentary quota and the NCPD. However, advocates argued that persons with disabilities need to participate in public councils and community groups, not only those representing issues of disability, in order for more laws and programs to be inclusive. They also argued for a higher quota in Parliament; currently one of the 80 seats is reserved to represent persons with disabilities, and no additional members with disabilities have been elected. Despite the existence of local and national structures to represent persons with disabilities, their effectiveness is constrained by a lack of resources below the district level to gather information from the public. Moreover, the leaders in these organizations are generally men with physical disabilities so representation of women with disabilities is minimal.

Empowerment of people who are LGBTI

People who are LGBTI are rarely seen in the public sphere and often prefer to maintain their privacy fearing issues of discrimination or personal security. Since same-sex sexual conduct has been decriminalized, people who are LGBTI are slowly becoming more empowered. Some people have been trained on their rights and the processes for reporting cases of discrimination—including maltreatment in health facilities—to NGOs such as the Health Development Initiative. However, organizations representing the LGBTI community lack funding and a platform to advocate effectively. Unlike women, youth, and persons with disabilities, people who are LGBTI do not have a formal council to participate in policymaking, and organizations are registered as human rights groups rather than formalized LGBTI organizations. While some donors are starting to avail them funding, the activities of LGBTI organization are at times hindered by local authorities, who implicitly or explicitly refuse to facilitate implementation or discourage their community's participation. Additionally, informants shared that few health providers dare to advocate for people who are LGBTI for fear of damaging their reputation.

4.5 Access to and control over resources

Access to health-related services, information, and knowledge

Education is an important social determinant of health, and disparities in literacy and educational attainment can lead to differential access to information and services. According to EICV4, the rates of completion for different levels of education are similar among men and women. Yet 16.3% of women aged 10 and older have had no education compared to 9.9% of men, and the literacy rate among women aged 15 and older is 67.6% compared to 77.3% among men. Similarly, 64% of children with disabilities aged 5-17 years attend school compared to 81% of children without disabilities. Among children with disabilities, 27% have never attended school compared to 14% of children without disabilities. According to LGBTI advocates, school dropout rates are greater among people who are LGBTI compared to people who are not LGBTI.

Financial barriers

Though health care is subsidized through CBHI, financial obstacles remain one of the greatest barriers to inclusive health care. Costs related to health include transportation to facilities, premiums for CBHI or other insurance, copayments and user fees, and investments for healthy living like mosquito nets, nutritious foods, assistive devices, clean

water, and sanitation. According to informants, financial barriers to health are the primary obstacle for poor households. Without adequate financial resources to afford health care in the first place, many people never experience other social or cultural obstacles.

Gender, disability status, and LGBTI identities all impact access to financial resources. As discussed, many women financially depend on their husbands and need their assent to pay for health-related expenses. According to informants, women also have different financial priorities—typically prioritizing the health and nutrition of their children—while some men unilaterally decide to spend household income for themselves. As a result of the added time burden on them, female household heads are at greater disadvantage since they typically have less time for income-generating activities and thus less income. Financial barriers also tend to be greater for persons with disabilities since they have more costly health needs—including treatment and assistive devices that are not all covered by CBHI—while having more limited access to income-generating opportunities. Informants reported that families raising a child with disability are often in a circle of poverty since the child may have increased health care costs and can require additional care from another family which then limits their time for employment. Likewise, people who are LGBTI are excluded from employment and other market activity and can be challenged to afford health care.

4.6 Personal safety and security

Cultural norms, such as the permissive attitude and silence surrounding sexual and gender-based violence within households, pose risks to women’s personal safety and thus health. According to the 2015 DHS, nearly half of all women (44%) have experienced physical or sexual violence but only 12% have sought help from health centers, police, or social workers to stop violence (DHS 2015). According to the National Union of Disability Organizations in Rwanda’s alternative report on the implementation of the UN Convention on the Rights of People with Disabilities, women with disabilities are four times more likely to experience SGBV compared to women without a disability (2018). According to informants, women with mental or psychosocial disabilities and women who are blind or deaf can appear to perpetrators of violence as relatively defenseless targets. As a result of infrastructural constraints, they also encounter obstacles reporting violence. Limited means of communication and prejudices regarding the intellectual capabilities of persons with disabilities may affect how seriously authorities take reports of cases of SGBV from persons with disabilities.

According to organizations representing people who are LGBTI, violence against them has decreased significantly since decriminalized in 2009. Nevertheless, cases of violence still occur and key informants report that fear of violence and stigma deter people who are LGBTI, especially transwomen, from participating in health programs or seeking care, especially at clinics that are not specifically for people who are LGBTI. Key informants indicated that they were not aware of trusted health centers outside of Kigali and people who are LGBTI will choose to travel outside their district for health care if resources allow. In Rubavu, for example, people who are LGBTI will travel to either Kigali or Goma to access sexual health services. An informant reported that, even though health care in Goma is not necessarily more LGBTI-friendly than in Rubavu, people who are LGBTI can bribe providers to facilitate access.

Chapter 5: Interventions

In this chapter, we describe the interventions and practices of USAID programs and implementing partners, as well as the activities of CSOs, government ministries, and other donors. We lay out which practices worked and should be scaled up and which practices can be improved.

5.1 Laws, policies, regulations, institutional practices

CSOs and other implementers use advocacy, partnerships, and training to address institutional barriers.

These barriers include policies that do not explicitly address the needs of different groups; limited dissemination and implementation of laws; the lack of appropriately skilled human resources; and limited financial resources for the capacity building of CSOs.

Advocacy

Civil society contributes to the implementation and dissemination of laws through policy analysis and advocacy. CSOs representing women, men, persons with disabilities and the LGBTI community all work to highlight the need for socially-inclusive policies and practices in the health, nutrition and WASH sectors. Use available forums and platforms to highlight gaps in policies and implementation, they attempt to direct the attention of policymakers and donors to their areas of activism.

Maintaining an open dialogue and continuing to raise issues of social inclusion are critical to capturing attention. Informants expressed that social inclusion should be considered during the design and analysis of all policies and programs. In particular, representative from multiple organizations argued that policies need to be analyzed to identify gaps and opportunities for promoting gender equality and be more specific regarding accommodations for persons with disabilities. Organizations supporting the LGBTI community highlighted the importance of continuously bringing up the topic to achieve explicit inclusion and practical acceptance of people who are LGBTI from the central level of government to the grassroots.

