REPUBLIC OF RWANDA

GENDER PROFILE IN THE HEALTH SECTOR

GENDER MONITORING OFFICE

OCTOBER | 2018

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I. INTRODUCTION

Rwanda aspires to be a middle-income economy by 2020, an upper middle-income country by 2035 and a high-income country by 2050. For this to be achieved, the country has invested in improving the health status of its population to enable them effectively participate and contribute to the country's socio- economic transformation journey.

The Health sector recorded tremendous achievements including improved access to health care, increased life expectancy, decline of infant, child and maternal mortality rates as well as improved use of family planning methods. It's important to highlight that such achievements are attributed to increased community health insurance coverage, role of community workers, increased number of health facilities and health professionals that enabled easy access to health care services.

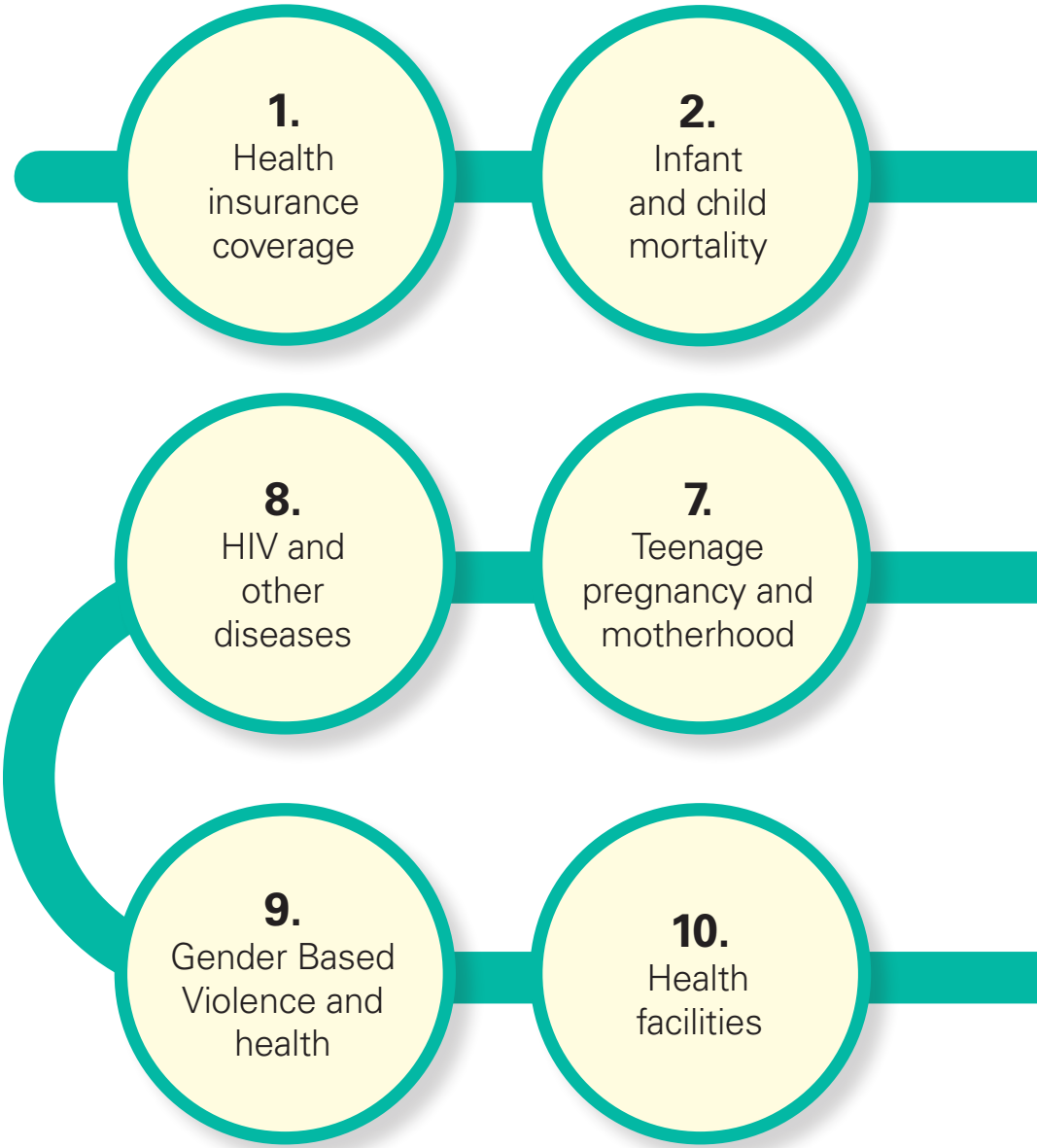
The Gender Monitoring Office (GMO) developed a Gender profile in the health sector to inform gender responsive decision-making, stakeholders evidence based planning, gender responsive programming, evidence based advocacy and enhancement of gender accountability within the Health Sector.

