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HFG BANGLADESH GENDER STRATEGY

July 2015 Update
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The Health Finance and Governance Project

USAID's Health Finance and Governance (HFG) project will help to improve health in developing countries by expanding people's access to health care. Led by Abt Associates, the project team will work with partner countries to increase their domestic resources for health, manage those precious resources more effectively, and make wise purchasing decisions. As a result, this five-year, $209 million global project will increase the use of both primary and priority health services, including HIV/AIDS, tuberculosis, malaria, and reproductive health services. Designed to fundamentally strengthen health systems, HFG will support countries as they navigate the economic transitions needed to achieve universal health care.

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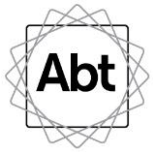

Abt Associates Inc. | 4550 Montgomery Avenue, Suite 800 North | Bethesda, Maryland 20814

T: 301.347.5000 | F: 301.652.3916 | www.abtassociates.com

Avenir Health | Broad Branch Associates | Development Alternatives Inc. (DAI) |
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Table 1: Monitoring Plan 9

ACRONYMS

ANC	Antenatal Care
BDHS	Bangladesh Demographic and Health Survey
CWFD	Concerned Women for Family Development
DCE	Discrete Choice Experiment
GIO	Gender Integration Opportunities
GIZ	German Society for International Cooperation
GOB	Government of Bangladesh
HCF	Health Care Financing
HFG	Health Finance & Governance Project
M&E	Monitoring and Evaluation
MNCAH	Maternal, Neonatal, Child and Adolescent Health
NGO	Non-Governmental Organization
NHA	National Health Accounts
NHSDP	NGO Health Service Delivery Project
OP	Operational Plan
PIO	Public International Organization
PMP	Performance Monitoring Plan
RMG	Ready-Made Garment
RMNCH	Reproductive, Maternal, Newborn and Child Health
SHI	Social Health Insurance
SSFP	Smiling Sun NGO Franchise Program
USAID	United States Agency for International Development
WHO	World Health Organization

1. GENDER EQUALITY AND FEMALE EMPOWERMENT IN BANGLADESH

Bangladesh is widely regarded as a positive outlier among developing countries. Despite low levels of per capita income, repeated natural disasters, weak governance, and the confrontational politics of a young democratic system, Bangladesh has achieved dramatic improvements in areas including education, fertility, mortality, and immunization. However, the concept referred to as the "Bangladesh paradox" denotes that the country is not without challenges, especially when viewed through a gender lens. Based on data collected for the USAID/Bangladesh 2010 gender assessment, labor force participation of women is low by South Asian standards at about 26%, and domestic violence is common.[1] Also from this data, we learn that: one in two women experience physical violence in the home; women's property ownership is rare; and less than 10% of all women are named as owners of marital property. Maternal and neonatal mortality and malnutrition rates also remain high. The World Health Organization (WHO) estimates that maternal mortality is about 170 per 100,000 live births (2013).[2] The 2010 Bangladesh Maternal Mortality and Health Care Survey finds that maternal mortality declined from 322 in 2001 to 194 in 2010, a 40 percent decline in 9 years.[3] The same source finds that two-thirds of maternal deaths are due to direct obstetric causes, including hemorrhage and eclampsia. Deliveries with medically trained providers are needed to address these cases – however, socio-culturally women often face barriers to accessing such care, particularly in rural areas. Findings from the 2014 Bangladesh Demographic and Health Survey (BDHS) reveal that 62 percent of live births (in the three years preceding the survery) are home deliveries – it is 42 percent in urban areas and 69 percent in rural areas.[4]

An estimated 30% of adult Bangladeshi women are malnourished.[5] Furthermore, in the last 30 years there has been a shift from a marriage regime of "bride price" to dowry, resulting in an increase in dowry-related violence against women. USAID/Bangladesh and its partner organizations recognize the importance of gender integration, but implementation remains uneven. Non-governmental organizations (NGOs) have successfully channeled resources toward the provision of health services, however, only a few are beginning to integrate and address gender and empowerment concerns in projects. Many NGOs continue to believe that by focusing on women beneficiaries they are addressing "gender," but fail to address underlying social norms and power relations that perpetuate inequality. Moreover, gender is sometimes treated as an "add on" – and not sufficiently woven into planning, design, implementation, and monitoring and evaluation. Furthermore, while indicators are mostly disaggregated by sex, they tend

