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IMPROVING MARKET PARTNERSHIPS AND ACCESS TO COMMODITIES TOGETHER (IMPACT) PROGRAM

GENDER EQUALITY AND SOCIAL INCLUSION (GESI) ANALYSIS AND ACTION PLAN

July 26, 2019

This publication was produced for the United States Agency for International Development (USAID), Cooperative Agreement No. 72068718CA00001

Implemented by:

PSI Madagascar in collaboration with Banyan Global.

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Recommended Citation: Rachel Mahmud and Malanto Rabary. USAID/Madagascar IMPACT Program Gender Equality and Social Inclusion Analysis and Action Plan. Prepared by Banyan Global. 2019.

IMPACT PROGRAM GENDER EQUALITY AND SOCIAL INCLUSION ANALYSIS & ACTION PLAN 2019

COOPERATIVE AGREEMENT NO. 7206871 8CA00001

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ACRONYMS

AC	Agents Communautaires (community health workers)
AOR	Agreement Officer's Representative
ADS	Automated Directives System
CHW	Community health workers
CNFM	Conseil National des Femmes de Madagascar (National Council of Women of Madagascar)
CSB	Commune-level supply points
DCA	Development Credit Authority
DHS	Demographic and Health Survey
FGD	Focus group discussion
FP/RH	Family planning/reproductive health
FHH	Female-headed households
GBV	Gender-based violence
GESI	Gender equality and social inclusion
GOM	Government of Madagascar
IMPACT	Improving Market Partnerships and Access to Commodities Together program
INSTAT	Madagascar's National Institute of Statistics
IPT	Intermittent preventive therapy
IR	Intermediate Result
ISM	Integrated Social Marketing program
JFET	Jeunes Femmes Engagées de Tuléar (Young Women Activists of Toliara)
MCH	Maternal and child health
MOH	Ministry of Health
PNSC	National Policy for Community Health
PA	Points d'approvisionnement (supply point)
PARC	Points d'approvisionnement relais communautaires (community liaison supply point)
PDSS	Plan de Développement du Secteur Santé (National Health Policy)
PSI/M	Population Services International/Madagascar
SILC	Savings and internal lending communities
SHOPS	Sustaining Health Outcomes through the Private Sector project
TMA	Total Market Approach
TMI	Total Market Initiative
TWG	Technical working group
UHC	Universal health coverage
USAID	United States Agency for International Development
WASH	Water, sanitation and hygiene
WB	World Bank
WHO	World Health Organization

ACKNOWLEDGEMENTS

The Team is grateful to the many individuals who provided technical input and advice during the development of the Improving Market Partnerships and Access to Commodities Together (IMPACT) Program Gender Equality and Social Inclusion (GESI) Analysis and Action Plan. The study was a significant undertaking, and its completion would not have been possible without all those who graciously shared their time, insights, and recommendations.

The Team wishes to thank the USAID/Madagascar team for their leadership. We address our grateful thanks to the Agreement Officer's Representative (AOR), Dr. Haja Razafindrafito.

We address our acknowledgement to all the key staff of the Government of Madagascar's Ministry of Health at the central and regional levels who were supportive to this study and participated actively in the interviews.

We are thankful to all partners in the public, commercial and social marketing sectors involved in this study.
The team expresses its gratitude to PSI/Madagascar with special thanks to Pierre-Loup Lesage, Senior Country Representative, Gilbert Andrianandrasana, Chief of Party, IMPACT program, and Mohamed Diallo, Deputy Chief of Party, IMPACT program.

We are grateful for the support from all IMPACT program consortium members: Ando Rambeloson and her team at PATH, Isabelle Salabert and her team at Telma Foundation, Aline Makureira and her team at MSH, and Iony Rasamoela and her team at Banyan Global.

Rachel Mahmud, Senior Program Officer, Banyan Global, and Malanto Rabary, Gender and Social Inclusion Specialist, Banyan Global, researched and wrote this integration plan with support from Marcella Kim, graduate research associate. Additional support was provided by Dina Scippa, Stephanie Gober, Eric Botoronono, and Alyssa Lang. The authors developed this publication with guidance from the U.S. Agency for International Development, particularly Dr. Andry Nirina Rahajarison, Senior Family Planning Program Manager and Gender Focal Point, Office of Health, Population and Nutrition, USAID/Madagascar.

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EXECUTIVE SUMMARY

In March 2019, Banyan Global conducted a Gender Equality and Social Inclusion (GESI) analysis with a women's economic empowerment lens to inform the USAID/Madagascar-funded Improving Market Partnerships and Access to Commodities Together (IMPACT) program led by PSI/Madagascar. Banyan Global specifically set out to identify key gender issues, inequalities, constraints, and opportunities in the health commodities supply chain in Madagascar. The findings and recommendations in this report are intended to support the IMPACT program in integrating gender equality, social inclusion and women's economic empowerment throughout the program cycle.

This report was prepared at the culmination of a multi-stage process, which included a preliminary literature review and data collection in the capital city of Antananarivo, Antsiranana (Diana region) and Toliara (Atsimo Andrefana region). The research team consisted of Malanto Rabary, the national Gender and Social Inclusion Specialist, and Rachel Mahmud, the Senior Program Officer and Team Leader from Banyan Global's home office. The literature review was conducted with support from Marcella Kim, graduate student research associate. The main data collection tools included semi-structured interviews and focus group discussions. Annex D provides a detailed list of interviewees.

Overview of Findings

Gender mainstreaming is often missing from universal health coverage (UHC) programs, policies and strategies. This is true not only in Madagascar, but globally. World Health Organization (WHO) Director-General Dr. Tedros Adhanom recently said, "Gender should be mainstreamed. It can't be done by a small unit — it needs to be done by each and every person. It's everybody's business and we have to mainstream it."[1] There is an immense potential to mainstream gender equality into the health commodities supply chain in Madagascar and to make it more inclusive by including the voices of marginalized groups. Improving gender equality and social inclusion will enhance the health sector's ability to meet the needs of Madagascar's entire population.

A priority for the Government of Madagascar's (GOM) Ministry of Health (MOH) is to operationalize UHC to address the gaps identified in the current healthcare landscape. The majority of Malagasy citizens struggle to afford and access adequate health services. A gender-informed and socially inclusive approach to UHC will help alleviate the equity gaps in access to health services, especially for women and youth.

Although health services and products are intended to be available to all beneficiaries regardless of sex, there remain social and cultural norms that limit women and youth from seeking help in a dignified and transparent way. Within Madagascar's relevant national health and poverty policies, gender considerations are rarely integrated in a way that meaningfully addresses the different health needs and barriers that women, men, girls, and boys face. For example, early and forced child marriage is pervasive across the country, particularly in poor, rural areas where access to healthcare is already limited. Young, pregnant girls face social stigma and therefore are less likely to seek health services or use family planning methods. Women and girls are more vulnerable to gender-based violence if they do not follow cultural norms to attend to unpaid household chores and care work. Women working in the formal and informal economies are more vulnerable to harassment, discrimination and a range of safety risks.

[1] Keeling, A., Dhatt, R., and Doshi, L. Opinion: There is no road to UHC without gender equality and women's empowerment. (1 February 2019).

Cultural norms dictate the type of jobs that are acceptable for men and women, which limits opportunities for all genders in the labor market. Men are expected to fill more labor-intensive roles that pay more, whereas women are expected to stay at home or hold jobs that are considered easier and therefore pay less. Within the health sector in Madagascar, there is a perceived balance between men and women in management-level positions in the public, commercial and social marketing sectors. While women more actively participate in the health sector compared to other sectors, this creates an illusion of gender equality on both the supply and demand side. In reality, there are social and cultural barriers that prevent women and girls from rising to the highest levels of decision-making and influence and limit their ability to benefit from health interventions. This is a consequence of the limited knowledge and understanding among health sector professionals about gender equality and social inclusion.

As the IMPACT program strengthens the Total Market Approach (TMA), now is the time to ensure that a TMA is as inclusive as possible and takes the different needs and considerations of women, men, girls, and boys into account in designing and executing an effective approach to achieving UHC.

Summary of Key Recommendations

Public Sector

- Build the capacity of government stakeholders to serve as advocates for GESI within their spheres of influence and to ensure the sustainability of a gender-integrated TMA beyond the life of the IMPACT program.
- Partner with women's and human rights organizations to include the voices of women, girls, youth and marginalized groups in government decision-making processes. Engage men in partnership discussions and build their capacity through training to serve as GESI champions.
- Ensure a gender balance among the government's technical working group members to ensure that diverse voices and perspectives are represented in policy and decision-making.
- Conduct regular consultation with GESI partners to identify shared priorities, lessons learned, and problem-solving strategies to overcome barriers to gender equality and social inclusion.

Commercial Sector

- Partner with financial institutions and commercial sector partners targeted through the development credit authority (DCA) financing scheme to address GESI constraints and opportunities. The commercial sector offers significant opportunities to enhance women's economic empowerment while at the same time expanding its reach through gender-informed approaches.
- Collect sex- and age-disaggregated data among private health commodity businesses, as well as data on leadership by examining who holds management and decision-making positions within the commercial sector.
- Integrate GESI components into trainings with financial institutions and commercial sector partners to raise awareness about gender constraints and opportunities in the commercial sector, as well as the business case for women's economic empowerment through the private health commodity sector.

Social Marketing

- Integrate GESI messaging throughout family planning and maternal and child health awareness campaigns. Consult with gender and social inclusion experts in designing and piloting gender transformative health messaging.
- Engage with men and develop key messages targeted toward men in family planning communication campaigns so that they are no longer obstacles to, but rather partners in family planning methods.

1. INTRODUCTION

1.1 Background

1.1.1 Improving Market Partnerships and Access to Commodities Together (IMPACT) Program in Madagascar

In September 2018, Population Services International Madagascar (PSI/M), along with Banyan Global, MSH, PATH, and Telma Foundation was awarded the cooperative agreement No. 72068718RFA00003 for the USAID-funded IMPACT program in Madagascar. The award is for US$31,985,102 (US$35,185,162 including cost-share) and runs from 2018 through 2023.

The goal of this program is to sustainably improve the health of the Malagasy population through a strengthened health system and efficient health markets, contributing to universal health coverage (UHC). The program aims to improve the capacity of the Malagasy health system to ensure that quality pharmaceuticals and health commodities are available and accessible to all Malagasy people on a sustainable basis. IMPACT's expected outcome is to increase total market performance for and use of health products for malaria, maternal and child health (MCH), and family planning (FP) and sustained health system performance. IMPACT has 13 priority regions: Haute Matsiatra, Vakinankaratra, Analanjirofo, Atsinanana, Amoron'i Mania, Vatovavy Fito Vinany, Atsimo Andrefana, Menabe, Melaky, Boeny, Sofia, Diana and Sava.

The IMPACT program is organized along five Intermediate Result (IR) areas:

- IR 1: Enhanced coordination among the public, nonprofit, and commercial sectors for reliable supply and distribution of quality health products (*led by PATH, MSH*)
- IR 2: Strengthened capacity of the Government of Madagascar (GOM) to sustainably provide quality health products to the Malagasy people (*led by PSI, MSH*)
- IR 3: Expanded engagement of the commercial health sector to serve new health markets according to health needs and consumer demand (*led by Banyan Global, Telma Foundation, PSI, MSH*)
- IR 4: Improved sustainability of social marketing to deliver affordable, accessible health products to the Malagasy population (*led by PSI*)
- IR 5: Increased demand for and use of health products among the Malagasy people (*led by PSI*)
- Cross-cutting: Gender equality, social inclusion and women's economic empowerment (*led by Banyan Global*)

Through a Total Market Approach (TMA) that draws on past social marketing successes under the USAID Integrated Social Marketing program (ISM) and global best practices in TMA, the IMPACT team will work with and through a strengthened GOM to build a more effective and efficient health market. IMPACT will do this by coordinating a Total Market Initiative (TMI) Technical Working Group (TWG) that will identify strategies for ensuring a reliable supply and distribution of quality health products. Despite successes under the previous ISM program, the IMPACT program recognizes that further investments are needed to strengthen Madagascar's health commodity market if the GOM is to achieve UHC. In addition, social marketing needs to evolve within the broader market context. Improved segmentation, cross-subsidy, and other approaches offer an opportunity to transition social marketing to a more financially sustainable model for promoting health commodities and services.

1.1.2 Gender Equality and Social Inclusion (GESI) Analysis Background and Purpose

Gender equality, social inclusion and women's economic empowerment are critical components to achieving UHC. Without understanding the different needs and experiences of women, men, girls, and boys, including those who are particularly marginalized and/or vulnerable, the IMPACT program will not be able to achieve its goals. This includes ensuring the meaningful representation of women, youth and marginalized groups at all levels of the supply chain; for example, a minimum of 30 percent women's participation is recognized as a critical mass that allows for real impact and change.[2]

The gender equality and social inclusion (GESI) analysis is an important output for Year 1 of the IMPACT program that sets the framework for a gender equality and social inclusion strategy. This USAID activity-level GESI analysis investigates how the status of women, men, girls, and boys in Madagascar affects the health commodity supply chain and how a TMA can address gender inequalities, social inclusion and women's economic empowerment to better achieve program objectives.

More specifically, the GESI analysis addresses the following research questions, as specified in Annex A of the report:

1. How does the relative status of women, men, girls, and boys – including vulnerable and/or marginalized groups (ie. people with intersecting identities such as women with disabilities, men having sex with men, etc.) – affect their differential access to/control over assets, resources, opportunities, and services related to the health commodity supply chain, and broader issues concerning family planning (FP)/reproductive health (RH); maternal and child health (MCH); and malaria?
2. How do gender roles, responsibilities and time use prevent or facilitate participation in the health commodities supply chain?
3. Do relevant laws, policies, and institutional practices contain implicit or explicit gender biases that may affect the ability of women, men, girls, and boys to participate in the project, assume leadership roles, and access affordable and high-quality FP/RH; MCH; and malaria services?
4. How do existing gender norms and cultural beliefs affect FP/RH; MCH; and malaria services?
5. How do existing patterns of power and decision-making influence the ability of women, men, girls and boys to decide, influence, and exercise control over material, human, intellectual, and financial resources in the family, community, and country related to FP/RH; MCH; and malaria?
6. What are the potential impacts, including unintended or negative consequences, of the project on women, men, girls, and boys, including vulnerable and/or marginalized groups?

In line with the requirements in the USAID Automated Directives System (ADS) 201.3.2.9 and ADS 205, the GESI Analysis and Action Plan will align with the 2012 USAID Gender Equality and Female Empowerment Policy, and the 2016 updated U.S. Strategy to Prevent and Respond to Gender-Based Violence. The GESI analysis findings and recommendations also point to linkages to women's economic empowerment, in line with the Women's Entrepreneurship and Economic Empowerment Act of 2018 and the Women's Global Development and Prosperity Initiative (W-GDP). The integration of women's economic empowerment into this GESI analysis is based on these USG initiatives as well as Banyan Global's thought leadership on the USAID-funded Women's Economic Empowerment and Equality Technical Assistance (WE3 TA) task order, under the Advancing the Agenda of Gender Equality (ADVANTAGE) indefinite delivery/indefinite quantity (IDIQ) contract, where Banyan Global provides advisory services to stakeholders to better analyze, design, implement, and monitor interventions addressing women's economic empowerment and equality constraints and opportunities in support of USAID's Gender

[2] Dahlerup, Drude. The story of the theory of critical mass. *Politics & Gender, 2*(4), 511-522. (2006).

Equality and Female Empowerment Policy.

As required in the ADS 205, the GESI analysis looked at the five domains: overview of laws, policies, regulations, and institutional practices; cultural norms and beliefs; gender roles, responsibilities, and time use; access to and control over assets and resources; and patterns of power and decision-making in Madagascar.

The findings in the report are based on primary research conducted in 2 out of 13 program priority regions in Madagascar: Diana and Atsimo Andrefana. The research team also conducted interviews in the capital city of Antananarivo, where implementing partners have their headquarters offices.

Section 1 of the report provides an overview of the research methodology; Section 2 provides background on gender equality, social inclusion, and health in Madagascar; and Section 3 provides a summary of the key findings from the field-based GESI analysis; and Section 4 provides key recommendations in the form of a GESI action plan for the IMPACT program. Annex A provides the Scope of Work for the Gender Analysis. Annex B presents a list of key documents consulted. Annex C includes the interview and focus group discussion guides used for field-based data collection; and Annex D provides a list of key interviewees.

1.2 Methodology

1.2.1 Literature Review

The research team conducted an extensive desk review of the secondary data sources specified in Annex B. The purpose of the desk review was to identify the major gender equality, social inclusion, and women's economic empowerment advances, gaps, and opportunities in Madagascar as a whole, with a specific focus on the three channels of the health commodities sector that will be the main units of analysis for the IMPACT program: public, commercial, and social marketing sectors. Based on the desk review findings, the research team designed the methodology and work plan, which connected the research questions to potential sources of information (both primary/stakeholders and secondary/documents) and the instruments to be used for collecting it. The work plan also included question guides tailored to each data collection method (Annex C), as well as a list of key stakeholders to consult during primary data collection (Annex D).

RESEARCH GUIDING PRINCIPLES

1. Do no harm
2. Free prior informed consent
3. Informant confidentiality
4. Protection of information
5. Non-discrimination and respect
6. Ethical data collection
7. Holistic participation
8. Collaborative learning
9. Cultural sensitivity
10. Intersectionality

1.2.2 Primary Data Collection

A team of two consultants (one international and one national) collected data in Madagascar from February 25 to March 15, 2019 in Antananarivo and coastal regions in the north (Antsiranana, Diana region) and south (Toliara, Atsimo Andrefana region). These regions were selected based on: 1) the presence of health commodity supply chain actors from the public, commercial and social marketing sectors; 2) the status of gender equality based on national statistics; and 3) the presence of implementing partners promoting gender integration and mainstreaming. The selection was made in partnership with the Ministry of Population and the IMPACT program consortium, and was ultimately validated by the USAID AOR.

