Gender Analysis
for USAID/Rwanda
Community Health and Improved Nutrition (CHAIN) Project
July 2014

EXTERNAL VERSION

Introduction

The government of Rwanda has made great strides in developing policies and strategies to support women's empowerment and the advancement of gender equality. Additionally, numerous mechanisms have been instituted to support their implementation. However, the existing inequalities have been ingrained in Rwandan culture and society and require persistent and consistent long-term efforts to bring about change.

This analysis identified gender issues that pose barriers to specific health outcomes, as well as opportunities to empower women and advance gender equality through health and nutrition activities.
Key findings include:

- Lack of male engagement in caregiving and domestic work is seen as a primary barrier to achieving desired health outcomes
- A woman's level of education and involvement in decision making and control of household resources are directly correlated to improved health outcomes of her family
- Social norms and stigmas are a major barrier to accessing health services, particularly for the most vulnerable people
- There are significant gaps in training and sensitization of health care providers which causes further marginalization of vulnerable populations

The recommendations specific to each Outcome of the CHAIN results framework that are detailed in the analysis should be considered when designing activities under this project The following are overarching recommendations to be considered as separate activities or across multiple activities:

- Consider commissioning a mapping of effective gender strategies to deepen and expand, as well as identify gaps in needed support.
- Highlight and support the MoH in addressing customer service issues within health facilities.
- Support MoH in building the capacity of health workers (community and professional) to provide appropriate services to the specific needs of marginalized and vulnerable groups.
- Cooperatives have proven an effective means for community education for social change and couple counseling on sensitive issues and income generating activities. Consider deepening and expanding this approach.

- Support programs and activities that engage fathers in caregiving (child feeding, supporting breast feeding) and domestic work (task shifting)

Background

The Rwanda Economic Development and Poverty Reduction Strategy II (EDPRS II 2013-2018) states that Rwanda economy will be more productive when all women and men are full participants, and when the needs of all groups with special needs are addressed. Even though women in Rwanda represent 52 per cent of the population, they do not participate fully in socio-economic and political spheres of life. Of particular relevance for some of the CHAIN project activities are the relative poverty of women, the extra workload on women, and the relative lack of economic opportunity. Child care responsibilities, and care of the sick, and cultural norms pertaining to household decision making and girls' education may also affect the proposed results[1].

A key target population for the USAID multi-sectoral nutrition strategy is pregnant and lactating women and children under age 2 aligning it with the international "first 1000 days" initiative. While women may attend activities, they do not often have the autonomy or influence within their household to follow through on recommendations. For women who do not attend the minimum number of antenatal care (ANC) visits and do not take sufficient iron/folate supplements, anemia is high. Skills transfer in the area of nutrition supports women's independence and empowerment, while sensitizing and engaging men garners their support for prioritizing nutrition interventions. Addressing decision making and gender roles at the household level could improve the effectiveness of activities under CHAIN project.

Women have a higher HIV prevalence rate than men (3.7% versus 2.2%) and female sex workers were found to have an HIV prevalence of 51%, highlighting the need to adopt project strategies for vulnerable women and girls. Key populations at risk for contracting HIV are sex workers, sero-discordant couples, and men who have sex with men. Young people aged 15-24 have also been identified as at risk, with young women significantly more at risk than young men. With high HIV prevalence among female sex workers and uncertain consistent condom use among clients, this is a group that requires targeted messages, extra assistance to access services and modification of services to better serve their needs. It will also be necessary for the CHAIN activities to consider women and girls' involvement in transactional sex, even if they are not self-identifying as sex workers.

Special focus on the girl child will be necessary considering the young age of many sex workers. The needs of young single mothers should be assessed as economic stress may push such girls

[1] Republic of Rwanda. Economic Development and Poverty Reduction Strategy 2013-2018. http://www.minecofin.gov.rw/fileadmin/General/EDPRS_2/EDPRS_2_FINAL1.pdf

into sex work. The predominately male clients of sex workers also require gender-sensitive messaging and approaches, including the consideration of many male norms that may hinder access to health care. One such example is the low level of male participation in People Living with HIV/AIDS (PLWA) support groups. Jobs in the transport industry are predominately held by men, and this may lead to casual or transactional and unprotected sexual encounters. The conditions in which truck drivers operate will be taken into consideration to ensure appropriate services.

The unmet need for family planning of 19 percent, with the poorest and least educated women those most likely to have an unmet need, needs further clarification to understand different gender dimensions. It is estimated that nearly half of all pregnancies (47%) and 40.5 per cent of all babies born in 2009 were unplanned. Family planning services are widely available but continuing barriers include insurance co-pay and non-covered medications, the time needed to go to the clinic, long waits for short consultations due to inadequate staffing and customer care, insufficient counselling and difficulty for young, unmarried women in getting access.[2] Additional barriers include misconceptions about contraception, fear of rumors about morality and religious beliefs prohibiting their use. The levels of satisfaction with different family planning choices will have a gender dimension. The location and availability of products valued by women should consider ease of access for women, and the same applies to products more likely to be purchased by men.

