
Technical Brief

Malaria, Gender and Human Rights

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1. Introduction

The purpose of this technical brief is to give practical assistance to country coordinating mechanisms (CCMs), program managers, partners, advocates and others concerned with Global Fund-supported programs in ensuring that malaria proposals and programs include measures to remove human rights and gender-related barriers to malaria prevention and treatment services. The guidance provided aims to ensure that all Global Fund supported programs are aligned with the Fund's *Strategy 2017-2022: Investing to End Epidemics*¹, particularly in what relates to Strategic Objective 3 (SO3) "Promoting and protecting human rights and gender equality". This objective commits the Global Fund to:

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

Global Fund Funding Requests *all* "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. 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.

By providing guidance on how to improve equity and quality of malaria programs, the Global Fund aims to further global efforts set under the World Health Organization (WHO) Global Technical Strategy for Malaria (2016-2030) (GTS) and the Action and Investment to Defeat Malaria (AIM) 2016-2030 which call for an incidence and mortality reduction of at least 90% globally; and malaria elimination in at least 35 countries by 2030. While there have been significant gains in the fight against malaria, in some areas, progress has stagnated. The Global Fund believes that addressing equity and quality issues in malaria programs is critical to getting back on-track in the fight against malaria. Achieving the ambitious targets set out in the GTS and AIM are a precondition to accelerate progress towards the broader Sustainable Development Goals and meet the principles of Universal Health Coverage.

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](#).

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

Assessing risk for malaria infection and disease progression involves simultaneous consideration of epidemiological, entomological, and social factors. Populations may be at high risk of infection due to exposure, high risk of developing severe disease if infected, due to their biological conditions, and/or higher risk of mortality with severe disease both due to biological conditions and/or lack of access to adequate care. Underserved populations are populations facing healthcare service deprivation due to barriers such as poverty, social exclusion, gender norms, cultural and traditional norms, financial barriers, and distance to health facilities. Because malaria prevention and treatment services are delivered by primary health care and community systems, underserved populations are likely to experience higher risk of morbidity and mortality related to malaria, due to the barriers that they face to access basic healthcare services.

Poverty may result in lack of access to or delayed seeking of care due to cost, fear of healthcare workers, lack of information, lack of access to preventive measures such as insecticide-treated nets (ITNs), or poor housing, among other factors. The likelihood of being infected with malaria is higher in poor and marginalized communities³. Yet, malaria itself is a burden to communities and increases poverty and its associated inequality due to lost productivity or income associated with illness or death. Marginalized populations including migrants, refugees, indigenous people, prisoners, geographically marginalized people may have barriers to accessing health services, while people working in high exposure occupations can be particularly vulnerable to malaria as they may face higher risks of infection. Populations moving from low to high transmission settings may be more vulnerable due to lack of immunity. A person's gender impacts on their risk to malaria, as well as their ability to access services. Social, economic and cultural factors play a crucial role in determining differences in gender-related vulnerability to malaria and access to malaria prevention and treatment services. Below are examples of barriers and vulnerabilities experienced by specific populations and that may impact on malaria program outcomes:

2.1 Barriers to access faced by malaria high-risk groups

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 developing severe 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 trimester⁴. However, WHO estimates that only 54% of women received at least one IPTp dose in 2017⁵.

Pregnant adolescents face higher risk of severe malaria than women over the age of 19⁶. They may also face greater barriers to antenatal and reproductive health care than older women. Parental or spousal consent requirements, lack of access to financial resources, limited mobility and lack of information are example of barriers affecting especially adolescents in their first

³ Ricci F. Social implications of malaria and their relationships with poverty. *Mediterr J Hematol Infect Dis.* 2012;4(1): e2012048.

⁴ 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/.

⁵ WHO, *World Malaria Report (2018)*. p 20

⁶ 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.

pregnancy or those married young. Fear of stigma, age-related discrimination and negative attitudes of health workers can also discourage pregnant adolescents to seek antenatal care⁷⁻⁸.

Pregnant women living with HIV are at high risk of severe anaemia and adverse birth outcomes if they contract malaria. Malaria in pregnancy can increase HIV viral load and thus the risk of vertical transmission of HIV⁹. 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 associated with HIV-related stigma and discrimination.

Children under the age of 5 years are among the most vulnerable to malaria infection as they have not yet developed any immunity to the disease and yet they are also at high risk of being underserved. The WHO World Malaria Report (2018) states that 30% of febrile children do not access any primary healthcare treatment¹⁰. Gender inequalities in health-seeking decision making at household level may determine delays in accessing care for febrile children.

