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USAID Health Financing Improvement Program

USAID Health Financing Improvement Program Gender Analysis and Strategy

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The USAID Health Financing Improvement Program
The USAID Health Financing Improvement Program supports the Ethiopian government in its efforts to further strengthen and institutionalize health care financing reforms and initiatives to provide accessible, high quality, primary health care services for all Ethiopian citizens with reduced financial barriers. Led by Abt Associates, the program is implemented in collaboration with core partners Breakthrough International Consultancy, Dimagi, the Institute for Healthcare Improvement, and Results for Development, and resource partner Harvard School of Public Health.

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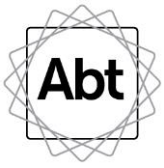

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USAID Health Financing Improvement Program
Gender Analysis and Strategy

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Acronyms

CBHI	Community-Based Health Insurance
DHS	Demographic and Health Survey
DRM	Domestic Resource Mobilization
EHIA	Ethiopia Health Insurance Agency
FGB/FMC	Facility Governing Board/Facility Management Committee
FGM/C	Female Genital Mutilation/Cutting
GBV	Gender-Based Violence
GEFE	Gender Equality and Female Empowerment
GOE	Government of Ethiopia
GPI	Gender Parity Index
GTP	Growth and Transformation Plan
HCF	Health Care Financing
IR	Intermediate Result
MEL	Monitoring, Evaluation, and Learning
MOH	Ministry of Health
PHC	Primary Health Care
RHB	Regional Health Bureau
USAID	United States Agency for International Development

1. Introduction

The five-year USAID Health Financing Improvement Program supports the government of Ethiopia (GOE) in its efforts to further strengthen and institutionalize health care financing (HCF) functions and systems to support universal health coverage of quality primary health care (PHC) services for Ethiopian citizens with reduced financial barriers. The Program builds on previous investments in HCF reform by USAID and the GOE. The consortium implementing the Program is led by Abt Associates, and includes core partners Breakthrough International Consultancy, Dimagi, Institute for Healthcare Improvement, and Results for Development, and resource partner Harvard T.H. Chan School of Public Health. Under the Program, Abt and its consortium partners work in close collaboration with the GOE to achieve four objectives/intermediate results (IRs):

1. Increase domestic resource mobilization for enhanced provision of quality PHC services;
2. Streamline pooling of risk-sharing/insurance mechanisms for wider access to PHC services with reduced financial barriers;
3. Facilitate strategic purchasing of health services from public and private health providers; and
4. Improve governance, management, and evidence-generation for health financing reforms and health facilities.

Promoting gender equality and advancing the status of women and girls is vital to achieving USAID development objectives. Aligned with USAID's Gender Equality and Female Empowerment (GEFE) Policy, the Program recognizes that gender is a key determinant of health.[1] Understanding and addressing the gender-related opportunities and barriers to HCF reform and the provision of PHC services is important the achievement of the Program's objectives.

The Program is committed to gender integration, recognizing that gender equality and female empowerment are inherently worthwhile, as well as being key determinants of positive health outcomes. The Program's gender integration efforts are grounded in an interconnected, mutually reinforcing, gender-transformative, evidence-based approach that contributes to improved HCF and quality PHC services.

In developing the gender strategy, the Program reviewed published and unpublished literature on themes related to gender equality and its influence on health and health-seeking behavior of women and girls in the Ethiopian setting. The Program also conducted a participatory workshop with program staff on April 1–5, 2019, to brainstorm possible approaches and interventions to integrating GEFE across the Program's IRs. This report presents the key findings of the analysis and articulates the Program's gender strategy. This gender analysis and strategy is a living document and the Program will revisit the strategy on an annual basis, prior to the annual work planning, along with the theory of change revision. Updates to the strategy may include modifying the activities or developing new ones to respond to lessons learned from implementation, as well as to address emerging gender needs, gaps, and opportunities.

[1] USAID, *Gender Equality and Female Empowerment Policy* (Washington, DC: USAID, March 2012).

1.1 Purpose

The purpose of this gender analysis and strategy is to provide guidance for evidenced-based, gender-transformative interventions that address the existing gender gaps and opportunities identified by the analysis across the Program's four IR areas.