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[1] Britt C, Ali. Younus Ali, Nasrin Rahman Jahan. April 2010. Gender Assessment USAID/Bangladesh. Arlington, VA: DevTech Systems, Inc.
[2] Maternal Mortality Ratio Interagency Estimates, Bangladesh, 2013. WHO Global Health Observatory Data Repository http://apps.who.int/gho/data/node.country.country-BGD
[3] 2010 Bangladesh Maternal Mortality and Health Care Survey. http://www.cpc.unc.edu/measure/publications/tr-12-87
[4] National Institute of Population Research and Training (NIPORT), Mitra and Associates, and ICF International. 2015. Bangladesh Demographic and Health Survey 2014: Key Indicators. Dhaka, Bangladesh, and Rockville, Maryland, USA: NIPORT, Mitra and Associates, and ICF International.
[5] Britt C, Ali. Younus Ali, Nasrin Rahman Jahan. April 2010. Gender Assessment USAID/Bangladesh. Arlington, VA: DevTech Systems, Inc.

to offer little information on changes in gender relations. As a result, important gender integration opportunities (GIOs) are being lost.

1.1 *Key Concerns Related to Gender in Bangladesh*[6]

Maternal and neonatal mortality: A high maternal mortality ratio is one of the strongest indicators of gender inequity. Poverty and the disempowerment of women – low status, lack of power, lack of access to information, limited mobility, lack of decision-making and choice, early age of marriage, and violence – contribute to maternal mortality, unintended pregnancies, problems in preventing and treating HIV/AIDS, and gender-based violence. Women, whether rural or urban, face many barriers to access to primary health care services including physical access and financial barriers to access. With the rapid urbanization of Bangladesh the urban barriers to access are increasingly seen as a challenge. The 2013 Urban Health Survey finds that 37 percent of deliveries in City Corporation slums are by trained medical providers (among women with live births) compared with 68% for women living in non-slums.[7] Gender equity and positive health outcomes are mutually reinforcing. Women's control over financial resources and decision-making are fundamental to their capacity to access and use health information, make informed decisions about their health and fertility, and to negotiate and insist on safe sex practices. To that end, identifying ways to reduce barriers related to access and control over money, and when and how health services are purchased such as through insurance or other prepayment mechanisms, could prove beneficial to achieving both health and empowerment goals. The 2010 BDHS indicates that in the five years preceding the survey (approximately 2010-2014) the infant mortality rate was 38 deaths per 1,000 live births, with neonatal deaths accounting for 61 percent of all under-5 deaths. This is another issue that can be addressed by improving pregnant women's access to care, particularly by a trained medical provider during delivery.

Labor-force participation: Increasing access to income and productive resources will improve women's ability to access services, support themselves and their children, and avoid coercive and high risk activities that increase vulnerabilities. However, the social and economic consequences of imbalances in opportunities available to men and women in the labor force need to be considered. Even though women's participation remains low, low-skill and low-wage jobs for women may begin to exceed formal sector opportunities for men in the next several years. Labor force participation for 20-24-year-old women more than doubled from 1995 to 2000, but declined for men in the same age group. The demographic bulge in the youth cohort could further exacerbate the situation, with growing resentment and frustration sustaining (or even increasing) the already unacceptable levels of violence against women.

The export-oriented ready-made garment (RMG) industry in Bangladesh is the largest empoyer of women in the formal manufacturing sector. Of the estimated 4 million people working in 6,000 factories, approximately 80% are women, mostly from low income families.[8] Work in the RMG industry provides women greater control over their labor and earnings and significantly affects their ability to negotiate with dominatnt family members, postpone their age of marriage, and be perceived and valued

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[6] Unless otherwise indicated, extracted from Britt C, Ali. Younus Ali, Nasrin Rahman Jahan. April 2010. *Gender Assessment USAID/Bangladesh.* Arlington, VA: DevTech Systems, Inc.

[7] National Institute of Population Research and Training (NIPORT), International Centre for Diarrhoeal Disease Research, Bangladesh (icddr,b), MASURE Evaluation. 2015. *Bangladesh Urban Health Survey 2013 Final Report*. Dhaka, Bangladesh and Chapel hill, North Carolina (USA): NIPORT, icddr,b, and MEASURE Evaluation.