Education of girls continues to be an important strategy for economic growth and improved health of the population. As an example, the percentage of women who have begun child bearing between the ages of 15-19 (as teenagers) is 24.9 percent of women with no education, 6.1 per cent for women with primary education and 3.6 percent for women with secondary education[3]. Encouraging secondary education for women is a probable strategy to delay child bearing. The main challenges to improving girls' educational outcomes include high dropout and repetition rates in upper primary school; low completion and achievement rates for girls with low transition rates into secondary and tertiary education; few qualified women teachers in secondary and tertiary education especially in the areas of science and technology which implies lack of suitable role models; lack of separate facilities and infrastructure (dormitories, separate toilets, menstrual hygiene management); gender insensitivity of the teachers and a gender blind curriculum[4]. This gender analysis will try to respond to the following questions with the aim of promoting equality throughout the CHAIN project interventions:

[2] Institute of Policy Analysis and Research-Rwanda Reproductive and Sexual Health in Rwanda: A Review of the Literature, Legal and Policy Framework and Media Analysis Pamela Abbott with Lillian Mutesi, Carine Tuyishime, John Rwirahira. Unpublished report. February 2014

[3] Rwanda Demographic and Health Survey 2010. Page 76. http://dhsprogram.com/pubs/pdf/FR259/FR259.pdf

[4] Gender Equality in Teaching and Education Management: A participatory qualitative research report by PRO-FEMMES TWESE HAMWE and VSO Rwanda. 2012. http://www.vsointernational.org/Images/rwanda_gender-equality-in-teaching-and-education-management_full_tcm76-39953.pdf

1) Where are the key entry points for inclusive community health and nutrition programming for vulnerable populations?
2) What are the major socio-economic and empowerment issues for the young single mothers
3) How do traditional and cultural norms "gender roles" affect health needs, health outcomes, and nutrition for female and male populations?
4) To what extent do parents from vulnerable households have knowledge about and nutrition information for feeding their children properly?
5) How do national policies and strategies create different levels of health seeking behaviors (risk-prone and risk-averse) for vulnerable populations to access better quality of health services for all?
6) What are major gender gaps in relation to the CHAIN project that the project activities should seek to address?

Activities will need to develop more systematic mechanisms through which to engage with men and boys in addressing health issues, especially in relation to reproductive health, family planning and gender based violence.

Existing Gender Assessments

This analysis draws heavily upon several existing general and sector-specific gender analyses that have been conducted recently of the health sector in Rwanda. In addition to those cited throughout the report, the draft gender analysis done for USAID/Rwanda in 2011, the Gender Assessment of Rwanda's National HIV Response prepared by the Rwanda Biomedical Center and UNAIDS in May 2013, were also referenced.

Stakeholder Consultations

In addition to a literature review, consultations were conducted in Rwanda with GOR, NGO, CBO and community representatives over the period of June 16-24. A complete list of persons consulted is included in Annex A.

Main findings by domain

1. Laws, Policies, Regulations, and Institutional Context

The Government of Rwanda has made great strides in creating the legislative framework to advance gender equality which now require support to ensure they are effectively implemented. As an integral part of policy and legal frameworks for social inclusion, Rwanda has made a strong commitment to gender equality and the empowerment of women as clearly articulated in the National Constitution of 2003 as amended to date, which requires 30 per cent

of women representation in all public decision-making positions. Last year, Rwanda achieved 64 per cent of women parliamentarians in the National Assembly. In addition, Rwanda has ratified numerous international conventions and instruments such as the Convention on Elimination of Discrimination Against Women (CEDAW), the Beijing Declaration and Platform for Action, United Nations Security Council Resolutions 1325 and 1820, and the Universal Declaration of Human Rights.

Nationally, gender responsive laws and policies, including the National Gender Policy (2010) and the Law on the Prevention and Punishment of Gender Based Violence (GBV) (2008) have been enacted. Relevant bodies/agencies have been set up at national and decentralized levels to advance, coordinate and advocate on gender issues, women's empowerment, and the fight against GBV. These include the Ministry for Gender and Family Promotion, the National Gender cluster, the National Women's Council and the establishment of Gender Desks within the Ministry of Defense and the National Police. Directors of Planning in Government ministries have also been appointed as "gender focal points" in their respective ministries by the Prime Minister's Instruction. In 2008, Gender-Responsive Budgeting (GRB) was launched and hosted by the Ministry of Finance and Economic Planning and is aimed at strengthening institutional capacity in gender-responsive programming, planning, budgeting, policy analysis and formulation so that sufficient and appropriate resources can be allocated to gender-sensitive programs and activities. The GRB Program was since piloted in four key ministries, including the Ministry of Health, in order to make development aid more effective for both men and women and ensuring that sex-disaggregated data is available and collected adequately. In 2010, the GRB Program was rolled out to other ministries with the aim to ensure that the monitoring system is set to contribute to the successful implementation of the Economic Development and Poverty Reduction Strategies (EDPRS).

Although homosexuality is not criminalized in Rwanda, Lesbian, Gay, Bisexual, Transgender, and Intersex (LGBTI) populations continue to face stigma and discrimination in the society. Traditional gender norms promote heterosexual relationships and do not condone homosexuality. The Gender Assessment of Rwanda's National HIV Response conducted in 2013[5] pointed out that ***stigma and discrimination keep LGBTI hidden and as a result they are less likely to be reached by HIV prevention services or have access to the necessary HIV prevention tools.*** These populations report facing discrimination from health care providers and 28 percent state that they would not disclose their sexuality to a health care provider if explicitly asked during a medical consultation. Due to the high degree of felt stigma among these populations, there are implications for health service delivery for them.

