Technical Brief

Malaria, Gender and Human Rights

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I. Introduction

The purpose of this Technical Brief is to assist applicants to consider how to include programs to remove human rights and gender-related barriers to malaria prevention, diagnosis and treatment services within funding requests and to help all stakeholders ensure that malaria programs promote and protect human rights and gender equality.

"Promoting and protecting human rights and gender equality" is Strategic Objective 3 (SO3) in the Global Fund's new *Strategy 2017-2022: Investing to End Epidemics*.[1] With regards to malaria, this objective commits the Global Fund to:

a) Scale up programs to support women and girls, including programs to advance sexual and reproductive health and rights;
b) Invest to reduce health inequities, including gender- and age-related disparities;
c) Introduce and scale up programs that remove human rights barriers to accessing services;
d) Integrate human rights considerations throughout the grant cycle and in policies and policy-making processes;
e) Support the meaningful engagement of key and vulnerable populations and networks in Global Fund-related processes.

To fulfill SO3, the Global Fund requires that *all* Funding Requests (formerly 'Concept Notes') "must include, as appropriate, interventions that respond to key and vulnerable populations, human rights and gender-related barriers and vulnerabilities in access to services."[2]

The Global Fund invests in programs to remove human rights and gender-related barriers to increase the reach and impact of grants by empowering those most affected by malaria, HIV and tuberculosis to seek, take up, and continue benefiting from health services. Furthermore, the new Strategy has elevated the Global Fund's commitment to gender equality, recognizing the urgent need to reduce infection rates among women and girls and to eliminate health disparities among men, women, adolescent girls and boys, and transgender people. Programs to remove human rights and gender-related barriers aim to address stigmatizing, discriminatory and punitive attitudes, practices, regulations, policies and laws that impede people's access to health services, and to protect and promote the realization of related human rights, such as the right to be free from cruel, inhuman or degrading treatment, and the right to redress, should rights be violated.

In addition, Global Fund-related processes and supported services must adhere to human rights-based and gender-responsive approaches to health. This means that the design, implementation, monitoring and evaluation of malaria programs must integrate human rights and gender-equality norms and principles, including non-discrimination, transparency and accountability. This approach also calls on applicants to put in place the necessary processes and programs to empower affected and vulnerable populations, by addressing their particular risks and needs, ensuring their participation in decision-making on malaria service provision, and providing mechanisms for complaint and redress in the event that rights are violated.

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[1] *The Global Fund Strategy 2017-2022: Investing to End Epidemics.* GF/B35/02 – Revision 1, p.3. Available online.
[2] *The Global Fund Sustainability, Transition and Co-financing Policy.* GF/B35/04 – Revision 1, pp.6, 11-13. Available online.

II. Human rights and gender-related vulnerabilities and barriers to accessing malaria services

Malaria is a disease of poverty. Where malaria services are not free of charge, poverty is an important barrier to prevention and care. Malaria may also sustain poverty where the burden of care is unevenly shared within communities and households. In certain circumstances, malaria disproportionately affects migrants, refugees, indigenous people, prisoners, geographically marginalized people and people working in high exposure locations. People for whom health information is unavailable or inaccessible due to language and cultural barriers may be especially disadvantaged. The following paragraphs elaborate on these barriers and vulnerabilities.

Gender norms – that is, societal expectations of appropriate gender roles – can affect risks of infection, access to services, prevention and control interventions, and the distribution of the burden of malaria morbidity and mortality.[3] Women and female-headed households disproportionately live in poverty in much of the world,[4] and gender norms may make it less likely that women have the autonomy to seek malaria services for themselves and their children.[5] Where services or transportation to reach services are not free, women may not have the economic autonomy to seek and utilize malaria services at a health facility or to buy medicine.

Even if services are free, as is usually the case with insecticide treated bed-nets (ITNs), women may still not have the autonomy to seek or receive them, depending on the means of distribution, or to purchase additional ITNs when needed. For example, a study in the Indian state of Haryana found that ITNs were much more likely to be used in households where women held decision-making power, including autonomy to spend money and to make decisions about children's health and education, as opposed to households where women did not have that authority.[6] Gender norms may also dictate who in the household can sleep under an ITN; both men and women - and sometimes children or adolescent girls and boys - may be excluded, depending on the context. A 2016 study among rural households in Kenya suggests that low-income female-headed households or households where women do not have economic and decision-making autonomy are less likely to receive information about and to participate in indoor residual spraying (IRS),[7] an important vector control measure in malaria programs.