Results from the two regions may be considered representative samples for the country with the understanding that there was limited time and resources that did not allow the research team to investigate all 13 priority regions.

The main data collection tools (semi-structured interviews and focus groups discussions) and persons consulted are summarized in Table 1 below. Annex D provides a detailed list of interviewees.

Table 1. Primary Data Collection Methods and Tools

Technique	Stakeholders	Purpose	Number of Persons Consulted
Semi-structured Interviews	USAID implementing partners, GOM counterparts. Central and local level	• To gather data on gender equality, social inclusion, and women's empowerment advances, gaps, challenges, constraints, and opportunities in line with the IMPACT program priority areas of intervention, cross-cutting issues, and geographical areas of intervention. • To assess gender integration within policy, planning, operations, and gender capacities, and to identify opportunities for future USAID programming. • To identify opportunities for enhancing collaboration.	• 40+
Focus Group Discussions	Women and men participating in USAID programs/projects	• To capture project participants' opinions and perceptions regarding gender constraints, and the benefits and opportunities associated with USAID programming.	• 18 men • 21 women • 2 youth (1 M, 1 F)
Debriefing Presentation for USAID on Preliminary Findings and Recommendations	USAID Offices/Teams IMPACT program staff	• To identify potential opportunities for collaboration • To validate and gather potential recommendations	• 3 USAID staff (2 M, 1 F) • 22 IMPACT program staff (11 M, 11 F)

1.2.3 Presentation of Preliminary Findings to USAID

Toward the end of the in-country data collection, the research team provided an on-site presentation of the preliminary findings and recommendations of the GESI Analysis to IMPACT program staff and USAID/Madagascar staff. The purpose of the presentation was to validate and expand upon the preliminary findings and recommendations.

1.2.4 Protection of Informant Information

The research team obtained free and prior informed consent, both at the organizational level and from all research participants. This included taking the following steps at beginning of all semi-structured interviews and focus groups:

- An explanation of the purposes of the research, how long the interview/FGD would take, and the procedures to be followed.
- A description of any risks to the person participating (if relevant).
- A description of any expected benefits to the person participating, or to their community, as a result of participating.
- A statement describing whether the data will be anonymous or stored confidentially.
- Contact details for the person to get in touch with if he/she had questions or concerns regarding the research.
- A statement that participation is voluntary, that refusal to participate will involve no penalty, and that the subject may stop participating at any time.

For interviews with at-risk individuals and/or groups, the research team did not record personally identifying information of respondents, including the names, ages, organizations, and even times and dates of interviews.

1.2.5 Limitations of the GESI Analysis

During the literature review, the research team found limited availability of quantitative data on gender equality, social inclusion and women's economic empowerment in the health sector in Madagascar, particularly at the regional level. This includes a lack of sex-disaggregated data in the health sector – including public, commercial, and social marketing channels – and outdated data on gender-informed health indicators, including the Demographic and Health Survey (DHS). There is a dearth of gender data among development programs and donors in Madagascar. The researchers only identified two recent USAID/Madagascar-funded programs that conducted a gender analysis or assessment. Additionally, USAID/Madagascar does not have a Country Development Cooperative Strategy (CDCS), a CDCS gender analysis, or a Mission Gender Order to guide the mission's approach to gender equality and female empowerment.

The IMPACT GESI team conducted field work in two regions of Madagascar – Diana region (Antsiranana) in the north and Atsimo Andrefana region (Toliara) in the south – using qualitative methods including semi-structured interviews and focus group discussions. In Antsiranana, the data collection focused on primarily urban populations; in Toliara, the data was collected primarily in rural areas. However, due to resource constraints, the research team was not able to capture a statistical representation of the 13 priority regions covered by the IMPACT program. IMPACT selected these two regions to conduct the gender analysis based on the following criteria:

- Presence of supply chain actors from all three channels of the health product distribution chain (public sector, commercial sector, and social marketing)
- Existence of ongoing health commodity interventions to facilitate connections to the IMPACT program
- High prevalence of gender-based violence (GBV) based on available statistics from the Ministry of Population

Diana Region – Antsiranana

- Northern region
- Long-standing foreign influence
- Overlapping intervention areas with USAID-funded health programs: Mahefa Miaraka, ACCESS, and IMPACT
- Elevated rate of GBV: 35%[3]
- Strong presence of public, commercial, and social marketing stakeholders: 65 points d'approvisionnement (PAs, or supply points), 6 points d'approvisionnement relais communautaires (PARCs, or community liaison supply points), 45 drug shops, 9 pharmacies, and 2 wholesalers

Atsimo Andrefana Region – Toliara

- Southwest region
- Diversity of local cultures
- High rate of GBV: 42%[4]
- Overlapping intervention areas with World Bank-funded programs
- Strong presence of public, commercial, and social marketing stakeholders (88 PA, 6 PARC, 69 drug shops, 9 pharmacies, 1 wholesaler)

While social inclusion – which is the process of improving the ability, opportunity, and dignity of those disadvantaged on the basis of their identity[5] – was considered as a key component of this analysis in addition to gender equality and women's economic empowerment, there is also a lack of available data around disadvantaged and marginalized groups in Madagascar. This was a key limitation in both the literature review and the field work. There were few key informants who had knowledge of and/or recognition of disadvantaged and marginalized groups, and therefore the findings in this area are limited. The IMPACT program will continue to investigate the gaps and opportunities for social inclusion as part of its gender integration approach.

[3] Direction de la Promotion du genre - Ministry of Population
[4] Ibid.
[5] World Bank Group. Social Inclusion. (2019). https://www.worldbank.org/en/topic/social-inclusion.

2. BACKGROUND

2.1 Gender Equality, Social Inclusion, and Health in Madagascar

Despite ranking positively compared to other countries on many global gender equality indicators, qualitative research shows that the reality of achieving gender equality and equity among Malagasy women, men, girls, and boys is dynamic and presents many challenges. Indicators such as the Social Institutions & Gender Index[6], the African Gender Equality Index[7], and the Gender Gap Index[8] are not representative of many Malagasy women's experienced conditions, especially those living in rural areas.[9] As seen in Table 2 below, the health indicators for Madagascar, particularly for maternal and child health, show there is much progress to be made to improve access and utilization of health products among women, youth and vulnerable and/or marginalized groups.

Table 2. Snapshot of Relevant Health Data and Statistics

- Population of youth in Madagascar under the age of 24: 60%[10]
- Women using modern methods of contraception: 38.8%[11]
- Total fertility rate: 4.129[12]
- Adolescent birth rate: 163%[13]
- Infant mortality rate: 32.7 per 1,000 live births[14]
- Child mortality rate 44.2 per 1,000 live births[15]
- Maternal mortality ratio: 353 (1990-2015)[16]
- Women giving birth in health centers: 38%[17]
- Births attended by a skilled health provider: 41%[18]
- Chronic malnutrition of children under 5 years: 47%[19]
- Babies 0–5 months exclusively breastfed: 41.9%[20]
- Women who have experienced some form of gender-based violence (GBV): 30%[21]

A priority for the Ministry of Health (MOH) is to operationalize UHC to address the gaps identified in the current healthcare landscape. The majority of Malagasy citizens struggle to afford health services. A gender-informed and socially inclusive approach to UHC will help alleviate the equity gaps in access to health services, especially for women and youth. After Madagascar's political crisis in 2009, there were notable decreases in progress as well as reversals on the country's health indicators. An important

[6] OECD. Madagascar – 2014 results. Social Institutions & Gender Index. (2014).
[7] African Development Bank Group. Empowering African Women: An Agenda for Action. (2015).
[8] World Economic Forum. The Global Gender Gap Report 2018. (2018).
[9] African Development Bank Group. Empowering African Women: An Agenda for Action.
[10] CIA Factbook. Madagascar. (n.d.).
[11] USAID. Madagascar: Enquete Menage sur la Planification Familiale; TRaC PF 2017 – Round III. (2017).
[12] World Bank Group. Fertility rate, total (births per woman) Madagascar. (2017).
[13] INSTAT. Madagascar Millennium Development Goals National Monitoring Survey. (2013).
[14] Fertility rate, total (births per woman) Madagascar, World Bank Group.
[15] Ibid.
[16] WHO, UNICEF, UNFPA, World Bank Group, and United Nations Population Division Maternal Mortality Estimation Inter-Agency Group. Maternal mortality in 1990-2015: Madagascar. (2015).
[17] USAID/Madagascar. Ending Preventable Child and Maternal Deaths: 10 Innovation Highlights from Madagascar. (2014).
[18] Ibid
[19] USAID. Madagascar: Nutrition Profile. (2018).
[20] UNICEF. Infant and young child feeding: Exclusive breastfeeding (<6 months) spreadsheet. (2018).
[21] UN Women. Global Database on Violence against Women: Madagascar. (2017).

vulnerability is Madagascar's large youth population. The deterioration of Madagascar's health sector led to higher rates of mortality of children under 5 in particular. Pneumonia, malaria, and diarrhea significantly contributed to child deaths under 5, many of which could have been prevented. Madagascar's current sanitation practices and infrastructure are weak and could exacerbate the spread of water-borne and communicable diseases.

Women report ill health more often than men by 14 percent on average. In urban areas, the gap is greater (20 percent). More strikingly, women above the age of 15 report ill health 60 percent more often than men.[22] Cultural factors in Madagascar make it difficult for women, especially girls, to comfortably seek and receive certain health products, particularly if they are not comfortable approaching community-based health service providers, who are often male. That being said, there are cases of male health service providers who are adequately trained to meet the needs of their communities. The USAID Mikolo project emphasized gender sensitization training to enable male and female health service providers to better understand women's and children's needs. Proliferating gender training across all relevant stakeholders creates a stronger foundation for a healthcare system that supports strong women and youth engagement and demand.[23]

Madagascar is among the top 10 countries in Africa with the highest rate of malaria, and the rate of infection has increased at a higher rate than most in recent years. More than 90 percent of the population is at risk of contracting malaria.[24] Children under the age of five and pregnant women are the most vulnerable to malaria infection because of their weaker immune systems. Between 2011 and 2016, the prevalence of malaria increased significantly in the tropical and semi-arid *(subdésertique)* zones in the western and southern parts of the country, and has remained relatively high in the equatorial zone where it is transmitted year-round. The rate of malaria in the high plateau *(hauts plateau)* region near the central highlands has remained relatively low (see epidemiological zones in Figure 1).[25]

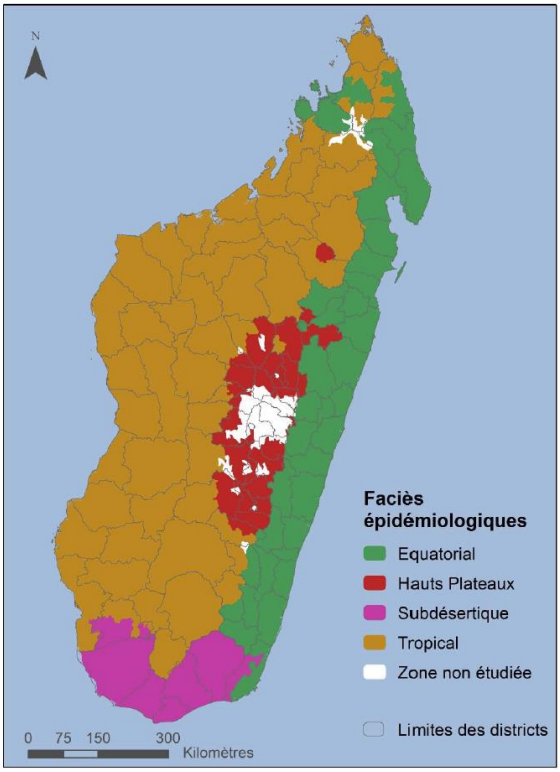

Figure 1. *Epidemiological zones of Madagascar*
Source: Enquête sur les Indicateurs du Paludisme 2016, INSTAT/Madagascar.

The mortality rate of infants is 33 per 1,000 live births.[26] The mortality rate of children under 5 is 44 per 1,000 live births.[27] These indicate significant progress in recent years. However, reducing maternal mortality is still a challenge, currently at 353 per 1,000 live births.[28]

Malnutrition during pregnancy and childhood can affect maternal and child health outcomes. Prevalence of stunting among children under 5 years is 47 percent as of 2012-2013.

[22] Sulla, Victoria. Face of Poverty in Madagascar: Poverty, Gender and Inequality Assessment. (March 2016).
[23] USAID. Mikolo Project: Five Years of Health Impact, 10 Stories of Success. (n.d.).
[24] Institut Pasteur de Madagascar. L'Institut Pasteur de Madagascar mobilisé dans la lutte contre le paludisme. (2019).
[25] INSTAT/Madagascar, Programme National de lutte contre le Paludisme, PNLP/Madagascar, Institut Pasteur de Madagascar, IPM/Madagascar, and ICF International. Enquête sur les Indicateurs du Paludisme 2016. (2016).
[26] World Bank Group. Mortality rate, infant (per 1,000 live births) Madagascar. (2017).
[27] World Bank Group. Mortality rate, under-5 (per 1,000 live births). (2017).
[28] World Bank Group. Maternal mortality ratio (modeled estimate, per 100,000 live births). (2017).

Prevalence of known low birth weight (less than 2.5 kg) is 11 percent as of 2012-2013.[29]

The United States is currently the largest bilateral health donor to Madagascar. Some of USAID's recent involvement in the provision of health in Madagascar includes the Mikolo project, Sustaining Health Outcomes through the private sector (SHOPS) Plus project, and the Integrated Social Marketing (ISM) project. Each of these projects have integrated gender considerations to a certain extent, including a gender assessment conducted by the ISM project in 2013. This is the most recent gender assessment the authors could find in the health commodities sector in Madagascar. Other primary donors and partners for water, sanitation, and hygiene (WASH) and health sectors include but are not limited to the Global Sanitation Fund, Global Fund, European Union, World Bank (WB), and United Nations Population Fund (UNFPA). These partners provide various forms of assistance, including technical and financial capacity building expertise, foundation building for community-based programs, and dissemination of important health information through media campaigns.

Over the past 10 years, other donors in Madagascar have increasingly incorporated gender into internal operational policies and are beginning to require that interventions consider gender by disaggregating data by sex and setting project-specific gender equality targets. For example, the WB programs in Madagascar are required to report on the number of women, men, girls, and boys who are beneficiaries. Since 2018, WB programs have improved in supporting, considering, identifying, and managing cases of GBV. The WB promotes social inclusion through consultation and participation to maximize the number of possible actors in the projects, especially the marginalized and the vulnerable. This includes marginalized groups such as persons living with disabilities, men having sex with men, HIV positive individuals, and lesbian, gay, bisexual, trans, and intersex (LGBTI) individuals.

2.2 Law, Policies, Regulations and Institutional Practices

Article 6 of the Constitution of Madagascar, which was adopted in 2010, states that discrimination on the basis of sex, education level, wealth, origin, religious belief, or opinion is unlawful. The constitution also provides other guarantees such as equality in the workplace regardless of sex and women's rights to ownership of and access to land.

Madagascar's National Health Policy (2015-2019), known as the Plan de Développement du Secteur Santé or PDSS, attempts to address some gender issues that affect health in Madagascar, including gender inequality in education, political participation, and employment, as well as the lack of gender considerations when selecting community health workers (CHW).[30] The PDSS also recognizes that there are gender norms related to childbirth that lead women to give birth at home, resulting in higher maternal mortality. However, like other relevant policies, gender considerations are rarely integrated in a meaningful way to address the different health needs and barriers that women, men, girls, and boys face. The National Policy on Community Health, revised in July 2017, does not make clear policy recommendations for addressing gender equity or social inclusion in the health sector. The policy references vulnerable groups but does not clearly define who qualifies as vulnerable or a strategy to reach groups with different needs. Furthermore, one assessment found that Madagascar's national strategy to address poverty does not specifically take gender considerations or social inclusion into account.[31]

[29] USAID. Madagascar: Nutrition Profile. (2018).
[30] Ministry of Public Health, Government of Madagascar. Plan de Développment du Secteur Santé 2015-2019. (September 2015).
[31] Raoelimiadana, J. 1975 - 2015: C'est encore loin l'égalité des femmes et des hommes? Intégration du genre dans la Stratégie Nationale de Relance de Développement (SNRD): l'expérience d'un groupe de travail à Madagascar. (2014).

In 2016, Madagascar developed a four-year strategic plan (2016-2020) for family planning and securing reproductive health products that includes targets, indicators, and a road map for addressing maternal mortality by taking a multi-sectoral approach.[32] The government also reformed its sexual and reproductive health and family planning law in January 2018 to replace outdated family planning policies from the early 20th century.[33] The GOM aims to reach 50 percent prevalence of contraception by 2020 mostly by targeting youth, and girls in particular who are more susceptible to early and forced child marriage, gender-based violence, and school dropout.[34]

The GOM has introduced policy to address discrimination against women in terms of violence and access to resources and agency, such as Madagascar's National Strategy for Combating Gender-Based Violence, which runs from 2018-2020. However, the government has not passed legislation specifically addressing domestic violence.[35] The GOM is also making legislative and communication efforts across different authoritative sectors/levels to reduce negative sociocultural and economic conditions for Malagasy women and children. The GOM conducted awareness campaigns and criminalized violence against women, particularly against pregnant women. The government also established a National Bureau for Sexual Gender-based Violence that provides free legal aid and psycho-social services to victims of GBV and other violence. Regarding land rights, the GOM adopted a 15-year Letter for Land Policy, producing an updated National Land Program (2016-2020), which secured land rights access to all persons regardless of sex, age, and wealth.[36] While the GOM has implemented legal interventions to address discrimination against women in terms of violence and access to resources and agency, the extent to which these interventions are being enforced and results are being measured is unclear.[37]

Despite legislation, the law does not guarantee women's safety in the workplace. Based on personal accounts and interviews conducted by the International Labor Organization, women do not seek out options to remedy harassment out of fear of retribution or lack of knowledge of their rights.[38] This is a cultural barrier that prevents women from seeking health services they need out of fear or lack of knowledge. In addition, there is no guarantee that female employees of health service providers have a safe working environment. The absence of these protections would be important to consider in commercial sector trainings and communications about GESI.

