TRANSPARENCY INTERNATIONAL Rwanda

HIDDEN BARRIERS

CITIZEN PERCEPTIONS AND EXPERIENCES ON HOW CORRUPTION THREATENS ACCESS TO HEALTHCARE FOR WOMEN, GIRLS, AND AND OTHER GROUPS AT RISK OF DISCRIMINATION

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TRANSPARENCY INTERNATIONAL
the global coalition against corruption

In partnership with Canada

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ISDA: Inclusive Service Delivery Africa

WHO: World Health Organization

CMI: Chr. Michelsen Institute

GMO: Gender Monitoring Office

LGBT: Lesbian, Gay, Bisexual, and Transgender

RNP: Rwanda National Police

RIB: Rwanda Investigation Bureau

CSO: Civil Society Organization

UNODC: The United Nations Office on Drugs and Crime

RBC: Rwanda Biomedical Centre

MoH: Ministry of Health

OoO: Office of The Ombudsman

RMS: Rwanda Medical Supply

CBHI: Community-Based Health Insurance

MINALOC: Ministry of Local Government

FGD: Focus Group Discussion

KII: Key Informant Interview

RSSB: Rwanda Social Security Board

MINIJUST: Ministry of Justice

FDA: Food and Drugs Authority

HIV: Human Immunodeficiency Virus

BMC: Bio-Medical Center

AIDS: Acquired ImmunoDeficiency Syndrome

1. BACKGROUND

It has long been acknowledged that the delivery of public services in the health sector, is critical because a lack of access to health care can be life-threatening be a leading cause of death, especially for vulnerable people (WHO, 2019; WHO, 2017a; World Bank, 2014). Upstream government establishes overall policies, allocates resources, and creates rules and incentive systems for service providers; downstream service providers' behavior is influenced by these constraints and incentives, as well as rules established locally; and citizens' decisions are influenced by the services offered and their characteristics. Along with increasing citizen accountability, it is critical to generate change through various pressure points, including groups already well-established and influential in the health sector. (WHO, 2018).

Transparency International reports indicate that many countries' healthcare systems continue to face serious problems, such as corruption and limited access to healthcare services, particularly for vulnerable people such as women, girls, and other groups at risk of discrimination(TI/ U4, 2022; TI, 2017). Transparency International estimated that US $ 500 billion of global healthcare spending is lost due to corruption each year, with women and girls being the most affected by this because they account for around two-thirds of all patients in public health systems. According to TI, women and girls are easier targets for extortion while accessing basic services due to their social and gender roles, asymmetric power relationships, lower bargaining power, and economic vulnerabilities (U4/CMI, 2020). In recent years, the Rwandan health system has reportedly improved as a result of enhanced care quality and decentralization of healthcare services (MoH, 2021). Policies and programs have been developed to respond to people's healthcare needs and to align the healthcare system with the global health agenda (WHO, 2022). Rwanda, according to various sources, is one of the few countries that has made progress towards universal health coverage as a

result of its inclusiveness, equity, and comprehensive and integrated quality service delivery (TI-Rwanda, 2021).

However, problems persist. Specific challenges, gaps, and barriers continue to increase women and girls' vulnerability to HIV in Rwanda, according to a 2018 report by the Gender Monitoring Office (GMO). According to their report, HIV prevalence has remained stable since 2005, at 3% among adults aged 15-49 years. However, face a higher prevalence than men in the same age group. This disparity is caused by social factors, such as women's economic dependence on men and their lack of confidence in using HIV prevention methods. The GMO also demonstrated that women and girls have unique health needs throughout their lives, which are related to both physical differences and societal roles. Lack of funds and distance to the health facility (especially for pregnant women) were identified as major barriers to women's access to healthcare services (GMO, 2018).

Corruption in the health sector was reported in the Rwanda Bribery Index (2022) conducted by TI-Rwanda as being relatively low (TI-Rwanda, 2022). Despite the challenges that the health sector faces, there has not been enough research conducted to identify loopholes and other issues that may make it difficult for the population, particularly vulnerable groups such as women, girls, and people with disabilities, to access healthcare services. Several studies have been conducted, but none have identified the most common barriers to citizens' access to healthcare services in Rwanda, particularly among women, girls, and people with disabilities. Based on the research gaps identified above, TI-RW intends to contribute by improving accountable governance in the health sector to deliver excellence in terms of improving people's lives and ensuring access to medical care for all. This survey was conducted in a bid to identify governance gaps, as well as corruption/discrimination risks and their impact on Rwanda's health sector performance, and to formulate appropriate recommendations to address the issues.

2.OBJECTIVES OF THE STUDY

2.1. General Objective

The main objective of this survey is to assess how Corruption threatens access to Healthcare for Women, Girls, and other Groups at Risk of Discrimination in Rwanda.

2.2. Specific objectives

Specific objectives include:

- ✓ Analyze the level of transparency and accountability in the delivery chain of health services in the district's health centers and hospitals in 5 districts
- ✓ Examine the level of access to health care services, particularly for women, girls, and other vulnerable groups (inclusivity) as well as the barriers they face in the district's health centers and hospitals
- ✓ Examine the perception and experience of respondents (Including women, girls, and other vulnerable groups) on the level of corruption in the district's health centers and hospitals in 5 districts
- ✓ Assess the effectiveness of accountability mechanisms in place to protect and secure victims (including women, girls, and other vulnerable groups) who report corruption and related complaints
- ✓ Analyze specific challenges facing women, girls, and other vulnerable groups to access healthcare services in the district's health centers and hospitals in 5 districts
- ✓ Suggest the strategies to mitigate identified challenges facing women, girls, and other vulnerable groups in accessing healthcare services in the district's health centers and hospitals in 5 districts

3.LITERATURE REVIEW

A literature review is a detailed summary of previous research on a specific topic. The literature review examines scholarly articles, reports, books, and other sources that are relevant to a specific area of study. The literature review in this study provides a general picture of the health sector in Rwanda, with a focus on institutional structure and legal framework. This section provides information on the various councils in Rwanda's health system, as well as the laws that govern these councils and the responsibilities of each council.

3.1. Overview of Rwanda's primary health care system

Rwanda has made remarkable strides in improving the health of its people (MoH, 2020; MoH, 2019). Although there are still disparities in health between urban and rural areas, income quintiles, and gender, most improvements have reportedly benefited the poor and increased equity (GMO, 2018). Community health insurance, improved service quality through performance-based financing (PBF), decentralization, and the expansion of community-based services have all contributed significantly to Rwanda's improved health status (MoH, 2020a; MoH, 2021). Improvements have also been facilitated by the government's ability to develop and scale up based on participatory consultation and grassroots evidence (ODI, 2011). Reaching the nearest health facility in Rwanda usually requires clients to take a long walk that, until recently, took an average of 95 minutes. Although efforts have been made to reduce walking time, many people still struggle to access health care. The government aims to reduce walking time to under 25 minutes by 2024 through an innovative approach that brings more health posts closer to communities. The health posts connect community health workers with healthcare facilities. Health workers provide essential primary care services and, when needed, refer patients to hospitals for specialized care, ultimately strengthening the health system's foundation and improving how people receive the care needed. Since August 2021, the Ministry of Health has established 1,179 health posts that provide basic health services to underserved communities across the country, thanks to the

support of administrative districts, communities, and partners (Rwanda Ministry of Health, 2022). In various areas of the country, the Ministry of Health has now established 21 new types of health posts, known as second-generation health posts, with upgraded services such as maternity, laboratory, dental care, ophthalmology, and circumcision (WHO, 2022;MoH, 2022).

3.1.1. Governance and Structure of the primary health care system in Rwanda

The overall administrative head of the Rwanda health system is the Ministry of Health, which governs all health facilities, both public and private. In Rwanda, public health facilities represent 64% of the total number of non-private health facilities, with 28% run by faith-based organizations (WHO, 2022). Currently, the system is divided into four levels.

Table 1: ***The structure of the primary health care system in Rwanda***

Levels	Mission
Central level	The Ministry of Health's mission is to provide and continuously improve high-quality affordable promotive, preventive, curative, and rehabilitative healthcare services, thereby contributing to poverty reduction and improving the general well-being of the population. To oversee the implementation of policies, strategies, and heal the-related programs, the Rwanda Biomedical Centre was established in 2011.
National referral hospitals	Five national referral and teaching hospitals have the mission of providing specialized health care, teaching in medical and health sciences schools, and conducting health-related research.
Intermediary level.	At the provincial level, referral and provincial hospitals form an intermediary level of referral hospitals. Three referral and four provincial hospitals are gradually being upgraded to relieve the pressure on services in national referral hospitals.
Peripheral level	This level consists of an administrative office (district health unit), a district hospital, and a network of health centers, health posts, and

	community health workers. A district health unit is an administrative unit in charge of planning, monitoring, and supervising implementing agencies. It reports to the vice-mayor for social affairs. There are 36 district hospitals, 499 health centers at the sector level, and around 45, 516 community health workers serving the population at the village level. In addition, Rwanda has a national blood transfusion service, national medical procuring and storing service, national referral laboratory, and health professional councils for supervising and monitoring professional practices.

Source: (WHO, 2022)

Table 2: ***Hierarchy of health service provision in Rwanda***

Level	Services provided
Village level (14 837 villages)/Community Health Workers	✓ Prevention, screening, and treatment of malnutrition ✓ Integrated management of child illness ✓ Provision of family planning ✓ Maternal and newborn health ✓ Sensitize the citizen to test for HIV, tuberculosis, and other major illnesses ✓ Behaviour change and communication
Cell level (2148 cells)/Health Posts	✓ PHC services including promotional, preventive, and primary curative services ✓ Basic package of services for those areas that are far from health centers ✓ Basic diagnostics with rapid testing
Sector level (416 sectors)/Health Centres	✓ Defined minimum package of activities at the peripheral level ✓ Complete, integrated services, such as curative, preventive, promotional, and rehabilitation services; ✓ Supervision of health posts and community health workers operating in their catchment area

District level (30 districts)/ District hospitals	✓ Government-defined complementary package of activities (for example, caesarean sections, treatment of complicated cases) ✓ Provision of care to patients referred by the primary health centers ✓ Carrying out planned activities for the health district and Supervision of district health personnel
Province level (4 provinces)	Gradually upgraded from secondary health care to specialized services to serve the population in the respective provinces. They provide a complementary package of activities and specialized care, including internal medicine, pediatrics, surgery, obstetrics, and gynecology

Source: (WHO, 2022)

3.1.2. Regulatory processes

The overall mission of the Ministry of Health is to promote population health through the provision of preventive, curative, and rehabilitative health services (MoH, 2015). One of the Ministry of Health's core functions is to regulate the health sector by (a) drafting and disseminating laws, regulations, and instructions to promote health sector performance; (b) establishing and disseminating standards applicable to the health sector; and (c) authorizing private health institutions. The Ministry of Health regulates the health sector in collaboration with the Rwanda Medical and Dental Council, the Rwanda Nursing and Midwifery Council, the Rwanda Allied Health Professions Council, and the Rwanda Pharmacy Council. Several codes and regulations have been established for health sector actors, such as the code for allied health professions, the pharmacy profession's code of ethics, and the nursing profession's codes (WHO, 2017b);(MoH, 2015).

Table 3: ***Rwandan Medical professional councils***

Council	Relevant information, including mission and functions
Rwanda Medical and Dental Council	Established under Law No. 30/2001 of 12 June 2001, revised to Law No. 44/2012 of 14 January 2013. **Related laws and policies include:** ✓ Law establishing medical professional liability insurance ✓ Law of Rwanda Medical and Dental Council ✓ Ministerial order establishing internships for medical doctors ✓ Registrations and licensing policy registrations for indexing of medical and dental students ✓ Council qualifying examinations policy
Rwanda Nursing and Midwifery Council	Established under Law No. 25/2008 of 25 July 2008. The mission of the Council is to protect the public and the integrity of the nursing and midwifery professions through the regulation of education and practice in collaboration with all stakeholders as well as the community, within available resources.
Rwanda Allied Health Professions Council	Relevant information, including mission and functions Established under Law No. 46/2012 of 14 January 2013
Rwanda Pharmacy Council	Established under Law No. 45/2012 of 14 January 2013. Related laws and policies include ✓ Law establishing the Rwanda Pharmacy Council ✓ Law governing narcotics drugs, psychotropic substances, and precursors in Rwanda

	✓ Law establishing Rwanda Food and Medicines Authority ✓ Law relating to the regulation and inspection of food and pharmaceutical products ✓ Continuing professional development policy for health professional councils in Rwanda ✓ an overview of the National Pharmacy Council ✓ Code of Ethics for Pharmacy Professions ✓ Guidelines for grading pharmacy professionals in Rwanda

Source:(WHO, 2017b)

3.1.3. Fundamental rights of a patient and any other health service user

The Rwandan government has been at the forefront of enacting laws and regulations aimed at protecting Rwandans' rights in a variety of public and private sector service domains(MoH, 2013). This includes laws and regulations aimed at protecting Rwandans' rights against poor quality services in a wide range of public and private sector service domains (Rwanda FDA, 2022). In 2013, the government passed Law No. 49/2012, in consultation with its healthcare partners, establishing medical professional liability insurance. This law defines the rights of medical service users as well as the responsibilities of health care providers.

Table 4: ***Fundamental Rights of the healthcare service users***

Rights	The provisions of the law
Right by a human person to dignity and privacy	The health professional shall discharge his/her duties with due respect for the human person's life, privacy, and dignity.
Right of access to medical procedures	No one shall be subjected to any form of discrimination while accessing consultation, healthcare services, or other paramedical procedures.