One example of advocacy results is the widespread adoption of the male-engagement approach. Through advocacy, most health and nutrition programs have recognized the importance of engaging men to address gender disparities. Some implementing organizations now work with districts to institutionalize male engagement through district performance contracts (Imihigo). In some districts, activities related to engaging men in evening school and health programs are included in the Imihigo and, as a result, performance against set objectives is monitored.

Sharing best practices and experiences through umbrella organizations facilitates the replication of successful formats. Umbrella organizations have been chartered to represent men, women, and persons with disabilities. The LGBTI community does not have an official umbrella organization but are represented by national

organizations like the Human Development Initiative and Never Again Rwanda. Through national networks, these organizations advocate for the needs of their base by helping implementers—including CHWs, facility-based providers, and local authorities—to understand and apply laws and policies for social inclusion. According to an informant, persons with disabilities are supposed to be treated ahead of persons without disabilities in health facilities, but few providers know the procedures around giving priority. Dissemination efforts help health service providers to understand and apply the policies like this one.

Integrated approach

Taking an integrated approach to the design and implementation of programs creates synergy. Better integration of programs can be achieved by engaging with existing societal structures, coordinating with other programs in the same geographic area, and collaborating with stakeholders working towards the same objective.

Engagement with advocacy organizations and other respected leaders builds trust, expands reach, and improves participation in program activities. For example, to better address the intersectional issues of gender and disability in SGBV prevention, the Indashyikirwa program partnered with National Council for Persons with Disabilities to ensure that the strategy addressed the needs of persons with disabilities and program communications used inclusive language. Informants shared that the partnership was a key to success, both in terms of recruiting persons with disabilities and improving sensitization training for implementers.

Partnerships can boost reach and reinforce messages. Some informants reported partnering with other organizations implementing in the same geographic area on similar or complementary topics. By creating partnerships, organizations can use each other's networks for outreach and can learn from each other about how best to reach vulnerable or excluded populations. The USAID Tworore Inkoko program, for example, partnered with Gardens for Health International (GHI) to give joint training. Already operating in the same district, GHI provides nutrition education and small plot horticulture training to caregivers of young children and pregnant women. Through this partnership, Tworore Inkoko leveraged GHI's network to reach more women and, together, the organizations reinforced each other's messaging about the importance of dietary diversity.

Holding consultative meetings with relevant authorities can align the approaches of organizations working on the same topic. These meetings can include law enforcement, social affairs committees, health system actors, and government agencies. For example, the National Public Prosecution Authority's intersectoral SGBV unit streamlines all efforts that respond to SGBV cases and takes a holistic approach to dealing with SGBV. The unit is a collaboration between the Gender Monitoring Office at the Ministry of Gender and Family Promotion, the Rwanda National Police, the Rwanda Investigation Bureau, and other government stakeholders. Though this unit is still its inception phase, implementing partners will be able to use it to coordinate comprehensive services for SGBV and synchronize program activities with those of other donors and the Government of Rwanda.

Training of health service providers

Most interventions include a capacity building component for training CHWs, community-based volunteers, or other health service providers. The objective of these trainings is typically to strengthen medical knowledge and skills while addressing cross-cutting components like gender, social inclusion, and human rights. If health facility personnel have medical knowledge on the heterogeneous range of disabilities as well as how to interact with a person with a disability, they can offer better quality care. For example, knowing Rwandan sign language or having access to a communication tool with images results in more effective communication between providers and patients who are deaf. NGOs or other organization deliver on-the-job training, but Disabled People Organizations (DPOs) emphasize the need for including specialized care for persons with disabilities in the curriculum of medical schools. They advocate for the curriculum to include both medical and sensitivity trainings to help students to understand causes of disability and treatment or assistive service as well as how to interact with persons with disabilities and communication skills. By expanding providers' understanding of patient-oriented care, these interventions will benefit health outcomes for persons with and without disabilities.

5.2 Cultural norms and beliefs

Sensitization efforts serve to address cultural norms, beliefs, and misconceptions that may result in social exclusion of groups from health programs. Strategies that programs use to build healthier and more inclusive cultural norms include behavior change interventions, facilitated dialogue, and beneficiary targeting.

Changing Behavior

A number of key informants noted that policymakers and implementing partners should identify and address the primary causes of social exclusion, which are rooted in culture and value systems. Once root causes are identified, key performance indicators and disaggregated data can track progress but achievement of indicators should not be the goal itself. Instead, development interventions should focus on behavior change. Key informants across the board highlighted that behavior change requires realistic long-term engagement and the allocation of necessary resources.

Effective interventions take account of the context in which they are implemented. To impact a health outcome, programs must first address the different underlying causes such as prevailing practices, attitudes, and behavior. The Bandedereho program, implemented by the Rwanda Men's Resource Centre, used a role model approach to address gender norms and encourage men accept household responsibilities like cooking and childcare with the aim of advancing gender equality and reducing SGBV. The program promoted gender-sensitive behavior and emphasized for men the importance of their participation in the health and nutrition of their households. An independent evaluation of the program showed that the intervention led to reported decreases in physical and sexual IPV, greater attendance and male accompaniment at antenatal care visits, greater modern contraceptive use, and less dominance of men in household decision-making (Doyle et al. 2018). Several key informants highlighted that all members of society have to work together to achieve gender equality in practice. For example, some implementing organizations establish gender clubs in schools,

where young boys and girls are mentored to become gender-sensitive adults, and boys are coached to become non-violent men.

Though behavior change is slow, progress has been made towards cultural acceptance of gender equality and social inclusion. Informants noted that knowledge of SGBV or condom usage for HIV prevention have been raised through health programs; the challenge now is changing practices. Factors that lead to sustained change, according to informants, are the direct involvement of and follow-up with beneficiaries. A couples-based approach with both the husband and wife participating is commonly used by implementing partners to promote gender-sensitive behavior. Some key informants claim that mixed-gender activities in which women have to speak publicly before men improves women's confidence and can make them feel more empowered in their household. Homegrown solutions like Umuganda, community-based nutrition schools, fathers groups, parents evenings, and other village-level structures in addition to cooperatives and savings groups are cited by key informants as appropriate entry points for encouraging behavior change.