[5] UNAIDS. (2013) Gender Assessment of Rwanda's National HIV Response. Kigali, Rwanda. http://www.rbc.gov.rw/IMG/pdf/gender_assessment_report_b5_fin.pdf

However, the Government of Rwanda is fully aware of the many challenges and gaps facing the promotion of gender equality and the fight against discrimination and GBV. It has therefore articulated the need for continued integration of gender equality into the development sector strategies, programs, and actions to address them in line with Vision 2020 and key strategies, such as EDPRS I 2007-2012 and EDPRS II 2013-2018. EDPRS II intends to focus on strategies that address the needs of all groups to realize rapid economic growth. It will mainstream gender and family in planning and budgeting and in all development programs/projects at national and local levels. Sector strategies and district plans will focus on interventions that reduce poverty levels among men and women, and reduce gender based violence, malnutrition and other related conflicts at both family and community level. The Ministry of Gender and Family Promotion has the mandate to assure the oversight of the implementation of gender-related laws and policies, whereas the Gender Monitoring Office has the responsibility to ensure proper monitoring and evaluation of programs and activities across development sectors in order to provide evidence-based data on gender issues for advocacy and decision-making purposes.

While Rwanda is making progress through interventions by both public and private institutions in integrating gender equality into strategies, programs, projects, and activities to promote gender equality and empower women, ***the transformative potential of policies on gender equality is limited by the deep-rooted social norms and practices within which, gender inequalities are embedded.*** However, a significant number of gender discriminatory laws have been revised, new policies and strategies have been put in place, although not exhaustively, and community education and dissemination of protective gender laws and policies have been carried out to the extent possible to challenge societal perceptions and norms. More efforts are still needed, though.

2. Cultural Norms and Beliefs

Significant cultural beliefs and gender differences emerge in knowledge and practices concerning WASH and nutrition. For example, male caregivers have been found to be less knowledgeable on these practices. This confirms the significant role and importance of addressing gender inequalities, including the involvement of men/husbands, in improving maternal and child health and nutrition. At community level, gender norms may restrict women's participation in public decision making fora, for example at cooperative meetings and at other platforms and events organized by CSOs. ***The differences in experience, skills, and confidence between men and women members need to be overtly addressed through specific interventions from the start. On-going mentoring support may be required to ensure high quality participation of women, especially young women. In all activities attention needs to be paid to the quality of women's participation.***

Many CSOs, including faith based organizations, may be run by or dominated by men. In discussions with the gender officers in five partner organizations, the cultural norms that even urban educated women impose on themselves in terms of voice and agency continue to restrain women's full participation. Some of the outputs for the CHAIN project provide an ideal vehicle for building gender sensitivity and greater gender equity first and foremost within Civil Society Organizations (CSOs). The efficacy of investing in gender integration within a CSO has been documented. CARE International found improved gender responsive programming after gender training resulting in an increase in the number of women enrolled in Internal Savings and Loan Groups (ISLG) under USAID/Higa Ubeho.[6]

In addition, the prevalence of gender based violence jeopardizes the achievement of results in all the project activities. Addressing Gender Based Violence (GBV) will require a multi-pronged approach, addressing societal and cultural norms, including male attitudes towards and female tolerance of violence, and ensuring accessibility of services. According to Rwanda's 2010 Demographic and Health Survey, 48 per cent of women have experienced physical and/or sexual violence. Overall, 56 per cent of women who are or have been married have experienced some kind of violence (physical or sexual) from their husband or partner, and 44 per cent have experienced some form of spousal violence in the past 12 months. Women who are employed and earning money are more likely to report having experienced physical violence than women who are unemployed or employed but not paid in cash. More than one in five women has experienced sexual violence (22 per cent). For 37 per cent of the women who experienced sexual violence, the first experience occurred when aged 15-19; 14 per cent first experienced it at age 10-14, and 2 per cent first experienced it before the age of 10. The existence of the GOR One-Stop-Centres for GBV with their combination of services covering treatment, counselling, and economic support is positive, but there is need for geographic expansion and programmatic augmentation.

3. Gender Roles, Responsibilities and Time Use

Women undertake the majority of care responsibilities for children, the elderly and the sick. In addition women spend more of their time on domestic duties than do men. These are well entrenched and accepted gender roles, and project activities will have to consider how to alleviate some of the burden on women, engage men more in care activities, and protect women from exploitation in this field of care.

Societal expectations, gender roles, perceptions, and preferences also shape income generating activity (IGA) choices made by women/girls and men/boys, and may limit the optimal mix of

[6] Gender Mainstreaming and Sexual and Gender Based Violence Prevention, Final report 2012, USAID/Higa Ubeho, CARE International. http://rwamrec.org/IMG/pdf/rwamrec_annual_report_for_january_2011_to_june_2012.pdf

IGA. Women widows may especially be affected by limited access to labor and gender based violence. The value of engaging more women into income-generating activities is in their subsequent ability to buy things for themselves as well as for the family. The downside of this is that they may end up overworked, trying to do all the domestic chores, farm the land and do income-generating activities. ***CHAIN activities will need to ensure gender inequities in terms of disproportionate demand on women's labor without the subsequent increases in resources are not exacerbated.***

Women work longer hours than men when account is taken of both productive and reproductive work (see Annex C for definition of terms). Men, on average, do 12.8 hours of productive work and 11.6 hours of reproductive work, a total of 24.5 hours a week. Women by contrast do an average of 14.9 hours of productive work and 29.6 hours of reproductive work, a total of 44.4 hours a week. Women perform all the domestic work, estimated at 5 hours a day for a total of 15.5 hours versus. 7 hour work day for men.[7]

There is a newer trend toward transactional sex where older men and women are abusing young boys and girls by offering to meet economic needs in exchange for sex. ***Transactional sex occurs in both poor and middle income households.*** Middle income youth are enticed into this particularly by social pressure for material items that demonstrate status. Similarly, young people are coerced into providing sexual favors for teachers and employers – believing they have no other option for advancing.