[8] Hossain, Md Tanjim and Moon, Jannatul Mawa. 2014. *RMG- The Leading Earning Sector in Bangladesh*. http://textilelearner.blogspot.com/2014/07/rmg-leading-earning-sector-in-bangladesh.html#ixzz3SsMfQtE9

as earning family members.[9] As an employee, health insurance can help lessen reliance on dominant family members or male counterparts who otherwise may play a significant role, and oftentimes barrier, to women's ability to access funds needed to pay for health care. When contributory health insurance is provided and paid directly from salaries, those monies are safegarded for health services and protected from any competing spending priorities.

Low status and intra-family food distribution[10]: Women have subordinate status vis-à-vis men and senior women in the family, and reproductive roles and cultural practices encourage early marriage and child bearing, as well as food restrictions. Women are often the last to eat the already limited quantities of food available for the family because culturally, and even when pregnant, they are expected to defer to their husband, children, and mother-in-law. As a result, maternal and neonatal mortality and malnutrition rates remain unacceptably high. A woman's education level and ability to control household resources are strongly associated with improvements in nutrition status for the entire family. When women are able to make decisions about the types of food to prepare and feeding preferences among siblings, nutrition levels improve – even in households that have similar budgets. The best way to address malnutrition is to empower women through a combination of education and income generation, and enact behavior change strategies targeted at men and women.

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[9] Kabeer, Naila and Mahmud, Simeen. 2004. *Rags, Riches and Women Workers: Export-oriented Garment Manufacturing in Bangladesh*. http://wiego.org/sites/wiego.org/files/publications/files/Kabeer-Mahmud-Export-Oriented-Garment-Bangladesh.pdf

[10] Extracted from Britt C, Ali. Younus Ali, Nasrin Rahman Jahan. April 2010. *Gender Assessment USAID/Bangladesh.* Arlington, VA: DevTech Systems, Inc.

2. INTEGRATING GENDER INTO HFG BANGLADESH ACTIVITIES

In Bangladesh, HFG will reinforce existing Government of Bangladesh (GOB) policies on gender, where applicable and related to HFG's activities in country. The gender strategy will be reviewed by the HFG Bangladesh team and updated annually to include specific approaches for any new activities. HFG Bangladesh approach to integrating gender into technical assistance, by activity, is as follows:

Activity 1- Technical Support for the NGO Health Services Delivery Project (NHSDP): As part of HFG efforts working with the USAID implementing partner Pathfinder of the NGO Health Service Delivery Project (NHSDP) to support the Smiling Sun NGO network to better achieve its mission of serving the poor, HFG conducted a secondary analysis of USAID's Smiling Sun NGO Franchise Program (SSFP) evaluation to better understand how demographic factors influenced a woman's decision to seek certain types of medical care for herself and her child within the NGO network in both rural and urban settings. The specific types of care assessed by women and children included antenatal care (ANC) visits; assisted delivery; measles immunization; receipt of vitamin A; family planning; and sick child visits. In addition, through a discrete choice experiment (DCE) study, HFG determined which health service attributes are most likely to influence demand for services at USAID-supported NGOs offering primary health care services. A particular emphasis on the key preferences of women for certain health center attributes was examined.

Activity 2 – Monitoring and Evaluation (M&E) Assistance to UNICEF Adolescent Empowerment Program Using Conditional Cash Transfers to Raise Age of Marriage: HFG was requested to provide technical assistance on a specific aspect of a UNICEF program with the aim to delay child marriage. The activity explicitly focused on its impact on adolescent girls. HFG worked with UNICEF to design, pilot, and evaluate a rigorous approach to monitor the effectiveness of two UNICEF Child Protection interventions – conditional cash transfers and adolescent stipends – to address major bottlenecks that delay child marriage, with a particular focus on informing progress for change in social norms around child marriage. HFG also worked with UNICEF to present the data collected using the approach from sites in two UNICEF program implementation zones.