Facilitating Discussion

Promoting open dialogue can address stigma and harmful cultural norms. Facilitated conversations with advocacy groups builds understanding of sensitive topics like SGBV, disability, and LGBTI issues and gives community members to an opportunity to discuss and address misconceptions. Members of CSOs representing LGBTI people try to brand themselves in society to give visibility to people who are LGBTI and demonstrate that they are community members too. Moreover, Building Hope for Future has offered training on a small scale to parents and family members of children who are LGBTI to share information and promote acceptance of their children. This CSO highlights the benefits of mutual support among parents who realize that they are not the only parent with a child that does not identify as heterosexual. The CSO also provides training to community leaders and local government to promote a top-down approach to acceptance and CHWs as the first point of entry to the health system.

Targeting and recruiting beneficiaries

Some program strategies are designed to reach one or more specific type of beneficiary. These are usually targeted at vulnerable or marginalized populations like youth, teenage mothers, female sex workers, victims of SGBV, or persons with disabilities. These strategies are used either when the message of a program is directed to a specific subgroup or to generate more inclusive community participation by recruiting people who are typically excluded or isolated. To encourage participation, some informants reported that their programs track who is participating in activities. Then, if services are intended to achieve community-wide coverage, implementers can identify who is not participating and provide extra attention. A key informant stated that targeting vulnerable families in their homes, rather than in group settings, allows for a better understanding of issues and potential solutions specific to them but that the approach is costly.

5.3 Roles, responsibilities, and time use

Roles and responsibilities tie in closely with cultural norms and beliefs. Many key informants noted that the different roles and responsibilities—and the time needed to fulfill them—form barriers to accessing health and nutrition services. Interventions to promote mutual understanding of household dynamics, peer leadership, and careful consideration of differential effects can contribute to the behavior change required for gender equality within the household.

Building understanding

Participatory exercises and assessment tools can offer insight into partners' or community members' responsibilities and time use. The Gender Action Learning System is a set of tools developed by Oxfam Novib for life planning, assessing gender roles and power relationships, and promoting empowerment. The assessment tools are usually complemented by gender transformative training at the community level on topics including collaborative budgeting, healthy relationships, and domestic violence. Similarly participatory mapping exercises, typically used in WASH programs, can show the distance individuals must travel—and thus the time they must spend—to fulfill responsibilities like fetching water or purchasing household supplies. These exercises may be particularly useful for identifying and acknowledging the obstacles and increased time burden for women with disabilities.

Leading by example

Role model or peer leadership approaches can challenge social roles through example. By sharing information and personal experiences, gender champions promote gender equality and actively encourage their peers to rethink the division of roles and responsibilities within the household. The curriculum used in the Bandebereho program is premised on the belief that true equality will only be achieved when men take on 50% of the world's childcare and domestic work. By electing and dispatching male champions, this program and others attempt to spark behavior change and break social norms. Champions share experiences at parenting meetings, for example, which were instated to handle and follow up with family issues. Attended by both mothers and fathers, these meetings provide an opportunity for both men and women to talk about household issues and responsibilities and create an avenue for authorities to intervene if needed. An important point noted by a key informant is that the nomination of community role models or volunteers should be monitored. Appointment by village leadership should be avoided since it could lead to champions who are not necessarily trusted or deemed capable by the community; moreover, the opportunity would not be equal to all community members.

Considering differential participation and effects

Many implementing partners reported that they use sensitization or awareness campaign approaches to address known differential effects of interventions. These approaches use radio, training of trainers, CHWs, or other forms of more public messaging so information is shared widely. In nutrition programs that encourage a varied diet, program activities may include advocating for all members of the beneficiary households to have access to more diverse sources of nutrition and be relayed to both men and women. While these programs—like maternal and child programs—are typically targeted to women since women are responsible for the health and nutrition of their households, men should be made aware of the importance of these topics and their roles in them as well.

In other cases, the design of the campaign is the cause of differential effects of an intervention. Mobile clinics or testing centers may be located in a central place that is difficult for people with physical disabilities to reach. If information is communicated via radio or displayed on murals or billboards, people with sensory disabilities may not get the message. If the subject of the outreach is socially sensitive, like HIV testing or promotion of family planning methods, the setting of the activity may impede young or unmarried people from engaging.

The accessibility and venue of the intervention may have differential effects on men and women. If the distance to the intervention site is far from target population's homes, women may not be able to go as their household responsibilities limit their time available for travel. At the same time, men are bound by ad hoc jobs and other employment responsibilities, which make their schedules less predictable, so a convenient meeting time should be set during evenings or Sundays. Key informants noted that running trainings in urban areas is more challenging due to the unavailability of program facilitators and beneficiaries.

5.4 Patterns of power and decision making

Cultural norms and societal roles and responsibilities lead to unbalanced power dynamics in the home and compromise the autonomy of women, persons with disabilities, and people who are LGBTI. Implementing partners and CSOs have addressed these issues by promoting economic empowerment among beneficiaries and gathering input in programming.

Economic Empowerment

An implementing partner stated that when existing household dynamics are more aligned between men and women, the programs activities are more effective at achieving the objectives. At the same time, less balanced household dynamics form a barrier to program outcomes. To empower women to have access to the household budget, for example, financial literacy education for both women and men needs to be accessible and comparable. This training can be provided not only through mainstream education in schools but also through special training programs.

Savings groups are one approach used to promote economic empowerment. An assessment of the CHAIN savings groups conducted by Three Stones International reported that women in savings groups said that they had more agency to make their own decisions and that savings groups provided a platform for women to express their opinions in their communities (Three Stones International 2018). When rolling out savings groups, implementers must consider household power dynamics. Creating savings group may only be successful in empowering women if their partners respects women's authority to make decisions about the income. The savings group assessment reported that the promoting and enforcing gender equality can safeguard against husbands' misuse of the money earned or saved by their wives. Likewise informants for this assessment suggested that designing more inclusive, mixed-gender saving groups

may support understanding, minimize household tensions over finances, and stimulate husbands' support of their wives' economic participation.

CSOs supporting persons with disabilities and people who are LGBTI promote cooperative development and other revenue-generating activities. The CSOs argued that these activities have a three-fold effect: first, they improve economic security and income available for health-related expenses; second, they contribute to reducing stigma and promoting empowerment through market participation; and third, they can build social cohesion and reduce isolation.

Input in Programming

One way to empower target populations is to collect input when designing and deploying an intervention. For social inclusion efforts to be successful, the voices of the excluded groups must be heard.