Women may also face risks linked to gender norms if tasks such as preparing food, seeking water or fuel, or agricultural work in the pre-dawn or early evening hours expose them to mosquitoes without protection. The same is true of men if they work in forests, fields, mines or other high-exposure locations at peak biting times.[8] Men may also be more likely to migrate for work, which can increase their exposure to mosquitoes and their risk of infection in higher-transmission settings. Men and

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[3] The Global Fund to Fight AIDS, TB and Malaria. Addressing gender inequalities and strengthening responses for women and girls: Information Note. Geneva, 2014.

[4] See, e.g., UN Statistics Division and UN Women. *Millennium Development Goals Gender Chart*. New York, 2014.

[5] Ibid.

[6] Tilak R, Tilak VW, Bhalwar R. Insecticide treated bednet strategy in rural settings: can we exploit women's decision making power? *Indian Journal of Public Health* 2007;51(3):152-8.

[7] Diiro GM, Affognon HD, Muriithi BW et al. The role of gender on malaria preventive behaviour among rural households in Kenya. *Malaria Journal* 2016;15(1):1-8;

[8] Global Fund, Gender information note, op.cit.

women working long hours in tasks expected of them according to gender norms may be disadvantaged due to limited opening hours at health facilities providing malaria services.[9]

While available evidence suggests that in the event of equal exposure, adult men and women are equally vulnerable to malaria infection, pregnant women are at greater risk of severe episodes of malaria in most endemic areas due to decreased immunity. Furthermore, cultural or gender norms may dictate limitations on mobility of pregnant women or their ability to frequent public places, possibly impeding their ability to utilize health services. Intermittent preventive therapy in pregnancy (IPTp) for malaria with sulfadoxine-pyrimethamine is recommended at each prenatal visit beginning early in the second trimester.[10] However, WHO estimates that only 52% of women received at least one IPTp dose in 2014.[11] UNICEF estimates that 85% of women globally receive antenatal care from a skilled provider, yet only 58% had the recommended four antenatal visits, and only 49% in sub-Saharan Africa.[12]

Pregnant adolescents face higher risk of severe malaria than women over the age of 19,[13] and they may also face greater barriers to antenatal and reproductive health care than older women. Pregnant women living with HIV are at highest risk of severe anemia and adverse birth outcomes if they contract malaria.[14] Malaria in pregnancy can increase HIV viral load and thus the risk of vertical transmission of HIV.[15] While pregnant women living with HIV are among the most vulnerable of all populations to malaria morbidity and mortality, they may face many barriers to care, including those related to HIV stigma and discrimination.

Forced displacement may make people especially vulnerable to malaria. For instance, refugees and internally displaced persons who are forced to move from low-endemicity to high-transmission areas may be highly susceptible to malaria infection, particularly if they are homeless or in sub-standard housing. They may also be excluded from health services due to language and cultural barriers, discrimination, lack of information concerning relevant services, or lack of identity documents or other requirements for health service eligibility.

Detention may increase people's risks and vulnerabilities to malaria. Though prisoners and detainees have the right to services equivalent to those in the community,[16] they often face discriminatory barriers to health care, and many detention settings may not provide malaria prevention, diagnosis and treatment services.

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[9] Ibid.

[10] World Health Organization. Intermittent preventive treatment in pregnancy (IPTp) (online fact sheet), March 2016, at: http://www.who.int/malaria/areas/preventive_therapies/pregnancy/en/.

[11] WHO, World Malaria Report, op.cit., p 26.

[12] UNICEF. Only half of women worldwide receive the recommended amount of care during pregnancy (online fact sheet), 2016, at: http://data.unicef.org/maternal-health/antenatal-care.html

[13] Mbonye K *et al*. Preventing malaria in pregnancy: a study of perceptions and policy implications in Mukono district, Uganda. *Health policy and planning*, 2005 (Advanced Access). Okonofua F, Davis-Adetugbo A, Sanusi Y. Influence of socioeconomic factors on the treatment and prevention of malaria in pregnant and non-pregnant adolescent girls in Nigeria. *Journal of Tropical Medicine and Hygiene*, 1992, 95:309-315.