2.3 Cultural Norms and Beliefs

Cultural norms and beliefs about gender and social inclusion in Madagascar influence the different ways women, men, girls, and boys access and utilize health products. In particular, cultural norms and beliefs significantly reduce women's and girls' access to reproductive health services, including family planning and maternal health. Emphasis on family planning and providing educational and health resources to young women and girls is key to transforming cultural norms and potentially lowering the rate of teen pregnancy.

Young married girls are more susceptible to discrimination and mistreatment when seeking family planning and maternal health services because of the social stigma against girls and unmarried women who are

[32] Brinkerhoff, D.W., O. Indriamihaja, A. Lipsky, and C. Stewart. L'environnement légal pour la planification familiale et la santé de la reproduction à Madagascar. Palladium, Health Policy Plus. (June 2017).
[33] Family Planning 2020. Madagascar: Commitment Maker Since 2015. http://www.familyplanning2020.org/node/440.
[34] World Health Organization. Plan Stratégique National en Santé de la Reproduction des Adolescents et des Jeunes 2018 – 2020. (December 2017).
[35] World Bank Group. Women, Business and the Law 2019. (2019). http://wbl.worldbank.org/en/reports
[36] USAID. Madagascar – Land Tenure and Property Rights Profile. (2019).
[37] OHCHR. Committee on the Elimination of Discrimination against Women considers the report of Madagascar. (2015).
[38] International Labor Organization. The reality of violence at work in Madagascar. (June 2018).

sexually active.[39] Despite the GOM's commitment to eliminating child, early, and forced marriage through the United Nations Sustainable Development Goals and other international conventions, Madagascar is among the countries with the highest prevalence of child marriage in the world.[40] In fact, the frequency of child marriage has increased over the years, with the latest data showing that 48 percent of 20-24 year old females were married by the age of 18.[41] The highest rates are found in the Toliara Region (69%), where customary law allows girls to marry as early as 10 years old, followed by Mahajanga (59%) and Antsiranana (58%) (see Figure 2).[42] Marriage under 18 is authorized with parental consent or judicial authorization; consequently, many girls enter into marriage based on their parents' wishes rather than their own consent.[43] Gender inequality is a key driver of child marriage, which is further exacerbated in Madagascar by extremely high rates of poverty (80%), customary laws and traditional practices, and limited schooling.

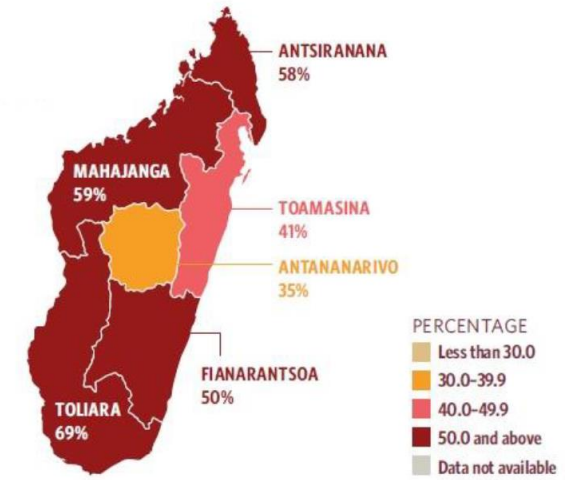

Figure 2. *Percent of 20-24 year old females married by age 18*
Source: Marrying Too Young, UNFPA (based on DHS, 2009)

The persistence of customary laws and social norms that allow for child marriage make it more difficult to prevent teen pregnancies. These occur more frequently when girls are uneducated, poor, and living in rural areas. Social and cultural norms associated with child marriage inhibit married women and children from being able to access and use health products, which effectively lowers the demand for health products, such as contraception, that are intended for their use. Sensitization is needed among health professionals and service providers about the prevalence and implications of child marriage, as well as community-level awareness raising about the harmful impact of child marriage and the benefits of delaying marriage for family health and gender equality. In regions where the majority of young women marry at very early ages, there is a greater need for family planning products and services to reach poor, rural areas. By understanding why and where young women marry at very early ages, the IMPACT program can adjust its regional strategies for increasing access to and utilization of family planning among girls under 18 years.

Gender norms exacerbate inequality and are introduced early on to boys and girls. In the southern region of Madagascar, for example, boys can make decisions about growing and expanding the family through marriage and reproduction, while girls must comply with their husbands' preferences and are beholden to the man's family. This automatically devalues the girl child compared to the boy child, and this inequality often manifests through early and forced child marriage.

Men and women are presented with different options with respect to accessing reproductive health services, and these are influenced by the highly gendered norms and different socio-cultural expectations for men and women. For instance, women are often encouraged to remain abstinent, while men are given more flexibility to use condoms with their partners to reduce their risk of sexually transmitted infections

[39] Marrying Too Young: End Child Marriage, UNFPA.
[40] Girls Not Brides. Madagascar – Child Marriage Around the World. (2019).
[41] Marrying Too Young: End Child Marriage, UNFPA.
[42] Dr. Olga Indriamihaja, interview by Malanto Rabary, Mar. 2, 2019.
[43] UNICEF. Percentage of women aged 20 to 24 years who were first married or in union before ages 15 and 18. (March 2018).

despite strong values promoting abstinence prior to marriage. Premarital sex is more tolerated in the south and north compared to the central highlands where people are more conservative. While becoming sexually active is considered a serious decision for male students, it has more serious implications for female students who, if they become pregnant, can no longer attend school due to the cultural stigma against young, single mothers and the feelings of shame associated with being single and pregnant.[44]

Many of these viewpoints are reinforced through public health programs. For example, HIV prevention programs used as a political messaging tool to push premarital abstinence have often reinforced stereotypes about men and women. The messaging shared negative ideas that women who are sexually active are considered impure or unfit to be married, while men who are sexually active simply need to take measures to protect themselves.[45]

2.4 Gender Roles, Responsibilities, and Time Use

Time use surveys from a USAID gender analysis in the east, southeast, and southwest found that women spend approximately four times as many hours on household activities compared to their spouses, yet men typically have the final say when making decisions regarding household affairs. This includes the time that women and girls spend accessing health services for themselves and others; this is considered a primary responsibility for women and girls to attend to whenever a family member is sick.[46] In times of economic hardship or emergencies, savings are used and assets under women's care are liquidated first. This further limits women's economic and financial independence, as their items are considered less important than other household assets.[47]

Binary gender systems delineate specific roles and responsibilities for men and women as well as married women and single women, particularly in terms of productive labor. Women's labor is undervalued compared to men's, particularly in rural areas where agriculture dominates. In the Diana region, for example, women are not expected to hold labor-intensive or "heavy lifting" jobs that pay more.[48] Because men tend to have jobs that are considered more labor intensive, the community gives them more social capital, priming them to be highly regarded for leadership and decision-making positions in the community.[49] It is widely understood that men are the primary income earners in a household, and that men will make decisions about how to spend that income. Consequently, women often depend on a spouse or male member of the family to generate income for household expenses, including healthcare.[50]

Female-headed households (FHH) in Madagascar are common, yet they are economically and socially disadvantaged compared to male-headed households (MHH). This is largely due to marital status. Approximately 22 percent of households in Madagascar are headed by a woman, and of those households, 65 percent are headed by a woman who is a single mother with children under the age of fifteen.[51] Most of these women are widowed, divorced, or separated from their spouses (74.3 percent of FHH in urban areas, and 77.5 percent of FHH in rural areas). Women are less likely to remarry compared to men, who

[44] Gastineau, B and Binet, C. Sexualité prémaritale à Antananarivo (Madagascar) Comment les étudiant (e) s s'affranchissent-ils des normes? (2013).
[45] Ibid.
[46] USAID. CRS Fararano Project Gender Analysis. (April 2016).
[47] Ibid.
[48] Gezon, L. Marriage, Kin, and Compensation: A Socio-Political Ecology of Gender in Ankarana, Madagascar. (2002).
[49] CRS Fararano Project Gender Analysis, USAID.
[50] Ibid.
[51] United Nations, Department of Economic and Social Affairs, Population Division. Household Size and Composition Around the World 2017 – Data Booklet (ST/ESA/ SER.A/405). (2017).

remarry at a rate of more than 90 percent in urban and rural areas.[52]

Women and men continue to fulfill traditional gender roles which relegate women and girls to unpaid household duties such as cooking, cleaning, and child rearing and leads to an imbalance in power and decision-making within the household. Married women cannot legally be recognized as the head of household in the same way that men are, and many women and girls continue to face sexual harassment and exploitation.[53] Despite the significant influence that women and girls have over family health, in some regions including the east, southeast, and southwest, men and boys have control and decision-making power over how household finances are spent on healthcare.[54]

With respect to where women tend to be concentrated in the economy, 87 percent of working women hold jobs in the informal sector.[55] Given that the informal sector lacks protections under the GOM, women business owners and employees in the informal sector are not adequately protected by the legislation that would otherwise guarantee their safety. If their businesses are not registered, these women may not be eligible for formal financing or have access to appropriate loan collateral.[56] This limits the ability of many women-owned businesses to expand and become more profitable over time.

A much smaller proportion of women secure employment within the retail, hospitality, and health services sectors. Given that women are already actively participating in the health sector, this offers the potential to increase the reach of health products to Malagasy people through women's entrepreneurship and the benefits of woman-to-woman health services and marketing.[57] Gender differences in the labor force are not completely explained by gaps in education or experience. The differences in earnings suggest a segmentation of the labor market due to various reasons, such as labor mobility. Wage gaps between men and women are most prevalent in the informal private non-agricultural sector. In the non-agricultural sector, for example, median earnings for women are 32 percent lower than men.[58]

While there is a lack of sex-disaggregated data on women's participation in the health services sector, the International Labor Organization reports that the female share of employment in senior and middle management roles in government, large enterprises and institutions is 24.5 percent.[59] Furthermore, the World Bank's enterprise surveys of business owners and top managers in small, medium and large firms shows that there is a strong representation of women in small- and medium-size business ownership (42.8% and 45%, respectively).[60] On average, 30 percent of small and medium-size businesses have a female top manager, as well as between 30-35 percent of permanent full-time workers that are female. Large businesses in Madagascar have significantly lower representation of women in leadership positions. While these data do not necessarily represent all enterprises in the health sector, they can be used as a proxy and allow the IMPACT program to set a benchmark for the minimum level of participation that women should be found in decision-making positions in the health commodity supply chain.

The proportion of female-headed households is higher in urban areas (36%) than in rural areas (28%).[61] In

[52] Face of Poverty in Madagascar, Victoria Sulla.
[53] Waite, Victoria et al. USAID. Women's Wage Employment in Developing Countries: Regulatory Barriers and Opportunities. (2018).
[54] Ibid.
[55] Institut National de la Statistique - INSTAT/Madagascar and ICF Macro. Enquête Démographique et de Santé de Madagascar 2008-2009. (2010).
[56] United Nations Conference on Trade and Development. Teaching Material on Trade and Gender, volume 1, module 4B. (2018).
[57] Ibid
[58] World Bank Group. Labor Markets Conditions in Madagascar. (2010).
[59] International Labor Organization. ILOSTAT, Madagascar. (2019).
[60] World Bank Group. Enterprise Surveys – Madagascar. (2013).
[61] Enquête sur les Indicateurs du Paludisme 2016, INSTAT/Madagascar.

urban areas, women who are separated from their husbands are the poorest, followed by those who are widowed and single. In rural areas, women in free unions (a relationship with no legal or religious recognition) are the poorest, followed by separated, widowed and single women. Overall, female-headed households are the poorest because they have fewer assets in terms of education, land ownership, and property (eg. farm animals).[62] Male-headed households where men are divorced are also economically disadvantaged compared to men who are married – they are 39 percent poorer. However, only 0.05 percent of urban MHH are headed by divorced men.[63]

2.5 Access to and Control Over Assets and Resources

There are gendered dimensions to access, utilization, and knowledge of health and health products. For example, Madagascar's National Institute of Statistics (INSTAT) latest survey of indicators of malaria in Madagascar (EIPM 2016) shows that women's knowledge of how malaria is transmitted varies by location. On average, only 50 percent of women cited mosquito bites as a means of contracting malaria. The percentage of women who understand this to be the means of transmission is the highest in the west and tropical zones (56% and 53% respectively). One in five women (20%) sleep under an insecticide-treated bed net every day to prevent malaria. The study also found that 72 percent of pregnant women surveyed slept under a mosquito net and that 76 percent of children under 5 slept under a mosquito net or were living in a dwelling that sprayed with insecticide. Additionally, 37 percent of pregnant women took at least one dose of Intermittent Preventive Therapy (IPT) with sulfadoxine pyrimethamine in their first prenatal consultation. Around one in five women (22%) reported having taken two or more doses of IPT, including at least one dose during a prenatal visit. One in ten pregnant women (10%) took three or more doses of IPT, including at least one dose during a routine prenatal visit, as recommended. The survey also found that pregnant women in urban areas are more likely to have taken IPT.[64]

There is also a link between mother's level of educational attainment and infant mortality. The most recent DHS data shows that for the five-year period 2004-2009, infant mortality varied from a minimum of 39 percent among children whose mothers completed a secondary education level or higher versus a maximum of 58 percent among those whose mothers completed little to no education. The same study finds that infant mortality is significantly lower in urban than rural areas by about 21 percent. Almost all (95.2%) women who did not make prenatal visits gave birth at home, whereas 68.5 percent of women who made one to three visits and 50.2 percent of those who had four or more visits gave birth at home.[65]

Boys and girls have a close sex ratio at birth and have equal access to health services. However, after girls reach the age of 10 and reach the age where they will require reproductive services, their access to health services may become limited due to cultural norms/factors.[66]

Malagasy women face inequality in the labor market that limits their ability to generate income, access employment, and access capital. When controlling for other factors, women's earnings are lower than that of men. Though the gap between women's earnings compared to men's earnings has decreased over time, it is still substantial. As of 2010, women's earnings were 34 percent lower on average than men's earnings with similar characteristics. Additionally, men at any age are more likely to have more than one job than women of similar ages.[67] Access to productive paid work – and the cultural expectation that men

[62] Face of Poverty in Madagascar, Victoria Sulla.
[63] Ibid.
[64] Enquête sur les Indicateurs du Paludisme 2016, INSTAT/Madagascar.
[65] INSTAT/Madagascar and ICF Macro. Enquête Démographique et de Santé de Madagascar 2008-2009. (2010).
[66] UNICEF. Madagascar UNICEF Annual Report 2017. (2017).
[67] Ibid.

should spend their time this way, rather than on unpaid household and care work – positions Malagasy men over women who are likely to earn less due to stereotypes that are reinforced within the labor market. Because they do not earn enough to subsist solely through their labor opportunities, women often must resort to obtaining financial resources from sexual and domestic partners.

While women can access loans and have equal rights to open bank accounts, credit requirements and financial guarantees create major barriers for many women. High interest rates (1% to 4% per month), and short repayment periods (six months to one year) create further barriers to expanding business and income-generating activities. As a result, the loans secured reinforce their situation of poverty and inequality. Furthermore, Malagasy law does not prohibit discrimination by creditors on the basis of sex or gender.[68]

2.6 Patterns of Power and Decision-Making

Barriers to women's and youth participation in community-level decision-making prevent their full participation in and benefit from health programs. In some rural areas and more conservative parts of the country, such as the southwest, it is taboo for women and men to hold meetings together.[69] Women are often not permitted to speak in public and therefore do not participate in community meetings. In some cases where women do not attend or participate in community meetings, they are still actively influencing men "behind the scenes." While this demonstrates one form of power women may have, this passive approach robs women of their potential voice and agency as community leaders and perpetuates the silencing of women's opinions. Women are even afraid to speak and express their opinions in safe spaces created by women's groups like *Jeunes Femmes Engagées de Tuléar* (JFET).[70]

In other places where women and men may be present at meetings together, women's participation is often marginalized or women do not feel comfortable speaking in public.[71] This reinforces the importance of providing gender training to ensure that all stakeholders are aware of these constraints and take gender considerations into account, especially if women are not comfortable voicing their needs. This potentially indicates that having women-to-women marketing strategies in the health sector may lead to improved communication between health service providers and consumers, thus better meeting the needs of women and children.[72]

Emphasis on family planning and providing educational/health resources to young women is key to improving gender norms and potentially lowering the rate of pregnancy among younger women. The level of knowledge of modern contraception methods is significantly high across Madagascar (more than 90 percent in rural and urban areas on average). However, usage of modern contraceptive methods is relatively low at 35 percent.[73] Knowledge of modern methods increases with education level, and the vast majority of women not using contraceptives had no contact with CHWs and therefore did not receive family planning information.[74]

Women's lack of power and ability to influence decisions jointly within the household and community is

[68] World Bank Ground. Women Business and Law 2019.
[69] Fleurica Bodanahary, interview by Rachel Mahmud and Malanto Rabary, Mar. 14, 2019.
[70] Ibid.
[71] Davis, Isobel. CLTS engagement, outcomes and empowerment in Malagasy communities. WSSCC. (2016).
[72] Ibid.
[73] Madagascar - FP2020 Core Indicator Summary Sheet, Family Planning 2020.
[74] Enquête Démographique et de Santé de Madagascar 2008-2009, INSTAT/Madagascar and ICF Macro.

one of the strongest factors that leads to GBV in Madagascar. Women feel unable to leave violent or threatening situations because of their financial dependence on men, which prevents them from seeking new opportunities. As a result, women in Madagascar often do not seek out the support systems that currently exist for them.[75] While several stakeholders and programs in Madagascar are working in support of GESI, the support system for addressing GBV seems insufficient and unknown by most IMPACT program partners.