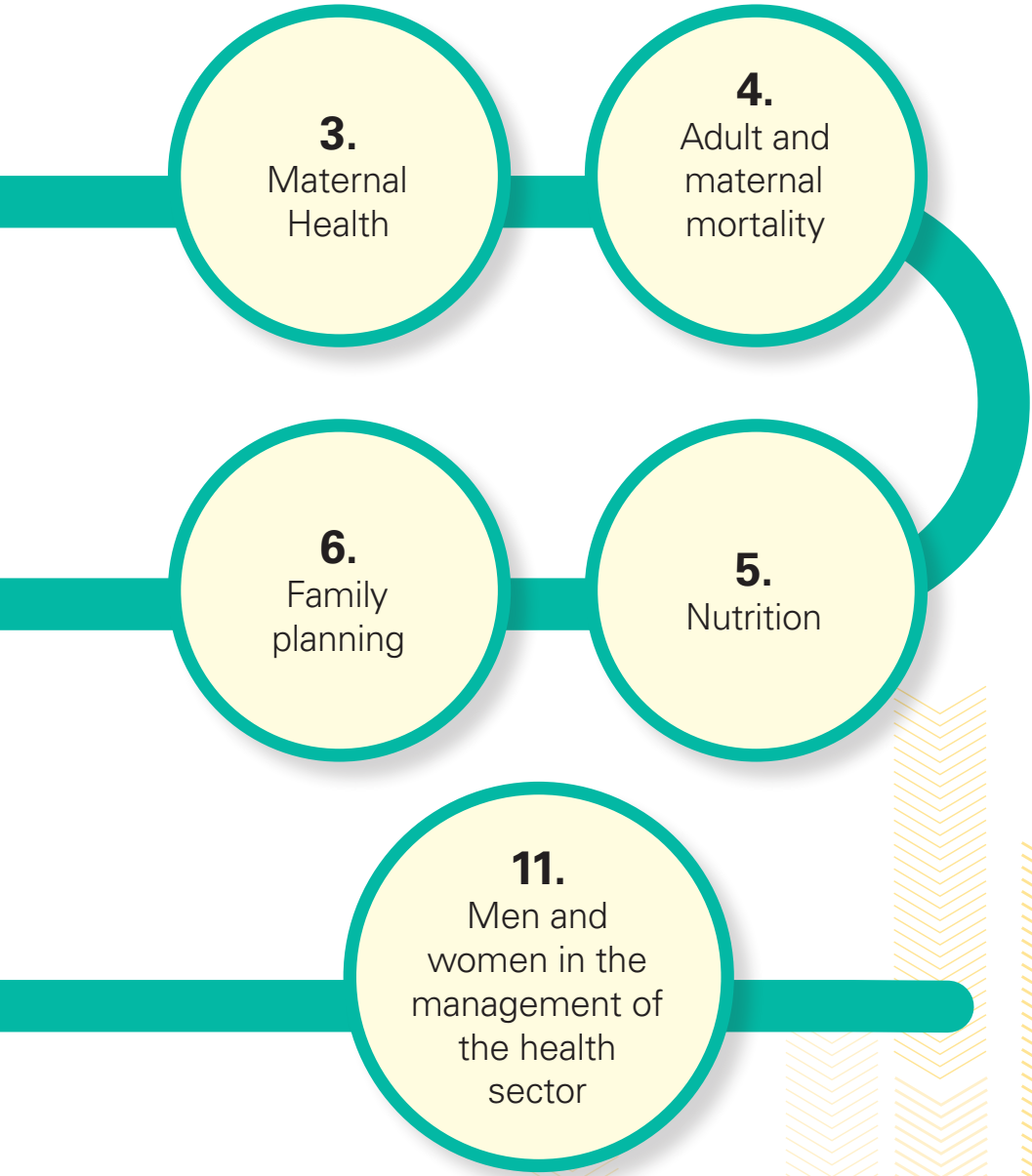
This profile contains quantitative and qualitative data and information on key selected indicators and contains data and information from nationally recognized sources and surveys with a special focus on Rwanda Demographic and Health Survey and Health Information Management System (HMIS).

GMO appreciates the engagement of key national stakeholders, technical support of IPAR and contribution of development partners especially the Belgian Embassy and the Belgian Development Agency (Enabel) who technically and financially supported the development of the current profile.

The Gender Monitoring Office commits to continue tracking accountability to gender equality in the health sector and avail user friendly information to guide gender responsive programming, decision making and delivery on gender commitments as enshrined in the health strategies, SDGs and National strategy for Transformation.

INDICATORS


1.
Health insurance coverage
2.
Infant and child mortality
8.
HIV and other diseases
7.
Teenage pregnancy and motherhood
9.
Gender Based Violence and health
10.
Health facilities


3.
Maternal Health
4.
Adult and maternal mortality
6.
Family planning
5.
Nutrition
11.
Men and women in the management of the health sector

II. LEGAL, POLICY AND DEVELOPMENT FRAMEWORKS

- **National Strategy for Transformation (NST):** The Strategy provides for gender equality and family protection as prerequisites to achieving equitable and sustainable development. It also underlines that Gender Equality is one of the cross-cutting areas through all development sectors.

- **Health Sector Policy (2015):** The policy commits that the ministry of Health shall involve in several inter-sectoral activities that include fighting against malnutrition, promotion of early child development, adolescent reproductive health and family hygiene, and fighting against Gender-based violence among others.

- **National Gender Policy (2010:** The policy envisages to creating an environment where both men and women equally contribute to and benefit from all opportunities and services.

- **The National Community Health Policy (2015):** Promotes gender Equality and Equity in Community Health promotion and highlights that both men and women need to be more involved and share responsibilities for scaling up community health prevention and care activities.

- **The Family Planning Policy (2012):** Provides that women and men shall have access to quality Family Planning services not only as a service, but as a fundamental human right. Women and men shall have access to the widest possible range of safe and effective Family Planning methods and fully participate in defining Family planning services they need.

- **Fourth Health Sector Strategic Plan 2018-2024 (HSSP IV):** It 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. It therefore provides that the health sector will eliminate gender barriers to receiving essential health services.

- **Third Health Sector Strategic Plan July 2012 – June 2018:** The Third Rwanda Health Sector Strategic Plan (HSSP III) provided strategic guidance to the health sector for six years, between July 2012 and June 2018. Its priority interventions included enhancing maternal and child health, improving community accessibility to health services, as well as ensuring provision quality health services.

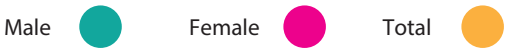
- **National Accelerated Plan for Women, Girls, Gender Equality & HIV (2010-2014):** The Plan identifies priority actions to address specific challenges, gaps, and barriers which increase women and girls' vulnerability to HIV in Rwanda and also sets ambitious targets aimed at addressing the specific needs and rights of women and girls in the context of HIV.

- **Law N° 21/2016 of 20/05/2016 Relating to Human Reproductive Health:** Provides that all persons have equal rights in relation to human reproductive health and that no person shall be denied such rights based on any form of discrimination. The law also provides that a pregnant woman, a woman who has given birth and a new-born have the right to be cared for so as to ensure their well being.

III. GENDER STATUS IN HEALTH SECTOR

1. HEALTH INSURANCE COVERAGE

	2013/2014			2016/2017		
% of population with Health Insurance	69.4	70.5	70	73.4	74.5	73.9
Community Health Insurance (Mutuelle de Santé)	93.4	94.5	94.0	92.8	94.2	93.5
RSSB/ RAMA	4.7	4.0	4.4	4.6	3.9	4.3
MMI	0.9	0.6	0.8	1.4	1.1	1.2
Employer	0.5	0.4	0.4	0.2	0.2	0.2
Other Insurance	0.5	0.5	0.5	0.9	0.7	0.8