The mechanisms through which input is collected need to be suitable for the target population. A key informant suggested that male field officers may intimidate or prevent women from raising issues or giving feedback, especially on issues related to gendered power dynamics. A tool that has been used by women is the "Every voice counts" scorecard exercise developed by CARE with women at the grassroots level. This exercise helps to catalyze dialogue with service providers and to make an action plan for improvement. The results and plan are then discussed with local government, other local authorities, and health centers. Authorities and service providers commit to the plan, and civil society monitors the implementation.

Umbrella organizations and the established mechanisms for input are not always used effectively to represent excluded subgroups. While structures exist for persons with disabilities to provide input, consultations or recommendations do not always have influence or any visible result. Most disabled persons organizations interviewed for this assessment highlighted that persons with disabilities are not a homogenous group. Donors and organizations tend to get in touch with the most established groups, which mainly represent persons with physical or sensory disabilities and are often run by men. Similarly, informants from organizations supporting people who are LGBTI reported that collaboration between their organizations and government institutions is limited because contacts and mechanisms have not yet been established. Because they often do not have a platform to speak for themselves, people who are LGBTI feel that their perspectives can be misrepresented by other programs.

5.5 Access to and control over assets and resources

As discussed previously, access to information and financial resources for health-related decisions are two important facilitators of inclusive uptake of services and participation in programs. Interventions to promote more equitable access to and control over assets and resources include cultivating acceptable avenues for health messaging and service delivery and building financial resources.

Entry points and avenues

Approaches to avail information and services to certain groups should be tailored to targeted beneficiaries. Informants shared the following methods that were successful in their programs:

- Visiting hotspots along trucking routes at night where sex workers are typically active.
- Including an income generation component to encourage youth participation. Once trust is built, these platforms can be used to address issues related to health, especially sexual and reproductive health.
- Using peer outreach, which is less likely to be hindered by stigmatization or fear of violated confidentiality. An informant suggested that peers meet in each other's homes to check in on one another. By meeting in homes, they can identify issues related to household health and suggest practical solutions. The more informal setting facilitates honest discussions about issues and advice. Peer education can also expand the impact of a program as participants share what they have learned with non-participants.
- Facilitating self-help groups and support networks with community-based volunteers who can respond to crises and mediate with families and communities if needed.
- Establishing safe spaces where participants can gather and freely discuss topics related to the program or receive health services. These spaces may have certain days for specific subgroups to gather as well as open days that facilitate wider understanding. Participants should feel safe and protected and empowered to say anything and ask any questions. For example, the Centers for Health and Rights run by HDI in Nyamirambo and Kicukiro offer specialized care to the LGBTI community in addition to serving youth, couples and other marginalized groups. These health centers have become safe spaces for people who are LGBTI, with specific consult days when they know a trusted doctor is available.

Financial resources

Savings groups and income-generating activities are used widely to build household financial resources for health. The CHAIN theory of change hypothesizes improving household economic wellbeing will increase ability to pay for health care and health-related investments, provide financial security, and engender stronger feelings of hope for a better future—all of which contribute to improved health outcomes. Implementing partners and other informants supported this notion and reported that limited finance and access to financial resources were the most pressing obstacles to inclusive health care access and program participation.

Chapter 6: Gaps and Opportunities

In this chapter, we make recommendations for USAID to prioritize—through both programming and policy advocacy—to address gender and social inclusion issues and promote more equitable and inclusive health outcomes for all Rwandans. Recommendations support the key strategic objectives for the USAID Rwanda Health Office for 2020-2025, as shown in Table 2 at the end of this chapter.

1. Stimulate demand for health care services, especially among excluded groups.

Despite specific USAID and Government of Rwanda objectives to increase demand, the uptake of health services appears to remain low among target groups. One objective of the CHAIN program was to improve health and nutrition status through increased utilization of quality services and products. To achieve this objective, CHAIN projects stimulated demand for high-impact health practices. Similarly, in HSSP4, the Government of Rwanda commits to building demand for essential health care services by raising awareness at the community-, household-, and individual-levels of available services and by promoting the regular practice of healthy behaviors and actions.

To stimulate demand and address the gap in uptake among excluded groups, USAID should:

- **Target high-risk populations.** To have the greatest impact, USAID should target health promotion programs to people at highest risk. Those at higher risk of communicable disease are often the most vulnerable and the socially excluded: the most poor, sex workers, people who are LGBTI. Consequently, USAID should carefully consider what messages and media are most effective to reach these groups. For example, programs can deliver WASH behavior change communication with very poor households during public works meetings or advertise clinics like the Centres for Health and Rights at places where people who are LGBTI meet.
- **Package services and interventions.** USAID should couple health messaging or service delivery for lesser-used services with services in high demand. While opinions among informants were mixed regarding the success of integrating nutrition monitoring into vaccination campaigns, USAID should explore other opportunities to pair services so the barriers to accessing a clinic only need to be surmounted once.
- **Facilitate enrollment in community-based health insurance.** Despite the enrollment fees for CBHI having been waived for the poorest households, 60% of people in the poorest quintile still do not have health insurance (EICV4 2015). In line with the societal roles previously discussed, informants noted that women, persons with disabilities, and people who are LGBTI have lower access to CBHI because their health is not prioritized within households or they are afraid to face officials in order to register. In addition, key informants also highlighted young people and moto taxi drivers as two groups with lower rates of enrollment. By advocating

for enrollment in CBHI—especially at the household-level so all family members are enrolled—USAID can reduce the financial barriers that disproportionately limit access to health care. USAID should work with the Government of Rwanda to discuss reasonable and acceptable ways to incentivize CBHI enrollment.

2. Design and implement programs in collaboration with the individuals and organizations supported by the programs.

Noted previously as a best practice, collaborative design and implementation can help USAID to build more widely accepted and successful programs. Without consultation, program design can ignore key cultural norms that hinder implementation. Throughout this assessment, implementing partners, donors, and CSOs have all stated that joining partnerships and leveraging strengths have been critical to the success of their programs, particularly with regards to inclusion. Joining partnerships also contributes to the capacity building of smaller NGOs and civil society organizations thus supporting sustainability and ownership.