4. Access to and Control over Assets and Resources

Women are poorer than men. They head 27.8 per cent of all households in Rwanda, yet account for 47 per cent of the poorer households[8]. Women's status may influence the health and nutritional status of their children, including stunting. Their primary occupation is subsistence agriculture; 82 per cent of women work in agriculture compared to 61 per cent for men[9]. Women and people over 45 are more likely to be engaged in agricultural employment (81.8 per cent of women compared to 61.3 per cent of men). Men have moved into non-farm[10]. Men generally work in the fields only in the morning and engage in other activities in the afternoons including marketing and non-productive activities (Ministry of Agriculture 2010). ***If more women are involved in farming, and their productivity impacts the nutritional status of their family, then it will be important to have measures aimed at involving female farmers in assessing their needs and constraints; improving participation of women in extension services and farming techniques; and making new farming techniques easily accessible to women.***

[7] USAID Draft Gender Assessment 2011 (unpublished).
[8] http://www.statistics.gov.rw/publications/third-integrated-household-living-conditions-survey-eicv-3-main-indicators-report
[9] Dito
[10] Dito (page 94)

Information on women's care for their children is limited. Research to understand more about how poor rural households, women and young children in particular, can increase their consumption of iron rich foods, such as fish, eggs, meat, beans and greens, is needed. Increasing the consumption of iron-rich foods of animal origin seems particularly important for both women and young children, especially given their current low consumption. ***Because increased incomes can translate into improved nutrition especially when such resources are controlled by informed women, the activities must address the gender dynamics of information, incomes and control over these resources.***

5. Patterns of Power and Decision Making

Unequal decision making and high levels of gender based violence could affect the results of CHAIN project interventions, as these issues are associated with female disempowerment, which is linked to lower health outcomes. Twenty-five percent of married women report that their husbands make the decisions regarding their health care with nearly 74 per cent making the decisions jointly (RDHS 2010). And, less-empowered women, those who do not participate in household decisions, are slightly less likely to receive delivery assistance or post natal care from a skilled provider (RDHS 2010). A wife's involvement in household decision-making is also associated with family planning. "A woman's desire and ability to control her fertility and her choice of contraceptive methods are affected by her status in the household and her own sense of empowerment. A woman who is unable to control other aspects of her life may be less able to make decisions regarding her fertility. She may also feel the need to choose contraceptive methods that are less obvious or do not need the approval or knowledge of her husband."[11] ***Use of any contraception is lower among women who do not participate in any household decisions***, i.e. 45 per cent compared to 54 per cent (RDHS 2010). It is also related to spousal violence. Women who do not participate in any household decisions experience higher levels of spousal violence, that is, 65 per cent. When women participate in 1-2 decision it decreases to 61% and for women who participated in three decisions spousal violence reduced to 49 per cent (DHS 2010).

Attitudes toward wife beating, is an indicator of women's empowerment, since agreement that wife beating is acceptable is an indication that women generally accept the right of a husband to control his wife's behavior even by means of violence. Over 56 per cent of women, 59 per cent in rural areas believe that wife beating is justified for at least one reason; this represents a decline since 2000 when 63% of women found this acceptable (RDHS 2000; 2010). ***CHAIN project activities will therefore need to develop more systematic mechanisms through which to foster women's empowerment, as well as to engage with men in addressing health issues, especially in relation to reproductive health, family planning and gender based violence.***

[11] Rwanda Demographic and Health Survey 2010. http://dhsprogram.com/pubs/pdf/FR259/FR259.pdf

Analysis of issues and recommendations by sub-purpose

Project Problem Statement: Health inequality, which is differentiated by categories of vulnerable populations, limits human development and the ability of Rwandans to break intergenerational cycles of poverty. Moreover, economic and health inequality are mutually reinforcing and need to be addressed concurrently if the development challenge they represent is to be resolved. In order to achieve the Mission Goal of accelerating Rwanda's progress to middle income status and better quality of life through sustained growth and reduction of poverty, we must address health inequality in Rwandan society.

Project Goal: Health and nutritional status of Rwandans improved.

Project Theory of Change: If priority populations access key health products and essential services, improve their socioeconomic status and food security, and adopt positive parenting and feeding practices, they will be able to improve and sustain the health of themselves and the vulnerable individuals in their care.