Source: *EICV4, 2013/14, EICV5, 2016/17*

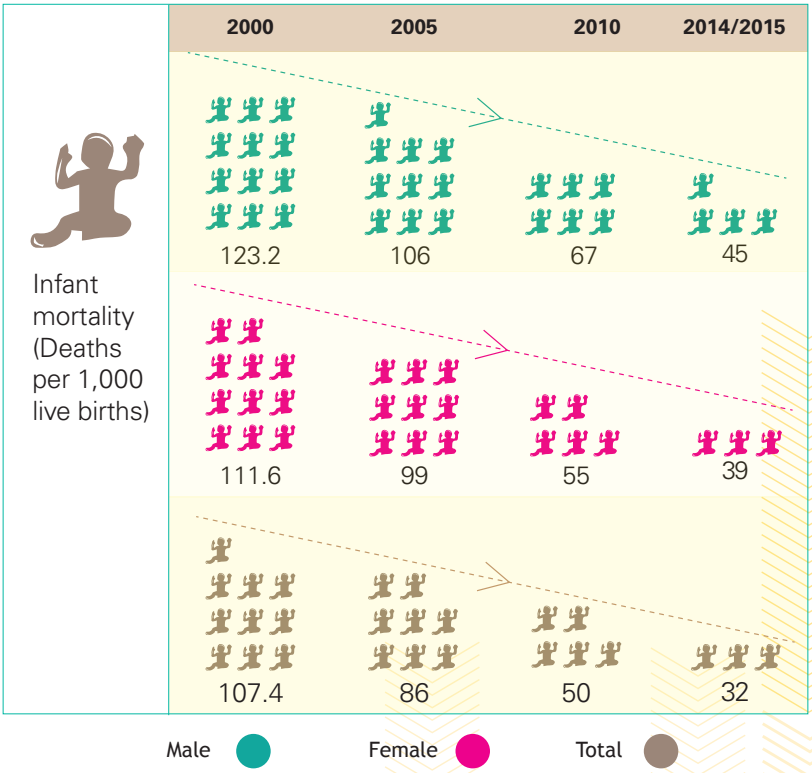
Male and Female access to health insurance increased from 70% in 2013/14 to 73.9% in 2016/17. The use of community health insurance (Mutuelle de santé) that covers most population in Rwanda, has greatly contributed to community access to improved health care and services. Most especially by women and children which greatly reduced the rates of maternal and infant mortality in Rwanda.

2. INFANT AND CHILD MORTALITY

Infant and Child Mortality has substantially declined nationally in the past 10 years as demonstrated below with observed drop for both males and females. The decline is attributed to the implementation of integrated management of childhood illnesses in all health facilities, exclusive breast feeding, aggressive immunization, increased community health coverage which guarantees easy and affordable access to health care as well as the introduction of National Community Health Worker (CHW) Program with timely follow up, reporting and referral to ensure timely management and treatment of child diseases.

a. Infant mortality

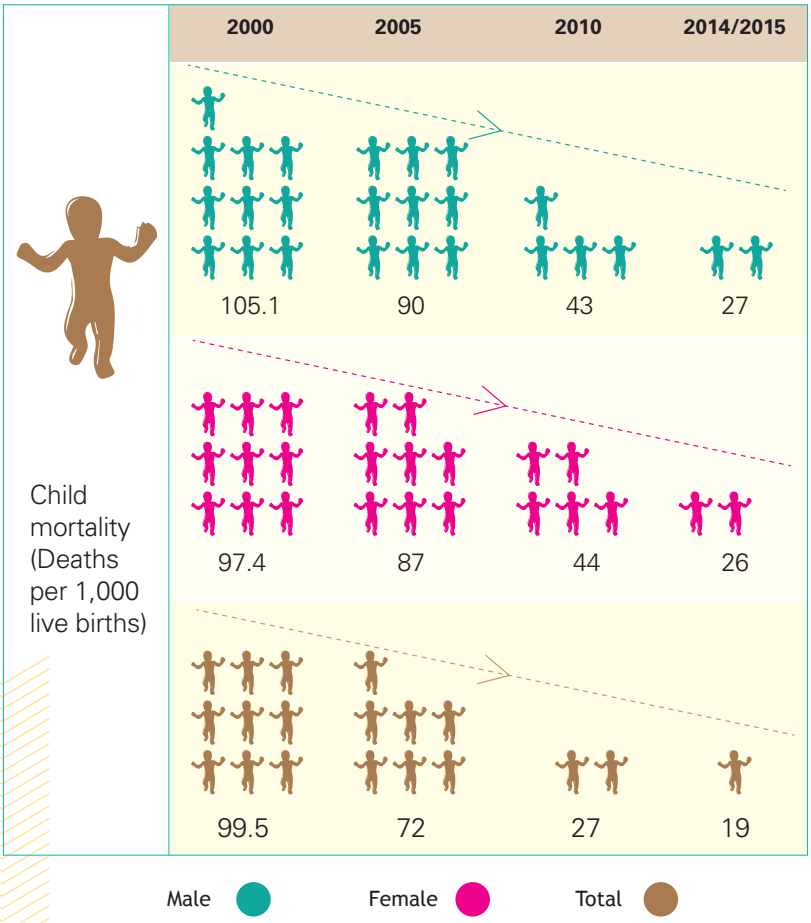
(The probability of dying between birth and the first birthday)



Source: *Rwanda DHS 2000, 2005, 2010 and 2014/15*

b. Child mortality

(The probability of dying between the first and the fifth birthday)



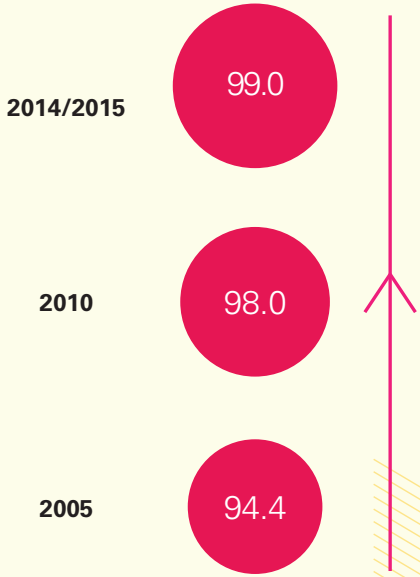
Source: *RDHS 2000, 2005, 2010 and 2014/2015*

3. MATERNAL HEALTH

a. Women receiving antenatal care from a skilled provider

Monitoring of pregnant women through antenatal care visits helps to reduce risks and complications during pregnancy, delivery and the post-partum periods.

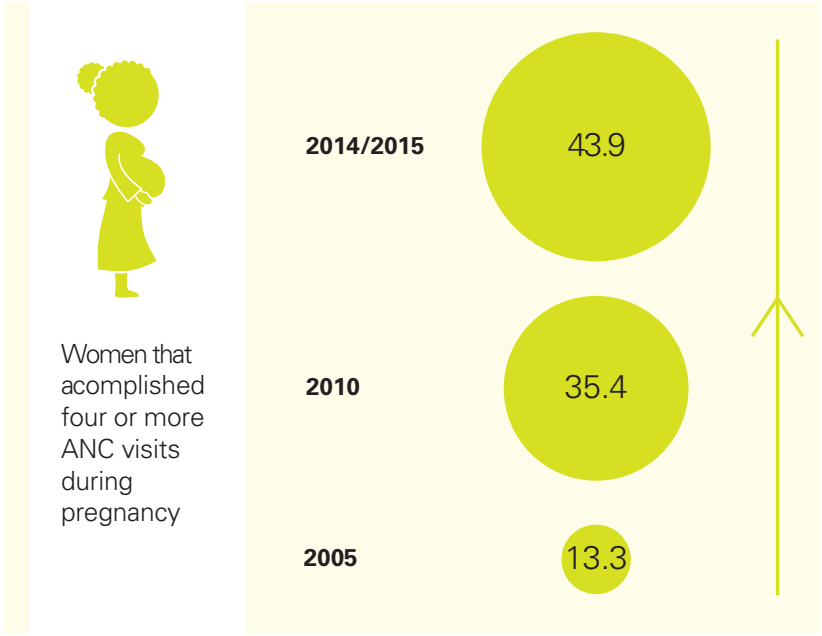
Percentage of women receiving antenatal care from a skilled provider