Patient's Right to Safety	The patient or any other health service user shall have the right; not to suffer from poor functioning of health services; not to suffer from adverse events or errors occurring in the healthcare setting etc.
Right to free choice of a health professional	Except for emergency cases, the patient or any other health service user shall have the right to freely choose a health professional.
Right to information	The health professional shall be required to provide the person benefiting from his/her examination, treatment, and advisory services with accurate, reliable, and appropriate information on his/her health state and proposed medical procedures.
Freedom of choice of a trusted person	A patient or any other health service user who has reached the age of majority may designate a trusted person of his/her choice who can assist him/her.
Right to consent	The prior consent of the patient or any other health service user to be examined or treated must be sought in all cases.
Right to refuse treatment and withdraw consent	The patient or any other health service user shall have the right to refuse treatment or any medical procedure, to withdraw consent during treatment
Consent of minors or other incapable persons	The health professional who intends to provide healthcare services to a minor or an incapable person must endeavor to inform his/her parents or his/her representative or his/her guardian and obtain their prior consent.
Right to consult and be given a copy of the patient's medical record	The patient or any other health service user shall have the right to consult his/her medical record and receive a copy thereof if need be.
Right to sue for compensation	The victim of health risks shall have the right to sue for compensation provided that the causal link between the health risk and the medical procedure is established.

Source: (MoH, 2013).

4.METHODOLOGY

4.1. Introduction

In general, research is the pursuit of knowledge through diligent search, investigation, or experimentation to discover and interpret new knowledge(WHO, 2001). Research methodology refers to the procedures or techniques used to identify, select, process, and analyze information about a topic. (BMC, 2020). To achieve the above assessment objectives, TI-RW will employ a participatory approach that enabled researchers to collect and analyze various perspectives from patients, nurses in health centers and hospitals, and members of the general public to examine Transparency, Accountability, Corruption/discrimination and Inclusiveness in the district's health centers and hospitals in 5 districts of Rwanda.

Similarly, the assessment approach is founded on the principles of independence, objectivity, transparency, validity, reliability, partnership, and usability. It ensures that the evidence obtained is credible, reliable, and useful by answering the assessment questions as effectively, logically, and unambiguously as possible, using both primary and secondary data sources, and combining qualitative and quantitative data elements. Thus, data collection included desk reviews of documents as well as the collection of primary data. These methods allowed for the collection of both primary and secondary data. This mixed-method approach enabled researchers to triangulate data thoroughly and produce a verifiable body of evidence. To answer the specific study questions in the assessment, qualitative data collection approaches were used. Furthermore, qualitative data helped to explain emerging themes in the analysis. On the other hand, administrative records provided a significant portion of the quantitative data.

4.2. Target Population and Sampling

The population of this study was made up of Rwandans and residents over the age of 18 from five districts. These districts were chosen with care because TI-RW intends to collect citizen feedback in areas where it has a physical presence in the country. This is also because the findings will allow TI-RW to conduct advocacy activities in the selected districts using district coordinators in 5 districts. Advocacy activities are designed to address emerging issues concerning the fairness, integrity, transparency, and accountability of healthcare service delivery to the most vulnerable people.

4.2.1. Sampling Strategy and Sample Size

To achieve the desired result, this survey used purposive sampling, also known as judgmental, selective, or subjective sampling. The application of this well-known sampling technique, which is a type of non-probability sampling, allows researchers to exercise discretion when selecting members of the population to participate in the survey based on their knowledge. As the study population, the baseline sampling frame was drawn from the entire population in the five (5) districts. Eligible respondents were the most vulnerable groups of people - including, very poor women (Ubudehe category I&II), Single women, household-headed women, people with disabilities, Persons with a diverse sexual orientation (LGBT), People living with HIV, Sex workers and people with serious health problems – who benefit from district's health centers and hospital's services in 5 districts in Rwanda.

The sample size it was computed using the Raosoft sample size calculator which utilises the formula below.

$n = (N(zs/e)2)/(N-1+(zs/e)2)$

Where:

z= 1.645 for a 90% level of confidence

s = p(1-p) p = estimated proportion

e = desired margin of error

N = population size

In this estimation, the size of the study population was 1,803,601 from five districts covered in this survey. The confidence level was taken at 90% with a margin of error of 5%. The table below illustrates the sample distribution in the 5 districts.

Table 5: ***Sample distribution per district***

SN	Study population	Study population Size(N)	Confidence level	Margin of error	Sample size(n)
1	RUBAVU	403,662	90%	5%	271 rounded to 280
2	HUYE	328,398	90%	5%	271 rounded to 280
3	KAMONYI	328,398	90%	5%	271 rounded to 280
4	MUSANZE	398,986	90%	5%	271 rounded to 280
5	KAYONZA	344,157	90%	5%	271 rounded to 280
	Total	1,803,601			1400

Therefore, the sample obtained for sampling errors of 5% (desired level of precision), at a confidence level of 90% was 280 per district, 1400 respondents in total. Patients (Outpatients) and the general public benefit from the district's health centers and hospitals in five districts.

With regards to the number of FGDs, the study used 3 FGDs in each of the 5 districts surveyed involving one group of PWDs, one for most vulnerable women and another for people with chronic diseases, which is 15 FGDs in total. The study used 9 KIIs including 5 from medical professionals at the health centers level and 4 officials at national level from MoH, RSSB and RMS.

4.3. Types of Data

4.3.1. Quantitative Data

Before collecting data, all aspects of the study were meticulously planned. Data were presented in the form of numbers and statistics, which were arranged in tables, charts, figures, or other non-textual formats. To collect numerical data, the TI-Rw research team used Kobo toolbox-programmed questionnaires on Android tablets.

4.3.2. Qualitative Data

Key Informant Interviews were conducted with medical staff and health facility administrators about the issues, challenges, and solutions to ensure the quality of services in the health sector. Researchers were able to gather information on the research issue through focus group discussions (FGDs) with citizens living near health facilities.

4.4. Data collection tools

4.4.1. Household Questionnaire Design

Given the nature of this assessment, the data collection tool, namely quantitative, is critical. The questionnaire was used to gather data from the respondents. The questionnaire included both closed-ended and open-ended questions. Each respondent was given a structured individual questionnaire by enumerators. It was given to interview individuals and was as brief as possible to use as little of the respondent's time (approximately 30 minutes) and avoid respondent fatigue. The questionnaire was translated into Kinyarwanda from English.

4.4.2. Key Informant Interview and Focus Group Discussions

The focus group discussions (FGDs) enabled researchers to gather information from a group of people selected and assembled to discuss and comment on the research issue based on personal experience, while KIIs involved experts in the field of health such as key medical professionals, health facility administrators, and officials from MoH, RSSB, and RMS were also selected to participate in a semi-structured interview about the issues, challenges revealed in the preliminary findings of the survey.

4.5. Data Analysis

The preliminary findings were analyzed to determine which areas required qualitative data collection. Following data collection (both quantitative and qualitative), the research team created tabulation plans that were used for preliminary analysis after data cleaning. The descriptive analysis approach guided the triangulated data exercise. In terms of qualitative

data, the researchers used the content analysis method to analyze data from interviews and focus groups. Both quantitative and qualitative data were analyzed and interpreted by researchers and statisticians. A weighted average was also used in this study, which provides more information than a simple average with little additional data needed. The weighted average score was calculated using the formula below;

$$W = \frac{\sum_{i=1}^{n} w_i X_i}{\sum_{i=1}^{n} w_i}$$

W= weighted average

n = number of terms to be averaged
w_i = weights applied to x values

X_i = data values to be averaged

4.6. Quality assurance measures

Conducting such a study necessitates a set of procedures to ensure high-quality data and information. To achieve this goal, in addition to ensuring effective work coordination and, more specifically data collection, the following measures were implemented:

- The use of a participatory approach in developing research instruments
- The research protocol and instruments were approved by the National Institute of Statistics of Rwanda;
- Training of enumerators and team leaders was conducted to ensure an understanding of the study objectives, methodology, and tools.
- Continuous field meetings between the consultants, the enumerators, and supervisors were organized to identify arising issues while collecting data and to develop appropriate solutions;
- The anonymous questionnaire was administered as a way of encouraging free and open expression by respondents.
- Supervision and overall coordinated data collection

- Tablets were used to capture data collected and more particularly to minimize data collection and entry errors.

5.7. Ethical considerations

Throughout the process, ethical standards for conducting quality research were strictly followed. The background of the assessment, its ultimate goal and objectives, the intended use of findings, and measures taken to ensure the confidentiality and anonymity of data sources were all explained to respondents. They were also allowed to seek clarification from the interviewer on any areas that were unclear before agreeing to participate in this assessment. Respondents were assured that their data would not be shared with anyone other than the TI-Rw research team and that their names would not be revealed to anyone without their prior consent. When conducting research involving human subjects, the TI-Rw research team strictly adheres to the "do no harm" principles.

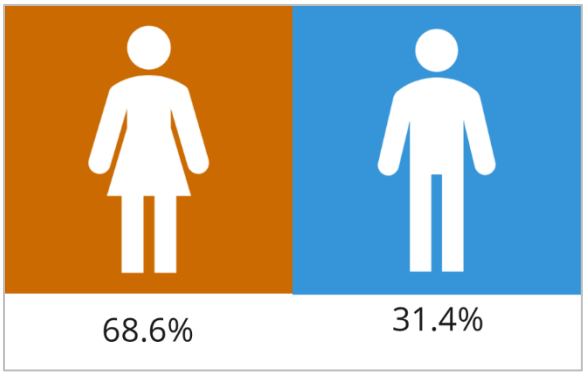
PRESENTATION OF FINDINGS

5.PRESENTATION OF FINDINGS

5.1. Demographic characteristics of respondents

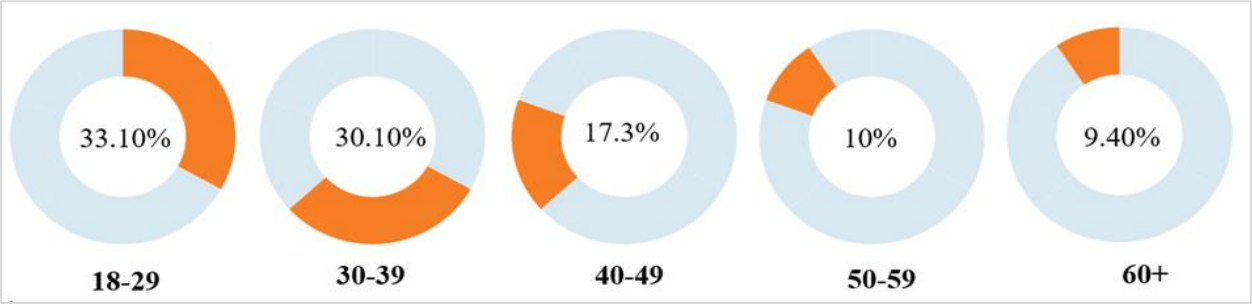
Demographic information allows people to better understand certain background characteristics of respondents to the study. It also contains information on respondents' status of the vulnerability, enabling readers to comprehend how having less access to healthcare affects vulnerable citizens. The demographic information collected from the study's respondents includes age, gender, marital status, place of residence, and degree of vulnerability.

Figure 1: Gender of respondents



According to the statistics, the majority of respondents are female, but men also participated in this survey. It is a positive outcome that a large number of females took part, especially since this study has a specific goal of examining corruption vulnerabilities against women and girls seeking healthcare services.

Figure 2: Age of respondents



As it turned out, most respondents are under the age of 40, with only a small number being above 40. No respondent to this survey is less than 18 years old because, by Rwandan law, everyone under that age is regarded as a child.

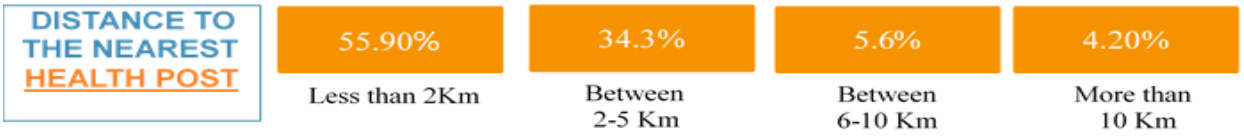
Figure 3: Marital status of respondents

Marital status is associated with some types of vulnerabilities, particularly because they are frequently not treated equally in society; thus, this study sought to collect marital status data to connect it with issues that arise in healthcare services. The majority of respondents (nearly 70%) were married, while 18% were still single. Respondents also include widows, divorcees, and separated people.

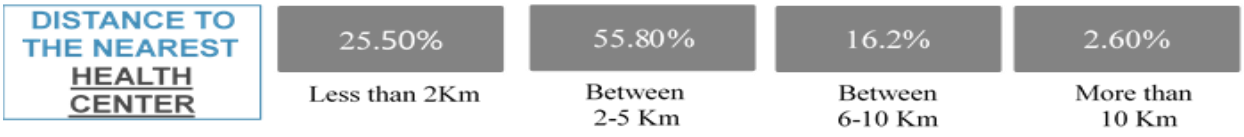
5.2. Vulnerability status of respondents

Figure 4: Distance to the nearest healthcare facility

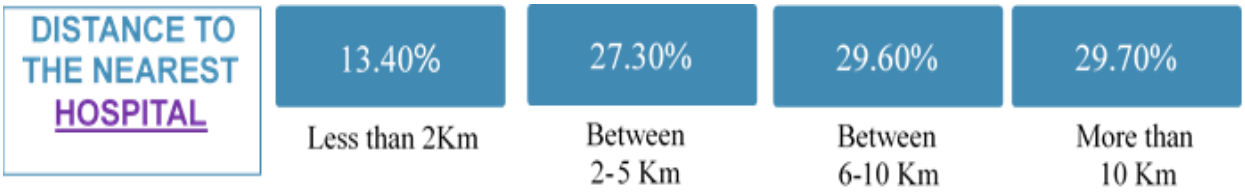
Distance to the nearest health post



Distance to the nearest health center



Distance to the nearest hospital



The figures show that around 28% people travel between two and five kilometers while the similar proportion travel between six and ten kilometers to reach the nearest healthcare facilities. This poses a significant barrier for persons looking for healthcare services, especially the most vulnerable, such as those with chronic illnesses, people with disabilities, or poor families who cannot afford transportation facilities. In the same vein, a significant percentage of respondents indicated that they use more than 10 kilometers to reach the nearest healthcare facilities. These statistics also support respondents' perceptions that insufficient transportation options significantly impede the ability of vulnerable persons to access healthcare services (see figure 25). Although the government continues to increase its efforts in the field of decentralization of health services, especially by building health posts close to the community, it is clear that there are still challenges to inclusive healthcare that need to be addressed.