1.2 Objectives

This gender analysis and strategy primarily aims to:

- Strengthen and guide gender integration efforts across all Program result areas.
- Prioritize gender gaps and opportunities identified in the gender analysis findings that can be addressed through advocacy and program activities.
- Guide implementation, monitoring, and evaluation of gender-transformative activities in alignment with the program's annual theory of change and work planning process.
- Generate learning from gender-transformative program interventions to contribute to a body of evidence of the contributions of gender integration to improved health outcomes.

2. Gender Analysis

2.1 Overview

Ethiopia is making rapid, admirable progress towards improved health for all, while also advancing GEFE. The current GOE has accelerated efforts to advance GEFE, from appointing Ethiopia's first female president (currently Africa's only female head of state), to a gender-balanced cabinet, through many levels of government. Significant challenges remain to overcome years of inequality between men and women in Ethiopia and progress has been uneven across the country. Important disparities in education, access to health services, and social norms highlight the need for continued efforts to advance GEFE for Ethiopian women and girls.

Women and girls in Ethiopia are strongly disadvantaged compared to boys and men, including in education, health, livelihoods, and basic human rights. Manifestations of discrimination against women are numerous and acute. The 2016 Ethiopia Demographic and Health Survey (DHS) found that nearly half (48%) of women have no education, while more than two-thirds of men have some education.[2] Total fertility remains high, at 4.6, with significant variation across regions, ranging from 1.8 in Addis Ababa to 7.2 in the Somali region, and a strong association between increased wealth and decreased fertility.[3] Thirteen percent of Ethiopian adolescents ages 15–19 are already pregnant or parenting, with a correlation between education and adolescent pregnancy.[4] The average age of marriage for Ethiopian girls is 17.1, fully six and a half years before their male counterparts.[5] Women are less likely to be employed, to own land, or to use a bank account than men.[6] Rates of violence against women and girls remain high: more than one in three women report experiencing spousal violence, one in 10 report sexual violence, and 65% have experience female genital mutilation/cutting (FGM/C).[7]

2.2 Legal Status of Ethiopian Women

Ethiopia's constitution and national policies are consistent with international legal instruments on gender equality, including the Convention on the Elimination of All Forms of Discrimination against Women, the Beijing Platform of Action, the African Charter on Human and People's Rights, and the Convention on the Rights of the Child. The Ethiopian constitution (Article 35) guarantees the rights of women as equal to those of men in all spheres including equality in marriage, the right to equal employment, the right to maternity leave with pay, the right to acquire, administer, control, use and transfer property, with emphasis on land and inheritance issues, and the right to access family planning and education. However, these important commitments do not fully reflect the reality of Ethiopian women and girls' lived experience.

[2] Central Statistical Agency (CSA) [Ethiopia] and ICF, *Ethiopia 2016 Demographic and Health Survey Key Findings* (Addis Ababa, Ethiopia, and Rockville, Maryland, USA: CSA and ICF, 2017). https://dhsprogram.com/pubs/pdf/SR241/SR241.pdf
[3] Ibid.
[4] Ibid.
[5] Ibid.
[6] Ibid.
[7] Ibid.

Equality between men and women is one of the pillars of the Ethiopia Growth and Transformation Plan II (2015).[8] The Ministry of Women, Children and Youth Affairs has committed to ending violence against women and included indicators in its 2016–2020 plan. A new Federal Family Code, based on the principle of gender equality, came into effect in July 2000. It raised the minimum age of marriage from 15 to 18 years and established the rights of women to share any assets the household had accumulated if a couple has been living together for at least three years without formal civil marriage.[9] The Ethiopian penal code criminalizes domestic violence and harmful traditional practices including early marriage, abduction, and FGM/C. However, enforcement of these laws remains a challenge and with nearly half of women receiving no formal education, knowledge of rights is uneven. There is limited capacity in the law enforcement and judiciary systems to enforce the new Federal Family Code. Attitudes of law enforcement personnel, judges, and religious leaders are also a challenge.