To ensure that the voices of excluded people are heard throughout the design and delivery of programs, USAID should:

- **Promote results-oriented thinking to address cross-cutting themes.** Cross-cutting themes like gender and social inclusion should be considered not only in the design of programs but also in delivery and evaluation. Advocates and implementing partners explained that merely making health programs and services accessible to women, persons with disabilities, and people are LGBTI is not sufficient; programs should be designed to deliver results specifically to at-risk and excluded populations. Increasing the direct involvement of people who will benefit from the programs in design and implementation and framing success according to benefits delivered will generate demand-side accountability for social inclusion. Several organizations and government offices suggested setting targets—to measure not only reach but benefits as well—for specific subgroups. They recommended that implementing partners communicate baseline indicators and intended outcomes with advocacy organizations and government and, together, they develop a shared responsibility for monitoring and mechanisms for accountability.
- **Consider inclusion during procurement.** Several advocacy organizations expressed frustration that USAID and other donors tend to partner with the larger and more established organizations, while smaller organizations mainly benefit through training events. They expressed the need for wider consultations during the program design stage and more opportunities for smaller organizations to participate in and benefit from partnerships with USAID.
- **Partner with advocacy organizations to enhance credibility.** Working through organizations that are considered leaders in the community builds trust, especially when trying to reach vulnerable or isolated people.

Partnerships can be mutually beneficial: USAID can capitalize on existing networks and expertise to target key populations with culturally appropriate messages while providing much-requested financial and capacity-building support. Organizations working with people who are LGBTI and people with psychosocial disabilities, in particular, noted that they are excluded from or not prioritized for funding and partnership opportunities because their bases' needs are not publicly acknowledged.

- **Use peer-to-peer outreach strategies.** Isolation, stigma, and incompatible scheduling are key barriers to inclusive health programming and service provision. Where natural networks form around a shared experience, USAID should capitalize on peer-to-peer outreach by training champions and encouraging them to speak openly about key health issues, like HIV prevention and treatment, and available support options. Through a peer-to-peer model that meets beneficiaries where they are, USAID can reach people who are concerned that public disclosure will result in stigmatization or compromise their safety and personal security. These strategies should be considered for use especially with people who are LGBTI, sex workers, and women experiencing SGBV.

3. Improve human resources to strengthen inclusive health care in communities.

Expecting a hostile reception or a health facility or provider unable to meet one's needs is a key deterrent to accessing health care. This issue was particularly relevant for people who are victims of stigmatization in their communities and people with less common health care needs. Efforts to expand inclusive community-level care should maintain a holistic approach and address the skills and attitudes of health care providers, other facility personnel, and local authorities.

To support inclusive community-level provision of health care services, USAID should:

- **Build capacity of first-line health care workers to accommodate and treat persons with disabilities.** Any projects involving outreach or capacity building with service providers should include training on working with persons with disabilities. While the needs of persons with disabilities are diverse, certain approaches to care can be implemented regardless. For example, health care workers should not assume that care options are off the table solely because a patient has a disability.
- **Provide sensitization training for non-medical staff at health facilities.** LGBTI advocates noted that their experiences at health facilities were influenced not only by the medical care providers but also the other clinic staff. In fact, they often met hostile or insensitive security guards or administrators and were discouraged from seeking care before even speaking with a provider. When working with health facilities, USAID should take a holistic approach and include non-medical personnel during sensitization training. Advocates from the LGBTI community can also be involved in these trainings to share their experiences and recommendations.

- **Emphasize patient privacy and confidentiality.** USAID should prioritize training on confidentiality between the service provider, facility staff, and patient. Experiences or fear of violated confidentiality was an oft-discussed deterrent to seeking care. Since health care workers are typically members of the communities which they serve, they are familiar with patients and their families. Advocates for women and people who are LGBTI explained that they feared that their conditions or sexual identities would be disclosed to other community members. Likewise, persons with disabilities who require support to reach a facility or communicate with a provider worry that they will not be able to maintain their privacy.
- **Work with local authorities to create an enabling environment for inclusive health and WASH services.** Engagement from local authorities is especially important for changing behavior at the community-level and creating a supportive and inclusive health care environment. Water and sanitation improvement projects, for example, typically require community buy-in and wide adoption to be most effective. Implementing partners should work with representatives to ensure the needs of all community members—especially those with disabilities—are served by the project. Since behavior change is a slow process, mobilizing local authorities to guide their communities even after a specific program has ended enhances sustainability.

4. Support the decentralization of health care services.

The intended reach of essential health services is not realized in all communities. Through its varied and ambitious policies, the Government of Rwanda has demonstrated its commitment to expanding access to quality and inclusive health care; however, the implementation of these policies at the local level is inconsistent. A recurring theme in the interviews was the gap between the national-level policy and its on-the-ground implementation due to breakdowns in the flow of information and a lack of resources.

To strengthen the decentralized implementation of health policy and service provision, USAID should:

- **Facilitate communication and knowledge dissemination from district-level administration to communities.** Through its commitments to self-reliance and effective governance, Rwanda has designed homegrown solutions for the administration of inclusive development. While processes and channels are in place to disseminate information and escalate issues, their use is limited by logistical constraints like a lack of communication equipment especially below the district-level administration. As a result, policy achievements are not implemented consistently throughout the country, and issues cannot be raised outside of the regular meeting schedule. Informants recommended strengthening communication channels between district authorities and community representatives.
- **Ensure faith-based health facilities are providing appropriate and adequate care.** Faith-based health facilities provide valuable service alongside a resource-constrained public system. A government informant noted, however, that the values of these organizations can influence the services they provide especially with

regards to sexual health. While the Government of Rwanda through the Rwanda Biomedical Center stocks district pharmacies with family planning commodities, health centers in rural areas run by religious organizations are not purchasing these supplies. The people served by these clinics must consequently travel to a neighboring sector for contraception. The increased burden—in terms of time, cost, and difficulty—can deter women and people who are LGBTI, particularly if they are living with a disability, from accessing reproductive and sexual health services at all. Family planning campaigns at the village level were offered as a potential workaround. After an initial consultation at a health center or registration during the campaigns, CHWs can provide family planning services.

- **Advocate for expanded capacity for service provision at the district level and below.** There are significant physical, financial, and human resource needs to support the further decentralization of the health system. In addition to its existing work on the accreditation and upgrading of health centers, USAID can advocate for: the retrofitting of clinics to make them accessible for all; the application of and adherence to ministerial orders and national building regulations to ensure future facilities are accessible for all; building more health posts at the cell-level and expanding mobile services to bring services closer to people in need; ensuring clinics have adequate equipment, especially for people with disabilities, and training staff on how to use it properly; and supporting health workers to upgrade credentials through formal education.