Cultural norms around land ownership also play into women's economic empowerment and decision-making. Land is often inherited or acquired by elders in the community (men and women), making it difficult for young adults to become landowners. Married couples or single men who do not own land typically work as tenant farmers, but single women with no land usually only work as low paying seasonal day laborers on fields.[76]

[75] CRS Fararano Project Gender Analysis, USAID.
[76] Marriage, Kin, and Compensation, Gezon, L.

3. KEY FINDINGS

As the primary managers of family health and well-being in Malagasy households, women play a critical role in ensuring the success of health commodity interventions. When women serve as health service providers, they have the potential to reach marginalized or untapped segments of the market through woman-to-woman marketing and approaches. By integrating gender into a health commodity supply chain management approach, USAID programs can ensure that men and women receive appropriate training and access to information and networks, and provide any additional resources needed to level the playing field for women and men to actively participate. Mainstreaming gender and social inclusion into health programs also includes collecting sex- and age-disaggregated data, at a minimum, as well as data on the representation of women and youth in decision-making and/or management positions.

As seen in Figure 3 below, the health commodity supply chain has three channels – public sector, social marketing and commercial – all of which are addressed under the IMPACT program's TMA. Data are limited on the typical profile or demographics (sex, age, socio-economic status) of clientele that seek health services from the public sector, social marketing, and commercial sector. According to USAID SHOPS Plus program, when Malagasy children are sick, their caregivers only seek out-of-home care 44 percent of the time. When caregivers do seek out-of-home care, more than 60 percent of the time they seek public sector services, and it is estimated that at least a quarter of the poorest households seek healthcare for sick children in the commercial sector.[77] Data are also limited on care-seeking within the social marketing supply chain. The GESI analysis examines each distribution channel to identify advances, gaps, and opportunities for gender equality, social inclusion, and women's economic empowerment.

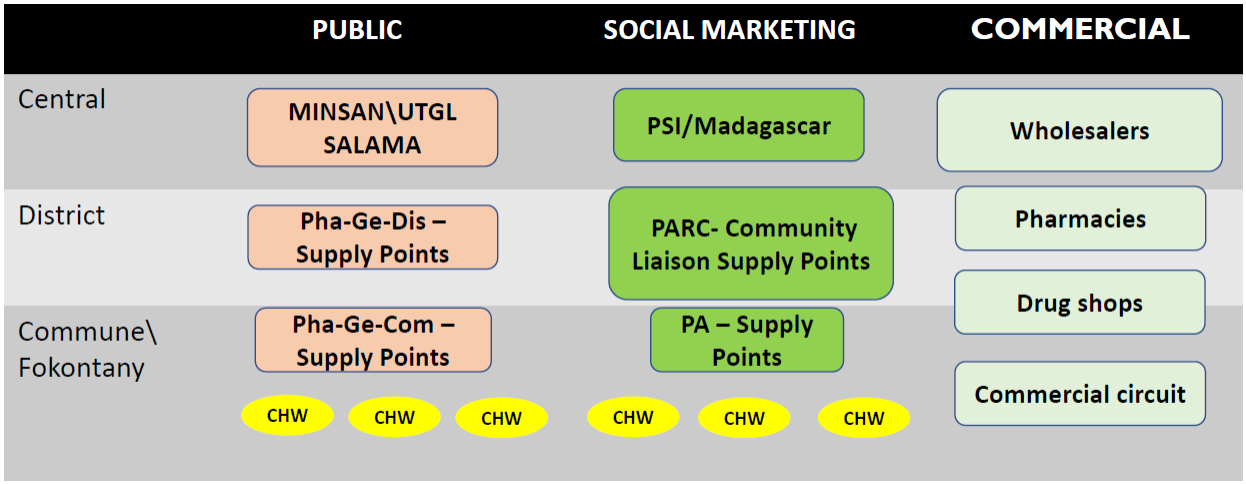

Figure 3. *Health commodity distribution channels*
Source: PSI/Madagascar

3.1 Public Sector

The public sector is the primary source of care and treatment in Madagascar, particularly among poor people.[78] SALAMA is the central distribution hub established by the GOM in 1996 to ensure the supply

[77] Ibid.
[78] Bradley S, Rosapep L, Shiras T. Sources for sick child care in Madagascar. (2018).

of generic essential drugs and medical devices for all public health facilities, as well as for private nonprofit organizations, such as PSI/Madagascar. SALAMA distributes and transports commodities to the district-level supply points, or Pha-Ge-Dis, who then distribute commodities to the commune-level supply points, or Pha-Ge-Com. CHWs distribute health commodities directly to consumers.

Although health services and products are intended to be available to all beneficiaries regardless of sex, social and cultural norms limit women and youth from seeking help in a dignified and transparent way. For example, a significant portion of women hide the use of contraception from their spouses and sexual partners; pregnant girls often do not access public health centers because of shame and the fear that they will be treated poorly by doctors; and some boys with sexually transmitted infections are equally fearful and embarrassed.

Men and women value health differently. Health is seen as a woman's duty, and men typically do not take responsibility for ensuring their own health or the health of sick family members.[79] If household finances are available, women tend to go straight to the doctor if they or their children are sick, whereas men reported that they only bring their wives or children to the hospital if there is a life-threatening medical reason. In focus group discussions in Antsiranana and Toliara, women reported that in most cases, men only come to a health center when they feel seriously ill. They often arrive with complicated cases that could have been treated more easily earlier. This delay results in increased health-related expenses for the public sector and financial stress on households.

Among the men and women interviewed in urban areas, people often use home remedies or self-treatment such as massage to treat minor or recurring illnesses such as fever, diarrhea, and sexually transmitted infections. If an individual's health does not improve after several days, only then will they seek treatment at a public hospital. In rural areas, however, men in particular reported that they often seek advice from traditional healers, who offer remedies for much less than the local hospital or private retailers, as well as the flexibility to negotiate prices or to agree to a payment plan. Men living in rural areas explained that going to the hospital is too expensive and they do not receive the bill until after treatment, which they often cannot afford to pay. The practice of traditional medicine is legally authorized and recognized in Madagascar. However, traditional healers are not authorized to handle pharmaceutical products or prescribe any drug product or proprietary medicinal product that falls within the competence of pharmacists. Traditional practitioners include traditional birth attendants, therapists, herbalists, and medico-druggists who market medicinal substances of animal or mineral origin.

Many people living in rural areas seek traditional medicine because there is a lack of qualified public health professionals serving rural areas. Doctors are concentrated in urban areas, whereas in Mangily, a rural area outside Toliara, interns often treat patients at public health clinics, and patients are less comfortable with inexperienced doctors. Women reported that they are more comfortable being treated by male doctors, who tend to be more experienced and trained, rather than female doctors, who tend to be interns in training.

[79] Adult female Focus group discussion, Mar. 6 (Antsiranana) and Mar. 12 (Toliara), 2019.

Public Sector Supply Chain Actors

Figure 4. *SALAMA Headquarters, Antananarivo*
Photo credit: Rachel Mahmud

Within SALAMA, management-level professional positions are shared nearly evenly between men and women (approximately 55% men vs. 45% women, according to staff). However, the sales department has many more women than men, and the warehouse management team employs all men except for one woman in a management level position who oversees a team of primarily male stockers. When asked about her experience as the only woman working on the warehouse floor, she said, "I am the only woman on this team of five men, I supervise them. At first it was very difficult, I had to ask the help of my male supervisor for me to introduce myself and hold my leadership with my supervisees. But once they find that you master your work, they accept you easily. They even preferred to be led by a woman."

Essential medicines are delivered directly from SALAMA to the national-level university health centers (CHU) and regional hospital centers (CHRR). Both men and women hold management and decision-making positions in the hospital; for example, in the Diana region CHU, approximately 60 percent of professionals, including doctors, are female. When stock is low or if shipments are delayed from SALAMA, public hospitals will source medicine from commercial wholesalers to avoid stockouts. Hospital administrators report that more female than male clients are at the public hospital, which reflects the cultural norm that women are primarily responsible for managing family health and that men seek formal medical treatment less frequently.

With recent changes in 2017-2018 to Madagascar's national law on family planning and sexual and reproductive rights, the new regulatory framework is more conducive to achieving gender equality and social inclusion, particularly for young women seeking family planning and reproductive health services. However, based on the findings from this GESI analysis, implementation remains a major challenge at all levels, primarily due to the lack of knowledge and understanding of the importance of gender equality and social inclusion among key players in each sector of the health commodity supply chain (public, commercial, and social marketing). Among nearly 50 people interviewed during the study, including beneficiaries and key informants, a small percentage understood the concepts of gender equality and social inclusion as they relate to access to and usage of health products. With the exception of a few key informants whose mandate includes gender equality and social inclusion, nearly everyone interviewed was unfamiliar with laws, strategies, and standards for GESI.

The national law on family planning and sexual and reproductive health, revised in July 2017, permits girls – for the first time – to access contraception without parental consent. Contraception products are sold through drug shops and pharmacies, as well as government-supported CHWs. However, according to key informants, the law does not specifically spell out the role of CHWs in distributing and administering different forms of contraception, and therefore CHWs are not adequately protected by the law. Given that CHWs are the primary distribution point for rural women to access contraception, this is concerning because most CHWs are not aware that they are not protected under the new law. In line with Madagascar's national strategy for achieving UHC, the role of CHWs in administering family planning methods should be clearly spelled out through the law for the assurance of both consumers and service providers.

Within the public sector, including among international organizations and donors, there is no clear definition for what constitutes "vulnerable" and "marginalized" groups, which are considered the target

for many health programs, such as the Non-Stop Drug Supply Fund (Fandraisana Anjara NO Mba Entiko, or FANOME). For example, the National Policy for Community Health (PNSC) states that:

> "The community ensures that all its members, including the most vulnerable, the poor and the marginalized, regardless of sex, freely express their views on health issues, participate in and benefit from any health development actions that concern them."[80]

> "When we talk about health, it's a women's affair. In the minds of Malagasy people, as soon as it concerns health, it is a woman's business. When it comes to positions of responsibility, it is rather men. Men think that family planning and taking care of children is women's concern."
> – Public sector official, GOM

The PNSC mentions there will be social protection for vulnerable populations, but it does not define who is considered vulnerable or who falls under these marginalized groups. The PNSC does not clearly define specific marginalized groups or provide a roadmap to identifying each one. According to most stakeholders interviewed, pregnant women and children under 5 are considered the most vulnerable groups, but this excludes other vulnerable or marginalized groups such as the elderly, men having sex with men, LGBTI, and ethnic minorities, among others. According to the PNSC, CHWs are critical to filling gaps in access to health products, particularly for vulnerable groups. The GOM provides limited training to CHWs to offer basic health services and education at the community level, and they would be better equipped to assist the GOM in achieving UHC if they received further guidance.

According to the PNSC, every citizen is equally responsible for ensuring community health, regardless of sex or age. But in practice, women are usually the ones who take care of everything related to family health because they are expected to remain at home to care for children, the elderly, and the sick. Men are expected to bring in money through paid work.[81]

Figure 5. *Community Health Workers, Toliara, Atsimo Andrefana Region*
Photo credit: Rachel Mahmud

Community Health Workers

CHWs are a critical element of the public health system, as stated in the national community health policy, and they also serve as a direct distribution point for the social marketing supply chain (see Figure 3).[82] CHWs are volunteers who, with limited training, offer basic healthcare services and health education at the community level. CHWs have brought innovative marketing techniques in providing access to medicine to community members, helping to sustain USAID's investments and improving the health of their villages, while facing the challenges of working in remote and often difficult-to-access regions that are far from health clinics and hospitals.

The majority of CHWs are women selected by their own communities at the fokontany administrative level. CHWs reach about 9.5 million people, or 64 percent of the population in rural areas. CHWs have long been recognized for their role in reducing

[80] Ministère de la Santé Publique. Politique Nationale de Santé Communautaire. (July 2017).
[81] Dr. Lheticia Lydia Yasmine, interview by Rachel Mahmud and Malanto Rabary, Mar. 5, 2019.
[82] USAID/Madagascar. USAID/Madagascar and Community Health Volunteers: Working in Partnership to Achieve Health Goals. (2015).

mortality and morbidity, and in expanding access to health services in low-resource settings. Reliable access to commodities on a timely basis is also essential for CHWs to provide health products and services. They acquire commodities through a network of more than 1,080 commune-level supply points (CSBs).[83] CHWs are part of the Integrated Community Case Management program to provide screening, early pregnancy services, referral of pregnant women for prenatal care, and distribution of important prenatal medications.[84]

CHWs hold a significant amount of responsibility for a volunteer position. Not only do they consult with community members on a range of health areas, but they are also expected to do a high volume of reporting, writing, and calculating for public health programs. However, serving as a CHW comes with a certain level of prestige or social status within the community because they are considered to be trustworthy, provide valuable services, and receive recognition because they are selected by village leaders.

> "I am the only male CHW left from the 14 that started. I have been practicing as an CHW for 15 years now. My secret lies in my personal belief in helping the community with health because the closest health center to our fokontany is 10 kilometers away, I wanted to save my family, expand my knowledge and experiences"
> - Male CHW, Toliara region

Being a CHWs carries some risk, particularly for women. CHWs are required to transport medicines from the district-level supply points (Pha-Ge-Dis) and commune-level supply points (Pha-Ge-Com) to remote areas sometimes 20 kilometers away. In rural areas such as Mangily, which is more than 20 km from the closest supply point, female CHWs are not safe traveling such a long distance alone. When a male CHW is available, he may accompany her for safety purposes. In addition to safety issues, this volunteer role places an additional time burden on female CHWs who have additional unpaid work responsibilities in their households and community. CHWs also need to transport goods, some of which pose a physical labor burden.

CHWs have extensive knowledge and understanding of community needs. According to interviews with CHWs, the vast majority (up to 90%) of men in the communities where they work refuse to let their wives or partners use contraception. This is tied to cultural norms and expectations in Malagasy culture, particularly in rural areas, where having many children is associated with masculinity. Furthermore, as health is considered a woman's issue, focus group discussions revealed that very few men use condoms as a form of birth control despite their wide visibility and availability. As a result of these factors, women who use contraception often do so without their partner's knowledge and may leave their health records at CSBs or at a friend's house so that their spouse or partner does not see them.

> "Women hide their family planning from their husbands. Sometimes women cannot use the contraceptive methods of their choice."
> - Female focus group participant, Toliara

During focus group discussions, men explained that the many rumors about the side effects of contraception on women's bodies may be contributing to men's reluctance to allow their partners to use family planning. Due to a lack of knowledge and education, many men interpret family planning to mean that women will stop having children permanently. For example, some men believe that by using contraception, you can no longer feel the pleasure of sexual intercourse, or that it brings bad things to the woman's body, including diseases such as cancer. Women's associations like JFET are working to change these misconceptions among men in rural areas through

[83] Ibid.
[84] Southern African Development Community. SADC Gender and Development Monitor 2016. (2016).

education and awareness-raising.[85] Despite these cultural challenges, contraception is widely available and the women of Toliara can obtain it at an early age. Young women may purchase contraceptives in the homes of midwives. Additionally, many mothers of sexually active girls insist that "women have the right to use contraception because it is for their health."[86]

Men who are open to family planning are typically aware of the other benefits it brings to maternal and child health and a family's socio-economic status. Young men, in particular, are more open to family planning for their partners and wives. Men in the south are more conservative about family planning and it is difficult to convince them of the benefits. CHWs work to educate them about the benefits of family planning for women's health, household income, and family well-being and ask them to compare their lives to those of others who have practiced family planning. To better engage with men about family planning, CHWs also try to schedule health messaging sessions after men return from work in the early evening so that couples can attend and learn together.

In 2013, USAID/Madagascar commissioned a pilot with CHWs to determine if providing pregnancy tests would increase the use of contraception. The study found that the number of clients using contraception increased by 24 percent when CHWs provided them with pregnancy tests.[87] These lessons learned and success stories should be replicated and scaled under the next phase of USAID's effort to increase UHC.

CSB/Pha-Ge-Dis/Pha-Ge-com

Both women and men hold positions of leadership and decision-making within the district-level supply points (Pha-Ge-Dis) and commune-level supply points (Pha-Ge-Com), and in some regions such as the north, women comprise a significant majority (80%) of women employees, particularly among service providers who are client-facing. At the commune level, the local community elects the members of the Management Committee of Pha-Ge-Com. The mayor of the commune, who is typically a man, is responsible for designating the president of the Pha-Ge-Com, and therefore has significant influence over health at the commune level. The percentage of women holding elected office at the municipal level, including mayors and chiefs of fokontany (village or commune), is extremely low at less than 5 percent.[88] Despite the gender balance among leaders of CSBs in some regions, women who serve this role still face security issues when transporting medicine, similar to the CHWs. CSBs are required to ensure their own safety, and female CSBs sometimes resort to having a man accompany them to transport drugs. Key informants reported that the greatest challenge remains the cost of transportation. There is also a lack of technology and resources available, such as computers, and a need for greater capacity building of these service providers.