USAID therefore is helping to measure three major bottlenecks: 1) social norms – through the acceptance of child marriage, the practice is justified by the aim to preserve the virginity and dignity of a girl before marriage in order to promote security and prevent sexual harassment; as well as social pressures such as the ability to pay dowry and ensure marriage of the daughter; 2) legislation/policy – proof of age is not asked for; parents have false birth certificates and there is no system to verify birth certificates; dowry is prohibited by law, but law is not upheld in practice, etc.); and, 3) financial – with regard to the financial incentives for or against child marriage.

Activity 3 - Health Care Financing Strategy Implementation Support: HFG helped facilitate the development of a health care financing (HCF) strategy. One of the key objectives of the HCF Strategy is the establishment of a social protection mechanism. This will start with the population that lives below the poverty line as well as informal sector employees, many of whom are women. HFG will support gender-sensitive approaches for implementation of the HCF.

Activity 4 - Conduct PIO Grant Attribution Analysis: HFG was requested to undertake a grant attribution analysis to track the flow of USAID's $40 million contribution to the World Bank Public International Organization (PIO) grant mechanism that supports the Bangladesh health sector program. The World Bank PIO grant is a mechanism to provide direct government-to-government assistance from USAID to the government of Bangladesh in fulfillment of the goals and objectives of USAID Forward, the first of its kind among USAID missions worldwide. The World Bank administers USAID's contribution to the sector as part of a multi-donor collaborative effort between USAID, the World Bank, and other international donor partners for achievement of the GOB Health, Population, and Nutrition Sector Development Program (HPNSDP) goals and objectives as implemented under 32 specific operational plans (OPs). As part of the work, HFG analyzed the attribution of USAID resources to eight individual OPs that are beneficiaries of the USAID funds, namely: OP1 - Maternal, Neonatal, Child and Adolescent Health (MNCAH) – Component 2: EPI in support of immunization; OP2 - Essential Services Delivery; OP4 - Tuberculosis and Leprosy Control; OP13 - Planning, Monitoring and Research; OP14: Health Information Systems and E-Health; OP16 - Procurement, Logistics and Supplies Management; OP17: National Nutrition Service; and, OP27 - Strengthening of Drug Administration and Management. The PIO report includes program indicators, results, and changes in outcomes, disaggregated by women and children for OP1 and for children for OP17. These OPs reflect USAID's focus on women and children.

Activity 5 - Design Provider-Based Prepayment Mechanism, Focused on a Smiling Sun NGO Network Provider: Conduct a feasibility study and, potentially, design an NGO provider-based prepayment mechanism to: (i) increase utilization of services through increased access and lower household direct out-of-pocket expenditures; (ii) increase sustainability of a selected Smiling Sun NGO health service provider through better cash flow and increased population participation; and (iii) prepare the provider to integrate, eventually, into the national social health insurance (SHI) scheme. The approach involves conducting a service provision cost and pricing analysis of the Smiling Sun NGO network provider Concerned Women for Family Development (CWFD), including a demand analysis to determine demand and based on findings, the preliminary design of a prepayment scheme may be produced. CWFD focuses on reproductive, maternal and child health services and has a client base that is predominately women and children, and therefore the feasibility study and analyses will directly address services provided to this population. Prepayment mechanisms lower financial barriers to care, while increased NGO sustainability will ensure that these services remain available to women and children.

Activity 6 - Provide Support to the Design and Implementation Research of a Formal Sector Social Health Insurance Scheme: HFG also intends to address formal sector health insurance. In particular, HFG will support BRAC and the German Society for International Cooperation (GIZ) in the design, development, piloting, and implementation of BRAC's SHI scheme for RMG workers (the "Health Security Scheme") to improve access and quality of health care available and reduce out-of-pocket expenditures on health. The purpose of the scheme is to: test the potential benefit of employer/employee contributive health insurance; develop tools and mechanism to provide health protection; improve access and quality of health care available; and reduce out-of-pocket expenditures on health. Findings from the pilot will inform scaling up and eventual integration into a yet to be designed national health protection scheme. As RMG workers are predominantly women, the activity will incorporate gender concerns in SHI design, development and piloting, as they are directly relevant, and particularly as pertains to understanding the key elements for improving service utilization and access. In the design of the implementation research, HFG will pay particular attention to drawing out any differences between women and men and the impact of the Health Security Scheme separately on women and men.