2.2 Information accessibility

Low literacy or language barriers are among barriers in access to information. These may particularly affect minorities, refugees or mobile populations, and women who generally have higher levels of illiteracy than their male peers. Traditional beliefs, gender, perceptions and practices may influence accessibility and access to information on malaria prevention and treatment thus affecting acceptance of certain malaria prevention and treatment services. Non-locals (visitors/travelers, migrants, refugees, IDPs) and minority ethnic groups may face barriers if they do not speak the region's official and/or local languages, as well as deprivation of services linked to discrimination, marginalization, lack of security and many other inequities.

2.3 Financial accessibility

Even where primary healthcare services (which normally include malaria services) are subsidized or free, the indirect costs may create disparities in access to these services. Even for community-based interventions such as ITN mass campaigns or indoor residual spraying (IRS), which are usually free of charge, indirect costs may impede equitable access and uptake. Populations in hard to reach or remote areas may require additional and higher transport costs; for example, transport to the sites of distribution of ITNs can impede access to the ITNs even when distributed free of charge; removing household contents for a house to receive IRS may be impossible for households with adults who work outside the home. Women often have less financial resources to access services and are therefore at risk of seeking sub-optimal services or delaying/not seeking treatment for themselves and their children if they are the main care giver.

2.4 Physical accessibility/suitability

Marginalized populations or populations living in remote areas are particularly affected by physical barriers to accessing services. Factors such as facility opening hours, distance to health care facilities, poor road networks and insecurity are additional impediments to accessing health services. These differences will often be gender specific, with adolescent girls being further marginalized due to their age, perceived risk of violence and other factors that may impact on how they access services.

Standard vector control methods (ITNs and IRS) may not be suitable and/or accessible to migrants and mobile populations such as seasonal workers, populations in remote areas, forest workers and mobile security personnel.

⁷ Kirby MJ, Green C, Milligan PM, Sismanidis C, Jasseh M, Conway DJ, et al. Risk factors for house-entry by malaria vectors in a rural town and satellite villages in The Gambia. *Malar J*. 2008;7:2

⁸U.W. Ibor GOA, A.I. Iwara, O.E. Okongor and I.I. Okino, 2012. . Ownership and Utilization of Insecticide Treated Nets in Cross River State, Nigeria. *Journal of Medical Sciences*. 2012;12:198-206.

⁹ Ibid

2.5 Human rights and gender-related barriers

Gender based constraints on access to healthcare services have been identified as key factors inhibiting improvement in health outcomes. In many societies, being a man or woman means not only having different biological characteristics, but also facing different expectations about one's appearance, qualities, behaviour, work, and roles appropriate to being male or female. Men, women, and transgender people may be excluded from health services due to gender norms, language and cultural barriers, discrimination or, lack of information concerning relevant services. 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 services¹⁰. In addition, womens' and girls' roles as primary caretakers of children and elderly might further inhibit their ability to access services which require them to find alternative options for care.

Women and girls may 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 times¹¹. Men are more likely to migrate for work, which can increase their exposure to mosquitoes if, for example, they migrate to higher transmission settings. Men are also reported to underutilize primary health care services for malaria as compared to women possibly due to gender norms that dictate that men must be strong and 'get over' their illness by themselves, or because men assign a lower priority to their health or feel uncomfortable asking for assistance¹².

Gender may impact utilization of malaria prevention services. In some circumstances gender norms could dictate who can receive long-lasting insecticidal nets (ITNs). Women may not have the autonomy to seek or receive ITNs, depending on the means of distribution, or to purchase additional ITNs when needed. On the other hand, in some communities, households with female care-givers are more likely to be linked to ITNs use. For example, in Nigeria, the sex of the care giver (being female) and a mother's education significantly increased the utilization of ITNs¹³. Similarly, in households in Haryana, India, where women held decision-making power, including autonomy to spend money and to decide about children's health education, ITNs were much more likely to be used as opposed to households that did not have similar female authority¹⁴. Gender norms may also dictate how household resources are distributed, including who in the household can sleep under an ITN. Both men and women - and sometimes children or adolescent girls or boys - may be excluded, depending on the context.

Often, people prefer to be served by a provider of the same sex. In some cases, religion dictates that a married woman cannot be seen by a male provider. Women with migrant background may also face greater disparities in the health services received due to cultural factors.

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)¹⁵. Additionally, cultural norms and safety precautions may not permit a woman to allow male sprayers to enter the house and conduct IRS¹⁶.

¹⁰ Ibid.

¹¹ Global Fund, Gender information note, op.cit.