[14] Gonzalez R, Sevene E, Jagoe G, Slutsker L, Menendez C. A public health paradox: The women most vulnerable to malaria are the least protected. *PLoS Medicine* 2016;13(5):e1002014.

[15] Ibid.

[16] UN Commission on Crime Prevention and Criminal Justice. *United Nations Standard Minimum Rules for the Treatment of Prisoners (the Mandela Rules)*. UN doc. E/CN.15/2015/L.6/Rev.1, 21 May 2015 (see rule 24).

III. Programs to remove human rights and gender-related barriers to accessing malaria services

All of the human rights and gender-related barriers noted above can be addressed by programs of various kinds, including advocacy and assessment efforts. Human rights and gender barriers may also be addressed in some cases by better targeting and implementation of existing programs informed by a thorough analysis and understanding of where barriers exist and whom they affect.

The following descriptions of types of programs – with some examples of real experiences – are meant to help planners and implementers of Global Fund grants to think through ways to improve program outcomes by removing human rights and gender-related barriers to malaria services in their specific settings. This list is not exhaustive. The resources noted at the end of this paper may be consulted for further information.

Human rights and gender assessments: If human rights and gender-related vulnerabilities and barriers are not yet clearly identified or not yet identified for particular populations or localities, it may be useful to request support for an assessment to help identify or situate these barriers to inform programs to address them. For example, the Roll Back Malaria Partnership published a matrix-format checklist to guide assessment of gender-related factors that impede or facilitate access to malaria services.[17] 'VectorWorks,' a five-year project funded by the U.S. President's Malaria Initiative (PMI), has summarized some guiding factors for integration of gender equality considerations in malaria programs, including in an assessment phase.[18] Guidance is also available for assessment of populations excluded from malaria information and services in complex emergencies and other challenging operating environments.[19]

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[17] Roll Back Malaria Partnership and Kvinnoforum. *A guide to gender and malaria resources*. Stockholm, 2005, pp 29 ff.
[18] VectorWorks. Achieving gender integration in malaria prevention: VectorWorks project strategy. Baltimore: Johns Hopkins Center for Communication Programs, 2015.
[19] World Health Organization, UN High Commission for Refugees, UNICEF et al. *Malaria control in humanitarian emergencies: an inter-agency field handbook (2nd ed.).* Geneva, 2013.

Meaningful participation of affected populations: Malaria may have a disproportionate impact on people who are remote from health services, living in poverty, and with limited access to mainstream sources of information. Global Fund support for malaria efforts is optimized if programs include measures to ensure that those most affected by the disease are part of country dialogues and other key decision-making on design, implementation and evaluation of programs. It is important to ensure the participation of women and adolescent girls who understand the challenges of enabling good access to malaria-related antenatal services and the best ways to reach all women with information on prevention measures. The interests of refugees and internally displaced persons should also be represented in key decision processes.

Strengthening of community systems for participation in malaria programs: Related to the point above, Community Systems Strengthening (CSS) may be especially useful to improve access to malaria services for underserved populations.[20] These include empowering communities to demand services and information, to monitor and evaluate quality of and access to services, and to play a meaningful role in decision-making related to malaria service provision. Community-based organizations and institutions, including schools and village committees of various kinds, may be engines of such mobilization. A lesson from the long history of malaria control is that there is no "one size fits all" strategy;[21] it is crucial for community-based organizations to play a meaningful role in determining the elements of effective and sustainable malaria responses.

Strengthening community participation may be especially important where malaria elimination[22] is an accepted goal. Elimination strategies represent an opportunity for rights-based action to reach traditionally excluded and geographically marginalized populations with diagnostic, preventive and treatment services. As noted by WHO, as countries approach elimination, "a high proportion of cases are found among vulnerable populations living in remote areas".[23] However, zealous pursuit of elimination may lead to such measures as involuntary screening, including at borders or points of internal displacement to prevent importation of cases.[24] There may be a temptation to apply coercive measures or to assess fines against people who do not comply with prevention directives or who fail to seek treatment.[25] Rights-based, respectful approaches and meaningful participation of affected communities are crucial in malaria elimination efforts.