5. Address the burden on community-based volunteers.

Stakeholders noted a tension between the workload and expectations of community-based volunteers and their compensation. Many health and wellness interventions are administered by community-based volunteers, including: the Community Health Program; Inshuti z'umuryango (IZU, a government-led child-protection program); Indashyikirwa; and several USAID health programs. Without a salary, community-based volunteers, including CHWs, must continue to pursue other income-generating activities which cut into the time they have available to practice. Addressing the challenging working conditions coupled and income insecurity of CHWs can lead to a more motivated and engaged workforce. In the long-run, improved retention can also reduce training and replacement costs.

To improve the working conditions of community-based volunteers, USAID should:

- **Ensure implementing partners budget for volunteer costs and are prompt with reimbursement.** In their work, volunteers often incur costs of their own and must advance payments for which they are reimbursed. For example, a CHW cooperative leader explained that CHWs receive one hour of airtime per month but typically deplete the allowance on work-related calls before the end of the month. When attending meetings, CHWs are provided reimbursed for transport costs—usually through mobile money—but they must advance the costs and reimbursements can be delayed. At minimum, USAID and its implementing partners should adequately budget

for any associated volunteer costs, like transportation and airtime, and limit the costs that volunteers must pay out of pocket.

- **Advocate for increased stipends.** USAID should consider increased support to community-based volunteers and advocate for the Ministry of Health and other donors to do the same. The burden of minimally paid labor on CHWs disproportionately affects women who make up 71% of the pool (LSTM 2016) and who are also typically charged with unpaid caring responsibilities in their own households. USAID should explore options for improving the livelihoods of community-based volunteers, targeting women in particular, through increased support to cooperatives or performance-based pay systems.

6. Partner with the private sector for inclusive health service delivery.

The expanding science and technology sectors have the potential to provide private-sector solutions to existing issues in the health system. In Vision 2020, the Government of Rwanda set an objective to transform its economy from low-productivity subsistence agriculture to higher-value products and knowledge-intensive goods and services. As Rwanda expands its science, technology and industrial sectors, USAID should support the development of local technological innovation for the health system.

To harness private sector innovation for the health care system, USAID should:

- **Strengthen the supply chain and promote local production.** By generating more demand for health care services among excluded populations, USAID will expand the market for health care services. By framing inclusive health care as a market opportunity, USAID can incentivize the private sector to develop solutions to existing problems, like gaps in the supply chain and distribution networks for medications and supplies outside of Kigali. Through public-private partnerships, business development support, and better loan mechanisms, USAID can also support the local manufacture of equipment, assistive devices, and sanitation solutions that address the needs of a wider population.
- **Explore digital health solutions with an eye on inclusiveness.** If the Government of Rwanda intends to address gaps in health access through private sector solutions—and through technological innovations, in particular—efforts must be made to ensure that these services are inclusive. Babyl, for example, is a digital health service provider that provides consultations, prescriptions, and referrals over the phone. By design, digital health services can help to mitigate some of the previously identified barriers, such as the time burden for women to go a clinic, inaccessible clinics for persons with disabilities, and the social proximity of health workers to the communities that they serve. Digital health solutions also have inherent challenges for inclusion. As noted, the most vulnerable populations are often excluded from economic participation or resources within the home and thus may be less likely to own a mobile phone. Using digital services may also pose challenges for people who

have limitations with hearing and vision without accommodation. Though not a replacement for all in-person services, digital health can complement the existing health system and, with consideration, be used to advance inclusive outcomes. USAID can serve as a thought leader and advocate by partnering with these services to expand access while considering adaptations for more inclusiveness.

7. Facilitate better data for decision-making and an inclusive research agenda with a focus on persons with disabilities.

Limited data on vulnerable populations contribute to their exclusion. Informants noted issues in the under-identification of persons with disabilities and a lack of related research. The gap in data is particularly noticeable for people with mental health issues and intellectual and psychosocial disabilities since these disabilities are often less visible and less publicly understood. Since programs and interventions are generally developed after a need has been identified, an absence of research consequently leads to a gap in programming. USAID should continue to support an inclusive research agenda so programs can be better designed to address key issues among excluded populations.

To promote an inclusive research agenda, USAID should:

- **Practice evidence-based intervention design.** USAID should continue to commission research ahead of new program design. Cultural shifts are slow but progress has been made, and new programs should take into consideration the current reality. Key informants working on behavior change noted that thorough research and an adaptable approach are particularly important for their programs. Effective interventions must be tailored to the needs of the people that they are trying to reach and address the root causes or cultural norms that influence behavior.
- **Conduct rigorous program evaluations.** By rigorously evaluating its own programs, USAID can build the global evidence base for improving access to inclusive health care and uptake of services. Designed to include a randomized control trial, the Sugira Muryango program promotes positive familial relationships and child development while evaluating the effectiveness its home-visiting approach. USAID should continue to allocate budgets for rigorous external evaluations and allow flexibility in design and implementation (for example, in the selection of geographic areas for the intervention) to accommodate research design.
- **Require disaggregated data.** To date, USAID has been very successful in sensitizing its implementing partners to the importance of disaggregating all monitoring data by gender in order to assess program effects on women compared to men. USAID should consider replicating this approach to collect similar monitoring data on the participation of other key populations in its program. The Washington Group on Disability Statistics has published question sets to identify persons with disabilities who are at-risk of participation restrictions. Their

short set of questions can be used within a larger survey or registration form to enable disaggregation of data by disability status (Washington Group 2016). USAID/Washington has developed how-to guidance for its partners and staff to use this method for disability data collection at the project and activity levels.

- **Facilitate sharing of research and data.** Finally, USAID should work with the Government of Rwanda and other donors to strengthen systems of data collection and dissemination. Key informants highlighted a need for identification of persons with disabilities in the census so their needs are addressed in national planning and policy. USAID can promote the use of the DHS Disability Module as well . Using the same information for decision-making and increasing transparency with evidence will improve credibility. By facilitating sharing of data and information between beneficiaries, CSOs, local government, national organizations, and donors, USAID can capitalize on ongoing research activities and limit the duplication of efforts.