Figure 5: Ubudehe category

Ubudehe is a term used to describe a long-standing cultural practice in Rwanda of working together and supporting one another to resolve issues in the neighborhood. Ubudehe classifications are based on people's assets and other financial resources. As the statistics show, the majority of respondents are in the first and second categories. The poorest residents who qualify for various types of government aid fall into these two categories. Therefore, it is beneficial that this study was able to locate many participants in these categories, especially since these groups contain some of the most vulnerable people targeted in the study.

Figure 6: Disability

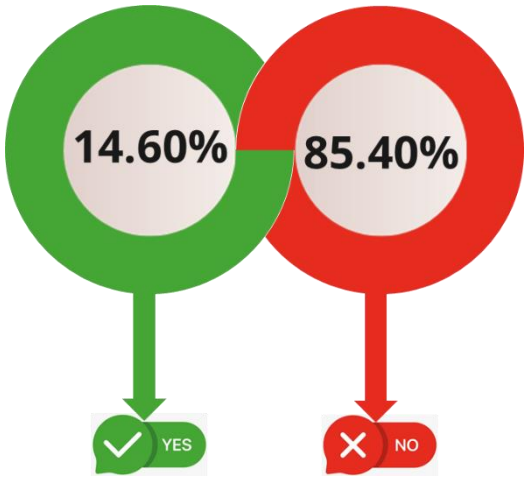
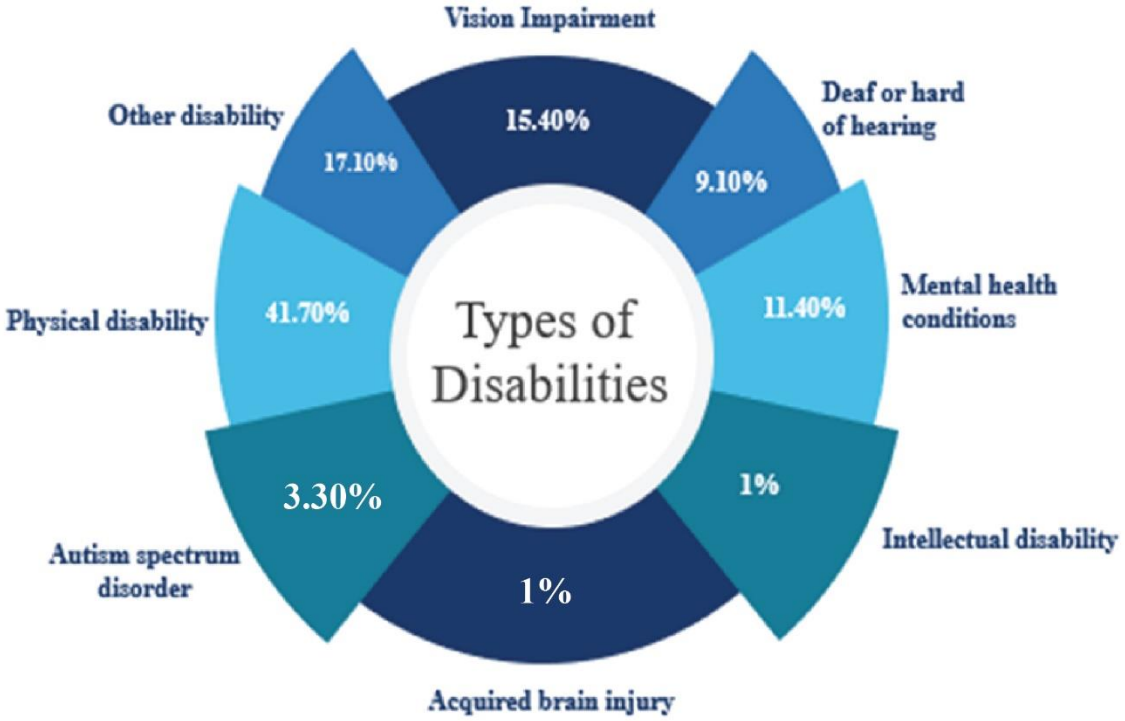
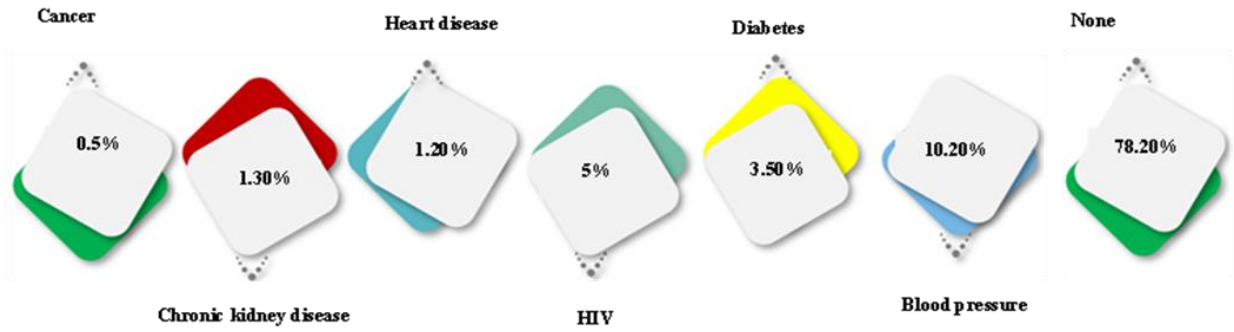


Figure 7: Types of Disabilities



As per the above figure, people with a range of disabilities were among the respondents where the majority have physical impairments, followed by visual impairments, mental impairments, and deaf or hard hearing. Some respondents have autism and other similar disorders that are not mentioned here. Limited access to healthcare, hurts everyone, but when it comes to people with disabilities it harms them badly due to their vulnerability status. An example is a person with a physical disability who must travel by foot 10 kilometers to the nearest clinic.

Figure 8: Chronic diseases

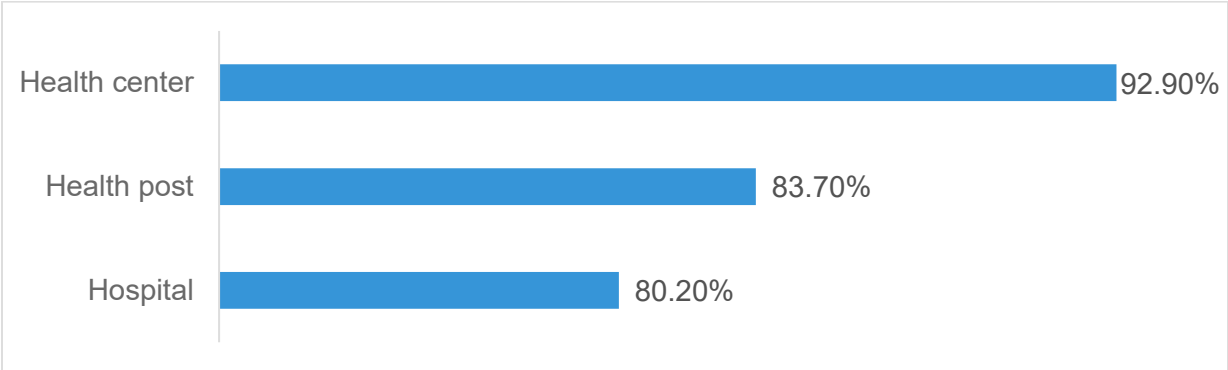


According to the statistics, among the respondents of this study, there are those suffering from chronic diseases. The most frequent chronic diseases identified were high blood pressure, diabetes and HIV. People with chronic conditions often have multiple and complex healthcare needs, whenever they face any barrier preventing them from accessing healthcare, it would can have a disproportionally bigger impact on their lives. Therefore, it was a positive outcome that persons who have chronic illnesses were able to take part in this study and demonstrate the challenges they encounter while trying to access medical care.

5.3. The level of transparency and accountability in the delivery chain of health services in the district's health centers and hospitals

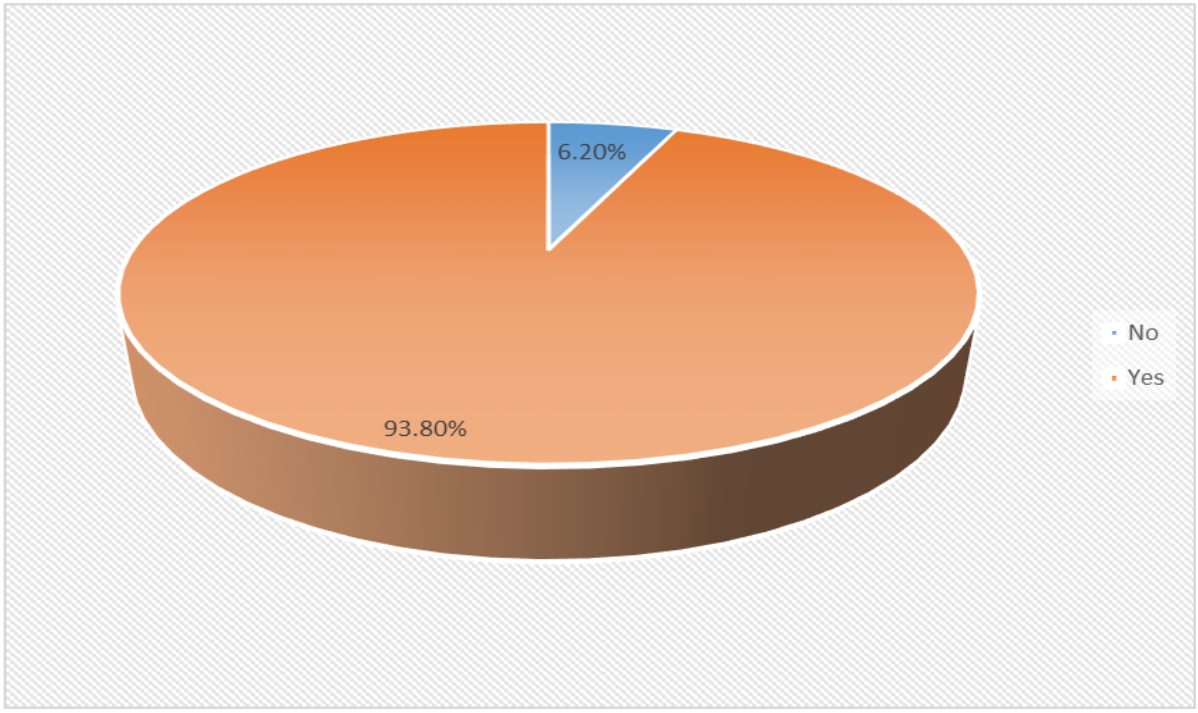
A lack of accountability in healthcare can have serious consequences for service delivery. It has the potential to erode care quality and increase the risk of lawsuits. A lack of accountability can lead to corruption and endanger the lives of patients. Transparency, which is inextricably linked to accountability, is critical throughout the healthcare spectrum. It has an impact on everything from how doctors practice medicine to how patients receive information. Transparency clarifies medical staff's roles, fosters patient trust, and leads to long-term improvements in outcomes. This survey measures the level of transparency and accountability in the delivery chain of health services in the district's health centers, health posts, and hospitals.

Figure 9: Patients who requested healthcare services in the past 12 months



According to the data in the above figure, more than 80% of respondents requested health care services in various facilities such as health posts, health centers, and hospitals in the previous 12 months. These findings also show that many people frequently seek treatment at health centers, as evidenced by the large number (more than 90%) of respondents who took part in this survey. This demonstrates the importance of the government's initiatives to decentralize medical services to citizens.

Figure 10: Respondents who received services requested



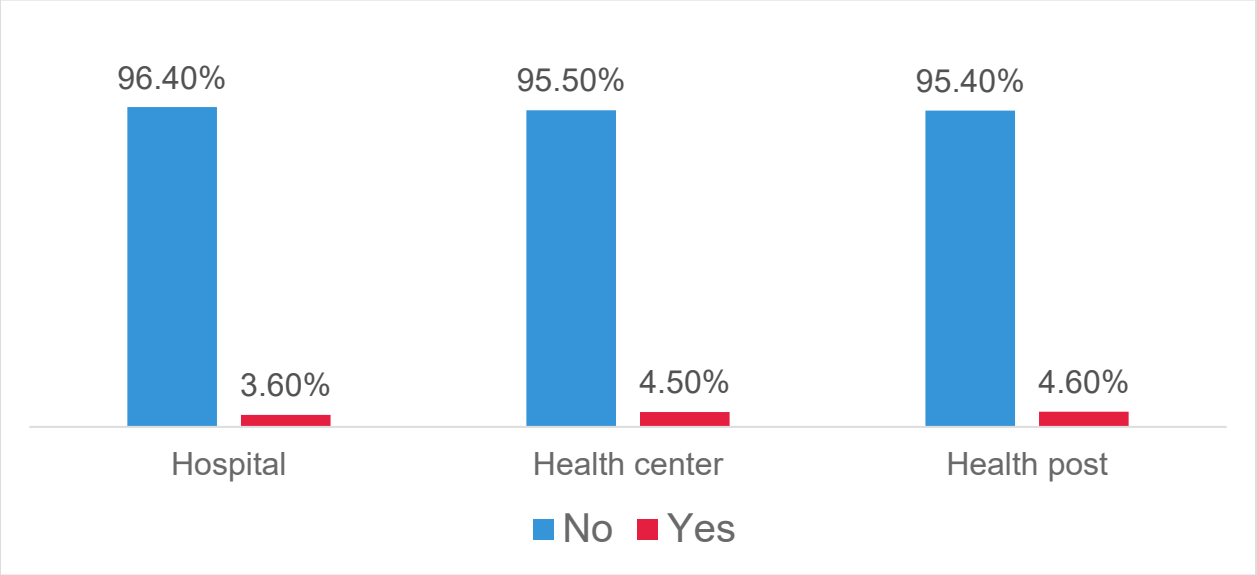
It is commendable that the majority of respondents (approximately 93.8 %) reported receiving the medical services requested. Despite the small percentage of respondents (6.2%) who reported not receiving the services needed, it is alarming given the sensitive nature of the services. If not treated, a patient's health will most likely deteriorate. Missed medical appointments are a strong predictor of mortality from all causes, especially for people with serious medical conditions. Given that medical care is tantamount to maintaining one's life, it is essential that everyone, regardless of financial means or other considerations, receive medical care. This was also revealed in the focus group discussion as well, as participants shared their perception that they were denied access to health care services.