Source: *RDHS 2005, 2010 and 2014/2015*

Women receiving Antenatal Care from a Skilled Providers at least once during pregnancy have kept increasing over the last 10 years. This is attributed to increased coverage in community health insurance scheme (Mutuelle de santé), increased skilled birth attendants, as well as the role of community health workers who follow pregnant women from early pregnancy to delivery.

b) Antenatal visits for pregnancy (4+ visits)



Source: *RDHS 2005, 2010 and 2014/2015*

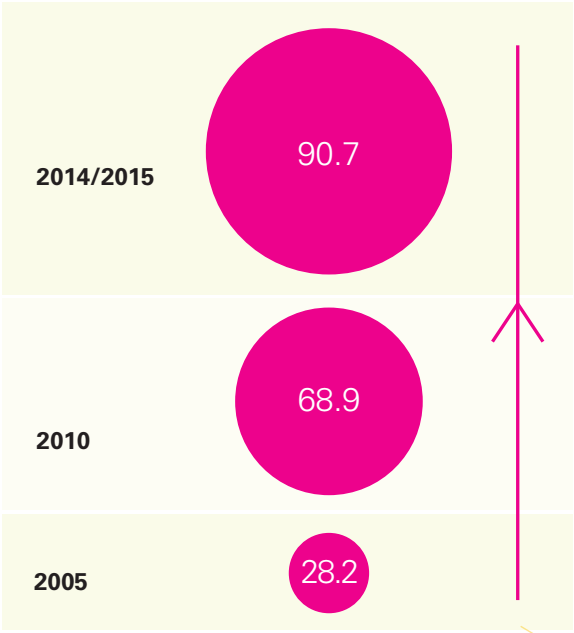
Although almost all Rwandan mothers (99 percent) receive antenatal care, the number of women completing at least four ANC visits as recommended by the World Health Organization (WHO) and the Ministry of Health remains few.

More efforts are therefore needed to continue mobilizing women on the benefits of antenatal consultations and encourage them to accomplish at least four required ANC visits during pregnancy through community forums such as Parents' Evenings (Umugoroba w'Ababyeyi).

c) Delivery care

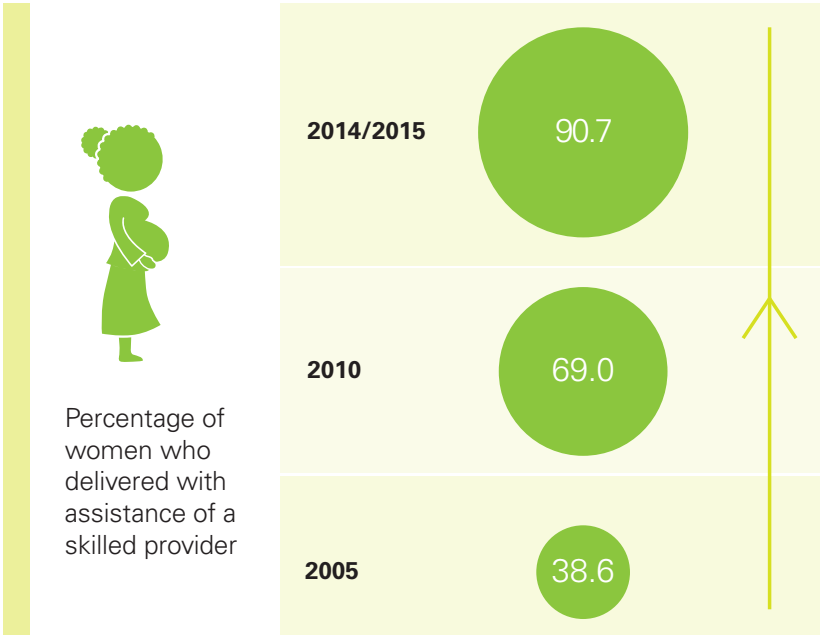
i) Women who delivered in a health facility

Percentage of women who delivered in a health facility



Source: *RDHS 2005, 2010 and 2014/2015*

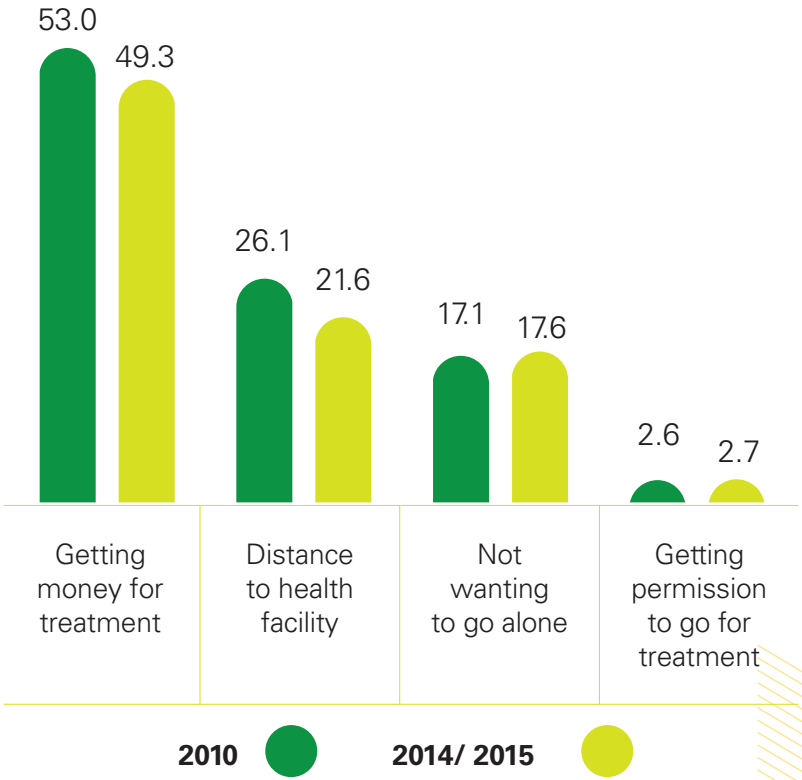
ii) Women assisted during delivery



Source: *RDHS 2005, 2010 and 2014/2015*

The proportion of women delivering in a health facility and assisted by a skilled provider has remarkably increased. This achievement is due to government commitment to support child and maternal health programs, increased health infrastructure, the use of RapidSMS system – whereby community health workers use mobile phones to monitor mothers and new born babies, and continuous capacity building for health service providers.