2.3 Gender Equality and Education

Access to education is strongly correlated with a number of important outcomes for women and girls, including employment, fertility, and FGM/C of daughters. There has been improvement in the participation of girls at primary school level in recent years as expressed by the Gender Parity Index (GPI). The GPI improved slightly from 0.87 during 2004/05 to 0.91 in 2015.[10] Gender disparities increase as children pass upwards from one level of the school system to the next. Women still constitute a small proportion of students at higher education institutions: 35% of undergraduate university students are female.[11] Overall, women are less educated than males. Forty-two percent of women and 65% of men were literate in 2012.[12] The persistence of child marriage in Ethiopia, coupled with gender norms for married women and girls, constitute an important barrier to increased educational attainment for Ethiopian women. While a quarter of women were attending school at the time they married, 75% of these women left school after marriage.[13] Rates are even higher in some regions and for women with less education.

2.4 Economic Status of Ethiopian Women

The economic empowerment of women is a critical gateway for many other development results. Women's participation in economic development is severely constrained by factors ranging from societal perceptions and traditional norms to limited access to strategic resources such as land. According to a land utilization survey by the Central Statistical Agency (2014/15), the number of male landowners is four times that of female owners, and males hold larger plots of land than do women (0.99 hectare vs 0.65 hectare).14 Only 19.5% of female-headed households have land, as compared with 80.5% of male-headed households.15 This limited access to land, among other factors, has a negative

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[8] National Planning Commission, Federal Democratic Republic of Ethiopia, *Growth and Transformation Plan II (2015/16 - 2019/20),* Vol 1. Main text. (Addis Ababa: National Planning Commission, May 2016).
[9] *The Revised Family Code*. Proclamation No 213/2000. https://www.refworld.org/pdfid/4c0ccc052.pdf
[10] The World Bank. data.worldbank.org
[11] USAID, *Fact Sheet: Empowering Ethiopian Women* (USAID, 2017).
https://www.usaid.gov/sites/default/files/documents/1860/Ethiopia-Fact-Sheet_Empowering-Women_Oct-2018.pdf
[12] Central Statistical Agency (CSA) [Ethiopia] and ICF, *Ethiopia 2016 Demographic and Health Survey Key Findings*. https://dhsprogram.com/pubs/pdf/SR241/SR241.pdf
[13] Central Statistical Agency (CSA) [Ethiopia] and ICF, *Ethiopia Demographic and Health Survey 2016* (Addis Ababa, Ethiopia, and Rockville, Maryland, USA: CSA and ICF, 2016).
[14] Central Statistical Agency (CSA) [Ethiopia], *Agricultural Sample Survey 2014/2015 (2007 E.C.)*. Volume IV Report on Land Utilization. (Addis Ababa: CSA, June 2015).
[15] Food and Agriculture Organization (FAO), *National gender profile of agriculture and rural livelihoods – Ethiopia*. Country Gender Assessment Series (Addis Ababa: FAO, 2019).

impact on women's engagement in agricultural production and productivity. As a result, women farmers produce on average 23% less than their men counterparts, and they have also significantly less value of production (on average 9,898 Birr/ha) than male-headed households (on average 11,273 Birr/ha).16 Moreover, women are often forced to sharecrop or lease out their plots as they do not have adequate family labor, access to oxen, or financial resources to hire the labor needed for plowing and managing their land.[17]

The recent Global Gender Gap Report (2018) showed that Ethiopia was ranked 111th of 149 countries in economic participation and opportunity.[18] The data indicated Ethiopia has moved down two places from 2017.[19] Women's employment tends to be concentrated in the informal sectors and unpaid family work, and there are significant gender wage differences for similar work. Women's annual earned income is estimated at US$1,428 (in purchasing power parity terms) compared with US$2,372 for men.[20] A significant proportion of women do not control their own earnings.[21] Women are also obliged to take on vulnerable forms of employment that fail to protect their basic labor rights. Unpaid care and domestic work remain to be the major constraint to gender equality and women's empowerment.[22]

The role of women as family heads is also limited. Women head one-quarter of Ethiopian households, the majority of which are in urban areas and belong to the lowest income quintiles.[23] The overrepresentation of female-headed households in the lowest income quintile highlights the pervasive socioeconomic challenges faced by this population.

Increasing women's economic empowerment in Ethiopia could drive overall economic growth. This link was underscored by the econometric model put forward by the World Bank in a report entitled "Unleashing the potential of Ethiopian women – trends and options for economic empowerment."[24] The simulation showed that by enhancing women's access to key productive factors such as regular employment, jobs in the informal sector, and access to entrepreneurial inputs and land, Ethiopia would benefit by as much as a 1.9% growth in gross domestic product per year.