"*Sometimes, there are cases where health centers and hospitals' pharmacists refuse to give us some medicines claiming they don't have them in stock. Unfortunately, at the same time, they give those medicines to other patients for unknown reasons".* **A woman with blindness disability who participated in the survey**

I once took my daughter-in-law to a hospital seeking antenatal care services. Though she was hospitalized, when I called a nurse, she said I was interrupting her yet my daughter-in-law was about to deliver. At the end of the day, I was the one to help her give birth on the floor and the nurse came later and took her to bed. **An old woman testified during the FGDs**

My child has been sick for 12 years. However, when I take him to the hospital, service providers do not take care of him. They always tell me that his disability does not need an emergency. They give me an appointment every month but they do not receive me. **A mother of a child with a disability who participated in this study**

Figure 11: Proportion of patients who have been solicited to pay extra fees to access health care services



As per the above statistics, the majority of respondents (more than 95%) affirmed that they had never been asked to pay extra fees while asking for medical treatment at different medical facilities. However, a small percentage (slightly below 5%) of people have been victims of such malpractice at various medical facilities. Although it seems that the number is small, the information they provide is based on experience or reality, and it is always challenging to discuss extra payments when a person speaks for themselves. It is often difficult for people to reveal information about themselves, especially when it comes to information about wrongdoing.

When this occurs, the most vulnerable citizens, including widows, single mothers, and poor families in general, may not be able to pay the solicited extra fees and therefore not receive medical services. These unethical practices, therefore, pose serious threats to inclusive service delivery in the health sector of Rwanda. Participants in the FGDs also expressed their concerns.

"Normally, we are informed that babies' vaccination record tracker notebooks are provided for free. However, once you lose it, community health workers demand about Rwf500 – 2,000 to help

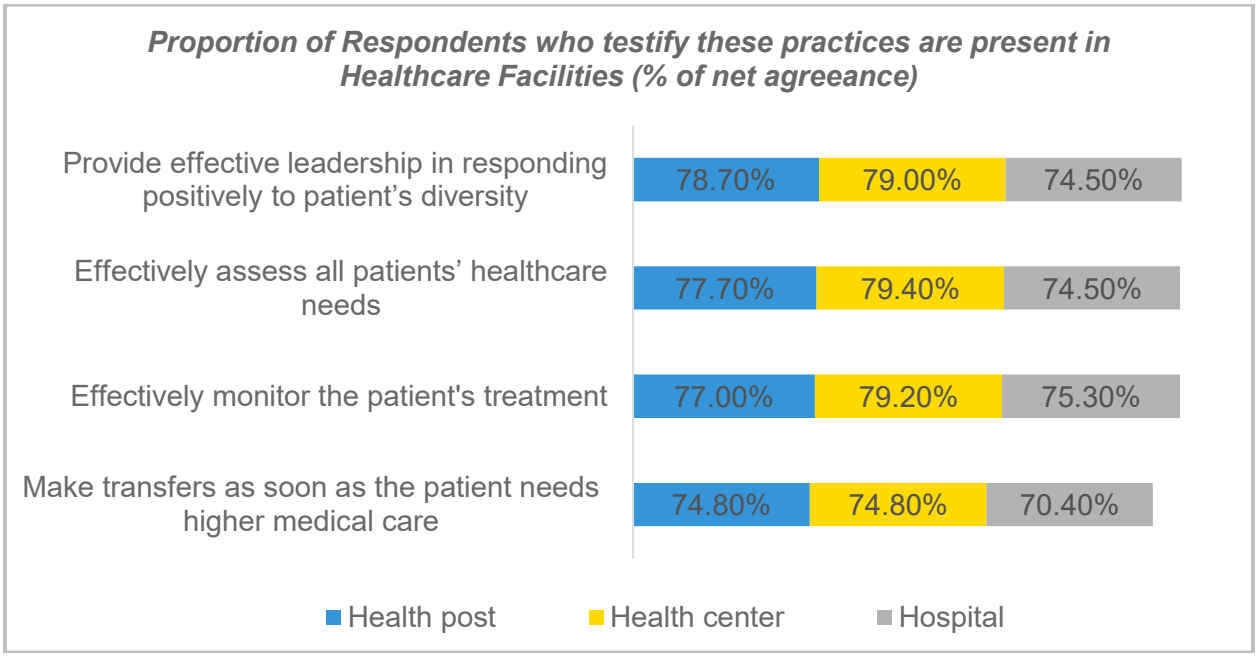
you get another one. You cannot get it unless you pay and they do not give you an invoice". **A participant in the FGD of people with chronic diseases**

"I was in hospital for a long time and I had no caretaker, I can testify how corrupt those supporting staff and security persons are. Patients or their caretakers usually bribe cleaners and security persons to allow any visitor to come in at any time. The bribe is always between Rwf500 – 2000". **A woman participant in FGDs**

In various health facilities, effective measures are being implemented to combat malpractices and bad behaviors of some medical staff. This has been reported by officials from health facilities during interviews.

A staff member at a Health Center in Musanze District: *At our health center, we try our best to make sure that all clients dissatisfied report malpractices. In so doing, we hang banners and posters on all entry points and doors or windows mentioning the phone numbers of the director or the president of health committee to whom they may report. In addition, we use suggestion boxes and Ijwi ry'Umurwayi (Voice of Patient) Program to report cases of poor service delivery and malpractice. This has yielded results because, for instance, we got information related to one of our staff who demanded payments to provide original copies of Igipande (babies' vaccination record tracker notebook) while they should be free of charge. The administration of the health center reprimanded him and he never did it again.*

Figure 12: Respondents' perceptions of good practices within healthcare facilities to assist patients in need of treatment

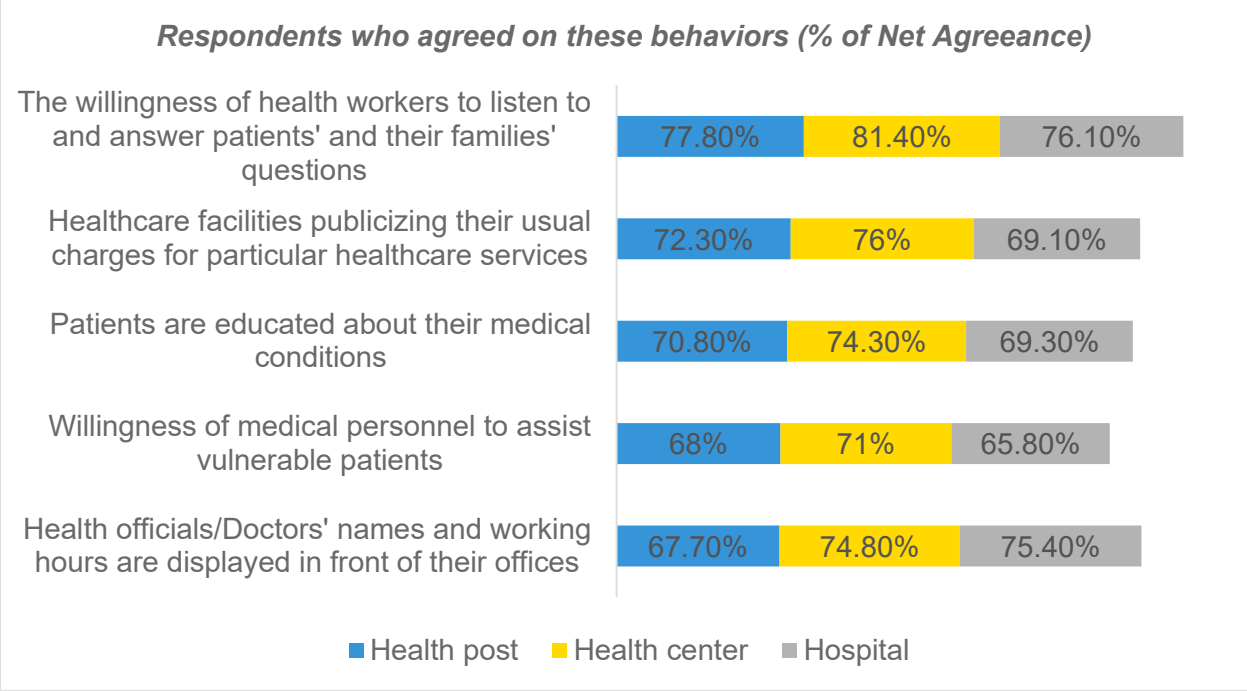


As per these findings, the majority of respondents agreed that there are good practices in healthcare facilities to assist patients in need of treatment. As per the statistics, 78.7% of respondents believe that there is effective leadership in health posts when it comes to positively responding to patients' diversity, compared to 79% who testify the same and 74.5% in hospitals and health centers, respectively. The respondents also testified that medical staff adequately assess each patient's healthcare needs in hospitals (74.5%), health centers (79.4%), and health posts (77.7%). The practice of effectively follow-up the patient's care at various medical facilities was also praised by the respondents. Hospitals (75.3%), health centers (79.2%), and health posts (77%) were among the healthcare institutions specified for good follow-up patient medical care. Additionally, respondents acknowledged the proper administration of medical transfers in health facilities. This was stated by respondents in the following healthcare facilities: hospitals (70.4% of respondents), health centers (74.8% of respondents), and health posts (74.8% of respondents). The majority of respondents recognize the value of these good practices, but more efforts are still needed, especially because although they are being implemented, they have not yet reached the desired level.

(% were obtained by gathering respondents who answered Completely True and Moderately True).

This is based on the fact that only a little more than 70% of the respondents agreed on these management practices in medical facilities indicating that some respondents still saw weaknesses in the implementation of these crucial patient support practices. Although there has been significant progress in the decentralization of health care services for the general public, these findings point to some management gaps in medical institutions that hinder the provision of universal health care. Effective leadership by healthcare professionals is crucial in modern healthcare settings. This is primarily motivated by the desire to improve healthcare delivery standards in light of the growing healthcare demand as well as the need for increased productivity and efficiency. Thus, the findings above show that there are still leadership deficiencies, especially when it comes to monitoring internal medical practices to ensure the quality of services. These leadership gaps might result in corruption or discrimination, which frequently badly impact the most vulnerable populations.

Figure 13: Respondents' perspectives on practices that promote transparency in healthcare facilities



A number of respondents pointed to specific practices for promoting transparency in healthcare facilities that still need improvement as shown in the below statistics. As per statistics, the respondents counted over 65% agreeing that these specified behaviors of medical staff are common in various healthcare facilities (% were calculated by adding up the number of respondents who selected always/often). More than 74% of respondents stated that it is a common practice in both health centers and hospitals to put medical staff' and doctors' names and working hours in front of their offices.

However, it seems less practicable in health posts (67.7%). In these findings, respondents also indicated that medical staff members are likely to be willing to assist vulnerable patients in health centers (71%), hospitals (65.8%), and health posts (68%). More than 70% of respondents commended the medical staff members demonstrated willingness to listen and address patients' inquiries in various healthcare facilities. In the same vein, the majority of respondents stated that different healthcare facilities frequently publicize the costs of the services offered and that patients are educated about their health conditions.

The majority of respondents indicated that these medical practices are valued, which is positive. These are actions that improve healthcare service delivery transparency. The statistics, however, indicate that there is still room for improvement as less than 80%, and even less than 70%, of respondents agreed with these fair practices, indicating weakness in some healthcare facilities. Transparency in medical care and other related services closes any room for corruption or discrimination because people are better informed about the services they are receiving and the requirements to access them. Patients will feel more confident in their capacity to demand accountability from service providers and to report any corruption/discrimination experienced when medical staff and health facility leaders are open to discussing with them their illnesses and other services.

On the other hand, lack of or poor transparency in the delivery of healthcare services opens the door to corruption and discrimination because it gives wrongdoers the chance to impose some illegal conditions in exchange for the treatments. Because they may not have the resources to pay bribes in exchange for treatments, vulnerable people, such as women, girls, and other groups at risk of discrimination, are frequently prevented from receiving health care services, especially if the service delivery process lack transparency. The thoughts of participants in FGDs on issues they often encounter in various healthcare facilities are shared below.