Activity 7 - Conduct Joint Analytical Work with the World Bank on Conducting Secondary Analyses of the NHA and on Urban Health: HFG is conducting joint analytical work with the World Bank focusing on: (i) secondary analysis of national health accounts (NHA) data to inform sector program implementation as well as the design of the next health sector program; and (ii) urban health, through the conduct of a landscape analysis and the design of research to inform discussions on how to resolve urban health challenges, including those that may relate to gender equality. The NHA work focuses on analyzing reproductive, maternal, newborn and child health (RMNCH) and urban health sub-accounts. The NHA secondary analysis captures the expenditures by/for the urban population. The urban health landscape review covers financing and governance arrangements for urban service provision, with a focus on reproductive, maternal and child health as well as primary health care services.

3. MONITORING PLAN

Gender is incorporated into the HFG Bangladesh ongoing performance monitoring plan (PMP). Selected indicators point to the project's gender related outputs. These indiciators are included on Table 1 below:

TABLE 1: MONITORING PLAN

ID	Performance Indicator	Disaggregated By	Data Source	HFG Bangladesh Indicator
A2*	Number of participants at HFG-supported events	Event Type, Participant Gender, Technical Area	Project records, HFG Event Participant Register	• Number of participants at meetings to discuss findings, receive disseminated information, and collaboratively work to develop road maps or similar
A3	Number of HFG-supported implementation plans	Technical Area, Type of HFG Support (e.g. financial, technical, organizational, etc.); Receiving Organization Type	Project records, plans created/ identified	• Road map/work plan for social health insurance program for civil servants
A4	Number of HFG-supported analytical reports	Technical Area, Type of HFG Support (e.g. financial, technical, organizational, etc.); Receiving Organization Type	Project records, reports created/ identified	• PIO analysis report; • NGO provider-based prepayment scheme demand analysis report; • NHA secondary analyses; Urban health landscape analysis
A5	Number of HFG-supported M&E tools	Type of M&E tool, Type of HFG Support (e.g. financial, technical, organizational, etc.); Receiving Organization Type	Project records, tools created/ identified	• Monitoring and implementation research program
A6	Number of organizations where HFG-supported technical resources are used	Type of Organization, Type of Technical resources, Technical Area	Project records; organization documentation; Technical Resource Use Questionnaire	• USAID • Smiling Sun Network • BRAC • Health Economic Unit (HEU) • Ministry of Establishment • National Accounts Cell • Ministry of Local Government

*A: Attribution indicators (Indicators which are attributable to HFG project efforts)

HFG will encourage government counterparts to disaggregate data collected and reported by age and gender to allow for the analysis of the differential effects of gender through the life course. HFG will reflect gender considerations to the extent possible and when practical, in the data sources genderated by indicators A3through A6.

Reporting Structure:

1. Quarterly Reports: The HFG project will submit quarterly reports which will describe, in narrative format, all gender-related activities which were completed in the previous quarter.
2. Annual Report: The HFG project will submit an annual report, which will highlight the most significant gender activities completed during the year in narrative, and will capture updated data for the indicators in the approved PMP.

Moreover, the HFG project will review and updates its gender plan annually, making adjustments as activities shift. The strategy will also be shared with all members of the HFG Bangladesh team, both in the home and field office, for their review and input.

4. EXPECTED GENDER IMPACT OF HFG TECHNICAL ASSISTANCE

The HFG project, through its technical assistance activities, will aim to understand and offer recommendations on addressing health systems issues that reinforce gender equality and mitigate discrimination. The HFG Bangladesh team members will keep in mind the gender dimensions of each of the activities and look to foster inclusiveness and promote gender equality and access, foster positive impacts on women and girls, and mitigate potential negative impacts. This section describes the specific gender elements for the technical areas that HFG will implement in Bangladesh, by activity.

Activity 1- Technical Support for the NGO Health Services Delivery Project (NHSDP): HFG's technical analysis of the SSFP evaluation and completion of a DCE allowed for a greater understanding of how certain demographic factors and health center attributes influence the decision-making process of a woman when seeking certain primary health care services for herself or her child. Study findings are intended to help the NHSDP network modify their service delivery models and financing mechanisms to potentially enhance program effectiveness and increase demand for services, particularly amongst women.