iii) Reported barriers preventing women's access to health care services

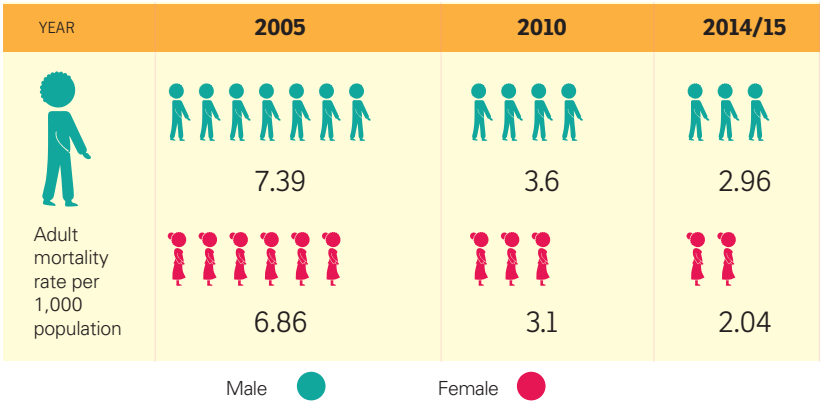


Source: *RDHS 2010 and 2014/2015*

Lack of money and distance to the health facility were reported among the top issues limiting women's access to health care services. However, this trend keeps reducing thanks to women's improved access to health insurance, existence of health centers/ health posts and contribution of community health workers.

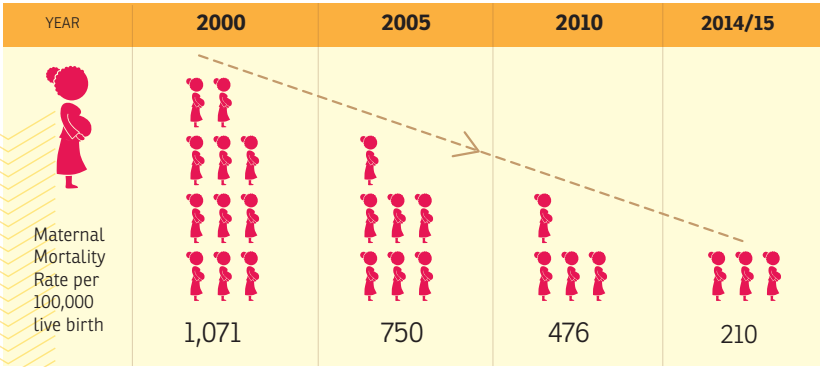
4. ADULT AND MATERNAL MORTALITY

a. Adult mortality



Source: *RDHS 2005, 2010 and 2014/2015*

b. Maternal mortality

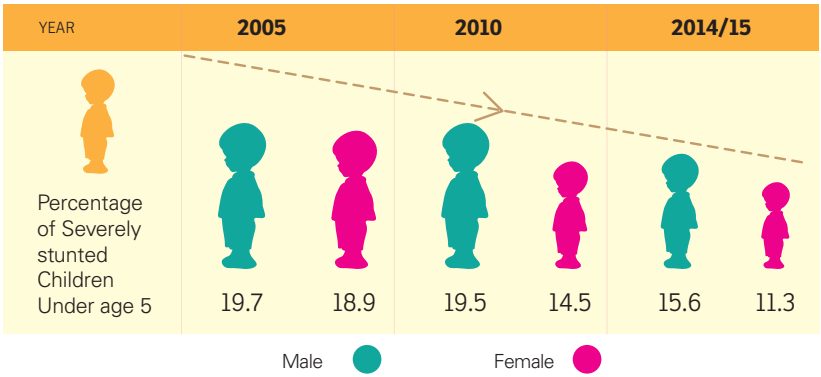


Source: *RDHS 2000, 2005, 2010 and 2014/2015*

The maternal mortality ratio reduced from 1,071 in 2000 down to 210 in 2014/2015. This reduction is attributable to institutionalization of maternal death audits, the role of community health workers, skilled birth attendance as well as strengthened capacity of health professionals to deliver quality Health services.

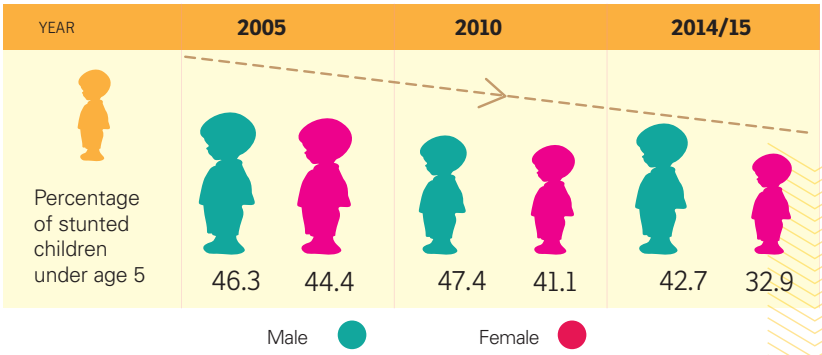
5. NUTRITION

a) Severely stunted children under age 5



Source: *RDHS 2005, 2010 and 2014/2015*

b) Stunted children under age 5



Source: *RDHS 2005, 2010 and 2014/2015*

Nutritional status of children under age 5 is an important measure of children's health and growth and consequently a country's future. While the stunting prevalence remains high, this has long-term effects on child development, school achievement and economic productivity in their adulthood.

The scale up and implementation of the ECD model, Policy and Strategic Plan at national and decentralized levels is therefore highly required to ensure accountability of the sectors for child development to secure Rwanda's future.