"I went to a hospital having an eye issue. After making a checkup, the ophthalmologist told me that the needed spectacle was not available on insurance. I said it was not true because I knew I could get it elsewhere on insurance. After some minutes, he told me I should get it from an optical center in the town. I went there and discovered that it was his shop/business". **A woman who participated in the FGDs from one of selected districts**

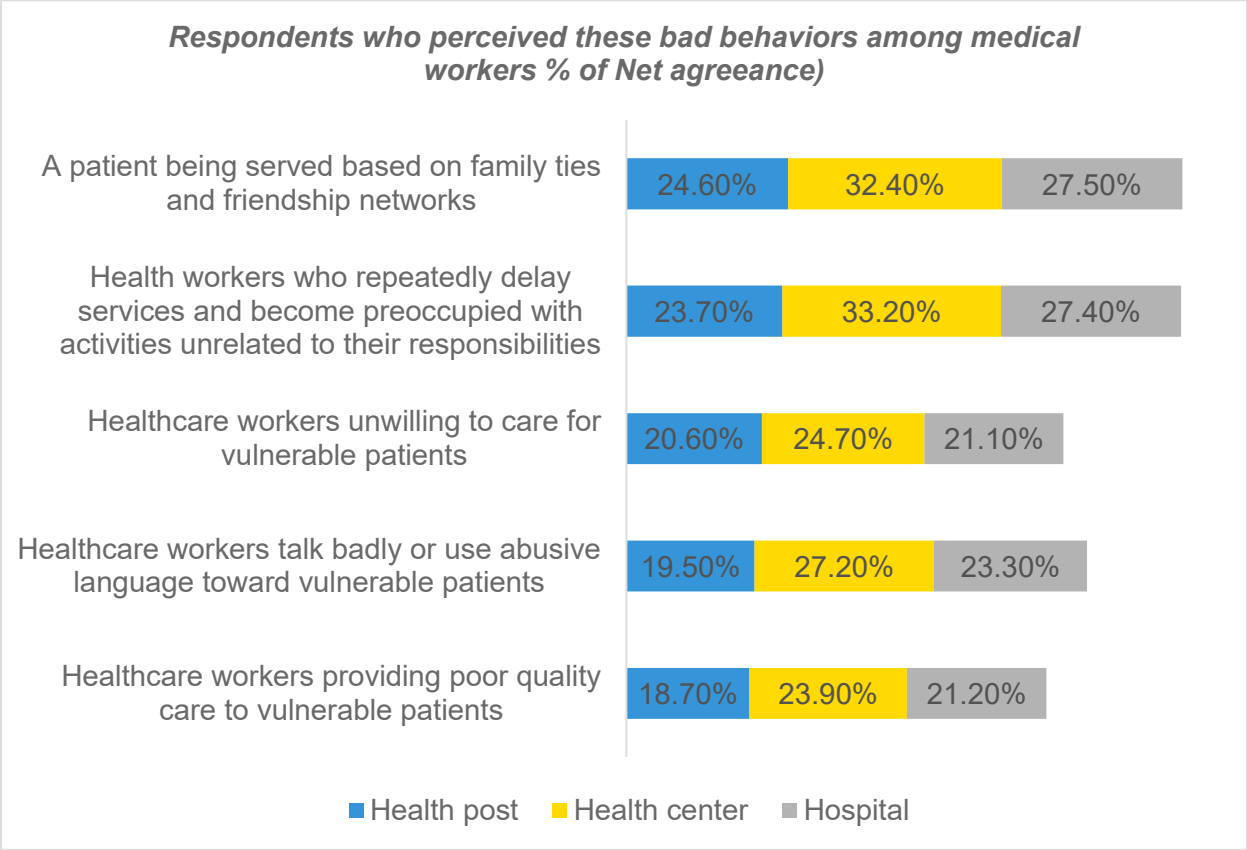
Due to poor antenatal care services at our hospital, most of the pregnant women no longer accept transfers to go there. Instead, they request transfers to go to another Hospital located very far from our area where they receive good service. When you turn up in our hospital, you witness all kinds of malpractices and injustices where vulnerable citizens have no one to help and receive them on time. **A woman with a chronic disease who participated in this survey**

One of the challenges mentioned by the Ministry of Health representative during the interview is the lack of sufficient doctors and other medical staff. Where he made note of the disparity between service providers and consumers, which can create gaps that could result in subpar services. He said that there is optimism for improvements in healthcare quality and that long-term solutions are being developed.

Health Facility Specialist at the Ministry of Health: *We are aware that doctors and healthcare workers are still few in our country. Therefore, the ministry has set a plan dubbed "Four by Four" in which we want to quadruple the number of doctors and healthcare workers. In so*

doing, we have seen an increase in medical schools in universities and higher learning institutions. Most of those schools are teaching doctors and nurses. Hitherto, in Rwanda, it is estimated that a doctor takes care of over 18,000 patients while he/she should care only about 10,000 per year.

Figure 14: Malpractices and bad attitudes of health workers in the medical facilities (% of agreeance)



According to 20 to 25% of the total respondents, healthcare workers in health posts, health centers, and hospitals are sometimes unwilling to care for vulnerable patients. Respondents also point fingers at healthcare workers who provide poor quality care to vulnerable patients; this issue is frequently seen in health posts, as indicated by 18.7% of respondents, health centers, as confirmed by 23.9% of respondents, as well as in various hospitals, as confirmed by 21.2% of respondents. Among the other bad behaviors that threaten healthcare service seekers revealed in this survey are healthcare workers' tendency to talk badly or abusively to vulnerable patients. The problem is visible in health posts (19.5%), health centers, (27.2%),

and hospitals, according to 23.3% of respondents. Other poor services revealed in this study include health workers who repeatedly delay services and become preoccupied with activities unrelated to their responsibilities. Corruption based on family ties and friendship networks, such as a patient being served based on family ties and friendship networks, is another serious bad behavior that disavantages those seeking health care services in various health facilities but do not have those connections. This issue is more prevalent in health centers than in other health facilities, according to 32.4% of respondents, followed by hospitals (27.5%), and 24.6% agree that these bad practices are also observed in health posts (% were calculated by adding up the number of respondents who selected Once or twice, Several times and Most of the time).

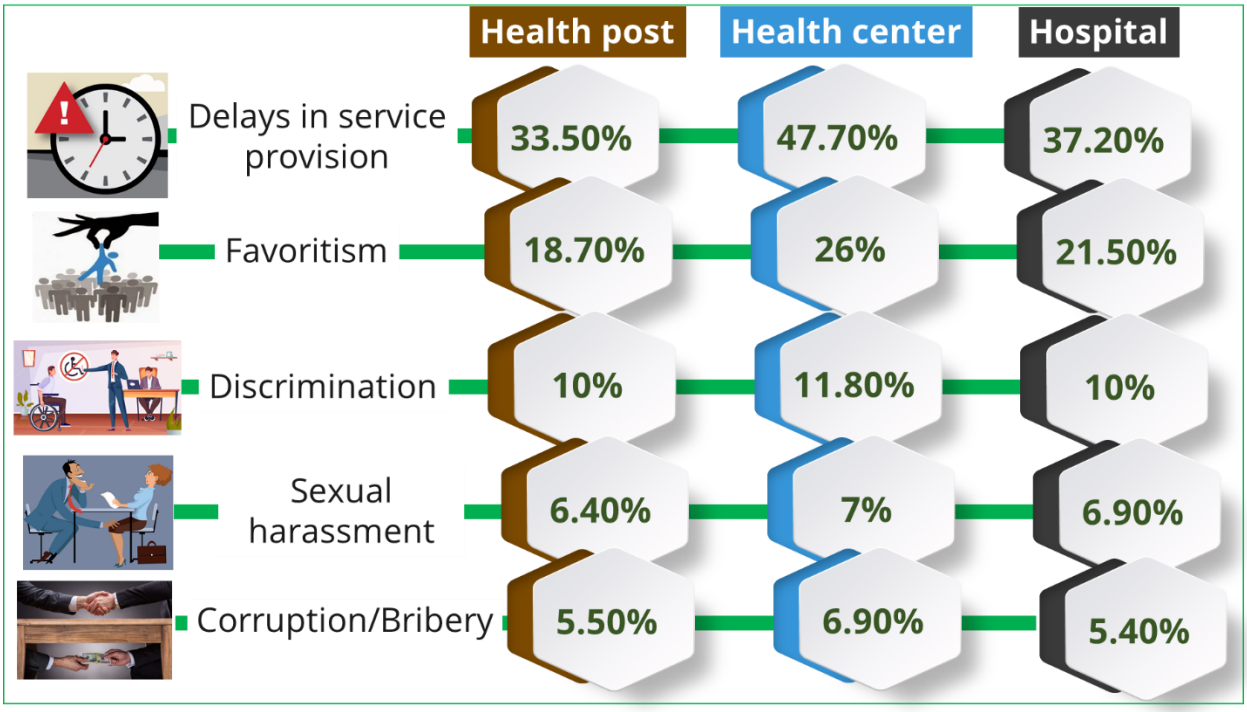
Whenever there are poor services in the delivery of health care services, it is a challenge for everyone seeking such vital services, but vulnerable citizens are often hit hard especially because they already have serious financial and social vulnerabilities. This can make them unable to access the services, which can pose serious effects on their health status. This is supported by a study conducted by (WHO, 2020) which shows that poor and marginalized citizens are disproportionately affected by the consequences of corruption in healthcare systems worldwide. As long as these impediments remain, Rwanda's inclusive healthcare services will remain obstructed. Participants in FGDs and KIIs also revealed the challenges they often face in healthcare facilities.

"Normally, people with disabilities should be among the patients who are received before others. However, at most health centers, they are told to wait and go to lines of people waiting for services. What is disappointing is that sometimes, due to favoritism, doctors receive patients who come after us and we get service later". **A woman with a physical disability who participated in this study**

It is very difficult to get a transfer to go to a specialized hospital unless you have someone with the power to help you. Sometimes, when I have a mental health crisis issue, they deny me a transfer to go to Neuropsychiatric Hospital. One of my neighbors was also denied a transfer to a specialized facility even though he needed it. We are not at all satisfied with the service at our hospital, because a neuropsychiatrist can come once a week. **A person with the neuropsychiatric problem who participated in this study**

I once got a transfer from a health center to a hospital but a doctor denied to receive me and said I should come back the following day. However, he kept on receiving other patients who had come after me. When I asked him why he cannot receive me, he said I had to wait. Some of the patients received ultimate appointments via phone calls and they were served before me. **Testimony of a woman with chronic disease from one of the districts selected in this study**

Figure 15: Respondents' perceptions on the existence of various forms of malpractices of health workers(% of agreeance)



According to statistics, delays in service provision are a major obstacle for patients visiting various healthcare facilities. Delays in service delivery are very prevalent in health centers as reported by 47% of the respondents, patients visiting hospitals also experience such delays as revealed by 37.2% while 33.5% of respondents who said that service delivery delays at health posts remain an issue. Favoritism is common in various health facilities, particularly health centers, and hospitals, as indicated by respondents ranging from 21% to 26%. 18.7% of respondents believe that such inappropriate behavior is common among health workers in Health Posts. Discrimination against people seeking health care is also one of the bad behaviors reported by respondents. Approximately 10% of respondents expressed their perception that discrimination exists in various health facilities such as health posts, health centers, and hospitals. Some respondents also expressed their perception that corruption/bribery and sexual harassment are present, though the numbers are smaller. Although these bad behaviors were reported by a small number of respondents, they are still worrying given the severity of their impact on the health of the most vulnerable people. Those suffering from chronic diseases like AIDS, those with physical disabilities, and the poor are among the vulnerable citizens who frequently seek healthcare services, so, understandably, they may face favoritism or discrimination as a result of their vulnerability status. Below are some views expressed by respondents during FGDs.

It hurts when you see a patient being treated specially or being served first due to family ties or just because he/she is a friend of a health service provider. Next time, you need to create a friendship with doctors, nurses, or other health service providers in a bid to secure attention in the future when you come back to the health facility. **Said a woman participant in the PWD's FGDs from selected districts**

When I gave birth to my firstborn, a doctor who operated on me asked me to visit him in his home after recovering but I refused. After some months, he was appointed as the head of the vaccination site. When I went for a vaccination, he took me out and did not receive me. I went to another site. **A woman participant in the PWD's FGDs from selected district**

A friend of mine went to a hospital seeking prenatal care services. Dismayingly, while making a checkup, a doctor stripped her and requested her to have sexual relations. Fortunately, at that very moment, another nurse entered the room which put an end to the planned harassment.
A participant in the Women's' FGD from one of selected districts

Normally, hospitals and health centers have set visiting times, and hours are specified. However, no matter when you come, security officers let you in when you bribe them and most of the visitors do so. **A woman participant in the PWD's FGD from one of selected districts**

Some female interns are victims of sexual harassment in health facilities and most of them are those doing supporting services. I know a young woman who was doing an internship in a hospital, after just two weeks, the director began to harass her and pressurize her into having sex with him. I met her mother trying to help her get an internship in another health facility.
A woman participant in the Women's' FGD from selected districts

Favoritism in health care services discourages those patients who may believe that their colleagues are treated better than them although they all need good services. As is common knowledge, favors are given in a reciprocal way, requiring the recipient of these favors to do the same as compensation. This may force the vulnerable who do not have sufficient financial means to decide not to seek treatment or submit to sexual overtures by healthcare providers. Interviews and focus groups with respondents revealed that some nurses exhibit such bad behaviors and tend to target women.

My brother who was a doctor at a hospital was caught red-handed sexually assaulting a female patient and he was drunk when it happened. To avoid other negative effects, he was advised to write a letter resigning and he did so. **A woman participant in the FGD from one of selected districts**

A nurse in charge of NCDs at a Health Center: *In our health center, we once had a nurse reported by citizens accusing him of sexually assaulting them. While we were making an investigation, he actually sexually abused another young lady and she reported him to the health center administration. Unfortunately, he escaped before the arrest and he is no longer here.*

Widows are very vulnerable to sexual harassment and assault in the health facilities. This is because when you turn up, they ask you if you have a husband. When you don't, they start telling you nonsense words. I have a friend of mine who was about to give birth but she was hesitant to go to the hospital because his husband was not available to accompany her. Finally, she delayed going to hospital which could undoubtedly have a negative impact. **A woman participant in FGDs from one of selected districts**

5.4. Testimonies Revealing barriers to Healthcare Access for women, girls, and other vulnerable groups

High-quality health services provide the right care at the right time, in response to the needs and preferences of the service users. Quality health care is consistent with seven measurable characteristics: effectiveness, safety, people-centeredness, timeliness, equity, care integration, and efficiency (Organization World Health, 2018). Providing high-quality healthcare services is critical.

To achieve full health coverage at an acceptable quality for all citizens, it is necessary to take into account not only individual barriers but also their cumulative impact on vulnerable people and their families. Although people with disabilities may have additional needs for general healthcare as a result of their disability, their impairments may worsen due to their vulnerability to poor health. During the FGDs, some respondents testified that some of the people with disabilities are considered a burden on service providers. They even add that there are still bad behaviors of service providers that make some of those seeking treatment fear or choose not to go to treatment. The Ministry of Health official during the interview said that

significant steps are being taken to support vulnerable individuals, especially those with disabilities, in having full access to healthcare.