Whenever there is a stockout of health products, prices go up in the commercial sector (pharmacies, wholesalers, drug shops, etc.) and stockouts encourage corruption within the public health system. Maternal health is impacted by corruption issues in particular because women and mothers are primarily responsible for managing family health. This includes managing the household budget that is used to pay for health products and services, so when medical expenses go up there is no way to recuperate the additional cost and therefore women have to sacrifice their own health and well-being to focus on that of the children. If finances are tight, men also are less likely to go to the hospital and will seek alternative methods of treatment that are less expensive, such as consulting with the local medicine man or using at-home remedies.

[85] Fleurica Bodanahary, Mar. 14, 2019.
[86] Adult female focus group discussion, Mangily, interview by Malanto Rabary, Mar. 12, 2019.
[87] Rakotoniaina, Samy. Pregnancy Tests Help Boost Family Planning in Madagascar. (January 2016).
[88] UNDP. Rapport du Coordonnateur Resident – 2015 Madagascar. (2015).

3.2 Commercial Sector

The commercial sector is a small but growing portion of the supply chain for health commodities. At the central level, twenty-nine wholesalers across Madagascar supply medicine to the commercial sector. Pharmaceutical wholesalers play an important role in supplying not only the commercial sector, but also the public and nonprofit sectors when there are stockouts or shortages. Wholesalers are predominantly owned and operated by men, and in some cases, foreigners. Wholesalers are unlikely to hire women because working in the warehouse or transporting goods is considered to be difficult or heavy-lifting work that is perceived as being culturally appropriate for men. In the rare cases where women work in warehouses, this study found that they play more of a managerial or supervisory role. While this presents a unique opportunity for women's economic empowerment through decision-making in management positions, this also reinforces gender stereotypes and negative social norms that limit potential employment and professional opportunities for both women and men.

Pharmacies and Drug Shops

There are more than 310 pharmacies and 3,000 formally registered drug shops across Madagascar (as of February 2019). Currently, data collected on ownership of pharmacies and drug shops are not disaggregated by sex. Based on our findings from key informants, most pharmacies are owned by men, but it is not considered uncommon for women to own pharmacies. For example, of the nine pharmacies located in Antsiranana, the major urban center in Diana region, women own and operate three. In Toliara, women own 50 percent of pharmacies. Irrespective of ownership, interviews conducted with key informants highlight similar challenges, including the lack of storage space to stock up on drugs during the rainy season.

> "I have had this pharmacy for 30 years. I will say that my strength is my thirst for documentation on the internet, to always be up to date on innovations. I graduated in the former USSR, I also receive several postgraduate trainings given by doctors and laboratory pharmacists, almost 3 or 4 times a year."
> – Female pharmacist, Diana region

Men and women working in the commercial sector are largely unaware of the impact that their limited coverage and market share has on inequality and inequity in access to health products. They also lack awareness of how gender inequality may limit the potential for women business owners to expand their companies to better meet customer needs, increase their market share, and generate more income. We interviewed one female entrepreneur who owns a pharmacy in an urban area in the Diana region. She did not report facing any barriers as a woman operating a pharmacy over the past thirty years. However, she has not yet accessed any formal loans as a business owner in thirty years, which would serve to expand her business and address some of her challenges, such as a lack of storage space. She participates in regular convenings of pharmacists in the region, which include both men and women, but does not participate in any of the existing groups for women entrepreneurs. There are no known trade associations specifically for women entrepreneurs in the private health commodity sector.

Unlike pharmacies, drug shops are typically operated by women because it is considered a simpler function and therefore more stereotypically women's work. Key informants reported that there is a social stigma against men who occupy positions that are traditionally held by women, and they are often criticized and must justify their choice to engage in "women's work." However, men still can hold these positions, and the men interviewed found the benefits included an improved work-life-balance, including time to go on vacation.

An important consideration moving forward for businesses that are owned and/or operated by women, including drug shops and pharmacies, is to better understand the time burden that women face outside of paid work. During the study, we found that women business owners are often difficult to reach because they are overworked and have many responsibilities beyond their business. By understanding the constraints they face, and by identifying other staff to support and train along with business owners, women entrepreneurs will be able to run their businesses more efficiently, delegate responsibility, and have the time to step away to seek new business opportunities or to fulfill other household and/or community responsibilities. Building the capacity of an entrepreneur's entire support team will ensure that business owners, and women in particular, have the support they need to fulfill their multiple duties. Inclusion of spouses and/or male family members in the process is also important to understand what role, if any, they play, to address cultural norms around women's time use, and to sensitize family members to the importance of sharing household duties to support women business owners.

Some entrepreneurs and physicians from minority groups, including those from the Muslim community, report that they do not have access to the same social networks and are often excluded from private health sector initiatives. Because medicine is highly politicized as it influenced by public and private health sector finances, doctors often do not share the latest teachings or developments with pharmacists who are not in their preferred social networks.

Access to Finance

> "Generally, the choice of staff to recruit is not related to gender. I do not consider the male/female status when I recruit an employee, I value the individual."
> – Director, financial institution (male)

There is a strong representation of women in leadership and decision-making positions within private banks in Madagascar. Some private financial institutions have many more female bank branch managers than men. However, at the regional level, cultural norms may be a barrier to recruiting and retaining female loan officers. For example, early and forced child marriage is commonplace in the north and south, which leads to teenage pregnancy and prevents women from pursuing the necessary education to go into professional fields such as finance. Other cultural norms suggest women should depend on men's income, and therefore women are expected to take on roles that are considered easy, including household chores, taking care of children, the sick and the elderly, cooking, cleaning, etc.[89] In the north, among those women who do succeed in education and engage in a field such a banking, there is still the risk of losing female loan officers if they decide to get married to a man who can offer more financial stability.

> "I must assume my role as mother, wife and entrepreneur at the same time without either being harmed."
> - Female entrepreneur, Antsiranana

As banks are actively seeking new clients, they do not distinguish between female entrepreneurs and male entrepreneurs. Bankers find that when women do take out loans, they tend to repay better than men, which they believe to be true because they think that women's mentality and skill sets make them more equipped to manage money and businesses. Bankers also report that women are more risk averse, and men often consult with their wives before making major financial decisions. In urban areas, more women apply for loans than men. However, in rural areas, there are many more male loan seekers. In some cases, the loan is taken out in the woman's name, but it is her spouse or male family member who is managing the business. In rural areas, loans are often based on a land guarantee, and according to customary practices, women do not inherit land, particularly in more conservative parts of the countries such as the south.

[89] Fleurica Bodanahary, Mar. 14, 2019.

Figure 6. *Malanto Rabary, GESI specialist, facilitates a discussion with loan officers in Antsiranana, Diana Region*
Photo credit: Rachel Mahmud

While banks recognize the value of female customers, historically there have not been customized loan products targeted for female clients. Access to credit remains a challenge as certain credit requirements block women. This includes having a credit guarantee in the form of collateral, which women are less likely to have than men because they own less land and fewer assets compared to men. Furthermore, according to Malagasy law, married women cannot access credit without their husband's signature. There is a dearth of data on the constraints and opportunities that women entrepreneurs in Madagascar face in accessing finance. Anecdotally, banks report that more women take out loans than men in urban areas, and that there are fewer female clients in rural areas. To address the constraints that women face in accessing finance in rural areas, USAID programs (Mikolo and Fararano, among others) have established savings and internal lending communities (SILCs) to offer easy access to credit and other financial services for households and healthcare providers, especially women, as well as social capital.

> "Access to credit needs collateral. There, women are robbed."
> – Vice President, JFET

When CHWs are SILC group members, they can use meetings to educate the community about health awareness and practices. Promoting community-based forums where more women can be reached, and also actively participate, would help increase women's access to and control over financial resources. These community-based forums are opportunities to reach more women to learn about their health and service options, as well as recruit women to participate in some part of the health commodities supply chain.

3.3 Social Marketing

Social marketing organizations, such as PSI/Madagascar (PSI/M), are largely donor-funded and seek to address major gaps in access to health commodities. The social marketing supply chain uses specific communication and distribution strategies to target vulnerable groups (including children under 5 and pregnant women), as well as offer an alternative solution to healthcare for people living in rural areas. Similar to the public sector, social marketing has several levels of supply points to distribute health commodities, as seen in Figure 7 below. In this case, a nonprofit organization such as PSI/M serves as the wholesaler or stockist, and then distributes commodities within 13 priority regions through 66 supply points (known as PARCs) located at the district level and 859 supply points (known as PAs) located at the commune level. CHWs distribute commodities directly to the end users.

PARC/PA

Community liaison supply points (in French, *Points d'Approvisionnement Relais Communautaires,* or PARCs) are individuals or private entities who already own businesses or have jobs but agree to work in partnership with PSI/M to distribute health products at the district level. Supply points (in French, *Points d'Approvisionnement*, or PAs) are based at the commune level and serve as a distribution point between the PARC (district-level) and the CHW (village-level). PARCs and PAs are critical players in the social marketing supply chain. PSI/M tracks these individuals who serve as supply points and disaggregates the data by sex. Both men and women hold these roles and there is a relatively balanced representation of both genders. Some in the social marketing sector perceive that female distributors (CHWs, PARC, PA) tend to be more patient and give more of their time and effort to convince clients about the use of medicines such as contraceptives, whereas male distributors are perceived to be more focused on prospective profit gains of selling health products. However, distributors that were interviewed for the GESI analysis – both male and female – consistently expressed their intrinsic motivation to improve the health of their community through this volunteer opportunity.[90]

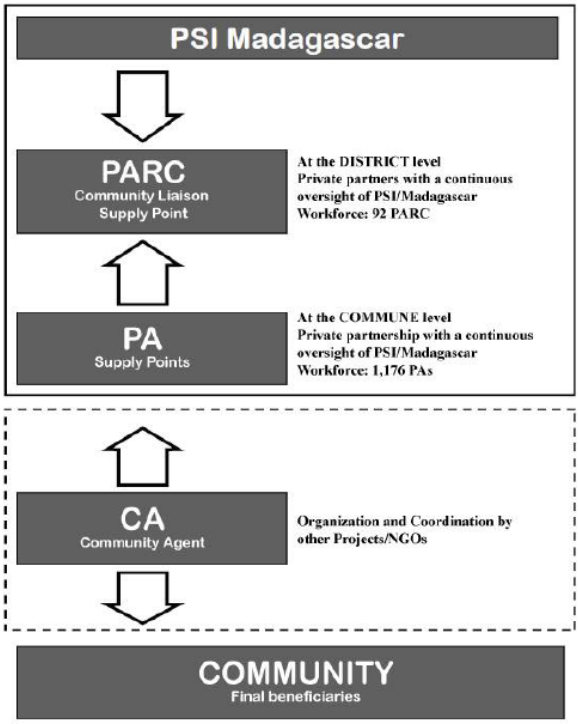

Figure 7. *Diagram of the community distribution circuit*
Source: PSI/Madagascar

PARCs serve as a district-level wholesaler, liaising between PSI/M and PAs based in the communes. The PARCs purchase the products that PSI delivers, store them, and sell them to the PAs. Family planning products tend to be the most profitable and widely purchased. However, much like CHWs, PARCs and PAs face challenges in the rumors associated with family planning and contraception, and they also play an important role in raising awareness among men about the importance of family planning and supporting women in the use of contraceptive methods.

There is typically one PA per commune. Within the social marketing supply chain, the PA is instrumental in ensuring access to health products that the CHWs will need to distribute. One male PA that was interviewed said that when he is absent or traveling, his wife fills in the role, and trains her in everything he learns from PSI/M. PAs are volunteers and typically have other full-time jobs. Though not paid, PAs reported that they see value in holding this role in terms of social status and standing in their community. They also see it as a way to give back to their community. Even for those who are already in a heightened social standing, playing the role of PA gives them further recognition and authority. These benefits extend to their spouses as well.

[90] Solofo, Mamy. Note on the Financial Management of Community Liaison Supply Points. Integrated Social Marketing Program (ISMP). Prepared by Banyan Global. (2017).

Many PARCs and PAs incur financial losses to provide this important service to their communities. To guarantee the sustainability of the supply chain, some system of cost reimbursement or financial incentives should be considered to keep them engaged and motivated for this social cause. This is particularly important to ensure the retention of both male and female volunteers. If given adequate support and resources, this volunteer role offers the opportunity to enhance women's leadership and influence on community health decisions through woman-to-woman messaging and relationship building, given that women are primarily responsible for managing the health of their families. Additionally, PARCs and PAs stand to benefit from the enhanced social status and visibility of this prestigious volunteer role, which could further advance individual women's economic empowerment.

> "You must be strong to support the [male] critics [of family planning]. You must always come back to them two, three, four times. After they come with their wives at the CHW sites, the first time the men are waiting outside. They do not forget to remind their wives to follow the schedule. When they are convinced, men really do advocate for family planning."
> - Male CHW, Toliara region

Women's Groups

Overall, there is a lack of engagement and consultation with women's groups within the health commodities supply chain. To adopt a Total Market Approach, the IMPACT program must consult with advocates for the rights of women, girls, and youth. The National Council of Women of Madagascar (CNFM) is one such platform that is used for gathering individuals, women's groups, or co-ed groups to lobby for women's increased leadership and decision-making. For example, as a result of CNFM's advocacy efforts, a woman was recently selected as the Minister of Education. The Council has published an open letter in the press to the president-elect to take gender into account under his new administration. CNFM is committed to working with the Ministry of Population to update the national gender equality policy and mainstreaming gender in all areas of the Sustainable Development Goals. CNFM is represented in every region of the country through its member network and thus is a strategic partner for USAID IMPACT program.

> "We're still always women, always inferior, despite sensitization."
> – Women's Rights Advocate, southern region

Jeune Femmes Engagées de Tuléar (JFET) is a civil society organization that advocates for women's rights at the regional level. JFET is a regional network of 17 women's associations that aims to increase young women's voice and agency in community-level leadership and decision-making. Its membership is primarily women, but JFET actively works to engage with men to sensitize them to the importance of women's economic empowerment. JFET works across different sectors and sees a strong partnership opportunity with the IMPACT project to incorporate health messaging into its community-based programs.

4. GESI ACTION PLAN FOR THE IMPACT PROGRAM

4.1 Purpose

Based on the findings of the GESI analysis, as well as preliminary feedback from USAID and PSI/Madagascar, Banyan Global developed a GESI action plan for the IMPACT Program. The purpose of the GESI action plan is to provide a set of specific and achievable recommendations for the IMPACT Program to mainstream gender and social inclusion across its programming. These recommendations will be integrated into IMPACT's annual workplan and will be carried out over the course of program Years 1–3. Each recommendation is designed to achieve greater gender equality, social inclusion and women's economic empowerment outcomes as well as overall IMPACT program goals.

The recommendations provided below are not exhaustive for the health commodity supply chain; they should be carried out by the IMPACT program in collaboration with key stakeholders. Once they are carried out, IMPACT will assess lessons learned, good practices, and case studies that can be shared with the broader development community. To ensure sustainability beyond the life of the IMPACT program, stakeholder engagement and capacity building is built-in as a key component of the recommendations and actions.

4.2 Recommendations

Recommendation 1. Partner with women's rights organizations and ensure gender balance among the Total Market Initiative Technical Working Group

Forge strategic partnerships with women's rights organizations and associations to ensure balanced gender representation among the Total Market Initiative (TMI) Technical Working Group (TWG), as well as members of government and the commercial sector who are involved in the Total Market Approach (TMA). The engagement and representation of women's organizations within program design and implementation is essential to ensuring a gender integration approach because women, girls, and youth voices are often marginalized or excluded from decision-making processes. By including women's organizations as members of the TMI TWG and ensuring a gender balance among members of the TMI TWG, the IMPACT program will model a gender integration approach to TMA for government partners, technical and financial partners, implementing NGOs, and donors.

	Activity	**Responsible parties**	**Timeline**
1	Identify and develop strategic partnerships (and memoranda of understanding where required) with key women's associations and human rights organizations, including the **Conseil National des Femmes de Madagascar (CNFM)**, the **Gender Mainstreaming Directorate and the Gender and Women Promotion Directorate** of the Ministry of Population, the USAID **Gender & Youth Working Group**, and regionally based organizations such as **Jeunes Femmes Engagées de Tuléar (JFET)**. This may also include key strategic women's business associations. Key partners will participate in the TMI TWG to advise on incorporating	Lead: PATH, MSH Support: Banyan Global	Y1-Y5

	Activity	Responsible parties	Timeline
	women, youth, and marginalized groups into a TMA.		
2	Ensure the continued engagement and participation of strategic GESI partners through quarterly consultations to identify shared priorities, strategies, and best practices, and problem-solving strategies to overcome barriers to gender equality and social inclusion in the health commodities sector.	Lead: Banyan Global Support: PATH, MSH	Y2-Y3, quarterly
3	Engage male members of the TMI TWG through partnership discussions with women's organizations, as well as training (see Recommendation 2), to build their knowledge and capacity to serve as GESI champions within their respective agencies. Identify key actions and track progress.	Lead: Banyan Global Support: PATH, MSH	Y1-Y3, ongoing
4	Produce and disseminate factsheets on GESI within a TMA to the TMI TWG to raise awareness and increase TWG member capacity to advocate for a GESI approach.	Lead: Banyan Global Support: PATH, MSH	Y1 Q4 – Y2 Q1
5	Advocate in partnership with the Gender & Youth Working Group for the development of a standard definition of vulnerable and marginalized groups. In collaboration with the Ministry of Population, TMI TWG to develop a strategy for reaching vulnerable/marginalized groups using a TMA.	Lead: Banyan Global Support: PATH, MSH	Y2
6	Host an annual workshop among strategic GESI partners and TMI TWG to reflect on the IMPACT GESI action plan and how IMPACT can further advance its work in GESI.	Lead: Banyan Global Support: PATH, MSH	Y2, Y3

Recommendation 2. Build the capacity of TMA stakeholders in GESI, particularly government stakeholders

Develop and adapt GESI training materials and tools to raise awareness of male and female GOM staff, donors, the commercial sector, and social marketing actors on their respective roles and responsibilities as they relate to integration GESI into the TMA approach. Build the capacity and skills of TMA stakeholders to serve as advocates for GESI within their respective sphere of influence and to ensure the sustainability of a gender-integrated TMA beyond the life of project.