2.5 Women's Participation in Politics

While the political participation of women and girls in Ethiopia is low, their representation has been increasing in recent years. The president of Ethiopia is a woman and the cabinet is gender-balanced. Women held 2% of the seats in the federal parliament in 1997. As of 2017, women hold 39% of seats.[25] A gender directorate, established in 2010, is overseen by the Ministry of Women and Children's Affairs. The influence of these directorates is uneven, due to gaps in capacity and funding.[26] Ethiopia ranked 52nd

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[16] Ethiopian Development Research Institute (EDRI) and International Food Research Institute (IFRI), *Gender differences in access to extension services and agricultural productivity; Ethiopian Strategy Support Program II* (Addis Ababa: EDRI and IFRI, 2012).
[17] Food and Agriculture Organization (FAO), *National gender profile of agriculture and rural livelihoods – Ethiopia*. Country Gender Assessment Series.
[18] World Economic Forum, *Global Gender Gap Report* (Geneva: 2018).
[19] Ibid.
[20] Ibid.
[21] Central Statistical Agency (CSA) [Ethiopia] and ICF, *Ethiopia Demographic and Health Survey 2016*.
[22] United Nations Development Programme (UNDP), *Ethiopia National Human Development Report 2018: Industrialization with a Human Face* (Addis Ababa: UNDP, 2018).
[23] Central Statistical Agency (CSA) [Ethiopia] and ICF, *Ethiopia 2016 Demographic and Health Survey Key Findings*. https://dhsprogram.com/pubs/pdf/SR241/SR241.pdf
[24] World Bank. *Ethiopia - Unleashing the potential of Ethiopian women: trends and options for economic empowerment* (Washington, DC: World Bank, 2009).
[25] Index Mundi. Ethiopia – Proportion of seats held by women in national parliaments. https://www.indexmundi.com/facts/ethiopia/indicator/SG.GEN.PARL.ZS
[26] EnCompass LLC. Transform: Primary Health Care Project Gender Analysis Final Report. November 5, 2018.

out of 149 countries in women's political empowerment in 2018, having advanced nine places on the list since 2006. This is the biggest improvement on the political empowerment sub-index for that same period in sub-Saharan Africa.[27] Despite GOE efforts to reach out to women in rural areas, gaps in knowledge about women's and girls' rights remain because of the long distances, low literacy levels, and entrenched power structures.

2.6 Gender Equality in Health Care

Ethiopian women and girls experience persistent gender inequalities in health and access to care, despite rapid progress in key areas over the past several decades. Women's health is adversely affected by poverty, poor nutrition, and restricted access to health care services due to financial constraints and gender norms that limit women's and girls' agency. For example, nearly one in five married women reported no involvement in decisions about their own health care.[28] More than two-thirds of women reported at least one problem in accessing health care.[29]

The most recent Ethiopia Mini DHS results show that modern contraceptive use among married women increased from 35% in 2016 to 41% in 2019.[30] Findings also revealed that four in 10 women (43%) received the recommended four antenatal care visits during their last pregnancy and institutional deliveries increased from 26% in 2016 to 48% in 2019.[31] While the GOE has committed to ending FGM/C and has criminalized the practice, two-thirds of women have experienced FGM/C, and 24% believe that it is required by their religion and 18% believe that the practice should be continued.[32]

2.7 Household Gender Norms

Ethiopian gender norms heavily influence daily lives and decision-making. While Ethiopia's legal framework has moved in the direction of gender equality, traditional attitudes and practices remain common. The current Ethiopian family code gives both spouses equal rights "in the management of the family" and states that the spouses owe each other mutual support and respect.[33] However, it is common in Ethiopia for men to be seen and treated as the head of the household. Men often feel pressure to earn sufficient income to sustain the family, since they are considered to be the primary source of household income. While women are less likely than men to report employment outside of the household, there are important differences by region and relative income in who makes decisions about how the earnings are spent.[34]