Some service providers at health facilities have bad mindset regarding people with disabilities. Most of them perceive that we (people with disabilities) are burdens to them. They, therefore, do not give us care. For instance, without listening to my issue, they once told me to return home the next day. This negatively affected me because my home is not near the hospital, so I had to use a lot of money on tickets." **A woman with blindness disability who participated in this study**

A friend of mine told me that a doctor who was taking care of her asked her to have a love affair. However, the doctor had already given her a medical appointment, then she was in a dilemma if she could deny it. I advised her to pretend that she had accepted until she is well-treated. Fortunately, the doctor was transferred to another hospital before their appointment date." **A woman participant in FGDs from one of selected districts**

Health Facility Specialist at the Ministry of Health: *The government has made remarkable progress in ensuring inclusiveness in healthcare service provision especially when it comes to people with disability. In this vein, the government of Rwanda through the Ministry of Health is planning to increase the number of specialized hospitals for people with disabilities. So far, we have three best hospitals namely GATAGARA, RILIMA, and INKURU NZIZA all of which the government is supporting. In the coming days, the government is pondering over how it will cover some costs including salaries of all their employees.*

When I visited a hospital, I observed a woman whose abdominal organ had undergone surgery. Before they could finish, the organ was supposed to be placed in a particular liquid. However, they were told that the hospital's pharmacy did not have that specific medication. The woman, who could not afford treatment, remained in the hospital until her relatives and friends donated Rfw70,000 to purchase medicine from another country. **A woman participant in the FGD from selected district**

Strategic advisor at Rwanda Medical Supply: *We acknowledge that certain healthcare facilities run out of certain medications. However, it is usually caused by medical facilities delaying requests. We have at least 94% of vital products, about 97% of essential products, and 87% of non-essential medicines in our stocks. However, there have been instances where certain hospitals have less than 37% of all necessary medicines in their stores. This is due to health facilities' delays in submitting requests. Frequently, it's because they have so many unpaid bills. To resolve this matter, we committed to keep delivering medicines on loan in the event that healthcare facilities experience such financial trouble.*

CBHI/ Mobilization and Registration division at Division Manager RSSB: *The RSSB is aware that some hospitals and health centers occasionally run out of their stock of medications. Healthcare stakeholders are attempting to adequately address this issue, which has been brought up repeatedly. The RSSB has shortened the period for paying healthcare facilities' bills from 45 days to 15 days to remedy the problem.*

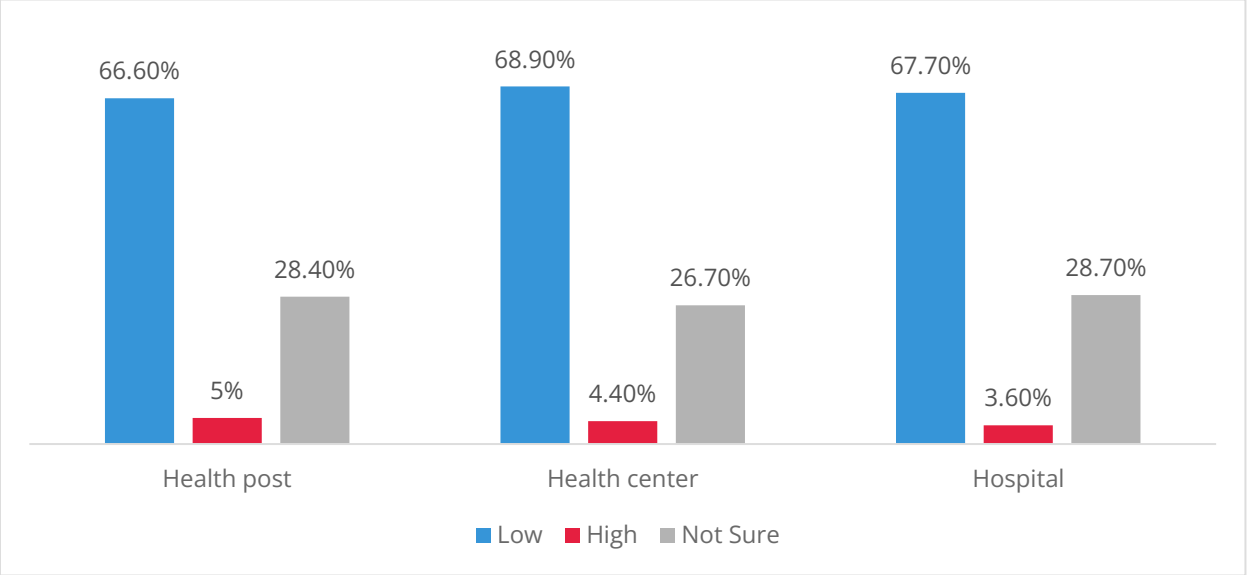
Health Facility Specialist at the Ministry of Health: *We are aware that sometimes some health facilities do not have medicines in their pharmacies while Rwanda Medical Supply has them in its stocks. This is because some of those health facilities delay requesting medicines when they have outstanding payments. However, none is denied medicines no matter how much debt it may have. Again, our advice is that when a health facility does not have a medicine or its alternative, a patient should automatically get a transfer to another hospital.*

5.5. The perception and experience of respondents (Including women, girls, and other vulnerable groups) on the level of corruption in the district's health centers and hospitals

Corruption in the health sector is a serious threat to access, quality, equity, efficiency, and efficacy of health services, as well as an impediment to achieving the long-term goal of universal health coverage. Corruption in the healthcare sector fuels inequality, disproportionately affecting the poor and other vulnerable groups who cannot afford to pay bribes. Widows, single mothers, teen mothers, women in extreme poverty, those suffering

from chronic diseases, and those with various disabilities are examples of vulnerable people who may not be able to afford to pay bribes to receive services and, thus, face the problem of limited access to health care, despite having no other options for treatment in private clinics. The purpose of this study is to investigate respondents' experiences and perceptions of corruption incidents in health facilities that prevent vulnerable groups from receiving proper healthcare services.

Figure 16: Respondents' views on the level of corruption in the health sector



As per these findings, the majority of respondents expressed their belief that corruption in healthcare facilities is at a low level, while a small number believe that corruption is at a high level and between 25-30% said they were unsure. Although respondents indicate their perception that corruption is at a low level, its impact on service delivery is severe, especially since numerous studies have revealed that corruption in healthcare services harms the most vulnerable citizens. According to TI, (2017), the poor are disproportionately affected by the impact of corruption in the health sector because they rely more on public services to access healthcare. Inequality is exacerbated by corruption in the healthcare sector. The poor and other marginalized groups are often hit hardest. According to TI, women's reliance on corrupt health services makes them vulnerable to abuse, preventing access to vital

contraceptive, reproductive, and child health services. Tragically, for many, this leads to poverty and, in some cases, death *(https://www.transparency.org/en/our-priorities/health-and-corruption).*

It is therefore critical to find a long-term solution to the corruption loopholes and risks that are still visible in health facilities to protect the most vulnerable citizens and ensure their access to healthcare services. Some of the respondents also testified that there are some doctors who exploit vulnerable women for sexual favours. During the FGDs, a female participant said:

When I was pregnant, I seriously fell sick and I spent so many days in the hospital. While there, I witnessed how unprofessional some healthcare service providers are. In that hospital, two young women had been impregnated by a doctor. This doctor used to check them solely at night, so no other doctor had to treat them. During the day they were admitted to the hospital without any treatment. I realized he was used to sleeping with them in his consulting room. One of those young women once told me she was accepting it because she was having financial difficulties. **A woman participant in FGD from one of selected districts**

At health facilities, single mothers, widows, and teen/young mothers are most likely to experience sexual corruption. Most of the time when a doctor asks you if you have a husband and you respond that you don't, the doctor's behaviors change right away. Sometimes, they ask for a phone number. **A single mother participant in an FGD from one of selected districts**

There is a clinic here in my city that has doctors who harass women patients. My friend went there to request a family planning service but a doctor sexually assaulted her and told her that she is beautiful. I know three women whom he assaulted. **A woman participant in FGDs from one of selected districts**

5.6. Intersectional analysis of how corruption/discrimination affects women, girls, and other groups at risk of discrimination while seeking healthcare services.

The healthcare system is critical to achieving health equity, and enacting laws and policies that promote health equity is thus regarded as a critical global mission. However, as reported in numerous studies, knowledge about disparities in healthcare utilization between groups defined by multiple and intersecting social categories is still limited (Nyamande et al., 2020). In developing countries, gender inequality is a major social issue that may harm women's health. In the study by Ogungbe et al., (2019), race, gender, sexual orientation, body weight, social class, nationality, and religion are common social identities in many developing and developed societies that are frequently subjected to discrimination. According to BMJ, (2023), current health disparities are the result of historical marginalization of various groups of people along multiple axes of discrimination. Health services will always fall short of their goals if people continue to ignore these multiple, interconnected, and context-specific forms of disadvantage. Eliminating healthcare disparities and achieving health equity should be top priorities in public health (Turpin et al., 2021). In this study, qualitative data were collected to analyze intersectionality to understand how different aspects of citizens interact to create unique experiences of discrimination or privilege in the delivery chain of healthcare. Respondents pointed out how specific forms of corruption affect women, girls, and how the victims might face discrimination when seeking healthcare services.

As various testimonies show, there are unique difficulties that hinder persons with hearing disabilities and people with visual disabilities from accessing adequate assistance. The fact that these people often face unique challenges related to their disabilities that prevent them from receiving healthcare properly may put them at risk for corruption in an effort to protect their lives.

A single mother with chronic disease in one of the districts selected under this study.

A friend of mine suffering from a chronic disease gave birth and, the fact that she is a very poor single mother, she was allowed to receive government support known as "Shisha Kibondo", the

flour used to make a highly nutritious complementary porridge for malnourished children. In my own eyes, she was refused assistance at the health center. She was required to pay a bribe to an official in charge of serving the support before she could get it. As the one who had accompanied her, I beseeched them to give her the support but they said her baby had no vaccination record tracker notebook. It is a handbook that is usually provided for free, and it is required at the time of vaccination only, so it was not clear why the lady was required to show it yet she did not come for vaccination services. In actuality, it was perceived as delaying the service in order to persuade the woman to accept payment of the bribe. He kept us waiting a long time, and since we were traveling a long distance and the woman was too weak to come back another time, especially since she is disabled, she made the decision to pay a bribe of 1000 frw to receive the help.

A single mother with a chronic disease in one of the districts selected under this study. *When I suffered Urinary Tract Infection, I went to a hospital but a doctor sexually assaulted me. When he was taking a test, because he was alone and no other person had accompanied me like a husband or any other relative, he stripped me and started touching me in my private parts. Right away, I stopped him, he then refused to treat me because I prevented him from reaching his goal of coercing me into a sexual act. I then went home without receiving any treatment. I suffered for two weeks without medicines. I continued to experience pain at home, and when I ran out of options, I made the decision to visit the doctor once more. When I arrived, I learned that the doctor had also harassed other patients sexually. I joined them in complaining about him. Due to pressure from different people, they decided to give me another doctor to treat him. Later, I learned that the doctor who was abusing women sexually had been transferred to another hospital. It is very sad to see someone who commits such crimes being awarded a transfer instead of arresting him.*

A widow with HIV/AIDS in one of the selected Districts: *Rwanda Biomedical Center (RBC) once came to our district with a mobile clinic that helped local residents to make tests for HIV/AIDS and other communicable/non-communicable diseases. At that time, I was diagnosed with a disease (HIV/AIDS) and doctors ultimately prescribed me drugs which I had to take through*

injections. After that period, I went back to a hospital to receive other HIV treatment shots, doctors discriminated against me. They whispered to one another that I might infect them. After spending a long time waiting for service, they sent me to their colleague who finally accepted. If I had a husband, I could have gone with him because, with his presence, they obviously had to speed up service.

A teen mother who is an orphan and also suffering from epilepsy disability from one of selected districts. *My mother passed away when I was still young and because our family is very poor, my father cannot meet all of our needs. The extreme poverty added to the fact that I was suffering from chronic epilepsy made my problems even worse. Unfortunately, it was during these difficult times that I was impregnated at a young age. The saddest thing is that I cannot receive any government support because local leaders categorized my family in the third Ubudehe Category. I tried all ways possible to receive "Shisha Kibondo (flour used to make a highly nutritious complementary porridge for malnourished children) government support meant for poor mothers, but they denied me the support because I fall under the so-called capable category. My father also endeavored to change the category but all his efforts are in vain. All of this increases the risk to my life and the life of my child, who already has malnutrition.*

Discriminatory corruption in healthcare settings is associated with poor health outcomes, and it may be especially harmful to people with disabilities, who are more likely to have pre-existing risk factors or medical conditions requiring regular or urgent treatment. People who experience discrimination might decide not to seek healthcare, which would make their lives worse. Some vulnerable people prefer to seek treatment at facilities located a long distance from their homes in order to escape discrimination at neighborhood healthcare facilities, even though they have serious challenges accessing transport facilitation. This runs completely counter to the government's measures, where various health posts are being built, to bring healthcare services closer to the community.

Feeling excluded raises the risk of depression and psychological alienation, causing vulnera ble women, such as widows or divorcees, to feel rejected and choose not to seek treatment

in health facilities. Other patients who face discrimination in the medical setting may lose trust in their providers, refrain from communicating openly, or choose not to seek healthcare at all. Given the extremely personal nature of healthcare, trust is essential to a good patient-provider relationship, and discrimination can cause significant damage to that trust. It is therefore critical for concerned institutions to take steps to address intersecting forms of discrimination in healthcare settings, such as those related to gender identity, Marital status, or income, and to ensure that everyone receives the same quality of care while taking into account the unique needs of each individual.

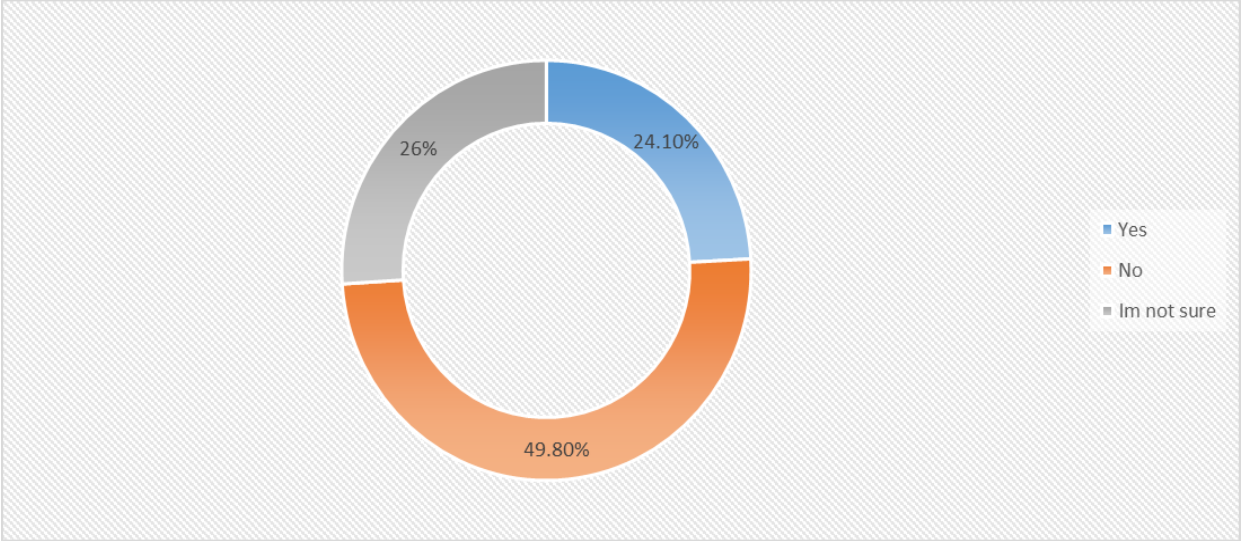
During the interview, the representative of the Ministry of Health indicated that proper measures are being established to promote universal health and remove all the obstacles that prevent vulnerable people from accessing healthcare.