Table 2: Assessment Recommendations according to the objectives of the USAID/Rwanda Health Office strategy for 2020-2025

	Recommendations
Strategic Objective 1: Improved quality of care at all levels - from community to tertiary facilities	Build capacity of first-line health care workers to treat persons with disabilities
	Provide sensitization training for non-medical staff at health facilities
	Emphasize patient privacy and confidentiality during provider training
	Ensure faith-based health facilities are providing appropriate and adequate care
Strategic Objective 2: Increased responsibility of district governments for service delivery	Facilitate communication and knowledge dissemination from district-level administration to communities
	Advocate for expanded capacity for service delivery at the district-level and below
Strategic Objective 3: Development of healthy, safe, and nurturing families and communities	Target high-risk populations
	Facilitate enrollment in community-based health insurance
	Work with local authorities to create an enabling environment for inclusive services for health, nutrition, and WASH
Strategic Objective 4: Strengthened service delivery systems for health, nutrition, and WASH	Package services and interventions
	Promote results-oriented thinking to address cross-cutting themes
	Partner with advocacy organizations
	Use peer-to-peer outreach strategies
	Ensure implementing partners budget for community-based volunteer costs
	Advocate for increased stipends for community-based volunteers
	Strengthen the supply chain and promote local production
Explore digital health innovations	
Cross-cutting recommendations	Practice evidence-based intervention design
	Conduct rigorous program evaluations
	Require disaggregated data
	Facilitate sharing of research and data

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Annex 1 - List of Key Informants

Implementing Partners		
Management Sciences for Health - Rwanda Health Systems Strengthening Activity (RHSS)	The RHSS activity aims to achieve strengthened and expanded performance of the Rwandan health system at the national, decentralized, and community levels. The project works to enhance the resilience of the Rwandan health sector to address new challenges, and to help building a country-owned sustainable health system capable of leading and managing change.	City of Kigali
JHPIEGO - Maternal and Child Survival Program (MCSP)	The MCSP project contributes to the reduction of preventable maternal, newborn and child deaths. Gender is one of the key cross-cutting priorities, also focusing on GBV prevention and response.	City of Kigali
Catholic Relief Services - Gikuriro	Gikuriro is an integrated nutrition and WASH activity. Key components are capacity strengthening of government stakeholders and local partners, and delivery of comprehensive nutrition and WASH services.	City of Kigali
SNV - Isuku Iwacu	The Isuku Iwacu program aims to increase local ownership and capacity to deliver sustainable, high quality sanitation and hygiene services in order to decrease childhood stunting.	City of Kigali
Society for Family Health - Rwanda Social Marketing Program	The Rwanda Social Marketing Program addresses maternal and child health, HIV and malaria, by using a behavioural change communication approach to promote positive health behavior.	City of Kigali
Global Communities - Twiyubake	The Twiyubake Program is aimed at improving the resiliency of at least 50,000 vulnerable households against adverse circumstances in 12 districts in Rwanda. This work is expected to reduce the risk and impact of health conditions such as HIV/AIDS on vulnerable populations, including people living with HIV/AIDS, orphans and vulnerable children, members of households caring for these two groups, very poor households (especially female and widow-headed households), and out-of-school youth, especially girls and young women.	City of Kigali
Cultivating New Frontiers in Agriculture - Hinga Weze	The Feed the Future Rwanda Hinga Weze Activity aims to sustainably increase smallholder farmers' income, improve the nutritional status of women and children and increase the resilience of Rwanda's agricultural and food systems to a changing climate.	City of Kigali
Abt Associates - Vector Link	VectorLink Rwanda project is responsible for conducting indoor residual spraying (IRS) in two targeted districts Kirehe and Nyagatare according to an agreement between U.S. President's Malaria Initiative (PMI) and the MOH's Malaria and Other Parasitic Diseases Division (MOPDD). Additionally, the project supports entomological monitoring and wall bioassay activities to assess insecticide decay rates and quality control for IRS.	City of Kigali
Chemonics - Global Health Supply Chain - Procurement and Supply Management	GHSC-PSM works with country partners and suppliers to ensure an uninterrupted supply of health commodities to promote well-being and save lives. It provides services through four health area task orders, including HIV/AIDS; malaria; population and reproductive health; and maternal, newborn, and child health.	City of Kigali

Intra Health - Rwanda Service Delivery Activity (Ingobyi)	The Ingobyi project works in collaboration with MoH to reduce preventable infant and maternal deaths, reduce the incidence of malaria, and bring high-quality, integrated health services to more Rwandan mothers, children, and adolescents.	City of Kigali
Caritas Rwanda - Gimbuka	The Gimbuka project aims to improve the nutritional status of pregnant women and / or HIV-infected AIDS and 36,000 children under 5.	City of Kigali
Association François-Xavier Bagnoud (FXB) - Turengera Abana	Turengere Abana aims to improve social-economic wellbeing of orphans and vulnerable children and their families affected by HIV/AIDS in Rwanda, through a community-led program of sustainable care and support in seven districts and by improving the nutritional status of women and children, especially those under two years of age, through community-based nutrition interventions.	City of Kigali
University of Tennessee - Tworore Inkoko Twunguke	Feed the Future Tworore Inkoko, Twunguke aims to increase the capacity of smallholder farmers to produce chicken meat, thus increasing the availability of animal-source protein and increasing the purchasing power of households, through heightened income levels, for nutritious foods.	Knoxville, TN
Boston College - Sugira Muryango	Boston College implements a research project to evaluate the Sugira Muryango home-visiting intervention. The main objectives are to build caregivers and parents' skills and knowledge about early childhood development and link families to complementary community resources.	City of Kigali

Organizations supporting persons with disabilities

Disability Rights Fund	Disability Rights Fund (DRF) and its sister organization, Disability Rights Advocacy Fund (DRAF) provides financial resources and technical assistance primarily to organizations of persons with disabilities in Rwanda to advocate for their rights and inclusion in development programs.	Boston, MA
Women with Disabilities Organisation of Rwanda (UNABU)	UNABU is organization that provides a range of empowerment, livelihood and advocacy activities for girls and women with disabilities.	City of Kigali
Umbrella of Organizations of Persons with Disabilities fighting HIV&AIDS and Health Promotion (UPHLS)	UPHLS aims to strengthen the capacities of member organizations, support, guide and coordinate programs to promote the rights of persons with disabilities for inclusive services in HIV/AIDS, health and employability.	City of Kigali
National Organization of Users and Survivors of Psychiatric of Rwanda (NOUSPR)	NOUSPR is dedicated to support Rwandan people with psychosocial disabilities and advocate for their rights, favorable policies and improved service delivery by state and non-state actors. Their work focuses on promoting the enjoyment of human rights of persons with psychosocial disabilities in all spheres of life.	City of Kigali
National Council of Persons with Disabilities (NCPD)	The NCPD is a public institution to serve as a forum for advocacy and social mobilization on issues affecting persons with disabilities in order to build their capacity and ensure their participation in the national development.	City of Kigali