Addressing gender-related vulnerabilities and barriers: As noted in the previous section, gender-related barriers to malaria services can take a number of forms, and programs to remove these barriers are varied. All malaria programs should be concerned with ensuring that all women and adolescents have access to sexual and reproductive health rights and services. Pregnant women should be informed about and have regular access to IPTp through antenatal services (*see* related Global Fund information notes).[26] Other possible program actions reflecting experiences from a number of countries are noted below.

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[20] See Global Fund to Fight AIDS, TB and Malaria. *Community Systems Strengthening Information Note*. Geneva, 2014.
[21] Rieckmann KH. The chequered history of malaria control: are new and better tools the ultimate answer? *Annals of Tropical Medicine and Parasitology* 2006;100(8):647-62.
[22] Elimination of malaria is defined by the WHO as the interruption of malaria transmission in a defined geographical area. World Health Organization. *Eliminating malaria.* Geneva, 2016.
[23] Ibid.
[24] Sturrock HJW, Roberts KW, Wegbreit J, Ohrt C, Gosling RD. Tackling imported malaria: An elimination endgame. *American Journal of Tropical Medicine and Hygiene*. 2015;93(1):139-144.
[25] World Health Organization. *Eliminating malaria (case study 9: Climbing towards elimination in Bhutan*. Geneva, 2015.
[26] Global Fund to Fight AIDS, TB and Malaria. Maximizing the impact of reproductive, maternal, newborn and child health (RMNCH): Information note, 2014; Global Fund to Fight AIDS, TB and Malaria. Addressing gender inequalities and strengthening responses for women and girls: Information note, 2014.

Addressing gender norms in ITN use: All people have a right to protection from malaria through the full range of prevention methods, including use of ITNs. If gender norms or other gender-related factors undermine acquisition or use of ITNs, those factors should be addressed. In one experience in Nigeria, for example, an analysis following an ITN campaign revealed that women and children were more likely to sleep under ITNs than men and adolescent boys. One possible explanation for this result was that posters, radio spots and other communications channels used in the campaign had especially emphasized the importance of women and children sleeping under ITNs.[27] In such a case, a funding request might include support to revise communications and mass media materials to reflect men's and adolescent's needs along with those of women and girls and to ensure that messages are presented in media used by all groups. As a further example, it was found in one location in western Kenya that in the middle of their pregnancies, women would sleep on the floor with the children rather than in bed with their husbands and would thus lose the benefit of the ITN on the couple's bed.[28] In this case, antenatal service providers were trained to promote ITN use and were equipped with free ITNs to distribute to pregnant women.

Addressing gender aspects of indoor residual spraying (IRS): The success of IRS programs for malaria control depends partly on gaining the trust and acceptance of households and communities to enable sprayers to attain good coverage. In some places it has been noted that women and female-headed households may not welcome IRS because they have poorer access to information about spraying or because they do not have a rapport with male-dominated spraying teams.[29] Efforts to include women as sprayers and community-level IRS promoters may help to overcome this barrier.[30] Similarly, it may be useful to assess women's concerns about IRS and design information efforts to address those concerns and to reach women where they are.

Measures to address gender-influenced occupational risks: Where men are at disproportionate risk because they migrate to work in an area of high malaria transmission, for instance, it may be useful for applicants to include in their funding requests support for malaria information/education programs targeting these workers. Mobile or other highly accessible services targeting this population may also be appropriate (see box below). Where the work of women and girls poses exposure risks – as with gathering fuel, preparing food, or agricultural field work in the early morning or early evening – applicants may build into funding requests support for the development and targeted dissemination of user-friendly information on malaria transmission, especially where girls are disproportionately denied formal education and would not have learned about malaria in school.[31] Working with women's groups, men's groups, young people's groups and community health committees to find ways to address these occupational risks may be useful. The case of men who are disproportionately exposed to malaria because of work in mines, construction or other occupations at peak biting times without protection should also be addressed. Informing or training health and occupational safety authorities, as well as employers, on the importance of providing personal protection measures as well as community level protection through vector control may help. Information and training for trade unions and other worker associations may also be effective.