Traditional gender norms give men the responsibility to make major decisions on issues that matter to all members of the family, without consultation. For example, only 35% of married women report that they made the decision to marry themselves.[35] Across three household decisions (woman's health care, major purchases, and visits to family), most women and men reported joint decision-making; however, 10% of women reported no involvement in any of these three decisions.[36] A majority of women do not

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[27] World Economic Forum. *Global Gender Gap Report*.
[28] Central Statistical Agency (CSA) [Ethiopia] and ICF, *Ethiopia Demographic and Health Survey 2016*.
[29] Ibid.
[30] Ethiopian Public Health Institute (EPHI) [Ethiopia] and ICF, *Ethiopia Mini Demographic and Health Survey 2019: Key Indicators*. (Rockville, Maryland, USA: EPHI and ICF, 2019.)
[31] Ibid.
[32] Central Statistical Agency (CSA) [Ethiopia] and ICF, *Ethiopia Demographic and Health Survey 2016*.
[33] *The Revised Family Code,* Proclamation No 213/2000. https://www.refworld.org/pdfid/4c0ccc052.pdf.
[34] Central Statistical Agency (CSA) [Ethiopia] and ICF, *Ethiopia Demographic and Health Survey 2016*.
[35] Ibid.
[36] Ibid.

believe that they can say no to their husband if they do not want to have sexual intercourse and only 30% agreed that they can ask their husband to wear a condom.[37]

Although men traditionally are the decision makers and earners for their families, women are responsible for many of the activities that occur inside the household, including household management, child rearing, and cooking. Indeed, only approximately one-third of husbands provide any help with household chores and only 18% provide daily help.[38] The more educated and the wealthier the woman, the more likely it is that her husband participates in the household chores. Urban women, and women with more education and higher incomes (rural or urban) were more likely to report that their husbands helped with household chores,[39] reinforcing the important link between education and empowerment.

A recent Ethiopian civil servant law entitles civil servants to paternity leave with pay for 10 working days at the time of his wife's delivery. This demonstrates GOE commitment to enhancing men's participation in areas traditionally considered women's affairs.[40] The tension between traditional social norms for men and the evolving expectations among some contemporary Ethiopians, particularly in urban areas, may be an opportunity to explore more equitable social norms at the household level.

As is common in many societies, many men in Ethiopia use violence to assert power over women and girls. Twenty-three percent of women report an experience of physical violence since age 15 and 10% report a history of sexual violence.[41] A third of ever-married women report experiencing violence perpetrated by their current or most recent partner, while 27% reported violence by their partner sometimes or often in the last year.[42] Attitudes towards the acceptability of physical violence between husbands and wives is changing rapidly, particularly among men. While in 2000, a large majority of both husbands and wives agreed that a husband was justified in beating his wife in at least one of five scenarios (85% of women and 76% of men), acceptance of men has fallen dramatically, to 28% by 2016. Women's attitudes have also shifted, albeit more slowly. In 2016, 63% of women agreed that physical violence was justified in response to at least one scenario, with wide variation across regions.[43] Other forms of marital control remain common, such as husbands insisting on knowing where the wife is at all times or limiting her access to female friends.[44] Widespread acceptance of gender-based violence (GBV), scarce access to comprehensive services, and stigma associated with GBV are all factors that keep survivors from reporting GBV. Two-thirds of women who have experienced physical or sexual violence never told anyone or sought help.

2.8 Women in Health Sector Leadership

Despite the significant progress Ethiopia has made in promoting gender equality and women's empowerment in the health sector, leadership commitment at all levels to empower women to higher leadership positions is still a major challenge. Managerial roles in the health care system are generally male-dominated, and female representation in leadership roles and on health facility governing boards/facility management committees (FGB/FMCs) is limited. The 2019 Program's baseline survey found that only 13% (9/67) of facility head /CEO positions are held by women; 19% (13/67) of health

[37] Ibid.
[38] Ibid.
[39] Ibid.
[40] https://chilot.me/wp-content/uploads/2017/10/federal-civil-servants-proclamation.pdf
[41] Central Statistical Agency (CSA) [Ethiopia] and ICF, *Ethiopia Demographic and Health Survey 2016*.
[42] Ibid.
[43] Ibid.
[44] Ibid.

facilities included in the survey have no women members on their FGB/FMC, and 45% have only one woman member.[45]