	Activity	Responsible parties	Timeline
1	Host a half-day external stakeholder workshop launching the gender action plan with key government, commercial sector, social marketing, and donor partners.	Lead: Banyan Global Support: PSI	Y1 Q4
2	Conduct one round table to sensitize the male and female representatives from key GOM ministries on their roles and responsibilities to respond and positively influence social norms and gender constraints in public sector health policy and implementation, based on the findings of the IMPACT GESI analysis. Support the GOM in developing an action plan to address the policy and practical barriers for gender equality and social inclusion, and track progress.	Lead: Banyan Global Support: PSI	Y2 Q2

	Activity	Responsible parties	Timeline
3	During a half day workshop, build the capacity of TMI TWG on gender mainstreaming and social inclusion and how GESI can improve the efficiency of the supply chain and beneficiaries' access to health products.	Lead: Banyan Global Support: PATH, MSH	Y2 Q3
4	Once a year, conduct a specific training and capacity building workshop for GOM TWG members on gender mainstreaming and social inclusion	Lead: Banyan Global Support: PATH, MSH	Y2 Q4, Y3 Q3
5	Conduct follow-up/refresher training on gender integration and social inclusion with IMPACT staff to continue building their capacity to serve as GESI champions within different technical and operational areas.	Lead: Banyan Global Support: PSI	Y2, Y3
6	Develop incentive program for IMPACT staff to serve as GESI champions through monthly competitions, brown bags, and "GESI champion of the quarter" awards to recognize concrete staff contributions to GESI within the health commodities sector.	Lead: Banyan Global Support: PSI	Y2, Y3
7	Hold pause-and-reflect learning sessions with IMPACT program staff to reflect on progress, gaps, and opportunities for gender integration and social inclusion throughout the life of project.	Lead: Banyan Global Support: PSI	Y2, Y3
8	Integrate the IMPACT program GESI focal point into existing GESI working groups, such as Gender & Youth Working Group and Ministry of Population and Gender Focal Points of different organizations (ADRA, Mikajy USAID Project, Care International, RanoWash, USAID, Mahefa Miaraka, Haitao, CRS, ACCESS, Impact)	Lead: Banyan Global	Y1-Y3

Recommendation 3. Support implementation of GESI best practices in the commercial sector

Partner with financial institutions – Baobab Bank, Access Bank, and Youth Bank Money Transfer – and commercial sector partners targeted through the Development Credit Authority (DCA) to address GESI constraints and opportunities within businesses and in terms of customer outreach. The commercial sector offers significant opportunities to enhance social inclusion and women's economic empowerment while at the same time expanding its reach through gender-informed approaches.

	Activity	Responsible parties	Timeline
1	Design and adapt appropriate GESI training modules and coaching tools for commercial sector partners targeted through the DCA, including partner banks, pharmacies, and drug shops.	Lead: Banyan Global	Y1-Y2
2	Develop data collection tool for capturing sex- and age-disaggregated data among project-assisted private health commodity businesses as well as data on leadership by examining who holds management positions (decision-making roles) within different types of businesses.	Lead: Banyan Global, PSI	Y1 Q4 Y2 Q1-Q2
3	During IMPACT capacity building and training for DCA partner banks, integrate GESI components to raise awareness about gender equality, equity, social inclusion, and the business case for facilitating women's access	Lead: Banyan Global	Y2, Y3

	Activity	Responsible parties	Timeline
	to finance, as well as its potential contribution to women's economic empowerment and broader economic growth		
4	Conduct one dissemination session to share lessons learned and success stories from GESI interventions within the commercial sector.	Lead: Banyan Global Support: PSI	Y3 Q4

Recommendation 4. Engage men to increase uptake of family planning/contraceptive methods

Despite the widespread availability and awareness of modern contraceptive methods among women, men's lack of acceptance of family planning methods is a major barrier to uptake. To increase the perception among men that family planning methods are safe and relevant, IMPACT should integrate GESI into social and behavior change communication strategies to increase demand for and use of family planning products among men and women.

	Activity	Responsible parties	Timeline
1	Integrate GESI messages throughout family planning and maternal and child health campaigns to address false rumors about family planning, cultural barriers and value systems of different target groups, and prevent the use of images that reinforce gender stereotypes related to health products.	Lead: PSI Support: Banyan Global	Y2-Y5
2	Develop key messages targeted toward men in family planning communication campaigns so that they are no longer obstacles to, but rather partners in family planning methods.	Lead: PSI Support: Banyan Global	Y2
3	Evaluate the impact of male-oriented SBCC campaigns	Lead: PSI Support: Banyan Global	Y4-Y5

Recommendation 5. Develop a plan to compensate community health volunteers in collaboration with TMA stakeholders

Community health volunteers fill a critical gap in the provision of health commodities to underserved, disadvantaged and marginalized communities. In order to achieve UHC, the IMPACT program should facilitate a better enabling environment for CHWs, who are primarily women. Beginning in Year 2, IMPACT should advocate for a plan to compensate community health volunteers through the ongoing review process of the Stratégie Nationale de Renforcement de la Santé Communautaire (National Strategy for Strengthening Community Health). By coordinating with the Government of Madagascar and other USAID-funded programs that build the capacity of CHWs – including the ACCESS project and Mahefa Miaraka, among others – the IMPACT program can propose gender-informed strategies to further support CHWs that will ensure the long-term sustainability of last-mile health commodity distribution.

ANNEX A: GESI ANALYSIS SCOPE OF WORK

USAID/MADAGASCAR
Improving Market Partnerships and Access to Commodities Together (IMPACT)

Activity-level GESI Analysis SCOPE OF WORK
FEBRUARY 2018

1. OBJECTIVE

In 2012, USAID adopted several comprehensive and interlinked policies and strategies to reduce gender inequality and enable girls and women to realize their rights, determine their life outcomes, influence decision-making, and become change agents in households and communities. These policies and strategies include: the 2012 USAID Gender Equality and Female Empowerment Policy; the 2016 U.S. National Action Plan on Women, Peace and Security; the 2016 U.S. Strategy to Prevent and Respond to Gender-Based Violence Globally; the 2012 USAID Vision for Ending Child Marriage and Meeting the Needs of Married Children; the 2014 USAID LGBTI Vision for Action; and the 2012 USAID Counter-Trafficking in Persons Policy.

The USAID Automated Directives System (ADS) 205 requires gender analysis as part of the project design to inform strategic decisions about each development objective and intermediate result. More specifically, the analysis must provide country and sector-level quantitative and qualitative data on the key gender gaps in each of five cross-cutting domains described in ADS 205.3.1, and also in the specific development objectives that the USAID mission has prioritized.

The goal of the IMPACT Program's gender analysis is to identify key gender advances, constraints, inequalities, and opportunities and offer conclusions and specific recommendations on how the IMPACT program can achieve greater gender integration into its strategic planning and activities in Madagascar. The analysis will also examine issues related to social inclusion and women's economic empowerment within the health commodities sector. This targeted analysis will concentrate on the following aspects of the health commodities sector, as part of the IMPACT program's scope of work:

- IR1: Enhanced coordination among the public, nonprofit and commercial sectors for reliable supply and distribution of quality health products
    - 1.1 The total market for health products in Madagascar is understood and documented
    - 1.2 GOM leads TMI stakeholders to coordinate health product quantification and forecasting, procurement, and distribution according to market assessments and segmentation
- IR2: Strengthened capacity of the GOM to sustainably provide quality health products to the Malagasy people
    - 2.1 Health commodities and pharmaceuticals are continuously available and accessible in the public sector
    - 2.2 The public-sector supply chain increases financial sustainability
- IR3: Expanded engagement of the commercial health sector to serve new health markets according to health needs and consumer demand

    - 3.1 Commercial actors are incentivized to expand into new health product markets
    - 3.2 GOM facilitates the work of the commercial sector
- IR4: Improved sustainability of social marketing to deliver affordable, accessible health products to the Malagasy population
    - 4.1 Socially marketed products are continuously available at convenient and accessible locations
    - 4.2 Socially marketed products achieve cost recovery at an affordable price for consumers
- IR5: Increased demand for and use of health products among the Malagasy people
    - 5.1 The market demonstrates sufficient and sustained demand for health products

In addition, the gender analysis will focus on the following cross-cutting themes:

- Women's economic empowerment and equality (WE3)
- Social Inclusion
- Gender-based violence (GBV)
- Youth engagement and positive youth development

The gender analysis findings and recommendations will be used to guide the IMPACT program's integration of gender, social inclusion, and women's economic empowerment throughout its strategic planning, including the development of a gender strategy for the program along with an action plan with specific objectives, activities, and recommendations. We will also incorporate findings into the design of the total market approach (TMA). Banyan Global will work with the program team to integrate gender and social inclusion considerations into work planning and implementation through activities that maximize the program's positive impact on achieving gender equality and equity, social inclusion, enhancing female empowerment, and maximizing the program's success in strengthening market partnerships and access to essential health products. Banyan Global will also ensure that gender and social inclusion considerations are fully integrated into monitoring and evaluation and program reporting. The program M&E plan will include the development of indicators to track changes in key areas relevant to gender, including gender roles, disaggregation of data by age and sex, and gender gaps identified from baseline to end line.

2. BACKGROUND

According to Article 6 of the constitution of Madagascar, gender equality and non-discrimination on the basis of gender, education level, wealth, origin, religious belief or opinion is guaranteed by law. The constitution also provides other guarantees such as equality regardless of gender in the workplace and women's rights to ownership and access to land. Due to these and several other factors, Madagascar ranks "low" on the Social Institutions & Gender Index, which classifies the *level of discrimination* in countries by examining the gaps that legislation, social norms and practices create between men and women in terms of rights and opportunities. Madagascar also scores in the top 10 overall country performance for The African Development Bank's (AfDB) Gender Equality Index, which examines gender equality in terms of economic opportunity, social development and law and institutions. However, it lags further behind when it comes to rankings on economic opportunities (27th) and human development (18th).

Despite this trend of ranking positively on global gender equality indicators, the reality of achieving gender equality and equity among Malagasy women, men, girls, and boys and is more dynamic and presents many challenges. Women and men continue to fulfill traditional gender roles, which relegate women and girls to unpaid household duties such as cooking, cleaning, and child rearing and leads to an imbalance in power and decision-making within the household. Married women cannot legally be

recognized as the head of household in the same way that men are, and many women and girls continue to face sexual harassment and exploitation.

In the health sector, there are specific social and cultural challenges based on gender that limit women's access to and use of health products. This is a direct result of gender inequities at the household and community level that prevent many women and girls from making decisions about their own health, as well as the health of their families. Through this project-level gender analysis, Banyan Global will investigate how the status of women and men in Madagascar affects the health commodity supply chain and how PSI's TMA can address gender inequalities in order to better achieve IMPACT program objectives.

3. METHODOLOGY

The key research questions for the gender analysis include the following:

1. How does the relative status of women and men affect their differential access to/control over assets, resources, opportunities, and services related to the health commodity supply chain, and broader issues concerning Family Planning (FP)/Reproductive Health (RH); Maternal and Child Health (MCH); and Malaria?
2. How do men's and women's respective roles, responsibilities and time use prevent or facilitate participation in the health commodities supply chain?
3. Do relevant laws, policies and institutional practices contain implicit or explicit gender biases that may affect men's and women's ability to participate in the project, assume leadership roles, and access affordable and high-quality Family Planning (FP)/Reproductive Health (RH); Maternal and Child Health (MCH); and Malaria services?
4. How do existing gender norms and cultural beliefs affect Family Planning (FP)/Reproductive Health (RH); Maternal and Child Health (MCH); and Malaria services?
5. How do existing patterns of power and decision-making influence the ability of women and men to decide, influence, and exercise control over material, human, intellectual, and financial resources, in the family, community and country related to Family Planning (FP)/Reproductive Health (RH); Maternal and Child Health (MCH); and Malaria?
6. What are the potential impacts of the project on women and men, included unintended or negative consequences?
7. How does the relative status of vulnerable and/or marginalized groups (including people with intersecting identities such as women with disabilities, men having sex with men, etc.) affect their differential access to/control over assets, resources, opportunities, and services related to the health commodity supply chain, and broader issues concerning FP/RH; MCH; and malaria?

In addition to addressing gender quality in the aforementioned key questions, the IMPACT program gender analysis must also provide findings and recommendations on the gender quality domains of the ADS 205. The domains are listed below.[91]

1. Laws, Policies, Regulations, and Institutional Practices that influence the context in which men and women act and make decisions.
2. Cultural norms and beliefs
3. Gender roles, responsibilities, and time use
4. Access to and control over assets and resources
5. Patterns of power and decision-making

In addressing the key research questions, the contractor is responsible for the following:

1. A literature review to develop a baseline on key gender advances and gaps in Madagascar within the scope of the IMPACT program. The literature review will concentrate on pertinent documents, including studies, assessments, surveys, and country-level gender analyses conducted by donors, non-governmental organizations (NGOs), the Government of Madagascar, academic communities, USAID, and USAID partners. These include, but are not limited to, annual reports and quarterly reports, sector assessments, evaluations, government legal frameworks, regional or sectoral gender analyses, official national- and regional-level data and statistics, periodic reports to United Nations human rights committees, and shadow reports and reports by the UN, regional and intergovernmental organizations. Such illustrative documents should include (where available):
    a. The USAID Gender Equality and Women's Empowerment Policy, the United States Strategy to Prevent and Respond to Gender-Based Violence Globally, and the USAID Counter-Trafficking in Persons (C-TIP) Policy
    b. Current USAID/Madagascar Country Development Cooperation Strategy
    c. Previous Gender Analysis/Assessment and Action Plans
    d. USAID Gender Mission Order
    e. Most recent Demographic and Health Survey and other sector-level surveys
    f. Publications and data on gender equality in Madagascar from the UNDP, World Bank and Government; and other major national and international organizations
    g. The Scopes of Work from current USAID IMPACT program
    h. USAID/Madagascar Project Appraisal Documents and gender gaps analysis
    i. Baseline surveys pre-award assessments, mid-term and final evaluations and sector assessments
    j. Data and recommendations of the United Nations agencies, the World Bank, Global Affairs Canada, and European Union regarding gender equality and gender-based violence (if available).
2. The design, implementation, analysis and presentation of results of an IMPACT program staff gender integration survey using SurveyMonkey. The results of the survey will be used to design appropriate training for IMPACT program staff on gender and social inclusion.
3. With approval and in consultation with PSI, conduct in-country representative, non-exhaustive consultation with USAID technical staff, including:
    a. USAID Mission Gender Advisor/Focal Point; and
    b. USAID technical office staff on specific sectors and areas of interest for the IMPACT program
4. Representative, non-exhaustive consultations and site visits (using mixed methods such as key informant interviews, focus groups, and field observations as appropriate) with a wide variety of key stakeholders, such as USAID partners and program participants, national or regional academic institutions or observatories, other donors, civil society organizations, and relevant government officials. The purpose of the consultations is to identify entry points and recommendations for the incorporation of gender equality, social inclusion, and women's economic empowerment in IMPACT program sectors and areas of interest. Stakeholders may include:
    a. Government of Madagascar representatives including: Ministry of Population, Social Protection, and Women, Ministry of Youth and Sport, Ministry of Public Health (key individuals and departments as identified by PSI), Ministry of Finance and Budget, Ministry of Trade and Consumption, Ministry of Education, Ministry of Justice, and National Statistics Institute;
    b. International Stakeholders such as UN Women, United Nations Development Programme (UNDP), United Nations Population Fund, International Rescue Committee, American Refugee Committee, European Union (EU), and multilateral

development banks (such as the World Bank, Inter-American Development, Asian Development Bank);

c. National non-governmental organizations, civil society organizations, and observatories.

4. DELIVERABLES

Banyan Global will provide the following deliverables:

1. **Work Plan/Schedule:** The proposed schedule and list of interviewees shall be submitted prior to the gender analysis team's arrival in Madagascar. PSI will provide contact information for relevant USAID technical staff, and a list of interview suggestions to assist the gender analysis team in advance.

2. **Field Data Collection:** Field data collection will include the following activities:
   - In-briefing on the gender analysis and a kick-off meeting on day one of the field mission with relevant IMPACT program staff;
   - Consultations with key USAID staff, as identified in collaboration with PSI.
   - Consultations with key stakeholders, including: key government partners; USAID partners; identified members of civil society, academics, religious leaders, and national leaders; and other donors in Madagascar.
   - A presentation of preliminary findings with relevant IMPACT program staff (COP, DCOP, and lead technical staff) of the gender analysis, including initial key findings from the literature review, key stakeholder interviews and site visits, and meetings with USAID partners and other donors, as well as preliminary recommendations for gender integration activities.

3. **Draft Gender Analysis and Integration Strategy Report:** A draft gender, social inclusion, and women's economic empowerment analysis and integration strategy report will be completed within 35 business days after the research team's departure from the field. The reports will address comments discussed during the presentation of preliminary findings. The final report must not exceed 40 pages, excluding the cover page, table of contents, and annexes/attachments. The report must be written in English.

For the gender analysis and integration strategy report:

- The executive summary should be 3–5 pages in length and summarize the purpose, background of the program being evaluated, main analytical questions, methods, findings, conclusions, and recommendations and lessons learned (if applicable).
- The analytical methodology shall be explained in the report in detail. Limitations to the gender analysis shall be disclosed in the report, with particular attention to the limitations associated with the methodology.
- The annexes to the report shall include:
  - The gender analysis statement of work.
  - A bibliography of sources consulted, including interviews, focus groups, and any other
  - data collection method.
  - A comprehensive annotated bibliography of all documents reviewed and copies of the documents not provided by USAID.
  - List of sites/organizations/institutions visited and individuals and groups interviewed.
  - All data collection tools, survey instruments, and questionnaires developed for interviews and focus group discussions.
  - Names, titles, agency, and contact information of individuals interviewed, met, etc.
  - Electronic copy of data sets.