Activity 2 - M&E Assistance to UNICEF Adolescent Empowerment Program Using Conditional Cash Transfers to Raise Age of Marriage: HFG's provision of technical input to the development of the M&E system to monitor a UNICEF program aimed at delaying child marriage by changing social norms around child marriage through the use of UNICEF's L3 framework, supports the UNICEF program that examines the mean national age of marriage of adolescent girls. The result of our work will be a rigorous M&E system for the program and a better understanding of the factors that lead to early marriage. HFG's technical assistance will enable the GOB, UNICEF, and their partners to adjust the program interventions for higher impact by developing an understanding of the program's progress in addressing bottlenecks to reducing child marriage, the causes of child marriage, as well as the social networks that influence social norms around child marriage.

Activity 3 - Health Care Financing Strategy Implementation Support: The HCF Strategy proposes to increase the efficiency of government services, many of which target women and children. The implementation of social health protection should reduce the out-of-pocket expenses for health care. As men heads of household traditionally control the household's resources, this could empower women to seek health care services without the need to negotiate for financial resources with a male head-of-household.

Activity 4 - Conduct PIO Grant Attribution Analysis: The PIO grant attribution analysis shows how USAID resources are attributed to eight OPs, including those that directly impact women and children, such as maternal, neonatal, child and adolescent health and immunization. The analysis can help USAID and potentially other development partners to better understand how USAID funds have thus far been allocated through the PIO grant mechanism, and can guide future decision making. In particular, results can be used by USAID/Bangladesh to enhance coordination with the GOB and other development partners in support of the HPNSDP, including the allocation of resources to their priority areas that may include targeting gender equality, female empowerment and social inclusion. For example, the PIO analysis found that USAID provided 33% of donor funding for the MNCAH OP (OP1), and therefore it is reasonable to conclude that USAID MNCAH assistance played a substantial role in

the outcomes also indicated in the analysis, which are: improved coverage and utilization of MNCH services, high immunization coverage, and achievement of the country's polio free status.

Activity 5 - Design Provider-Based Prepayment Mechanism, Focused on a Smiling Sun NGO Network Provider: The objective of HFG's NGO sector prepayment mechanism work is to increase utilization of services through increased access and lower houesehold direct out of pocket expenditures, and to increase provider sustainability through better cash flow and increased population participation. The Smiling Sun network is the largest health service network in the NGO sector in Bangladesh, providing a range of primary, reproductive health, family planning and maternal and child health services to over 20 million people each year, and targeting low income populations, women and youth. As women and youth make up the majority of Smiling Sun clients, the gender impact of this activity (if HFG is funded to move from assessing mechanism feasibility to actual design and piloting) will be increasing their access and utilizaiton of health services, as well as reducing their direct out of pocket expenditures, at the selected Smiling Sun NGO (and perhaps at other providers within the network should NHSDP scale up the activity). Enhanced sustainability of Smiling Sun NGO health providers is expected to improve the availability and quality of services.

Activity 6 - Provide Support to the Design and Implementation Research of a Formal Sector Social Health Insurance Scheme: With respect to the formal sector, HFG's planned collaboration with BRAC and GIZ on the development and implementation of BRAC's SHI scheme for RMG workers is expected to improve access to and utilization of health care services through the provision of health insurance. As women comprise the majority of RMG employees, it is anticipated that this will significantly improve women's access to, utilization of, and health seeking behavior towards services, as well as empowering RMG workers to make independent decisions about utilization.

Activity 7 - Conduct Joint Analytical Work with the World Bank on Conducting Secondary Analyses of the NHA and on Urban Health: HFG collaborative analytic work with the World Bank focuses on NHA secondary analyses and urban health work the specifics of which are currently under discussion. The NHA secondary analyeses are expected to provide information that will inform discussions on the financing of RMNCH services, including equity, efficiency, and adequacy of financing. Better understanding of the urban health situation will provide an overview of existing sector dynamics, including: policy, financing mechanisms, stakeholders, studies, and data, with an emphasis on gap identification, and research focused on addressing those gaps. A focus of the urban health landscape review will be on reproductive maternal and child health and primary health care services. Information resulting from both the NHA and urban health work can be used by decision makers as well as those involved in project design and implementation to program activities that may address any gender inequities evidenced by the data.

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