National Union of Disabilities Organizations of Rwanda (NUDOR)	NUDOR is a civil society organization established by national organizations of persons with disabilities. NUDOR exists to strengthen the voice of the disability movement in Rwanda. Together NUDOR and its members are working so that persons with disabilities can enjoy the equal rights to which they are entitled.	City of Kigali
Rwanda Union for the Deaf (RNUD)	The Rwanda National Union of the Deaf (RNUD) is a national non-governmental organization established by people who are deaf and is dedicated to advocate for equal opportunities for Deaf Rwandans and for their human rights as provided by international and national law.	City of Kigali
VSO	VSO is an ngo working with girls and boys and women and men from different backgrounds, their families, communities, local leaders and national decision-makers. Amongst others, VSO works with PLWD through their inclusive education program, specialist service provision, local authority disability mainstreaming and civil society capacity building.	City of Kigali
Autisme Rwanda	Autisme Rwanda is a daytime learning center for children between 2 and 14 years old who have autism. They focus on communication, behaviour and social interaction skills of children.	City of Kigali
Rwanda Down Syndrome Organization (RDSO)	RDSO is a new organization that is working to support and advocate for people with Down Syndrome and their families.	City of Kigali
Disability District Platform in Nyanza	The disability district platform in Nyanza works under NUDOR and consists of a committee of 7 members. They conduct advocacy to the local government and health centers about cases of specific needs of people with disabilities in the district.	Nyanza district

Organizations supporting people who are LGBTI

Never Again Rwanda	Never Again Rwanda is a peacebuilding and social justice organization, guided by a vision of a nation where citizens, including LGBTI, are agents of positive change and work together towards sustainable peace and development. NAR aims to empower Rwandans, and especially youth, with opportunities to become active citizens through peacebuilding and development.	City of Kigali
Horizon Community Association (HOCA)	HOCA is the first organization representing LGBTI in Rwanda, mainly working with MSM.	City of Kigali
Health Development Initiative (HDI)	HDI strives to improve both the quality and accessibility of healthcare for all Rwandans through advocacy, education and training. HDI has extended experience working with the LGBTI community.	City of Kigali
My Right Alliance	My Rights Alliance promotes the rights of LGBTI, working on advocacy and access to justice and health.	City of Kigali
Safe Friendly Society	Safe Friendly Society promotes the rights of MSM; they work on advocacy and access to justice, training of healthcare providers, and research and documentation.	City of Kigali

Rights for All (RIFA)	RIFA is a non-profit organization representing lesbians and bisexual women, transmen and LBT who are sex workers, in order to improve their health and rights and protection.	City of Kigali
Rwanda Rainbow Rights	Rwanda Rainbow Rights works on capacity building of MSM to provide them with economic skills and on HIV-prevention of MSM and sex workers.	City of Kigali
Building Hope for Future	Building Hope for Future is an organization that works with transwomen and transwomen who are sex workers, in order to make sure that all transwomen have access to schooling and health, and that they can live in a society without fear of being judged.	City of Kigali
Other Sheep Rwanda	Other Sheep Rwanda is part of an international network of Christian groups from various cultures that advocate for full inclusion of LGBTI individuals in their religious communities. Other Sheep Rwanda operates from Rubavu.	Rubavu

Organizations supporting women and men

National Women Council	The National Women's Council is a forum for advocacy, social mobilization and capacity building for women and girls. It is affiliated to MIGEPROF and has structures from grassroots up to national level, and provides for women's participation in local governance.	City of Kigali
Profemmes - Twese Hamwe	Profemmes aims to contribute to the improvement of the socio-economic status of women, promoting the culture of peace for sustainable development through coordination and capacity building of member associations.	City of Kigali
RWAMREC	Rwanda Men's Resource Centre (RWAMREC) is a Rwandan non-governmental organization that aims to promote gender equality, and prevent gender-based violence through promotion of positive forms of masculinities in Rwanda.	City of Kigali
Rwanda Women's Network	Rwanda Women's Network (RWN) is a national humanitarian non-governmental organization dedicated to promotion and improvement of the socio-economic welfare of women in Rwanda since coming to being in 1997. Their core programs include healthcare and support and SGBV prevention and response, among others. RWN has a clinic in Kigali, Village of Hope. RWN's target group includes: survivors of the 1994 Tutsi genocide, victims and survivors of SGBV, as well as other vulnerable groups including poor and vulnerable women, children and people living with HIV/Aids.	City of Kigali
Community Based Nutrition Schools	The community based nutrition schools are implemented by Caritas Rwanda. The group consists of 10 members, all pregnant or lactating women, and led by one of the members. Women in the CBNS learn and exchange about balanced diets and a health living environment.	Ruhango

Ministries, government bodies and service providers

MIGEPROF	The Ministry of Gender and Family Promotion ensures that the elaboration, coordination and implementation of appropriate policies on gender equality and women empowerment, family promotion and children's rights protection are a success.	City of Kigali
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MINALOC	The Ministry of Local Government ensures the coordination of good governance and high quality territorial administration programs that promote economic, social and political development throughout the nation.	City of Kigali
RBC	The Rwanda Biomedical Center is the implementing agency of MoH. The KII was conducted with the Maternal and Child Health Division Manager.	City of Kigali
RSSB	The Rwanda Social Security Board manages the Medical Community-Based Health Insurance (CBHI) scheme.	City of Kigali
District Health Office	The District Health Office implements the central level policies in the district.	Musanze
District Hospital	The Hospital is a referral hospital, but also acting as a district hospital. It is responsible for the north part of the Western province, and part of the Northern province, serving 700,000 people.	Musanze
CHW cooperative at district level	The cooperative of community health workers at district level oversees all CHW cooperatives in the district. The cooperative works inside the community and meets once every 3 months at district level (with local government, representatives from hospitals and health centers, etc.) to discuss health issues in the district, including CBHI enrollment.	Ruhango
CHW cooperative at sector level	The cooperative of community health workers at sector level oversees all CHWs within the sector.	Ruhango

Donors

DFID	The UK Department for International Development is one of Rwanda's Development Partners, with extensive experience on gender and social inclusion.	City of Kigali
The World Bank	The World Bank is one of Rwanda's Development Partners. Even though not a major actor in the health sector, it implements a regional project on sexual & gender based violence.	City of Kigali