6. FAMILY PLANNING

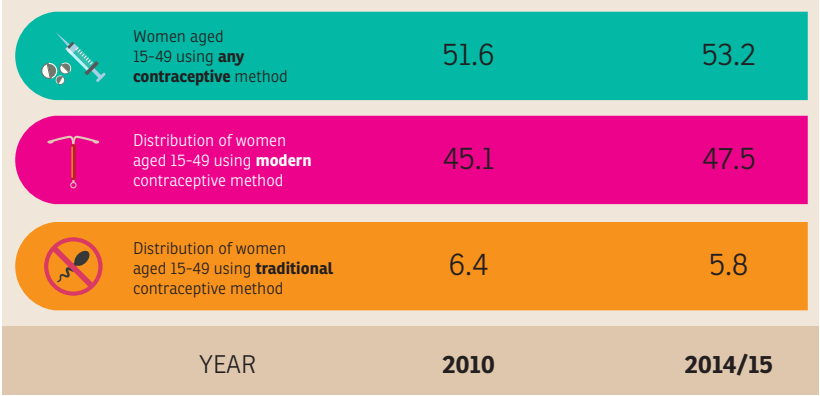
a. Knowledge of contraceptive methods

YEAR	2005	2010	2014/15
Percentage of women and men aged 15-49 who know any contraceptive method	98.1	99.5	99.8
Men	94.9	99.3	99.5
Women			

Source: *RDHS 2005, 2010 and 2014/2015*

Acquiring knowledge about fertility control is an important step toward gaining access to and use of a suitable contraceptive method in a timely and effective manner. Knowledge of contraception methods is nearly universal among both women and men in Rwanda thanks to community based health initiatives like FP education programs at health centres.

b. Family planning use among Rwandan married women



Source: *RDHS 2010 and 2014/2015*

Use of modern contraceptive methods among all women has increased from 15.2% percent in 2005 to 27.8 percent in 2015. This has given women more opportunities to comfortably perform income generating activities and other responsibilities.

c. Male engagement in family planning (%)

YEAR	2012	2013	2014	2015	2016
Use of Condom	29,553	37,706	39,374	36,284	39,398
Vasectomy	2,394	3,120	3,090	2,955	3,309

Source: *Ministry of Health, HMIS*

The involvement and participation of men in family planning remains marginal; especially for the use of vasectomy.

7. TEENAGE PREGNANCY AND MORTHERHOOD

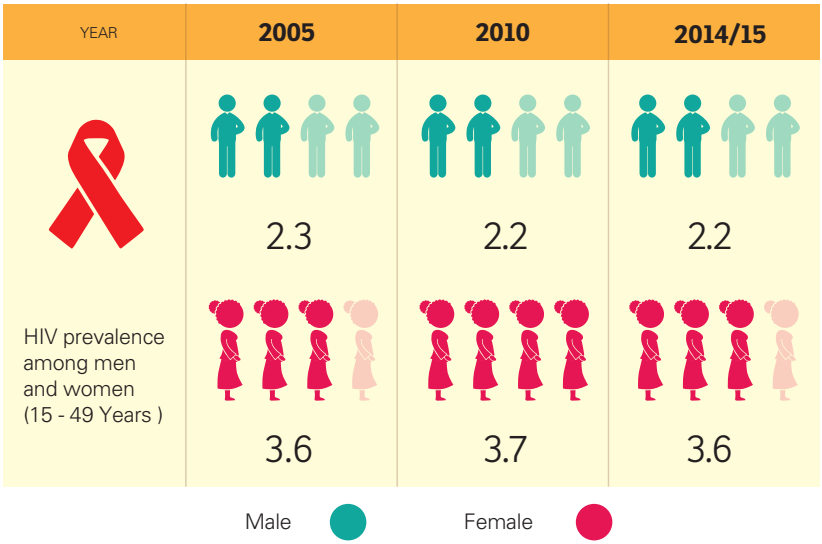
YEAR	2005	2010	2014/15
% of women aged 15-19 who have had a live birth	3.3 	4.7 	5.5 
% of women aged 15-19 who are pregnant with first child	0.8 	1.3 	1.8 
% of women aged 15-19 who have begun childbearing	4.1 	6.1 	7.3 

Source: *RDHS 2005, 2010 and 2014/2015*

Teenage pregnancy and motherhood has been on the increase in the last 10 years and is undermining national development efforts. This is attributed to defilement, domestic violence, poverty and low knowledge of reproductive health. The situation requires urgent response such as improving knowledge and skills of parents and youth on sexual reproductive health. This can be achieved through synergy among various actors ranging from public, private sector, civil society and faith based organizations.

8. HIV AND OTHER DISEASES

a. HIV prevalence (%)



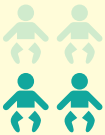
Source: *RDHS 2005, 2010 and 2014/2015*

HIV prevalence has been stable since 2005 and remains at 3 percent among adults age 15-49 years. The trend shows that women have a higher prevalence than men of the same age group (15-49 Years). This gap is due to biological but also social factors including economic dependence of women upon men and limited confidence in decision making to apply HIV prevention methods.

b. Malaria prevalence

I) Prevalence of malaria among children (%)

YEAR	2010	2014/15
Prevalence of Malaria among children aged 6 - 59 months	1.5 (Male)	2.5 (Male)
	1.2 (Female)	1.9 (Female)

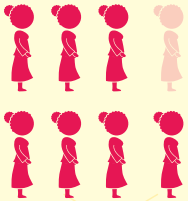


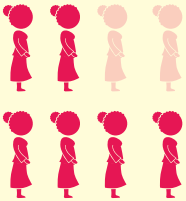
Male Female

Source: *RDHS 2010 and 2014/2015*

ii) Prevalence of malaria among women (%)

YEAR	2010	2014/15
% of women aged 15-49 having malaria	0.7	0.6





Source: *RDHS 2010 and 2014/2015*

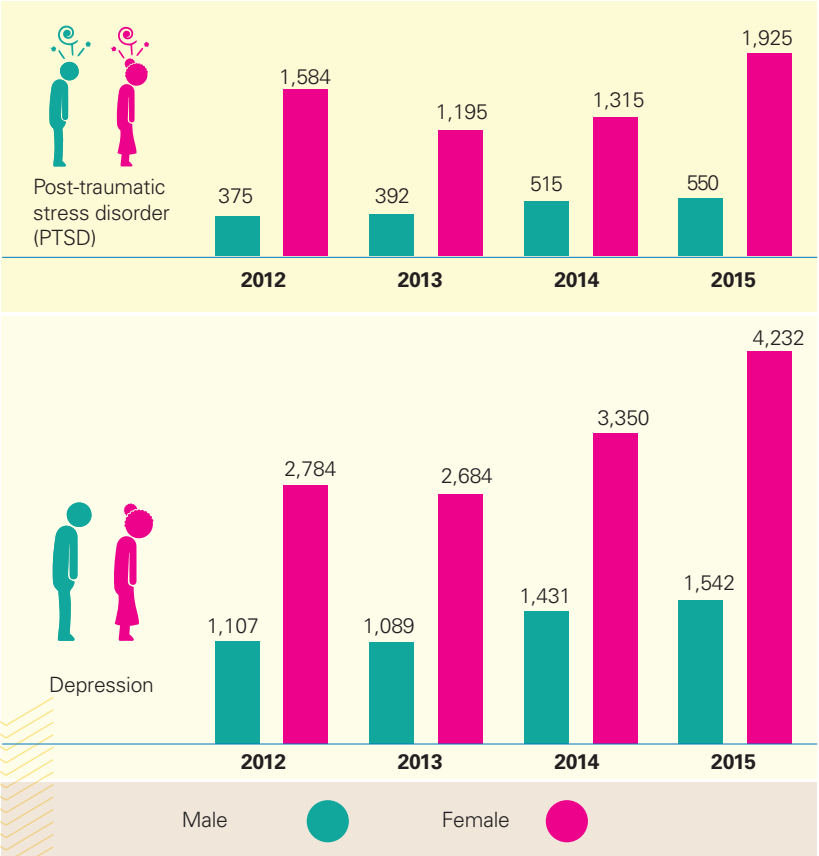
iii) Use of mosquito nets by pregnant women