Potential Gender Issues	Recommendations
Sub-purpose 1: Increased capacity of Rwandans to access and demand quality services and products	
• The low level of male participation in PLWHA support groups may impede uptake of behavior changes and health services being promoted, affecting both men's and women's health outcomes.	• Incorporate community outreach and mobilization efforts focused on men and boys. These can include: community meetings, training or sensitization activities, theater, sport and other cultural activities; marches; and mass-media campaigns using radio, television, billboards, etc. • Incorporate facility-based programs which involve health services for men, or individual and couples counseling. Ensure appropriate service structures as well as adequate provider skills and attitudes that facilitate men's access and participation.
• Young, poor women are at higher risk of contracting HIV than young men, often due to economic pressure (particularly	• Seek to identify specific barriers that young women engaged in transactional sex or the sex industry face to accessing health

within female-headed households) to engage in transactional sex or become sex workers. With minimal economic means or access to information about STIs and safer sex, these women are unlikely to access health services.	information and services. Target services to overcome these barriers. • Train providers on the importance of relevant and respectful care to all clients, including women, girls and marginalized groups. • Work with MOH to assess and improve (if needed) working conditions of providers as disrespect can stem from and/or contribute to unfavorable working conditions (lack of training, mentorship, human resources, adequate pay, adequate facilities, etc.) • The project should consider clients' preferences for either male or female health care providers. • ***Partner with the youth workforce development project*** to provide a comprehensive package of support to youth to include health information, products and service referrals. • ***Partner with the education office*** to negotiate with schools to incorporate HIV awareness into the curriculum, to seek opportunities to build self-esteem of students and raise their awareness about their opportunities for advancement, as well as to discourage and appropriately address teachers who coerce students into transactional sex.
• There is a tendency for men involved in the transport industry to engage in casual or transactional and unprotected sexual encounters, with alcohol consumption being a factor in this behavior. Due to male norms that stigmatize accessing health care and the transitory nature of their work, they are not likely to be reached by health messaging and services provided through standard means.	• The project should support innovative ways of targeting health information, products and services to mobile populations of men who engage with sex workers. The ROADS project is an excellent example of this. Consider deepening and expanding this type of work. • Consider supporting an outreach campaign aimed at mobile populations, using forms of media commonly accessed by these people, i.e. radio, road signs, etc., to inform them of the risks of unprotected sex, and the benefits of accessing health services.

• LGBTIs are also at risk for contracting HIV, but due to fear of stigmatization and/or a history of harassment within the health system, they are averse to seeking health services.	• Consider providing basic health services in a location where these people are comfortable accessing them (such as at the Never Again Rwanda center). • Consider collaborating with the Democracy and Governance office to integrate a health component into their project – raise awareness of health issues and services amongst LGBTI people, strengthen advocacy efforts, and sensitize health professionals.
• Women who do not participate in household decision making have lower contraception use rates and experience higher rates of spousal violence. Alcohol use in men is associated with higher rates of spousal violence and HIV contraction. Women who are disempowered in their relationships, particularly within sero-discordant couples are at risk of contracting HIV.	• Support programs that foster 'couple communication' to build trust, respect and joint decision making and emphasize couples testing and counselling. Consider offering social services linked to the first pre-natal appointment (where couples are mandated to attend together) to engage couples in this type of discussion. Consider including referral services for alcohol addition/issues since alcohol use has been cited repeatedly as an issue. • Support GoR program on evening dialogues for communities, which engage whole families in conversations on sensitive issues. • Support GoR in incorporating messaging into existing groups that men/boys are a part of.

• Despite surveys that show that both boys and girls have a high level of knowledge about how to contract and prevent contraction of HIV, young people aged 15-24 are among key populations at risk, with young women significantly more at risk than young men. Standard delivery of health messages, services and products may not be accessible or enticing enough to them to overcome the social pressures to engage in unprotected sex with multiple partners from an early age.	• Young people should be engaged in developing and promoting interventions to increase knowledge and reduce risk among their peers. • Garner community support for school-based interventions; consider collaborating with the Education Office to offer club-like programs for youth both in and out of school.
• Women are primarily responsible for maintaining the health of family members and providing water for consumption. Women's (particularly poor women) ability to do this is limited because they are overburdened with household chores and caregiving, limiting their mobility and exposure to services and products. Additionally, they have minimal access to financial resources to invest in preventative measures that may reduce their burden and improve family health.	• Ensure that health messaging and services are offered at a time and through a means that target women can access them. This will require a micro-level understanding of women's movements in target communities and through which means they obtain information, the times of day and locations most convenient for women to obtain services – require implementers to conduct micro-level gender analysis. • Include woman-friendly financing options for health products – seek advice from the Economic Growth Office when designing such activities.
• Poorest and least educated women are most likely to have an unmet need for modern contraception, and with a low level of priority given to this by their husbands, who make the majority of decisions regarding their wives' health care, these women are unlikely to receive the products and services they	• Review strategies to consider how men and women/boys and girls are involved in the decisions on choice and utilization of contraceptives. The Pyrethrum cooperative in Musanze has developed effective strategies for community education and couple counseling on sensitive issues and income generating activities - they could be tapped for

need.	cross-visits to engage other communities. • Support activities that engage religious and community leaders to emphasize prioritization of health care – use of services and products and healthy behaviors; seek opportunities to council men on the importance of their involvement in family planning and health care.
• Religious beliefs and social norms stigmatize young and unmarried women who access family planning, reducing their uptake of these products and services. Additional barriers include insurance co-pay and non-covered medications, time needed to go to the clinic, poor customer service, long waits for short consultations, insufficient counselling and disrespectful attitudes of health care provider toward this population.	• Seek male religious and other community leaders and well-known role models to speak publicly in support of gender equality, human rights, and women and girls well-being, to act as agents of change. • Identify and adopt effective strategies for increasing the funds that women have to spend on health care • Work with GoR to address working conditions of providers including facility, human resources, appropriate training and leadership, etc.
Sub-purpose 2: Improved protection of vulnerable populations against adverse circumstances	
• Women's time deficit combined with social norms limiting their mobility reduces their participation in socio-economic and political spheres of life, leaves them with minimal capacity to engage in economic opportunities and limits their role in group decision-making and leadership processes. • Social norms limit men's engagement in caring for their children. However, when men are sensitized to the value of their participation in child care, their effort has the added effect of freeing women's time to engage in livelihood activities that improve the nutrition of the family.	• Ensure business and marketing skills training is women/family friendly (e.g. training for women by women) and done at convenient times, in safe and convenient venues. • Differentiate interests of and barriers for young and old, men and women in IGAs and micro business opportunities • Consider ways to mitigate potential violence against women getting higher incomes than their male partners • Consider how to target female headed households and households with single mothers and widows and to increase their access to key resources, including credit • Value added activities should be initiated, to the extent possible, within women's homes or within convenient reach of their homes, while initiating a social change process that both extends women's