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[27] Garley AE, Ivanovich E, Eckert E, Negroustoueva S, Ye Y. Gender differences in the use of insecticide-treated nets after a universal free distribution campaign in Kano State, Nigeria: post-campaign survey results. Malaria Journal 2013;12(1):1-7.
[28] Roll Back Malaria Partnership and Kvinnoforum, op.cit., p 18.
[29] Boene H, Gonzalez R, Vala A et al. Perceptions of malaria in pregnancy and acceptability of preventive interventions among Mozambican pregnant women: implications for effectiveness of malaria control in pregnancy. *PLoS One* 2014;9(2):e86038.
[30] See, e.g., PMI-AIRS, "Women take charge in malaria prevention (case of Benin)," 2014, available online at: http://www.africairs.net/2014/05/women-take-charge-malaria-prevention/
[31] Diiro GM, Affognon HD, Muriithi BW et al. The role of gender on malaria preventive behaviour among rural households in Kenya. Malaria Journal 2016;15(1):1-8.

Providing malaria services to migrant workers in the Greater Mekong Sub-region

Thousands of migrant workers cross borders or migrate long distances within borders to engage in agricultural or construction labor in the Greater Mekong Sub-region of Southeast Asia, encompassing Thailand, Cambodia, Laos, Myanmar, Vietnam and Yunnan Province, China. Migrant workers often lack basic information on malaria, as well as access to prevention and treatment services.[32] A President's Malaria Initiative (PMI) supported project has undertaken a number of measures to address barriers to information and services faced by migrant workers in Thailand, Cambodia and Myanmar. Linguistically accessible malaria information has been made available where workers tend to stop or seek taxis and at border checkpoints. Mobile health workers who visit the migrants' work sites are able to give information and conduct testing or refer people to nearby services.[33] Some clinics provide more complete mobile services. A telephone hotline provides malaria service information in the language of the workers. The project also works with health officials in catchment areas with significant migrant populations to remove policy and documentation barriers to care for itinerant workers. Project reports indicate that thousands of migrant workers have been reached with services in all three countries.[34]

Improving access to services for refugees and others affected by emergencies: Refugees and others who have lost their homes or have been severely affected by emergencies face some barriers to health services that may be similar to those faced by migrant workers. Forced displacement can expose people without acquired immunity to unaccustomed levels of transmission. People may also suffer from malnutrition and lack of adequate shelter. In these situations, special care should be taken to identify these vulnerable populations and provide a level of basic services, including mobile services if indicated.[35] In addition, standard distribution methods for vector control may need to be adapted. In such cases, the Global Fund *Challenging Operating Environments Policy* enables countries to consider reprogramming existing grants or requesting emergency funds to allow for flexible service delivery.[36] Coordination with experienced emergency service providers can be crucial. Information on malaria prevention and care should be provided to emergency-affected communities in their own language and in practical and understandable terms. In some cases, training of health workers on the importance of respectful service provision for refugees and IDPs may be warranted.

Malaria in people living with HIV: People living with HIV may face stigma and discrimination linked to HIV that also impede access to malaria services. UNAIDS and the Global Fund recognize seven categories of programs to remove human rights barriers to HIV services (see HIV and Human Rights Technical Brief);[37] these programs may be useful if particular populations are facing HIV-related barriers to malaria services.

Programs targeting barriers to malaria services for pregnant women and adolescents living with HIV or HIV-positive women are of vital importance given the vulnerability of these women to malaria morbidity and mortality. These include programs to prevent mother-to-child HIV transmission. Further guidance is found in the Global Fund's Information Note on Reproductive, Maternal,

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[32] USAID CAP-Malaria. Reducing malaria among mobile and migrant populations in Southeast Asia: technical brief. Phnom Penh, 2014.
[33] Ibid.
[34] See CAP-Malaria Semi-Annual Reports (Oct. 1, 2015 to Mar. 31, 2016) for Burma, Cambodia and Thailand, at http://capmalaria.org/index.php/resources/downloads/viewcategory/13-annual-and-semi-annual-report-fy-2016
[35] WHO, UNHCR, UNICEF et al., *Inter-agency field handbook*, op.cit.
[36] See The Global Fund *Challenging Operating Environments Policy* GF/B35/05. Available online.
[37] UNAIDS. Key programmes to reduce stigma and discrimination and increase access to justice in national HIV responses. Geneva, 2012.

Neonatal, Child and Adolescent Health and a forthcoming Information Note on Resilient and Sustainable Systems for Health.[38] Malaria program designers and managers and HIV program managers may work together on strategies for integration of malaria services in HIV programs.