A review of the current regional health service provision, administration, and management regulations and HCF implementation guidelines also showed that gender equality has not been adequately considered. Emphasis given to enhance women's participation in leadership positions also varied among regional regulations and guidelines. The regulations of Oromia and Harari regions and Dire Dawa City Administration clearly stipulate that at least two (of the seven) health facility board members should be women. In contrast, the regulations of Amhara, Tigray, and SNNP regions and the Guideline for Management of Federal Hospitals refer to gender equality in general terms, such as the selection of FGB/FMC members will take into account gender balance. The federal and regional guidelines for outsourcing of non-clinical services at public hospitals are not gender sensitive. The regional community-based health insurance (CBHI) directives also do not adequately consider gender equality in the selection of CBHI board members.

[45] The baseline survey report was being finalized at the time this gender strategy was developed.

3. Gender Strategy

The Program understands that gender inequality remains pervasive in Ethiopian society and implements its activities with consideration of the role of gender norms in communities, health facilities, CBHI boards, FGB/FMCs, and stakeholder organizations with which the Program partners. The Program will address gender issues through interventions that will directly address the health and economic empowerment of women and girls, while engaging men and boys as allies for equality.

3.1 Approaches to Address Gender Equality and Female Empowerment by IR

Program leadership refined the findings from the gender gap analysis and narrowed down the possible approaches/interventions listed by staff considering the impact on GEFE, alignment with the Program's non-GEFE goals, budget, staffing, and synergy with work led by other stakeholders. Below are the Program's approaches by IR.

IR 1: Increased domestic resource mobilization for enhanced provision of quality PHC services

The Program works with the Ministry of Health (MOH) and regional health bureaus (RHBs) to generate more resources from all plausible sources to help ensure universal health coverage through PHC services. Gender analysis findings showed gaps in the allocation and use of resources for services targeting women. The Program will focus on the allocation of more domestic resources to services from which women could benefit. In this regard, the Program will advocate and provide technical assistance to the MOH, RHBs, woreda administrations, and health facilities:

- To allocate more resources to health facilities to build breastfeeding and child care corners in health facilities for female staff and clients.
- To allocate more resources for ambulance services and efficient use of health facility internal revenue for continuity of ambulance services. These services can particularly benefit pregnant women in accessing facility-based care.
- To allocate more funds for exempted health services (services targeting women and children).

The Program will integrate advocacy and technical assistance activities in annual implementation plans starting from Year 2. It will use facility-level supportive supervision, regional and zonal level review meetings, thematic meetings, FGB/FMC training sessions, and other forums/events (where applicable) as platforms for advocacy.

IR 2: Streamlined risk-pooling mechanisms for wider access to PHC services with reduced financial barriers

Under this IR, the Program works with RHBs and the Ethiopian Health Insurance Agency (EHIA) for the sustained continuation and expansion of CBHI, which aims to increase access to and use of health services with reduced financial barriers. This will lead to greater health protection of the poor from

catastrophic health spending and impoverishment. The gender analysis findings showed gender inequality in accessing health care services due to women's reduced employment and gender norms that give men disproportionate control over household finances and community decision-making. The Program, therefore, will work for enhanced participation of women in the CBHI program in general, and female-headed indigent households in particular. Specifically, the Program will:

- Advocate to EHIA to prioritize female-headed households in the indigent selection process. This will allow women's greater access to CBHI without fees, as the GOE at all levels (federal, regional, and woreda) covers enrollment and annual fees for citizens identified as indigent.
- Advocate to EHIA for the representation and participation of more women on CBHI boards.

This will be done by providing technical assistance to EHIA in revising: 1) indigent selection criteria in such a way that preference will be given to women-headed households in the case where two households have the same economic status; and 2) the CBHI Directive so that it considers gender balance in the selection of CBHI board members. The Program will integrate technical assistance and advocacy activities in its Year 2 activity implementation plan.

IR 3: Improved arrangements for strategic purchasing of health services from public and private providers

The Program will work with the GOE in institutionalizing the use of a costing tool (for costing health care services at health centers and primary hospitals). The Program will also work with the GOE to set a regular process for and develop skills to undertake periodic revision of user fees at the regional, woreda, and health facility levels. The gender analysis identified that the existing user fee-setting parameters lack gender consideration. The Program, therefore, will advise the MOH, RHBs, and EHIA to consider gender-specific health services (reasonable fee setting for services that women use) in user fee-setting exercises.