	mobility and increases men's involvement in support for domestic duties. • Consider working with male leaders to talk to men/fathers about the value of fathers in childcare and develop actionable tasks that fathers can engage in (or train men to deliver these messages or create groups that are accessible to men at times convenient to them)
• Women tend to be relegated to the low end of value chains. They also have limited access to extension services and improved farming techniques, leaving them with sub-optimal production levels, resulting in lower nutritional contribution to the family diet.	• Ensure that women and vulnerable groups are not excluded from accessing and using equipment or technologies that are introduced for improved agricultural production and consider ways to introduce technology specifically for women. • Increase awareness of possible inequalities with regard to inheritance practices affecting women and orphans; and mechanisms to address these e.g. loss of farming assets
• Community groups focused primarily on information sharing are minimally attended by men. However, cooperatives with an economic component tend to attract both men and women, providing a forum for reaching men with health and social messages.	• Support activities to develop and use gender relevant training products and core gender modules in cooperatives and other community groups to build gender awareness • Activities should promote gender equality in leadership and governance of groups and encourage greater participation of women in leadership roles and when necessary provide training of women for leadership positions • Consider supporting expansion of the cooperative strategy used by Rwanda Pyrethrum Project Pyramid 2 that promotes equality within the group, household and community through community education and women's economic empowerment. The group members suggested cross visits to other communities to share their strategy, and taking their theatre troupe on the road to start raising awareness with neighboring communities.

• Women undertake the majority of care responsibilities for children, elderly and the sick. With minimal resources and few options for child care, women take children with them when they labor in the fields, where they are unable to properly provide for their needs.	• Ensure that care and support practices address women's time and knowledge constraints and other barriers that affect their capacity to care for their children • Ensure adequate consideration is taken of the needs of children for space and safety in homes, day care centers and other caregiving facilities
• Male participation in community groups and evening dialogues is low because they prefer to use that time to drink with their friends[12]. Reducing alcohol consumption and engaging men in dialogues on social issues will have a positive effect on the health and well-being of the entire family.	• Support approaches that use affirming messages underscoring the positive roles men and boys can play to improve their own health and in support of the health and rights of women, girls and communities at large.
• Due to stigma, lack of knowledge and social norms around people with disabilities they do not receive adequate/appropriate care. In urban areas people with disabilities are hidden from society; in rural areas they are exploited as leverage for begging. They are also not afforded proper protection against sexual exploitation and their resulting health needs are neglected.	• Support incorporation of disability issues into the GOR evening dialogues program to raise awareness of the health needs and proper care for people with disabilities, as well as to reduce stigma and exploitation.

[12] Testimony from FXB-supported cooperative members

• Girls often suffer low self-esteem, have few role models demonstrating a positive future and are marginalized by gender-insensitive messaging and teaching methodologies. These factors, among others, make them particularly susceptible to risk factors for dropping out such as sexual abuse, pregnancy and lack of prospects for future employment. • Parental involvement in schools improves the retention and success rate of their kids. Widows may especially be affected by heavy workloads making it difficult for them to participate in school activities. Labor constraints may also compel them to pull their children from school to help at home.	• Support programs to empower women and girls to improve self-esteem, build negotiation skills, and train in public participation. • Support activities that identify and address gender specific risk factors for school drop outs • Ensure projects consider gender roles and possible gender stereotyping in the different educational opportunities, especially at secondary and post- secondary level, and build capacity of youth especially young women to get employment or generate an income after studies are completed. • Careers counselling and screening of applications for vocational and other training must consider gender dimension, especially for women and men in non-traditional skills and greater emphasis on women and vulnerable groups in wage employment • The sex-disaggregated impacts of training e.g. types of employment obtained will be tracked • Ensure a local understanding of the different barriers of boys and girls to school enrollment and retention and success
• Sexual and domestic violence is rampant and jeopardizes school retention rates, reduces labor productivity, and increases the risk of HIV contraction and other health issues. Alcohol abuse is often a factor in sexual violence.	• Support projects that foster alternative ways for men to resolve conflicts within the household through promotion of positive norms for masculinity • Address the vulnerabilities to HIV inherent in intimate partner violence