Improved services in prison and pretrial detention: Overcrowding, lack of malaria prevention measures, poor or no access to malaria services, malnutrition, and high risk of HIV characterize many prison and other detention facilities around the world. To ensure that people in state custody can realize their human right to malaria services equivalent to those in the community, it is useful to assess and address barriers to services in these closed settings. Prison health care providers often receive less technical support than their peers in other health services and may benefit from training and targeted measures to ensure that malaria prevention and control supplies reach prisons. Women in prison frequently lack access to basic health services; programs to serve them are important to overcome both gender-based barriers and prison-related stigma and marginalization. Advocacy or other efforts to ensure that malaria services in prison are overseen and given technical support by health ministries and not interior or corrections ministries, as recommended by WHO and the UN Office on Drugs and Crime,[39] may also be warranted.

IV. Conclusion

Human rights and gender-related vulnerabilities and barriers to accessing services can undermine malaria prevention and control efforts. Removing these barriers can be crucial to ensure that services are sustainable and reach all who need them. This Technical Brief notes numerous ways in which barriers can be removed. As mentioned above, the Global Fund requires that all Funding Requests "must include, as appropriate, interventions that respond to key and vulnerable populations, human rights and gender-related barriers and vulnerabilities in access to services."[40] The nature and extent of barriers should be carefully assessed, and programs to remove human rights and gender-related barriers to malaria services should be rigorously monitored and evaluated, including aspects of cost and cost-effectiveness. While human rights-based and gender-responsive approaches to malaria have not been as well defined as those for HIV and tuberculosis, these efforts are essential to ensure that malaria prevention, diagnosis and treatment services are effective and indeed, universal.

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[38] Global Fund to Fight AIDS, TB and Malaria. Maximizing the impact of reproductive, maternal, newborn and child health (RMNCH): Information note, 2014; The Global Fund to F Information Note on 'Resilient and Sustainable Systems for Health: Information Note (forthcoming).

[39] World Health Organization – Europe and UN Office on Drugs and Crime. *Good governance for prison health in the 21st century. A policy brief on the organization of prison health*. Copenhagen, 2013.

[40] *The Global Fund Sustainability, Transition and Co-financing Policy.* GF/B35/04 – Revision 1, pp.6, 11-13. Available online.

V. Further Reading

Malaria – gender and women's issues

- Global Fund to Fight AIDS, TB and Malaria. Addressing gender inequalities and strengthening responses for women and girls: Information Note. Geneva, 2014. At: http://www.theglobalfund.org/en/applying/resources/
- Roll Back Malaria Partnership, World Health Organization, UNICEF et al. Consensus statement: optimizing the delivery of malaria-in-pregnancy interventions. Geneva, 2013. At: http://reprolineplus.org/resources/consensus-statement-optimizing-delivery-malaria-pregnancy-interventions
- Roll Back Malaria Partnership and Kvinnoforum. *A guide to gender and malaria resources*. Stockholm, 2005. At: https://www.k4health.org/toolkits/igwg-gender/guide-gender-and-malaria-resources
- UN Development Programme. *Discussion paper: Gender and malaria*. New York, 2015. At: http://www.undp.org/content/undp/en/home/librarypage/hiv-aids/gender--hiv-and-health-discussion-papers.html

Malaria, forced migration and challenging operating environments

- UNICEF, UNHCR, World Health Organization et al. *Malaria control in humanitarian emergencies: an inter-agency field handbook (2nd ed.)*. Geneva, 2013. At: http://www.unhcr.org/en-us/protection/health/456c11bd4/malaria-control-humanitarian-emergencies-inter-agency-field-handbook.html?query=malaria

Malaria and community-based action

- Global Fund to Fight AIDS, TB and Malaria. *Community Systems Strengthening Information Note*. Geneva, 2014. At: http://www.theglobalfund.org/en/applying/resources/
- Roll Back Malaria, World Health Organization. *Community involvement in rolling back malaria*. Geneva, 2002. At: http://apps.who.int/iris/handle/10665/67822
- US Agency for International Development. *Leveraging the Global Fund new funding model for integrated community case management: a synthesis of lessons from five countries*. Washington DC, 2015. At: http://ccmcentral.com/documents/leveraging-the-global-fund-new-funding-model-for-integrated-community-case-management-a-synthesis-of-lessons-from-five-countries/