YEAR	2005	2010	2014/15
 % of pregnant women aged 15-49 who use mosquito nets	 20.0	 72.5	 73

Source: *RDHS 2005, 2010 and 2014/2015*

All local actors need to put efforts together and mobilize pregnant women to use mosquito nets as a strategy to reduce malaria prevalence.

c. Mental diseases

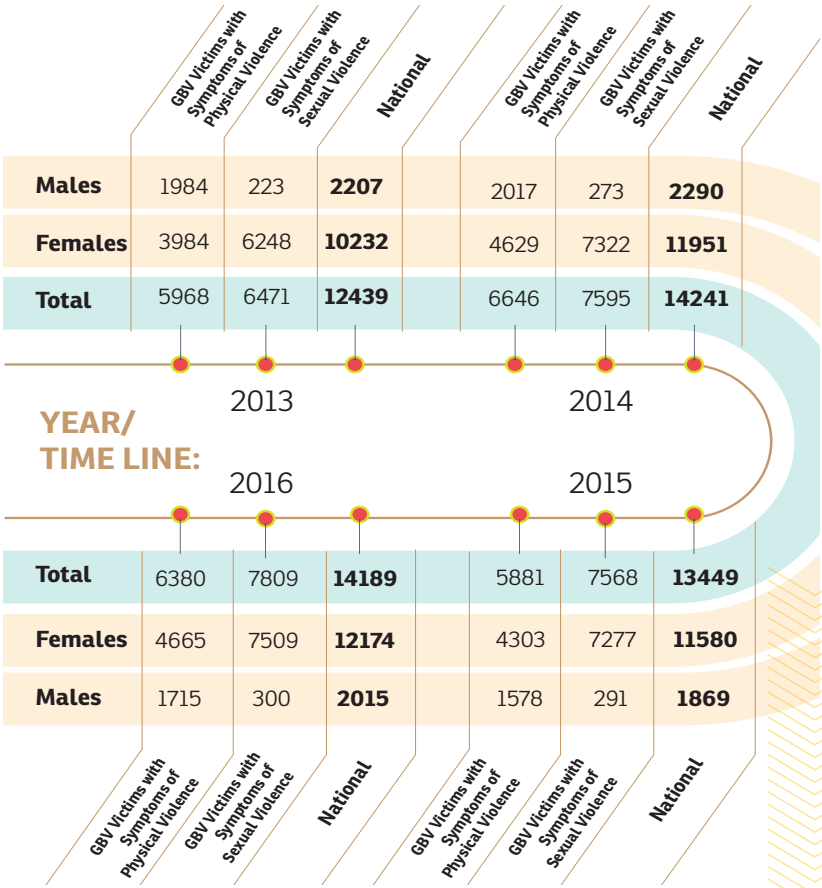


Source: *MoH, HMIS*

The above data indicates an increase in cases of post-traumatic stress disorder and depression for both male and female in the years 2014 and 2015. Among the causes include issues relating to maternal health, child abuse and family conflicts etc. This situation calls for strong and aggressive mental health and counselling services at different levels of health system targeting both rural and urban areas.

9. GENDER BASED VIOLENCE AND HEALTH

i) Number of GBV cases received at Isange One Stop Centers



Source: *NISR, Statistical Year Book, 2017*

Isange One Stop Centers have tremendously improved prevention and response to GBV in Rwanda. With existing Isange One stop Centers in 44 District Hospitals and increased community awareness, reporting on GBV cases have kept increasing for both male and female.

10. HEALTH FACILITIES

The Government of Rwanda has made great effort to increase the number and quality of health infrastructure and facilities to ensure easy community access to health care and services.

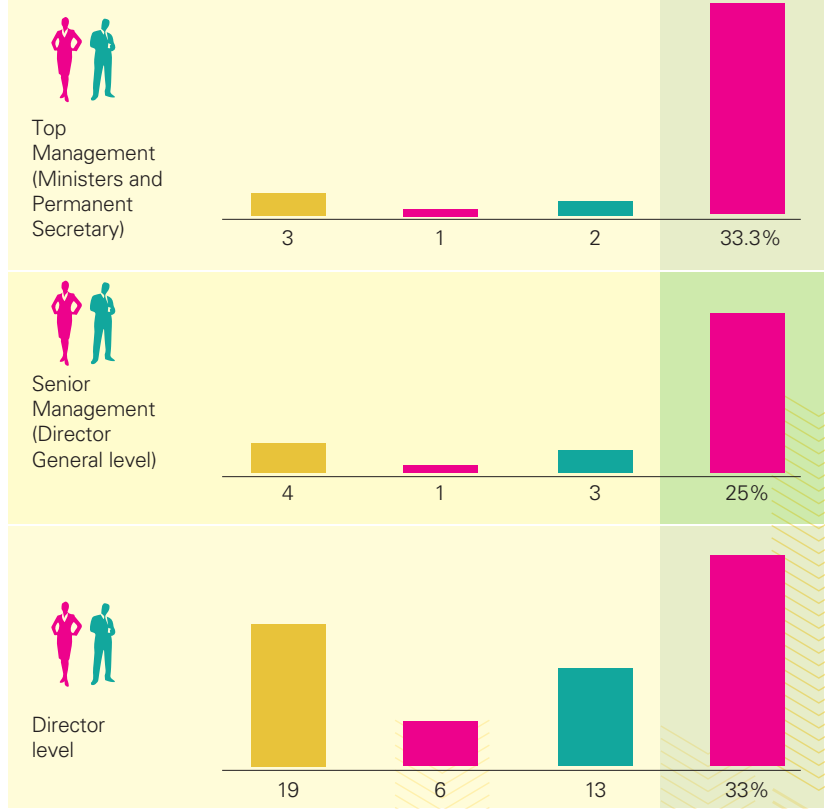
Health Facility	Number
Health Posts	406
Health Centres	499
District Hospitals	44
Referral Hospitals	4
Community Health Workers	45,516