• Poverty and the desire for material objects that bring social status, as well as the predatory nature of some adults, lead young boys and girls into transactional sex. Additionally, girls in particular are susceptible to coercion by teachers into sexual activity in exchange for high marks. The emotional and physical consequences of this often lead students to drop out of school.	• Consider supporting reproductive health programming for adolescent and pre-adolescent girls and boys that addresses sexual coercion and abuse and promotes elements of healthy relationships. • Support efforts to raise awareness in schools, families and the community at large on the plague of sexual coercion of youth and engage them in devising strategies for reducing the extent of the problem.
Sub-purpose 3: Increased nutrition knowledge and adoption of appropriate nutrition practices	
• Women's status in the household and community is linked to the health and nutritional status of their children, including stunting. Although women may have knowledge about nutrition, if the husband is not also aware of good practices and/or does not prioritize them, a woman with low status will not be able to apply those practices – selling rather than eating the nutritious foods that are available. • Increased incomes can translate into improved nutrition especially when such resources are controlled by informed women. • Women do a significant portion of the agricultural work in Rwanda, yet have limited access to inputs such as credit, extension services and labor saving devices relative to men. The resulting lower productivity rates effects the nutritional status of women and children. Men, believing their labor is heavier and requires them to consume more calories than women, use their income to supplement their diets (with prepared food from the market) without providing the same	• Support activities that seek to identify and adopt contextually effective strategies to engage men in supporting their wives and children's nutrition and health needs • To the extent possible, project should ensure a gender balance when hiring extension agents to help implement the activities • Ensure that implementers have a good understanding of community dynamics including gender, age, powerful individuals etc., that will drive adoption of new techniques, and thus how best to articulate messages to community members – including language, format, key concerns. • Project implementation should include a target group analysis to understand constraints in use of services by women and vulnerable groups • The project should ensure that consideration is given to possible lack of labor in female headed households and children's and young people's involvement in household labor, and use appropriate mitigation measures where necessary

for their families.	
• While women are responsible for water and hygiene within the household, they are rarely engaged in decision making at the household or community level related to resources needed to provide safe water or facilities for hygiene. Women's financial resources and time burden, as well as men's limited knowledge about these issues within the household perpetuate unhealthy practices.	• Support efforts to disseminate information on good WASH practices at the community and household level (through community health workers, cooperatives/associations, schools) through means attainable by (illiterate) women. • Raise awareness amongst community leaders and men about the need to prioritize improved water and hygiene and to engage women/caregivers in decision making about these facilities.
• Women's lack of education, low level of literacy and disempowerment in their homes and communities contributes to their inability to properly care for their children. Women have limited access to information about proper nutritional practices, relying heavily on community health workers, who are reportedly providing misinformation (i.e. encouraging early supplementation).[13] • Stigmatization of caregivers of malnourished children by community health workers and health center staff further disempowers women and leads to long-term consequences of malnutrition as caregivers avoid contact with health workers[14]. Inability of women to fulfil this caregiving responsibility can also be a trigger for abuse by their	• Support campaigns via means targeting both rural and urban populations, which could include community education sessions, radio and social media that address stigma and misinformation, provide guidance on good practice – giving women information through multiple mediums that they can access. o Supported campaigns should also encourage male involvement and positive attitudes among health care professionals. • Support efforts to provide health care workers with comprehensive training on infant and young child feeding (IFYC), as well as sensitize them to the negative effects of stigmatization of mothers of malnourished children.

[13] Engaging Rwandan families to ensure feasible and effective infant and young child feeding recommendations: A report of their trials of improved feeding practices. USAID/BASICS 2009
[14] Partners in Health. February 2014. Stigma and Malnutrition: Insights from Qualitative Study of Childhood Malnutrition Programs in Southern Rwanda

husbands.	
Sub-purpose 4: Improve performance and engagement by CSOs and GOR entities	
• Internal financial and staff capacity to mainstream gender within the CSOs and GOR entities and integrate gender perspectives into their external approaches may be limited • Many GOR and CSOs entities, including faith-based organizations, may be run by or dominated by men. • Cultural norms and beliefs that women, including educated ones, impose on themselves in terms of voice and agency continue to restrain women's full participation in public and private decision-making fora • Lack of capacity building and focused gender training for CSOs and GOR entities to enhance staff's knowledge and skills on gender issues in their respective fields of interventions • Women and men in the community and associations/cooperatives have differences in experience, skills, and confidence.	• Seek opportunities to strengthen appropriate service structures as well as adequate provider skills and attitudes that facilitate men's access and participation. • Seek male religious and other community leaders and well-known role models to speak publicly in support of gender equality, women's empowerment, human rights, and women and girls well-being, to act as agents of change. • Include assessment of potential gender bias in and gender stereotyping in all social and behavior change communication materials • ***Consider partnering with the Democracy and Governance Office*** to support opportunities to promote gender equality in leadership and governance of groups and encourage greater participation of women in leadership roles, and when necessary provide training of women for leadership positions • Ensure projects are advancing gender equality through their capacity building support: o provide gender training for relevant extension workers o female trainers used whenever possible to serve as role models for stakeholders o use gender relevant training products and core gender modules in Internal Savings and Loan Groups (ILSG) to build gender

	awareness o train groups/associations' members on gender equality and women's empowerment emphasizing men and women working together to change their socio-economic conditions and promote joint decision-making at the household level o additional training for women to increase their skill level to be comparable to that of men within the areas of focus of the association/cooperative
• Women's low status, limited education and lack of self-esteem prevent them from voicing their concerns about the health care system. Rather, they stop using health services. • Women's limited role in community organizations, particularly at the leadership level, combined with men's minor role in family health care and nutrition, minimizes these issues in forums advancing community concerns.	• Ensure that the cooperatives, associations and other community groups supported are organized to be inclusive of women. This may mean providing additional support to women to build their skills and esteem to be able to effectively voice their perspectives and concerns and advance their priorities within community groups. ***(Health, Education, Economic Growth, Democracy and Governance collaboration)***