IR 4: Strengthened governance, management, and evidence generation for the health financing reforms and health facilities

The Program will work with the MOH, RHBs, and EHIA to institutionalize HCF reforms by building the capacity of FGB/FMCs and enhancing community participation. The gender analysis findings showed gender gaps in the leadership and management of health facilities and CBHI programs. As part of the institutionalization process, the Program will advocate for the inclusion of gender (whenever applicable) in: the revision and/or development of legal frameworks, implementation manuals, and guidelines, for first and second generation HCF reforms; the development of communication materials and success stories; and the generation of evidence. Accordingly, the Program will advocate and provide technical assistance to RHBs and/or EHIA:

- For enhanced participation (decision-making) and representation of women on FGB/FMCs and reflect this in the governing board implementation manual that are to be revised.
- To give priority to female entrepreneurs/women-owned businesses when outsourcing non-clinical services and reflect this in the outsourcing guidelines to be revised.
- To give priority to female-headed households in the indigent selection process and reflect this in the CBHI indigent selection manual, which is to be revised.
- For the consideration of women on CBHI boards through updates to be made in the CBHI implementation manual, which is to be revised.

Furthermore, the Program will:

- Consider gender in behavior change communication materials, success stories, and photos, and will seek to include representation of women in both gender accommodating and gender transformative ways.
- Ensure that Program-generated data and data secured from counterparts (whenever applicable) are disaggregated by gender.

3.2 Gender-Specific Monitoring Plan

The Program will monitor implementation of this strategy by using a set of performance indicators (Table 1). Some of these are identified as key performance indicators and are included in the Program's Monitoring, Evaluation, and Learning (MEL) Plan (indicators 2.1, 2.2, 3.1, 4.1, and 4.2). Other indicators (1.1, 1.2, and 1.3) will be tracked separately through surveys/supportive supervision, program and activity reports, and health accounts reports.

Table 1: Gender-related performance indicators

IR	Indicator	Data source	Data collection methods	Frequency of reporting
IR 1	1.1 Proportion of health facilities with breastfeeding and/or child care corner	Health facilities and/or USAID Transform: Primary Health Care project	• Supportive supervision • Facility surveys/reports from USAID Transform: Primary Health Care project	Annually
	1.2 Percent of health facility budget allocated to ambulance service	Health facilities	• Supportive supervision • Facility survey	Annually
	1.3 Percent of spending on reproductive health out of total health spending*	Health Accounts Study report	• Review of Health Accounts Statistical Report	Years 2 and 4
IR 2	2.1 Percent of female-headed indigent households among the total indigent households enrolled in CBHI schemes	Schemes	• Supportive supervision • Scheme survey	Annually
	2.2 Percent of CBHI boards with at least one woman board member	Schemes	• Supportive supervision • Scheme survey	Annually
IR 3	3.1 Availability of user-friendly health services costing tool and operational manual with gender-sensitive parameters	MOH	• Report	Year 2
IR 4	4.1 Number of policies, legal frameworks, and guidelines revised to improve health financing reforms with gender considerations	USAID Health Financing Improvement Program	• Program report	Year 2
	4.2 Percent of health facilities with two or more women members participating in board meetings	Health facilities	• Supportive supervision • Facility survey	Annually

* Expenditures on reproductive health will be used as a proxy indicator to measure the intervention for more funds for exempted services, as these services are more often used by women and girls than are other exempted services. Expenditure data for reproductive health services can be extracted from the Health Accounts Statistical Report.

3.3 Operationalizing the Gender Strategy

The Program's gender analysis and strategy will be electronically distributed to staff and readily available on the Program's shared drive. The activities outlined in the strategy will be integrated in Program annual implementation/activity plans and will be operationalized by Program staff. Gender-specific activity indicators that can be captured through surveys will be incorporated into supportive supervision checklist/data collection tools in order to track changes over time. Progress in implementing gender strategy activities will be reported annually to USAID. The strategy will be reviewed annually and updated, as needed, based on changes in the Program and/or by client request. The strategy will be referenced during annual implementation planning and reporting.