- The report findings and recommendations will present general findings and recommendations (including the ADS205 gender analysis referenced in the methodology) as well as specific recommendations by IMPACT program intermediate results:
  - IR1: Enhanced coordination among the public, nonprofit and commercial sectors for reliable supply and distribution of quality health products
  - IR2: Strengthened capacity of the GOM to sustainably provide quality health products to the Malagasy people
  - IR3: Expanded engagement of the commercial health sector to serve new health markets according to health needs and consumer demand
  - IR4: Improved sustainability of social marketing to deliver affordable, accessible health products to the Malagasy population
  - IR5: Increased demand for and use of health products among the Malagasy people
- The gender integration strategy will identify successful strategies, approaches, and lessons learned that the IMPACT program can use to enhance accessibility and equitability of its programs to improve the wellbeing of women, men, girls, and boys. They will also provide recommendations on how to incorporate gender in monitoring and evaluation systems.

This gender analysis shall comply with ADS Chapter 205 requirements for gender analysis, which is available through the following link:
https://www.usaid.gov/sites/default/files/documents/1870/205.pdf

4. **Final Gender Analysis and Integration Strategy Report:** A final version of the report will be completed within 10 business days after receiving feedback from PSI and/or USAID on the draft report. It will address and incorporate reviewer feedback on the draft report.

	Deliverable	Date	Responsible Person
1	Work Plan/Proposed Schedule	15 Feb '19	Rachel Mahmud
2	Site Visits and Consultations in Madagascar (3 weeks in country)	25 Feb '19 – 15 Mar '19	Rachel Mahmud, National Gender Specialist
3	Presentation of preliminary findings and recommendations to IMPACT program staff in Madagascar (1-2 days in country)	18 Mar '19 – 22 Mar '19	Rachel Mahmud, National Gender Specialist
4	Draft Report submitted to PSI	21 May '19	Rachel Mahmud
5	Revised Report submitted to PSI	Within 10 business days of receiving PSI and/or feedback	Rachel Mahmud
6	Final report submitted to USAID	28 June '19	PSI/Banyan Global

All quantitative data collected by the analytical team must be provided in machine-readable, nonproprietary formats as required by USAID's Open Data policy (see ADS 579). The data should be organized and fully documented for use by those not fully familiar with the analysis. USAID will retain ownership of all survey and datasets developed. All project data and records will be submitted in full and should be in electronic form in non-proprietary software and easily readable format, organized and documented for use by those not fully familiar with the gender analysis, as well as for submission to the Development Data Library, and will be handed over to USAID, who owns the data.

5. SCHEDULES AND LOGISTICS

Banyan Global will require support from PSI's logistics officer OR from a logistics officer hired specifically to support the gender analysis, who shall be responsible for the administrative support and logistics required to fulfill this task. These shall include all travel arrangements, appointment scheduling, secretarial services, report preparations services, printing, duplicating, and translation services (as needed).

6. TEAM COMPOSITION

The gender analysis team will include the following:

1. **Team Leader: Rachel Mahmud**
The team leader is a Banyan Global HQ gender expert who is responsible for leading meetings, coordinating, and gathering different points of view of members of the team; drafting the work plan; preparing the gender analysis and integration strategy report, and presenting findings to senior-level program staff.

2. **National Gender Expert: Malanto Rabary**
The national gender expert is responsible for providing in-country support to the Banyan Global HQ gender expert throughout the gender analysis process. The national gender expert will contribute to the research conducted for the literature review, support the identification of and secure meetings with key stakeholders for field data collection, support the preparation of the gender analysis and integration strategy report, and co-present findings to senior-level program staff.

3. **Intern, Gender Practice: Marcella Kim**
The intern for Banyan Global's gender practice is responsible for conducting desk research during the literature review phase, drafting sections of the literature review, and report editing/formatting.

4. **Logistics Officer: Nicole Raharinirina**
Banyan Global's team leader and national gender expert will require logistics support in preparation for and during the 3-week field data collection period. The logistics officer shall be responsible for the administrative support and logistics required to fulfill this task including all travel arrangements, appointment scheduling, secretarial services, report preparations services, printing, duplicating, and translation services (as needed).

7. SUBMISSION TO THE DEVELOPMENT EXPERIENCE CLEARINGHOUSE

The final approved report will be a public document to be submitted to the Development Experience Clearinghouse (www.dec.org) (DEC) following the required Office of GenDev format (see Annex II).

In accordance with AIDAR 752.7005, Banyan Global and PSI will make the final gender analysis report publicly available through the Development Experience Clearinghouse within 30 calendar days of final approval of the formatted report.

8. BRANDING AND MARKING

The Contractor shall comply with the requirements of the policy directives and required procedures outlined in USAID Automated Directive System (ADS) 320.3.2 "Branding and Marking in USAID Direct Contracts" (version from January 8, 2007) at https://www.usaid.gov/ads/policy/300/320; and USAID "Standard Graphic Manual" available at: http://www.usaid.gov/branding/gsm, or any successor branding policy.

ANNEX B: LIST OF KEY DOCUMENTS CONSULTED

Adult female focus group discussion, Antsiranana, interview by Malanto Rabary, Mar. 6, 2019.

Adult female focus group discussion, Mangily, interview by Malanto Rabary, Mar. 12, 2019.

Adult male focus group discussion, Antsiranana, interview by Eric Botoronono, Mar. 7, 2019.

Adult male focus group discussion, Mangily, interview by Malanto Rabary, Mar. 14, 2019.

African Development Bank Group. Empowering African Women: An Agenda for Action. (May 2015). https://www.afdb.org/fileadmin/uploads/afdb/Documents/Publications/African_Gender_Equality_Index_2015-EN.pdf

Bradley S, Rosapep L, Shiras T. Sources for sick child care in Madagascar. (2018). Rockville, MD: Sustaining Health Outcomes through the Commercial sector Plus Project, Abt Associates Inc.

Brinkerhoff, D.W., O. Indriamihaja, A. Lipsky, and C. Stewart. L'environnement légal pour la planification familiale et la santé de la reproduction à Madagascar. Palladium, Health Policy Plus. (June 2017). http://www.healthpolicyplus.com/ns/pubs/7146-7260_LegalEnvrnmentAssessmentMadagascarFRJune.pdf

CIA Factbook. Madagascar. (n.d.). https://www.cia.gov/library/publications/the-world-factbook/geos/print_ma.html

Conférence des Nations Unies Sur le Commerce et le Développement Matériel Pédagogique sur le Commerce et le Genre, volume 1, module 4. (2017). https://unctad.org/fr/PublicationsLibrary/ditc2016d1_fr.pdf

Council on Foreign Relations. Women's Workplace Equality Index: Madagascar. (2018). https://www.cfr.org/interactive/legal-barriers/country-rankings/mdg

Dahlerup, Drude. The story of the theory of critical mass. *Politics & Gender, 2*(4), 511-522. (2006). doi:10.1017/S1743923X0624114X.

Davis, Isobel. CLTS engagement, outcomes and empowerment in Malagasy communities. WSSCC. (2016). https://www.wsscc.org/wp-content/uploads/2016/12/Gender-and-Community-Led-Total-Sanitation-CLTS-engagement-outcomes-and-empowerment-in-Malagasy-communities.pdf

Dr. Lheticia Lydia Yasmine, interview by Rachel Mahmud and Malanto Rabary, Mar. 5, 2019.

Dr. Olga Indriamihaja, interview by Rachel Mahmud and Malanto Rabary, Mar. 2, 2019.

Family Planning 2020. Madagascar: Commitment Maker Since 2015. Accessed Mar. 21, 2019. http://www.familyplanning2020.org/node/440

Family Planning 2020. Madagascar - FP2020 Core Indicator Summary Sheet: 2017-2018 Annual Progress Report. (n.d.). https://www.familyplanning2020.org/sites/default/files/Madagascar%202018%20CI%20Handout.pdf

Fleurica Bodanahary, interview by Rachel Mahmud and Malanto Rabary, Mar. 14, 2019.

Gastineau, B and Binet, C. Sexualité prémaritale à Antananarivo (Madagascar) Comment les étudiant (e) s s'affranchissent-ils des normes? (2013). African Journal of Reproductive Health 17:2 pp. 168-185. https://www.jstor.org/stable/23485931

Gezon, L. Marriage, Kin, and Compensation: A Socio-Political Ecology of Gender in Ankarana, Madagascar. (2002). Anthropological Quarterly, 75(4). Pg. 675-706. https://www.jstor.org/stable/3318166

Girls Not Brides. Madagascar – Child Marriage Around the World. (2019). https://www.girlsnotbrides.org/child-marriage/madagascar/

Global Campaign for Equal Nationality Rights. Madagascar Reforms Its Nationality Law, Guaranteeing Mothers' Independent Right to Confer Nationality On Children. (Jan 2017). https://equalnationalityrights.org/news/78-madagascar-reforms-its-nationality-law-guaranteeing-mothers-independent-right-to-confer-nationality-on-children

GSMA. HNI Madagascar: Information via Mobile to Tackle Gender-Based Violence. (March 2015). https://www.gsma.com/mobilefordevelopment/wp-content/uploads/2015/08/HNI-case-study-final-1.pdf

INSTAT. Madagascar Millennium Development Goals National Monitoring Survey. (2013). https://madagascar.unfpa.org/sites/default/files/pub-pdf/OMD_Summary_0.pdf

INSTAT, Programme National de lutte contre le Paludisme, PNLP/Madagascar, Institut Pasteur de Madagascar, IPM/Madagascar, and ICF International. Enquête sur les Indicateurs du Paludisme 2016. (2016). Calverton, MD, USA : INSTAT, PNLP, IPM and ICF International. https://dhsprogram.com/publications/publication-MIS23-MIS-Final-Reports.cfm

INSTAT and ICF Macro. Enquête Démographique et de Santé de Madagascar 2008-2009. (2010). Antananarivo, Madagascar: INSTAT and ICF Macro. https://dhsprogram.com/publications/publication-FR236-DHS-Final-Reports.cfm

Institut Pasteur de Madagascar. L'Institut Pasteur de Madagascar mobilisé dans la lutte contre le paludisme. (2019). http://www.pasteur.mg/linstitut-pasteur-de-madagascar-mobilise-dans-la-lutte-contre-le-paludisme/

International Labor Organization. ILOSTAT, Madagascar. (2019). https://www.ilo.org/ilostat/faces/oracle/webcenter/portalapp/pagehierarchy/Page21.jspx?_adf.ctrl-state=9ydqzo30l_4&_afrLoop=20418614813604 94&_afrWindowMode=0&_afrWindowId=null#!%40%40%3F_afrWindowId%3Dnull%26_afrLoop%3D20418614813604 94%26_afrWindowMode%3D0%26_adf.ctrl-state%3Dumqojsj2n_4

International Labor Organization. The reality of violence at work in Madagascar. (June 2018). https://www.ilo.org/global/about-the-ilo/newsroom/features/WCMS_632496/lang--en/index.htm

International Monetary Fund. Republic of Madagascar Economic Development Document 2017-2019. (July 2017). https://www.imf.org/~/media/Files/Publications/CR/2017/cr17225.ashx

Keeling, A., Dhatt, R., and Doshi, L. Opinion: There is no road to UHC without gender equality and women's empowerment. (February 2019). https://www.devex.com/news/opinion-there-is-no-road-to-uhc-without-gender-equality-and-women-s-empowerment-94223

Lawson, L. Rice, sapphires and cattle: Work lives of women artisanal and small-scale miners in Madagascar. (2018). https://www.jstor.org/stable/j.ctt22h6r60.13

Ministère de la Santé Publique. Guide de mise en œuvre de la politique nationale de santé communautaire. (2014).

Ministère de la Santé Publique. Liste Nationale des Medicaments Essentiels et des Intrants de Sante a Madagascar. (October 2014).

Ministère de la Santé Publique. Plan Stratégique National en Santé de la Reproduction des Adolescents et des Jeunes. (December 2017). https://madagascar.unfpa.org/sites/default/files/pub-pdf/PSN%20SRAJ%20MDG.pdf

Ministère de la Santé Publique. Politique Nationale de Santé Communiautaire. (July 2017). http://www.healthpolicyplus.com/ns/pubs/7165-7302_PNSC.pdf

Mariko, Soumaïla and Victor Rabeza. Enquête de Base sur la Santé de la Reproduction et la Survie des Enfants dans les zones d'intervention USAID, à Madagascar. (2005). https://dhsprogram.com/publications/publication-FR164-DHS-Final-Reports.cfm

MenEngage Alliance. MenEngage Madagascar. (n.d.). http://menengage.org/regions/africa/madagascar/

Moreira, C. et al. Boys go fishing, girls work at home: Gender Roles, Poverty, and Unequal School Access among Semi-nomadic fishing communities in South Western Madagascar. (2017). Pg. 499-511. https://doi.org/10.1080/03057925.2016.1253456

OECD. Madagascar – 2014 results. Social Institutions & Gender Index. (2014). https://www.genderindex.org/country/madagascar-2014-results/

OHCHR. Committee on the Elimination of Discrimination against Women considers the report of Madagascar. (2015). https://www.ohchr.org/en/newsevents/pages/DisplayNews.aspx?NewsID=16734&LangID=E

Profil Genre Madagascar. Agence Francaise en Developpment. (2015).

Promundo, Sonke Gender Justice, Save the Children, and MenEngage Alliance. State of the World's Fathers: Time for Action. (2017). https://sowf.men-care.org/

Rakotoniaina, Samy. Pregnancy Tests Help Boost Family Planning in Madagascar. (January 2016). Management Sciences for Health. https://www.msh.org/news-events/stories/pregnancy-tests-help-boost-family-planning-in-madagascar

Raoelimiadana, J. 1975 - 2015: C'est encore loin l'égalité des femmes et des hommes? Intégration du genre dans la Stratégie Nationale de Relance de Développement (SNRD): l'expérience d'un groupe de travail à Madagascar. (2014).

Razafinrakoto, M., Roubaud, R., Wachsberger, J.M. L'énigme et le paradoxe : Economie politque de Madagascar. (2017). Institute de Recherche pour le Développement AFD Agence Française de Développement. Marseille.

Selebogo, Mothepane Yaliwe Petunia, Ojakorotu, Victor. SADC Gender and Development Protocol: An Evaluation of Equality, Empowerment and Gender Based Violence in South Africa (2008-2012). (June 2013). Gender & Behavior, edition 11(1). https://search-proquest-com.proxy-um.researchport.umd.edu/docview/1431278636?accountid=14696

Solofo, Mamy. Note on the Financial Management of Community Liaison Supply Points. Integrated Social Marketing Program (ISMP). Prepared by Banyan Global, 2017.

Southern African Development Community. SADC Gender and Development Monitor 2016. (2016). https://www.sadc.int/files/8415/0340/7935/SGDM_2016_ENGLISH.pdf

Sulla, Victoria. Face of Poverty in Madagascar: Poverty, Gender and Inequality Assessment. (March 2016). World Bank, Poverty Reduction and Economic Management (PREM), Africa Region. https://openknowledge.worldbank.org/handle/10986/18250

The DHS Program. Madagascar MIS 2016 Malaria Fact Sheet (French). (2016). https://dhsprogram.com/publications/publication-MF18-Malaria-Fact-Sheets.cfm

United Nations Conference on Trade and Development. Teaching Material on Trade and Gender, volume 1, module 4B. (2018). https://unctad.org/en/PublicationsLibrary/ditc2018d1_en.pdf

United Nations, Department of Economic and Social Affairs, Population Division. Household Size and Composition Around the World 2017 – Data Booklet (ST/ESA/ SER.A/405). (2017). https://www.un.org/en/development/desa/population/publications/pdf/ageing/household_size_and_composition_around_the_world_2017_data_booklet.pdf

UNDP. Human Development Indices and Indicators: 2018 Statistical Update. (July 2018). http://hdr.undp.org/sites/all/themes/hdr_theme/country-notes/MDG.pdf

UNDP. Rapport du Coordonnateur Resident – 2015 Madagascar. (2015). https://www.undp.org/content/dam/madagascar/docs/rapportsUNDP_MDG/Rapport_CR/mdg2016_Doc_RC2015.pdf

UNFPA. Country programme document for Madagascar. (2015). https://www.unfpa.org/sites/default/files/portal-document/DP-FPA-CPD-MDG-7%20-%20Madagascar%20CPD%20-%20FINAL%20-%2025%20Nov14.pdf

UNFPA. Marrying Too Young: End Child Marriage. (2012). https://www.unfpa.org/sites/default/files/pub-pdf/MarryingTooYoung.pdf

UNICEF. Infant and young child feeding: Exclusive breastfeeding (<6 months) spreadsheet. (2018). https://data.unicef.org/topic/nutrition/infant-and-young-child-feeding/

UNICEF. Madagascar Annual Report 2017. (2018). https://www.unicef.org/about/annualreport/files/Madagascar_2017_COAR.pdf

UNICEF. Madagascar UNICEF Annual Report 2017. (2017). https://www.unicef.org/about/annualreport/files/Madagascar_2017_COAR.pdf

UNICEF. Percentage of women aged 20 to 24 years who were first married or in union before ages 15 and 18. (March 2018). https://data.unicef.org/topic/child-protection/child-marriage/

UN Women. Global Database on Violence against Women: Madagascar. (2017). http://evaw-global-database.unwomen.org/en/countries/africa/madagascar

USAID. Analyse du système de financement de la santé à Madagascar. (February 2018). http://www.healthpolicyplus.com/ns/pubs/8204-8361_ASFSaMadagascar.pdf

USAID. CRS Fararano Project Gender Analysis. (April 2016).