Health Facility Specialist at the Ministry of Health: *As part of achieving universal health coverage depicted also in increasing health facilities including health posts at every local level, the Ministry of Health always endeavors to make sure that the quality of healthcare service is superb. At this juncture, the ministry and health institutions have toll-free numbers to receive complaints and we urge all health facilities to provide a phone number to be used by clients who are not satisfied with service. In addition, all hospitals and health centers have customer care officers and M&E Officers. More importantly, at every hospital, there is a special health committee comprised of different people who make up a kind of board. Those include normal citizens, the private sector, community health workers, focal persons from the ministry, and many others. Over and above, these days, we are kicking off a new project called "IJWI RY'UMURWAYI (Patients voice)" and, through this project, we want to increase the level of patients' feedback on how they receive service and fight injustices in service delivery.*

5.7. Effectiveness of accountability mechanisms in place to protect and secure victims (including women, girls, and other vulnerable groups) who report corruption and related complaints

People who report corruption may face several risks as a result of their actions. Given the sensitive nature of the information they reveal; they may face retaliation from those involved in the reported wrongdoing or their associates. Hence, people who report corruption must be protected and prevented from harm for them to do so safely and confidently. With this in mind, the purpose of this study was to determine the effectiveness of accountability mechanisms for reporting corruption in healthcare facilities.

Figure 17: Awareness of mechanisms for reporting corruption in healthcare facilities



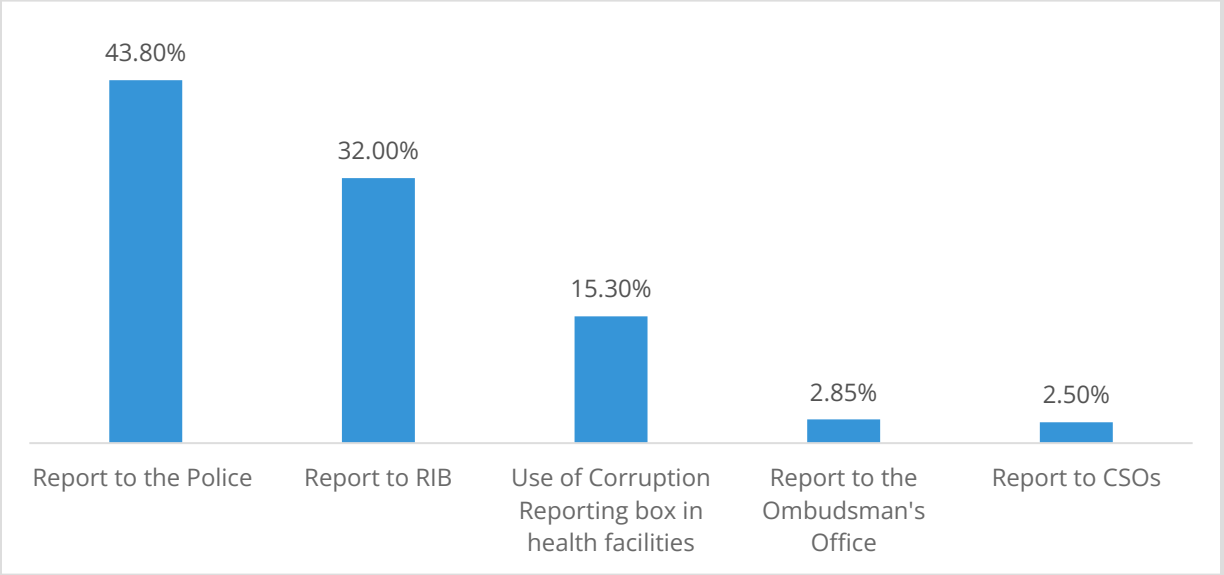
As per the statistics, the majority of respondents (around 50%) are unaware of the mechanisms for reporting corruption in healthcare facilities. Corruption victims in health care services are the most vulnerable people who lack the confidence to find a way to report it, often including illiterate or those who do not have a telephone or other means to contact relevant authorities, so, understandably, these people may not know how to file complaints of corruption. It is critical to raise community awareness, particularly among vulnerable

citizens, about the various mechanisms for reporting corruption cases in healthcare facilities. Corruption disproportionately affects disadvantaged groups and individuals. Due to pre-existing inequalities and intersectional discrimination, corruption has a disproportionate impact on women, girls, people with disabilities, people with chronic diseases, and people living in poverty, as they are often more reliant on public services and have limited means to seek alternative private services. Thus, if no efforts are mobilized to raise awareness about reporting corruption in health facilities, it can put the lives of these vulnerable groups at risk.

5.7.1. The most common channels for reporting corruption cases in healthcare facilities

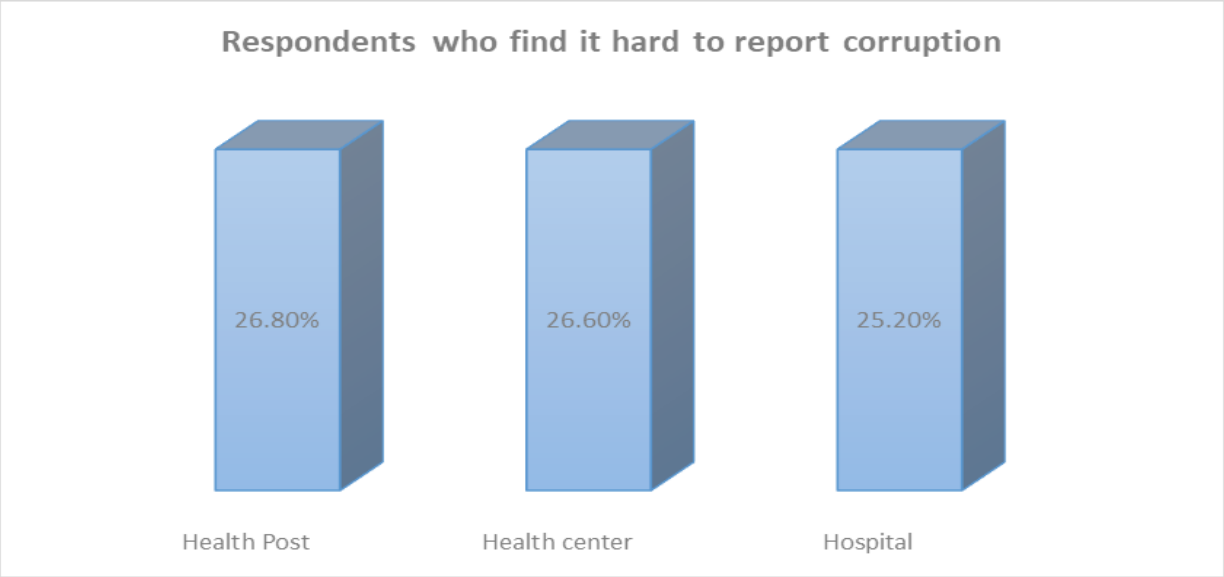
Effective complaint mechanisms are an important tool for detecting and preventing corruption and other forms of malpractice. Complaint mechanisms enable the identification of problems that would otherwise go unnoticed by providing citizens with channels to report any incidence or suspicion of corruption or other malpractice, as well as the subsequent implementation of corrective action. Therefore, credible and functional complaint mechanisms are an important tool in managing corruption risk and potential reputational damage for public institutions, businesses, and non-profit organizations (Transparency International, 2016). This study sought to identify the common channels that are frequently used in reporting cases encountered in healthcare facilities.

Figure 18: The common channels for reporting corruption cases in healthcare facilities



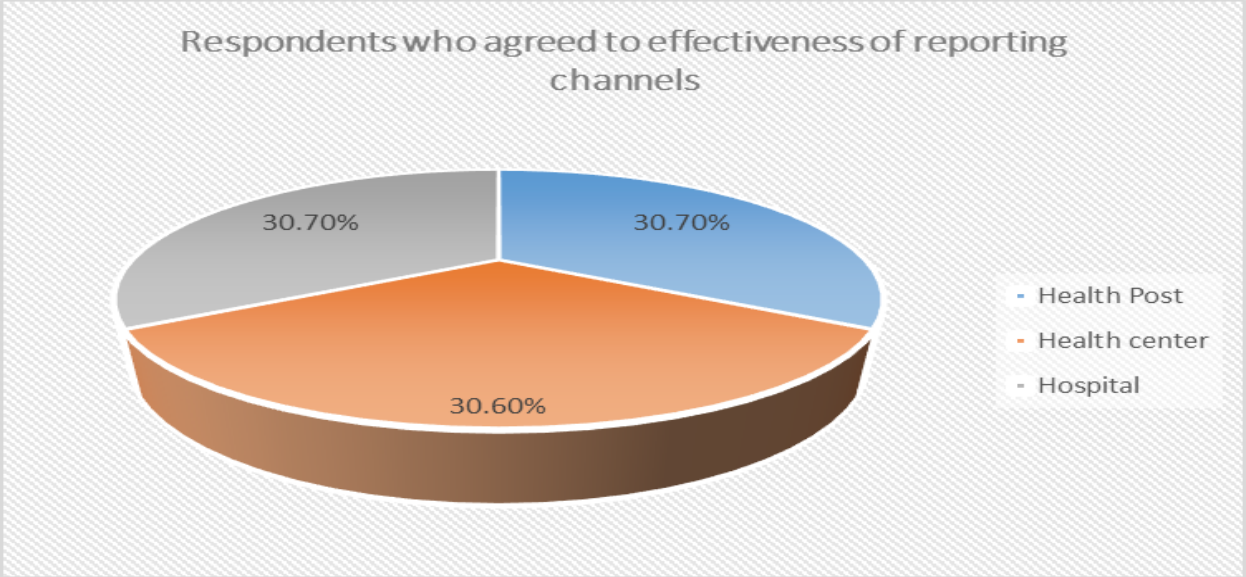
According to these figures, a large number of respondents frequently report corruption cases to the Rwanda National Police (RNP). As revealed in these statistics, the respondents testified that the RIB Stations are also often used by the citizens to report corruption encountered in health facilities. Given that the RNP and RIB are government agencies that are very close to the community and frequently engage the public in anti-corruption campaigns, it is not surprising that people go to these offices to report corruption. Respondents also stated that people who encounter corruption while seeking health care services, report it using suggestion boxes fixed in various health facilities. As revealed in these findings, the Office of the Ombudsman and the CSO are rarely used to report corruption. Community members, particularly service seekers, are often the first to witness or experience corruption, particularly when seeking health care. They can be useful in reporting corruption through standard reporting channels at various levels to help expose it. To engage citizens in reporting corruption, more reporting mechanisms that are closer to the community are needed.

Figure 19: Perceptions of respondents regarding the difficulty of reporting corruption in healthcare facilities



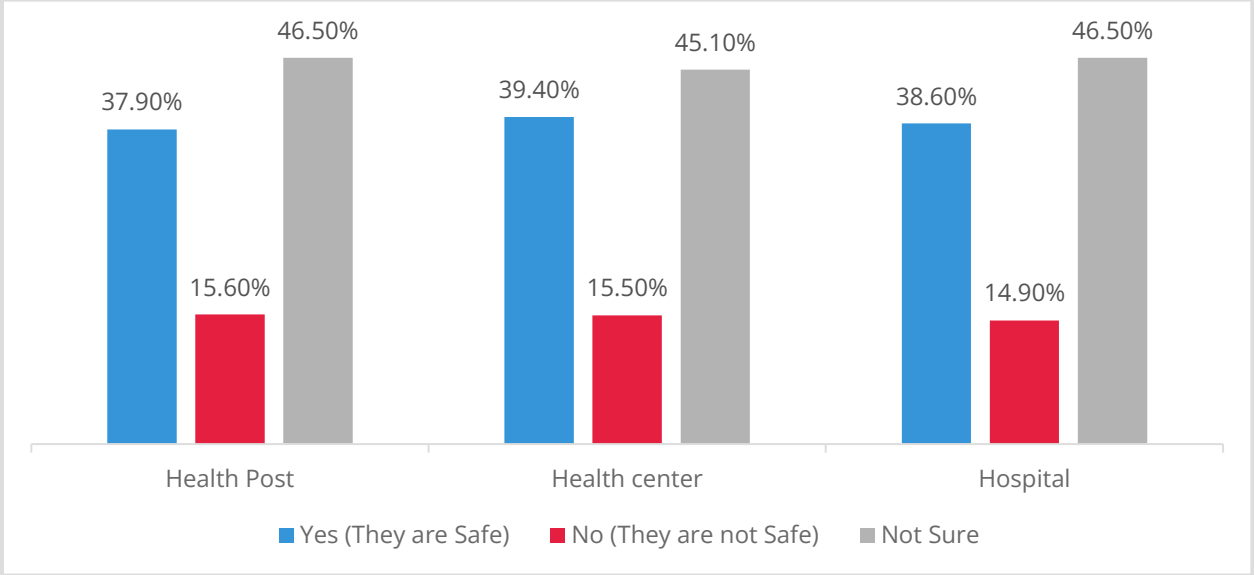
Corruption is a widespread social problem that affects everyone. Corruption affects everyone because the costs of corruption are borne by society as a whole, whether they represent a small or large business or work in government, whether they are employers or self-employed, rich or poor. Therefore, everyone in society has a vested interest in preventing corruption, and everyone must bear some of the blame. Corruption should never be accepted as an unavoidable fact of life. Everyone has the ability and responsibility to help foster a culture of transparency, integrity, and accountability. To achieve this, a simple method for everyone to report corruption cases encountered or known needs to be developed. Worryingly, the number of respondents between 25 and 27% indicated that it is hard to report corruption in healthcare facilities. Whenever reporting corruption is still hard, people will be afraid of being targeted which could affect them. Either the perpetrators will try to take revenge or expose those who made claims of corruption to their colleagues, making them more vulnerable to poor services because they are suspected of reporting corruption. Thus, finding a fair way to file corruption complaints is critical, so that those who file them are not exposed and are protected from any potential harm, especially given that the perpetrators of corruption have authority over them.