Additional Recommendations and opportunities for Mission Consideration

- Ensure project implementers document any consultation process demonstrating the inclusion of women and vulnerable groups, including orphans and people living with HIV
- Consider commissioning a mapping of health activities in Rwanda that have been particularly effective in engaging men to bring about positive social change related to gender norms. Many government, NGO and CBO activities are addressing the issues identified above. A mapping of these activities will identify effective strategies to deepen and expand, as well as gaps in needed support.
- Consider conducting a study to gather more information on how gender inequality in Rwanda affects women's and children's nutrition and health status
- Support GOR efforts to collect and analyze data on people living with disabilities in Rwanda, to more accurately reflect the breadth and scope of the disabled population and their needs. Following this, support efforts to train health workers to appropriately address the specific needs of people with various disabilities.
- During stakeholder consultations, community and NGO representatives repeatedly raised the issue of insensitive and disrespectful health care workers. However, MOH and health facility workers did not seem to be aware of this issue. Nor were they aware that fees associated with health care (such as transport costs, insurance co-pays and out of policy medications, as well as long wait times that resulted in lost labor) were a barrier to people accessing health services and products. Consider working with the MOH to conduct an audit or customer satisfaction survey to identify challenges and measures to address them.
- A number of the recommended strategies to address the gender issues relevant to this project overlap with other sectors under the Mission's scope. Likewise, the outcomes of this project may be enhanced by interventions undertaken by other sectors. When designing activities, consider engaging with the relevant sectors to develop an integrated approach.
- Sex disaggregated data should be collected in project monitoring wherever possible. At a minimum, all indictors where individual are counted (e.g number of people doing…) should be sex disaggregated. This is a best practice, a potentially useful management tool to determine who the project is reaching, and of potential use to the GoR, which is trying to increase capture of sex disaggregated data in the context of monitoring the *National Gender Strategy*. Whenever possible, indicators should also seek to monitor the project's impact on improving gender outcomes.
- The findings of this analysis should be incorporated into each implementing mechanism issued under this project. If the scope of any planned activities changes significantly, an update to this analysis is recommended. This analysis may be annexed (minus procurement sensitive information) to the relevant procurement documents so that offerors can respond accordingly in their proposals. Once the activities move to implementation, recommendations should be reviewed again with stakeholders and experts. Specifically, it is recommended that the main Request For Proposals and Applications require the implementing partner to

conduct a gender analysis as part of baseline activities and then integrate those findings into their work plan.

Annex A : Stakeholders consulted

Organisations
National Children's Commission
Ministry of Local Government
Rwanda Biomedical Centre (RBC)
Rwanda Men Resource Centre
Gender Monitoring Office
Never Again Rwanda/USAID supported activity
Lesbian, Gay, Transgender, Bisexual associations
Health Development Initiative
Ministry of Health
USAID- funded Rwanda Pyrethrum Program
Ruhengeri Hospital
Handicap International
USAID-funded Biodiversity Conservation activity
USAID-funded Dairy Competitiveness Activity
USAID-funded Society For Health activity
USAID-funded Family Health Program
USAID-funded Integrated Health Systems Strengthening activity
USAID-funded Higa Ubeho activity

USAID-funded Ubaka Ejo activity
USAID-funded FXB Rwanda
USAID/Rwanda
USAID/E3/Washington

Annex B: Resources

USAID/Rwanda Gender Assessment. December 2011
http://pdf.usaid.gov/pdf_docs/pnadz185.pdf

Linking Sexual and Reproductive Health and HIV: a case study from Rwanda. Gateways to integration. A glimpse of the future: eliminating new HIV infections among children and keeping their mothers alive. 2013.
http://www.emtct-iatt.org/wp-content/uploads/2013/09/Rwanda_case_study_final.pdf

Annex C: Gender Term Definitions

Female Empowerment: When women and girls acquire the power to act freely, exercise their rights, and fulfill their potential as full and equal members of society. While empowerment often comes from within, and individuals empower themselves, cultures, societies, and institutions create conditions that facilitate or undermine the possibilities for empowerment.

Gender Equality: Concerns fundamental social transformation, working with men and boys, women and girls, to bring about changes in attitudes, behaviors, roles and responsibilities at home, in the workplace, and in the community. Genuine equality means expanding freedoms and improving overall quality of life so that equality is achieved without sacrificing gains for males or females.

Gender Integration: Identifying, and then addressing, gender inequalities during strategy and project design, implementation, and monitoring and evaluation. Since the roles and power relations between men and women affect how an activity is implemented, it is essential that project managers address these issues on an ongoing basis.

Gender-Sensitive Indicators: Point out to what extent and in what ways development programs and projects achieved results related to gender equality and whether/how reducing gaps between males/females and empowering women leads to better project/development outcomes.

Reproductive work: Childbearing/rearing responsibilities, and domestic tasks such as water and firewood collection, cooking and cleaning as wealth as caregiving, done by women, required to guarantee the maintenance and reproduction of the labor force. It includes not only biological reproduction but also the care and maintenance of the work force and the future work force (infants and school-going children).

Productive work: Work done for pay in cash or kind. It includes both market production with an exchange-value, and subsistence/home production with actual use-value, and also potential exchange-value.