Source: *Ministry of Health, Annual Health Statistics Booklet, 2016*

11. MEN AND WOMEN IN THE MANAGEMENT OF THE HEALTH SECTOR

i) Male and female representation in MoH

Level	Total	Women	Men	Women as % of All Employees
Top Management (Ministers and Permanent Secretary)	3	1	2	33.3%
Senior Management (Director General level)	4	1	3	25%
Director level	19	6	13	33%



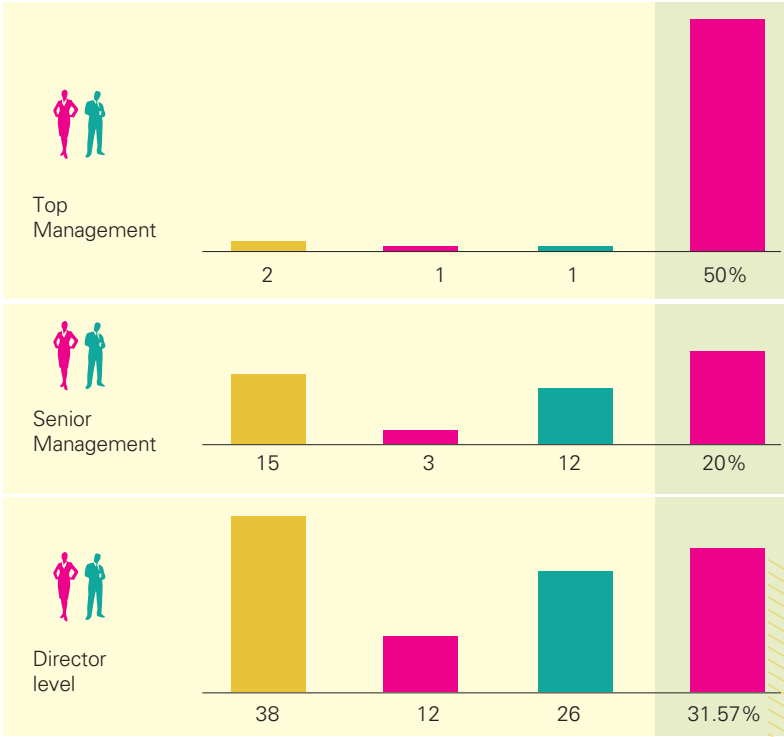
Source: *Ministry of Health, GBS 2017/2018*

Male and female representation in MoH (Continued)

Source: *Ministry of Health, GBS 2017/2018*

ii) Male and female representation in RBC

Level	Total	Women	Men	Women as % of All Employees
Top Management	2	1	1	50%
Senior Management	15	3	12	20%
Director level	38	12	26	31.57%

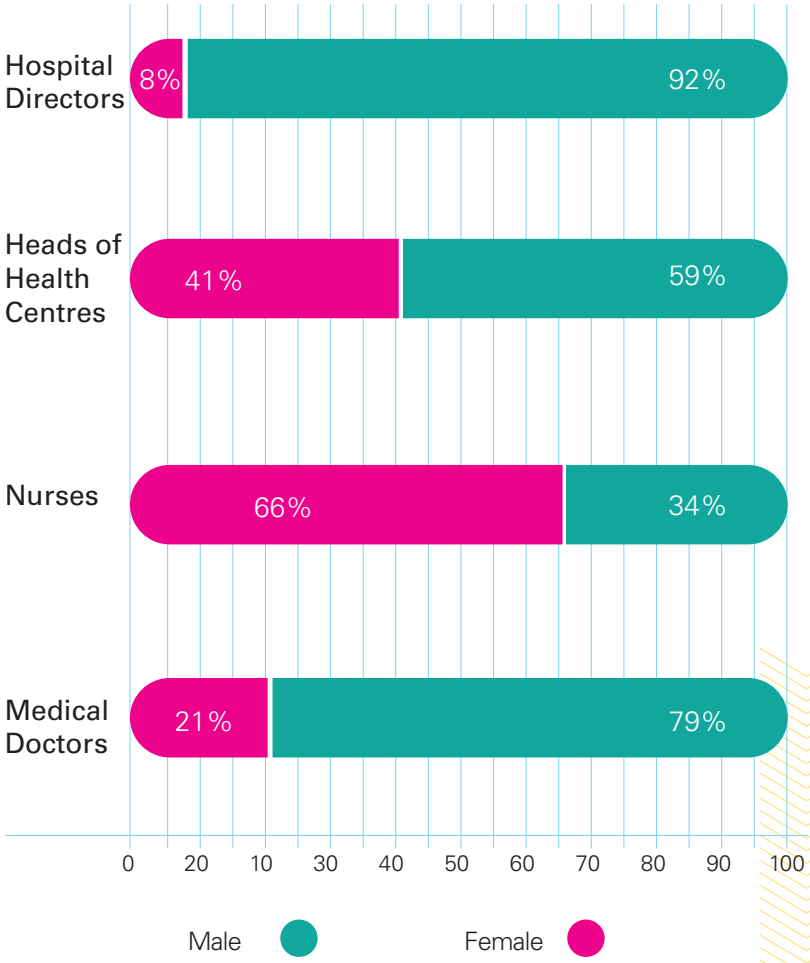


Source: *Ministry of Health, GBS 2017/2018*

Male and female representation in RBC (Continued)

Source: *Ministry of Health, GBS 2017/2018*

iii) Health sector staff representation at decentralized levels



As reflected on the data above, representation of female as hospital directors and medical doctors is still very low and this calls for measures to attract more women in medical carrier and medical specialization.

IV. KEY STRATEGIC RECOMMENDATIONS

1. While infant, child and maternal mortality rates have dropped remarkably in the last 10 years, more efforts and initiatives still need to be devised for continuous improvement and monitoring of quality health care services and progressive reduction of child and maternal mortality ratios.

2. There is need to strengthen collaboration between community health workers and local leaders to encourage pregnant women to fulfil the standard antenatal visits recommended by the World Health Organization.

3. In order to curb down teenage pregnancy issues that is evidently on the rise during the last 10 years, strong parents' involvement in reproductive health is needed. To this effect, parents need to be provided with skills and knowledge to effectively interact with the youth on reproductive health matters. A comprehensive sexuality education package in the new competence-based curriculum, along with education on HIV and AIDS, gender-based violence is also needed in schools.

4. Strongly engage men in family planning initiatives emphasizing their role as agents of change in the family well-being and the community at large.

5. While the prevalence of malnutrition remains a national threat, especially among children below five years, there is need to educate households on mind-set change to increasingly and effectively utilize nutritious food within their means and vicinity.

6. Heighten awareness on services provided by Isange One Stop Centres with regard to prevention and response to Gender Based Violence and encourage communities to timely report GBV cases for health, legal, counselling and psychological support and rehabilitation.

7. Institutionalize the collection and management of sex disaggregated data across all actors in the health sector and promote the culture of using generated data to inform evidence planning, programming and decision making.

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