Perceptions of respondents on the effectiveness of the channels used to report corruption cases in terms of follow-up including the appeal process in health facilities



People should be able to report corruption confidentially or even anonymously through effective reporting channels. Confidentiality is needed to build trust with those who report corruption and face numerous risks while doing so, as well as to allow them to report cases with tangible facts. The identity of the person reporting corruption should be protected and disclosed only if she or he agrees or if required by law. However, the statistics in these findings show that the channels used in reporting corruption are not effective enough. This is based on the fact that only about 30% of respondents praised the effectiveness of corruption reporting channels in health posts, health centers as well as in hospitals (% were calculated by adding up the number of respondents who selected very effective and effective). Corruption harms both society and business, posing serious financial, operational, and reputational risks. The corruption reporting system is a critical tool for reducing corruption risks in a variety of healthcare settings. Therefore, there is a pressing need for better approaches to reporting corruption while simultaneously protecting the complainants and guaranteeing that the complaints are conveyed to the designated parties in good condition.

Figure 20: Respondents' perceptions of the effectiveness of measures to protect those who report corruption in the healthcare sector from harassment and abuse



The safety of those who report corruption is critical to the success of anti-corruption detection and enforcement, and it should be a key component of any corruption reporting system. Persons who report corrupt practices may endanger themselves, family members, and colleagues because those involved in corruption receive substantial benefits and face serious criminal and other punishments. Meanwhile, more than 14% of respondents indicated that people who report corruption in health posts, health centers, and hospitals are not safe and may face repercussions if they are suspected of doing so. According one a study (UNODC, 2015), corruption is a serious crime with far-reaching consequences, but most cases go unreported and unnoticed. People are hesitant to report because they believe authorities will not take their report seriously and that nothing will be done. This study also revealed other factors contributing to this reluctance including a lack of knowledge about available reporting mechanisms and a fear of retaliation. Thus, there is a need to improve the safety of people who file corruption complaints in the context of improving collaboration between administrative bodies and citizens who frequently encounter corruption cases while seeking health care services in health facilities. During FGDs, respondents identified major obstacles to reporting or denouncing corruption cases in various health facilities.

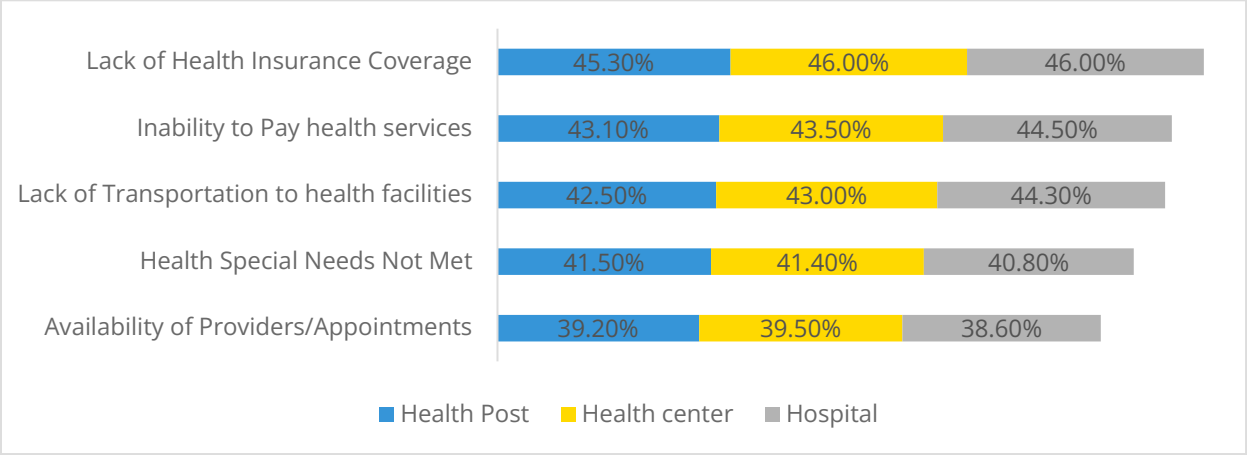
I am a victim who experienced retaliation from health service providers (revenge) after my friend reported their malpractices. When I went for the circumcision of my little son, though I had insurance and transfer, a doctor said I had to fully pay for myself 100% which I denied. It was because I was accompanied by the specific individual who had previously reported him. The doctor accepted to circumcise my son but it's very dismaying that he never covered/dressed the wound with gauze. My son's situation worsened after a few days, and I took him to the same hospital again. However, when I turned up, another doctor denied receiving him saying the one who had circumcised him was absent. I reported the case to a Customer Care Officer who intervened and doctors accepted to help me after a long discussion they had. **A woman with a blindness disability from one of selected districts**

I'm a victim of doctors' sexual assault and they intimidated me when I tried to report them. When I went for a pregnancy checkup, a doctor started touching me everywhere, especially my sexual parts. He explained that he was performing a routine checkup when I questioned why he was touching me. Later on, his colleague came and requested me to again go for a checkup. I woke up and said I was going to report them but they intimidated me that they would do their bests and that no other doctor could take care of me. However, both of them continued to laugh with joy. The fact that they thought I don't know foreign languages, and they started talking in English and making comments about my sexual parts. Because I was hospitalized, I ultimately went back to my room. In the following days, all nurses and doctors started whispering that I was rude and that I did not want to have a checkup. One day, another doctor came and said he would take me out of the hospital, saying I was denying a checkup. I told him the truth that his colleagues had assaulted me and I immediately took his photo with my smartphone. I told him: "I will report all of you!" He was very afraid and he called his colleagues who had assaulted me and they apologized for what they had done. I kept quiet and did not report them because they begged forgiveness. **A women participant in FGDs from one of selected districts**

I will never report a doctor due to what I witnessed. I once went to a hospital. I heard doctors whispering that there was a patient who had reported them to their supervisor and that she was

coming back. They were discussing their desire to exact revenge on her. **A participant in the FGD of people with disability from one of the selected districts**

Figure 21: The main barriers preventing women, girls, and other vulnerable people in the community from accessing health care services



Respondents in this study identified the main barriers to healthcare access for women, girls, and other vulnerable people in the community. According to statistics, the main barriers that prevent vulnerable citizens from receiving proper health care services are a lack of health insurance coverage, limited transportation options, and inability to pay for medical services. More than 45% of respondents agreed that these barriers pose a serious threat to inclusive healthcare services in health posts, health centers, and hospitals. Health Special Needs Not Met, Unable to Pay for Health Services, and Lack of Transportation to Health Facilities are among the other barriers that were mentioned by more than 41% of the respondents.

These barriers to women, girls, and other groups at the risk of discrimination from accessing health care services are very consistent with other findings of various studies that show women and girls as a vulnerable group of people who often face threats and discrimination that make them victims of various diseases. These are not new issues, as they have been raised in previous studies. In Rwanda for example, lack of money and distance to the health

facility were reported among the top issues limiting women's access to health care services in a study conducted by the Gender Monitoring Office in the past five years.

Although community participation in Community Based Health Insurance (CBHI) contributions is frequently high, we cannot ignore the fact that it does not always reach 100%, and some districts do not even reach 80%, leaving a gap in accessing health insurance coverage for low-income families. As was revealed on the social media of Rwanda Social Security Board (RSSB), the contribution of CBHI in all districts ranges from 79 to 98% in the 2022-2023 fiscal year, compared to 92 and 62% in the fiscal year 2020-2021 *(https://www.ktpress.rw/2020/10).* Therefore, this confirms respondents' views that a lack of health insurance is one of the barriers that prevent vulnerable citizens from accessing healthcare.

According to the World Health Organization (WHO), women's and girls' health and well-being are jeopardized by gender inequality and discrimination across the world. Women and girls frequently face greater barriers to health information and services than men and boys. Women and girls are also subjected to unacceptable levels of violence as a result of gender inequality, and they are particularly vulnerable to harmful practices. Rigid gender norms also hurt people with diverse gender identities, who are frequently subjected to violence, stigma, and discrimination in healthcare settings *(https://www.who.int/health-topics/gender#tab=tab_1).* Therefore, to improve access to health care services for women, girls, and other people who are at risk of discrimination, it is necessary to take measures that remove these barriers that may endanger the health status of these vulnerable citizens. The responders to the FGDs and KIIs reported that there are still some frauds committed mostly by individuals in the Community Based Health Insurance process.

We find fixing errors on the Community-Based Health Insurance (CBHI) card extremely challenging because local officials demand bribes. For instance, the Socio-Economic Development Officer (SEDO) of our cell requested Rwf500 to make improvements. He claims that the money is for

purchasing megabytes (data bundles) to access the system, although he is responsible for paying for it and is employed by the government. He denied me the services I wanted because I couldn't afford the money. **A male participant in FGDs from one of the selected districts**

Director of CBHI/Medical Benefits Division*: The fact that the payment of Community Based Health Insurance (CBHI) is made based on UBUDEHE categories, there are cases of some local leaders who were caught changing UBUDEHE Categories of CBHI users in a bid to help them pay less or get CBHI government support allowed to vulnerable citizens who are in UBUDEHE Category 1. Due to this fraud, some local leaders have been dismissed and others were scolded.*

6.CONCLUSION

The survey aimed to assess how Corruption threatens access to Healthcare for Women, Girls, and other Groups at Risk of Discrimination in various health facilities operating in five districts of Rwanda. As per the findings, efforts are being made to promote universal healthcare access, such as decentralizing medical services through the construction of health centers and health post facilities. More efforts are also being made to provide citizens with affordable community health insurance. Nonetheless, the statistics show small gaps that are still prevalent in various health facilities, preventing vulnerable women and other vulnerable citizens from accessing quality healthcare services.

Favoritism in various health facilities, particularly health centers, and hospitals, was mentioned as one of the barriers preventing vulnerable citizens from accessing healthcare . One of other bad behaviors reported by respondents is discrimination against vulnerable groups in health posts, health centers, and hospitals. Bad behaviors of some medical staff that lead to sexual abuse, favoritism, bribery and other malpractices that harm vulnerable people seeking healthcare were also revealed by respondents during FGDs. The thoughts of officials from various institutions in the health sector on the issues raised in this study were also gathered via interviews with representatives of the Ministry of Health, (MoH), Rwanda Social Security Board (RSSB) and a Rwanda medical supply (RMS). They contend that while there are still a number of issues (Individual not institutional cases) that pose threats to universal healthcare, there are also proper measures intended to eradicate bad behaviors, which are particularly prevalent among individuals working in healthcare facilities.

7. RECOMMENDATION

The study's recommendations aimed to suggest specific interventions to address the issues and constraints revealed by the findings. These recommendations will be used by various decision-making bodies to address identified issues that prevent vulnerable people from accessing healthcare.

Table 6: ***Recommendation***

Identified issue	Solution required	Concerned institutions
Even though overall level of corruption is perceived to be low, the level is perceived to be somewhat higher by members of vulnerable groups	Establishing an operational committee to measure, keep track of, and expose corrupt activities and risks of corruption in all healthcare facilities. On a regular basis, the committee must report on inappropriate behaviors in healthcare facilities that may lead to corruption. Perpetrators of corruption in the healthcare sector should face justice.	MoH, RBC, RMS, RSSB, MINALOC, OoO, RIB, RNP, MINIJUST, CSOs, Healthcare facilities
Findings revealed a very low level of citizen awareness of channels for reporting corruption in healthcare facilities	Increase efforts to raise citizen awareness of channels for reporting corruption in healthcare facilities. Conducting awareness campaigns using various channels suitable for the community, such as community meetings, community works, radio, and through community health programs	MoH, RBC, RMS, RSSB, MINALOC, OoO, RIB, RNP, MINIJUST, CSOs, Healthcare facilities

Respondents stated that there are no effective mechanisms in place to protect those who report corruption in healthcare facilities.	Establishing whistleblower channels that allow people to report corruption, in a confidential manner and with a simple form, includes a hotline for phone complaints, digital whistleblower platforms, and other reporting options.	MoH, RBC, RMS, RSSB, MINALOC, OoO, RIB, RNP, MINIJUST, CSOs, Healthcare facilities
Findings revealed barriers preventing women, girls, and other vulnerable people in the community from accessing health care services, such as a lack of insurance, inability to pay service fees, limited medical appointments, and waiting for services for a long time. It was found that some people are not helped despite their inability to pay for healthcare services.	Establishing a task force to closely monitor the selection of the most vulnerable citizens benefiting from free CBHI. Increase efforts in campaigns to encourage all citizens to pay CBHI contribution. Increasing the number of medical professionals to improving access to medical appointments.	MoH, RBC, RSSB, MINALOC, CSOs, Healthcare facilities
The findings revealed inappropriate behaviors among healthcare providers that lead to corruption/discrimination/	Establishing anti-corruption/discrimination/injustice committees in all health facilities, as well as appointing a focal person for gender equality. Mobilizing the public to report any inappropriate behavior	MoH, RBC, Healthcare facilities

favoritism as well as sexual harassment against vulnerable citizens in various health facilities	observed while seeking medical care. Establishing appropriate accountability mechanisms to closely monitor the services provided in various health facilities' consultation rooms. Ordering all healthcare facilities to establish a Code of Conduct that sets the standard of conduct expected of healthcare professionals, support workers, and others who are related to the provision of services in healthcare facilities, and it should clearly reflect the behavior and attitudes of such staff	
Some respondents reported being denied or charged extra fees to access healthcare services.	Establishing and posting (in open spaces) prices for all healthcare services, and monitoring compliance	MoH, RBC, RSSB, Healthcare facilities

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