USAID. Defining and Advancing Gender-Competent Family Planning Service Providers: A Competency Framework and Technical Brief. (September 2018).

USAID. Fonctionnalité et performance du programme des agents de santé communautaires à Madagascar: Une synthèse d'évaluations qualitatives et quantitatives. (April 2013). https://www.urc-chs.com/sites/default/files/Madagascar_synthesedevaluationsqualitativesetquantitatives_ASC_Avr2013.pdf

USAID. Guatemala Gender Analysis Final Report. (September 2018).

USAID. L'environment Légal pour la Planification Familiale et la Santé de la Reproduction à Madagascar. (June 2017). http://www.healthpolicyplus.com/ns/pubs/7146-7260_LegalEnvrnmentAssessmentMadagascarFRJune.pdf

USAID. Madagascar: Enquete Menage sur la Planification Familiale ; TRaC PF 2017 – Round III. (2017).

USAID. Madagascar – Land Tenure and Property Rights Profile. (2019). https://www.land-links.org/wp-content/uploads/2010/12/USAID_Land_Tenure_Madagascar_Profile-2019.pdf

USAID. Madagascar: Nutrition Profile. (2018). https://www.usaid.gov/sites/default/files/documents/1864/Madagascar-Nutrition-Profile-Mar2018-508.pdf.

USAID. Madagascar Project Appraisal Document: Gender Analysis. (n.d.).

USAID. Ending Preventable Child and Maternal Deaths: 10 Innovation Highlights from Madagascar. (2014). https://www.usaid.gov/sites/default/files/documents/1864/EPCMD-_10_Innovation_Highlights_from_Madagascar.pdf.

USAID. USAID/Madagascar and Community Health Volunteers: Working in Partnership to Achieve Health Goals. (2015). https://www.chwcentral.org/usaidmadagascar-and-community-health-volunteers-working-partnership-achieve-health-goals

USAID. Mikolo Project: Assuring the Quality of Community-Based Health Services in Madagascar- A New Approach. (March 2017). https://www.msh.org/sites/msh.org/files/quality-chvs-cs.pdf

USAID. Mikolo Project: Empowering Women with Access to Savings, Credit, and Health Messages. (April 2018). https://www.msh.org/sites/msh.org/files/project_highlights_usaid_mikolo_silc_and_cslf.pdf

USAID. Mikolo Project: Five Years of Health Impact, 10 Stories of Success. (n.d.). https://www.msh.org/sites/msh.org/files/mikolo_successstories_v3_english.pdf

USAID. Mikolo Project: Use of Pregnancy Tests Increases Uptake of Family Planning in Madagascar. (March 2017). https://www.msh.org/sites/msh.org/files/pregnancy-cs.pdf

USAID. Women's Wage Employment in Developing Countries: Regulatory Barriers and Opportunities. (2018). https://www.nathaninc.com/insight/womens-wage-employment-in-developing-countries-regulatory-barriers-and-opportunities/

Waite, Victoria et al. USAID. Women's Wage Employment in Developing Countries: Regulatory Barriers and Opportunities. (2018). https://www.nathaninc.com/insight/womens-wage-employment-in-developing-countries-regulatory-barriers-and-opportunities/

WHO, UNICEF, UNFPA, World Bank Group, and United Nations Population Division Maternal Mortality Estimation Inter-Agency Group. Maternal mortality in 1990-2015: Madagascar. (2015). https://www.who.int/gho/maternal_health/countries/mdg.pdf?ua=1

World Bank Group. Enterprise Surveys – Madagascar. (2013). http://www.enterprisesurveys.org/data/exploreeconomies/2013/madagascar#gender--size

World Bank Group. Fertility rate, total (births per woman) Madagascar. (2017). https://data.worldbank.org/indicator/SP.DYN.TFRT.IN?locations=MG

World Bank Group. Labor Markets Conditions in Madagascar. (2010). http://siteresources.worldbank.org/INTMADAGASCAR/Resources/LaborMarkets.pdf

World Bank Group. Maternal mortality ratio (modeled estimate, per 100,000 live births). (2017). https://data.worldbank.org/indicator/sh.sta.mmrt

World Bank Group. Mortality rate, infant (per 1,000 live births) Madagascar. (2017). https://data.worldbank.org/indicator/SP.DYN.IMRT.IN?locations=MG

World Bank Group. Mortality rate, under-5 (per 1,000 live births). (2017). https://data.worldbank.org/indicator/SH.DYN.MORT?locations=MG

World Bank Group. Social Inclusion. (2019). https://www.worldbank.org/en/topic/social-inclusion

World Bank Group. Women, Business and the Law 2018. (2018). http://wbl.worldbank.org/

World Economic Forum. The Global Gender Gap Report 2018. (2018). https://www.weforum.org/reports/the-global-gender-gap-report-2018

World Health Organization. Plan Stratégique National en Santé de la Reproduction des Adolescents et des Jeunes 2018 – 2020. (December 2017). https://madagascar.unfpa.org/sites/default/files/pub-pdf/PSN%20SRAJ%20MDG.pdf

ANNEX C: INTERVIEW GUIDES FOR THE GESI ANALYSIS

IMPACT GESI Analysis Interview Guide:
Government stakeholders (Ministry of Population, Ministry of Health, etc.)

ADS Domain: Gender roles, responsibilities, and time use

1. What are men's and women's respective responsibilities' in protecting their families from malaria, and in seeking timely treatment?
2. Do both women and men access sexual and reproductive health services?

ADS Domain: Cultural norms and beliefs

3. Are there accepted cultural norms or practices that affect women's and men's vulnerability to infection, or women's and men's ability to access prevention and treatment services?
4. Are behavior change messaging adapted for different groups (men, women, girls, boys, others)? If so, how?
    a. What have been the most effective BCC methods at the community level?

ADS Domain: Access to and control over assets and resources

5. Are health services set up to accommodate both women and men? How?
6. How does the quality of health services encourage or discourage women, men, boys and girls to access malaria/family planning/MCH prevention, diagnosis, and treatment services?
    a. Are there certain attitudes, behaviors or practices by health service providers and encourage or discourage men, women, boys and girls from seeking treatment?
    b. Do pregnant adolescents or unmarried women experience stigma and discrimination?
    c. Can language or illiteracy act as a barrier?
7. What challenges do adolescent girls' face to their ability to protect themselves from infection?
8. How can the health system improve its ability to reach adolescent girls for malaria prevention, diagnosis and treatment?
9. Are there any other marginalized or vulnerable populations, such as the disabled, refugees, internally displaced populations, or people living with HIV/AIDS, who face particular challenges to their ability to protect themselves from infection?
    d. What is the health system currently doing to meet their needs?
    e. How can it improve prevention and treatment services for these populations?

ADS Domain: Patterns of power and decision-making

10. What leadership roles do women play in influencing community-based health?
11. At the community level, who controls and has power over the narrative about key health issues and priorities? What priorities for reform in health policies are advocated by women community leaders? By men?
12. Who control the narratives around marriage and family planning norms in the family and community?

ADS Domain: Laws, policies, regulations and institutional practices

13. Are there any national or local laws that facilitate or prohibit women's and men's ability to access prevention and treatment services? Adolescent girls and boys?

    a. Defilement law?
    b. Mandatory testing?
    c. Mandatory male presence at first antenatal care visit?
14. Are there restrictions on how health products are sold? What are those restrictions?
15. Do laws and regulations guarantee women access to all types of health care, information, and education, including sexual and reproductive health care?

IMPACT GESI Analysis Interview Guide:

Commercial stakeholders (pharmacies, wholesalers, drug shops, etc.)

Introductory/informational questions:

1. What area does your company specialize in? What is the scope of your products and services?
2. How many employees work for your company?

ADS Domain: Gender roles, responsibilities, and time use

3. Are there gendered divisions of labor within the company? What positions/units within the company are commonly filled by women and men? Does the company employ any youth or people from ethnic minority/protected/disabled/marginalized groups? (If so, what positions do they commonly hold?)
    a. *Comment for interviewer: also consider gender makeup of senior management team and higher-paying positions that require greater technical skills or education*
4. In your experience, are there qualified women candidates for positions commonly filled by men in the health product supply chain? If so, in your opinion, why aren't there more women holding these positions? If not, why do you think that is?
5. Are any informal sector activities that you work with to support your business? If so, what are they, and who is typically managing those activities (women, men, girls, boys, ethnic or social minorities)?

ADS Domain: Cultural norms and beliefs

6. Are there cultural stereotypes that contribute to women opening certain types of businesses in the health products supply chain? What are they?
7. When you think about your customers, which members of the household typically has the authority to buy and use health prevention measures that you sell (bed nets, family planning, other medicine)?

ADS Domain: Access to and control over assets and resources

8. Are digital financial services important in the health services sector? If yes, how so, and does women's access to them differ than men's?
9. Where are women most present in the health product value chain (supply, production, processing, transportation, or trade)?
10. What decision-making and leadership roles and opportunities have you seen women take on in the health sector?

ADS Domain: Patterns of power and decision-making

11. What stereotypes affect women's ability to take on leadership positions at the heads of public or commercial sector institutions

ADS Domain: Laws, policies, regulations and institutional practices

12. Does your company have written policies or guidelines to prohibit sexual harassment of staff? Can we see them?

IMPACT GESI Analysis Interview Guide:

Civil society organizations (NGOs, women's organizations, etc.)

Introductory/informational questions:

1. What area does your organization specialize in? What is the scope of your services?

ADS Domain: Gender roles, responsibilities, and time use

2. How do the different roles and daily activities of men, women, boys and girls prevent or promote their risk of malaria infection? How do they facilitate or prevent them from accessing treatment in a timely manner?

ADS Domain: Cultural norms and beliefs

3. Are there certain stereotypes in Madagascar that hinder youth in accessing entrepreneurial or professional opportunities?
4. Are there accepted cultural norms or practices that affect women's and men's vulnerability to infection, or women's and men's ability to access prevention and treatment services? [For example, cultural norms limiting women's mobility, and therefore, ability to access malaria prevention and treatment services? Or male cultural norms that expect men to be "strong" and get over the infection themselves?]
5. Do financial institutions have strategies or policies directed at the creation of financial products that meet the needs and demands of women?
6. Do financial institutions have strategies or policies directed at promoting women's savings, such as minimal initial savings requirements?
7. Do male and female role models exist promoting gender equality, female empowerment, and an end to violence against women and girls, including sexual harassment?
8. How does the level of unpaid care-taking and household work of women and girls limit the time available to access health services?
9. Do men and women have unequal education or knowledge in areas that are important for successful entrepreneurship and/or business? If yes, in what areas?
10. Do social norms hinder women from moving independently in public spaces? How do these norms impact women's ability to participate in training, vocational, educational, or other capacity building programs?

ADS Domain: Access to and control over assets and resources

11. Where are women most present in the value chain (supply, production, processing, transportation, or trade)?
12. What decision-making and leadership roles and opportunities have you seen women take on in the health sector?
13. What constraints do female, youth, or minority group entrepreneurs face in growing and operating their business?

ADS Domain: Patterns of power and decision-making

14. How does the lack of co-responsibility in households and lack of community-based childcare services factor into women's ability to participate and take on leadership positions in business networks, cooperatives, unions or business associations?
15. Who controls the narratives around marriage and family planning norms in the family and community as well as nationally?

16. Are girls engaged as leaders in discussions about early marriage and sexual and reproductive health? How?
17. What role does gender-based violence play in women's and men's decisions to protect themselves or their family from infection, or to seek treatment? Is it a factor for adolescent boys or girls?
18. Who controls and has power over the narrative about key issues and priorities in the sector?

ADS Domain: Laws, policies, regulations and institutional practices

19. What priorities for reform in health policies do you advocate for?

GUIDE POUR LES FGD AUPRES DES GROUPES CIBLES - FEMMES

Introduction avant la discussion/entretien

Bonjour. Mon nom est _____ et je suis accompagné par mon/ma collègue_____. Nous menons une étude pour le compte du Projet IMPACT. L'étude va informer sur les chaines d'approvisionnement des produits de santé à Madagascar basés sur le genre.

Nous aimerions vous poser une série de questions afin de comprendre mieux la situation dans laquelle vous vivez.
La participation à cet entretien est volontaire et si vous ne voulez pas répondre à une ou plusieurs questions, n'hésitez pas à nous le faire savoir. Vos réponses seront gardées confidentielles. Vos noms ne seront pas enregistrés. Notre discussion/entretien durera environ 1 heure. Nous vous remercions d'avance pour votre participation. Voulez-vous y participer ?

Consentement reçu ?

Nom, age, état civil, nombre des enfants

1. Quelles sont les maladies les plus courantes au sein de votre communauté ?
    a. Follow-up : Pour les femmes ? Hommes ? Filles ? garçons ?

2. Où est ce que vous vous approvisionnez en produits de santé dans votre communauté ?
    - Publique, privée, marketing sociale ?
3. Si vous voulez acheter un Produit de Santé, qui décide sur le type de Produit de santé à acheter ?
    - Est-ce que les femmes chefs de ménages, les veufs/veuves, les jeunes désœuvrés, les déplacés peut-y-participer dans la prise de décision ? Pourquoi ou pourquoi pas ?
        - Pourquoi il y a une inégalité dans la prise de décision ?
4. Dans votre communauté, quels sont des problèmes majeurs en matière d'accès aux produits de santé relatif au palu, contraception/ planning familiale, la sante de la mère et de l'enfant
    a. Est-ce qu'il y a une égalité d'accès aux produits de sante entre femmes et hommes ?
    b. Existe – t-il des blocages culturels, coutumes ?
    c. Quels problèmes sont les plus fréquents ?
    d. Quelles en sont les causes visibles et profondes ?

5. Quelles sont des conséquences de ces problèmes d'accès au niveau des femmes, hommes, jeunes?
    a. sur votre condition de vie
    b. sur votre état de sante
    c. sur le statut entant que des femmes ou hommes ; des jeunes ?

6. Pourquoi les gens pensent que la sante c'est une affaire des femmes seulement ?
    a. Est-ce que les hommes sont concerné par la sante des enfants, de la famille ? Pourquoi ou pourquoi pas ?

7. Que dit la loi par rapport a l'accès aux services et produits de la sante ?

8. Quels sont vos suggestions pour améliorer l'accès aux produits de la sante a Madagascar ?

Merci pour votre contribution !

GUIDE POUR LES FGD AUPRES DES GROUPES CIBLES - HOMMES

Introduction avant la discussion/entretien

Bonjour. Mon nom est _____ et je suis accompagné par mon/ma collègue_____. Nous menons une étude pour le compte du Projet IMPACT. L'étude va informer sur les chaines d'approvisionnement des produits de santé à Madagascar basés sur le genre.

Nous aimerions vous poser une série de questions afin de comprendre mieux la situation dans laquelle vous vivez.

La participation à cet entretien est volontaire et si vous ne voulez pas répondre à une ou plusieurs questions, n'hésitez pas à nous le faire savoir. Vos réponses seront gardées confidentielles. Vos noms ne seront pas enregistrés. Notre discussion/entretien durera environ 1 heure. Nous vous remercions d'avance pour votre participation. Voulez-vous y participer ?

Consentement reçu ?

Demander à chaque personne : Nom, âge, état civil, nombre des enfants

1. Quelles sont les maladies les plus courantes au sein de votre communauté ?
   - Follow-up : Pour les hommes ? Femmes ? Filles ? garçons ?
   - Que pensez-vous de la prevelance du paludisme ?

2. Où est ce que vous vous approvisionnez en produits de santé dans votre communauté ?
   - Publique, privée, marketing sociale ?

3. Si vous voulez acheter un Produit de Santé, qui décide sur le type de Produit de santé à acheter ?
   - Est-ce que les femmes chefs de ménages, les veufs/veuves, les jeunes désœuvrés, les déplacés peut-y-participer dans la prise de décision ? Pourquoi ou pourquoi pas ?
     - Qui prend la décision ?

4. Dans votre communauté, quels sont des problèmes majeurs en matière d'accès aux produits de santé relatif au palu, contraception/ planning familiale, la sante de la mère et de l'enfant
   a. Est-ce qu'il y a une égalité d'accès aux produits de sante entre femmes et hommes ?
   b. Existe – t-il des blocages culturels, coutumes ?
   c. Quels problèmes sont les plus fréquents ?
   d. Quelles en sont les causes visibles et profondes ?

5. Quelles sont des conséquences de ces problèmes d'accès au niveau des femmes, hommes, jeunes?
   a. sur votre condition de vie
   b. sur votre état de sante
   c. sur le statut entant que des femmes ou hommes ; des jeunes ?

6. Est-ce que vous pensez que que la sante c'est une affaire des femmes ? Pourquoi ou pourquoi pas ?
   a. Est-ce que les hommes sont concerné par la sante des enfants, de la famille ? Pourquoi ou pourquoi pas ?
   b. Il y a des rumeurs que les hommes/les maris/les partenaires pourraient constituer des barrières a la pratique de la contraception par les femmes/ses femmes, quelles sont vos opinions la dessus ?

7. Que dit la loi par rapport a l'accès aux services et produits de la sante ?

8. Quels sont vos suggestions pour améliorer l'accès aux produits de la sante à Madagascar ?

Merci pour votre contribution!

ANNEX D: LIST OF KEY INTERVIEWEES

Disclaimer: In cases where an individual or organization could be at risk of legal, social, or physical hard due to their participation in this research, names, dates and contact information have been redacted or omitted in order to protect participants, ensure quality data collection, and adhere to Do No Harm and Ethical Data Collection protocols and standards. For all interviewees, free and prior informed consent was obtained before the interview.

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