¹² WHO. Gender, health and malaria. 2007.

¹⁰ WHO, World Malaria Report (2018)., p 20

¹³ 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. Roll Back Malaria Partnership and Kvinnoforum, op.cit., p 18.

¹⁴ 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.

¹⁵ 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.

¹⁶ 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>

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Though prisoners and detainees have the right to services equivalent to those in the community¹⁷, they often face discriminatory barriers to health care, and many detention settings may not provide malaria prevention, diagnosis and treatment services.

In many circumstances, migrants, refugees, nomads and displaced persons may be excluded from services and information because of ethnic, cultural, linguistic or other discriminatory barriers, stigmatizing attitudes, illegal status and associated fear of deportation, lack of identity documents or other requirements for health service eligibility.

In some countries and communities, there are practices, policies and laws that may drive away or delay people from seeking health care including malaria services. For example, mandatory requirement of spouses to accompany the expectant mother for ANC visits, lack of informed consent and confidentiality, mandatory testing, and demands for bribes or high fees constitute barriers in access to services.

¹⁷ 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).

3. Approaches to address inequities, human rights and gender-related barriers in malaria interventions

The human rights and gender-related barriers noted above are not exhaustive and countries should identify other potential barriers that impact on the ability of different population groups to access and utilize services. Those barriers can be addressed by better targeting and implementing existing malaria programs informed by a thorough analysis and understanding of where barriers exist and whom they affect. In their malaria funding requests, applicants should explicitly identify high risk and underserved populations, inequities, human rights and gender-related vulnerabilities/barriers, as well as potential opportunities to engage population groups that are impacted by those barriers, in program design. It is important to note that gender-related vulnerabilities often persist across population groups and are reinforced by intersectional inequalities. This means that certain members of population groups at higher risk of malaria are likely to be affected by multiple barriers leaving them behind in the malaria response. For instance, barriers faced by women and girls among refugees, IDPs or migrant groups may be further exacerbated by their gender.

Non-exhaustive examples of high-risk and underserved populations, potential inequities, as well as human rights and gender-related vulnerabilities/barriers are presented below, under each intervention module, as per established by the Malaria Modular Framework.

Table 1: Examples of high-risk populations, potential inequities, human rights and gender-related vulnerabilities/barriers

Malaria module intervention	Potential underserved or high risk population	Potential inequities, human rights barriers or gender barriers
LLIN mass campaigns	<ul style="list-style-type: none"> • Populations living in hard to reach areas • Refugees, IDPs, migrants • Prisoners • Socially or legally excluded populations 	<ul style="list-style-type: none"> • Language barriers or limited access to information (e.g. adolescent girls and women with limited literacy/ mobility) • Limited access to receive nets; E.g. gender norms dictate who sleeps under the bed nets.
	<ul style="list-style-type: none"> • Populations with low literacy/language barriers • Households with gender/age-related disparities and inequalities • Households with unsuitable physical structures/sleeping habits 	<ul style="list-style-type: none"> • Limited access to information (e.g. adolescent girls and women with limited literacy/ mobility) • Limited use of nets
IRS	<ul style="list-style-type: none"> • Female headed households 	<ul style="list-style-type: none"> • Limited acceptance due to issues related to male sprayers

	<ul style="list-style-type: none"> Household with occupation-related issues, for example: household members with occupations that require long hours outside household 	<ul style="list-style-type: none"> Unavailability of household occupants thus house unavailable for IRS
Chemoprevention – IPTp	<ul style="list-style-type: none"> Pregnant women Pregnant adolescents 	<ul style="list-style-type: none"> Cultural and gender norms or age of consent related barriers that may limit access to ANC Literacy and language barriers
IEC/SBCC	<ul style="list-style-type: none"> Refugees, Internally displaced persons Mobile populations Migrants Prisoners Socially and legally excluded populations 	<ul style="list-style-type: none"> Social and cultural barriers Literacy and language barriers
Case management	<ul style="list-style-type: none"> Hard to reach populations Mobile populations Migrants 	<ul style="list-style-type: none"> Access, financial and security (real and perceived) barriers to prevention, diagnosis and treatment services.

If underserved and high-risk populations, along with the human rights and gender-related vulnerabilities and barriers that they face are not yet clearly identified, it may be useful to request support for an assessment to help identify or situate these barriers to inform programs to address them through the Global Fund application. Countries may therefore include in their funding application actions to identify areas and/or populations with barriers to malaria and primary health care services. Comprehensive guidance on **assessing** and identifying risk factors and barriers impeding equitable and integrated people-centred malaria programs, and underserved populations is available in the [Malaria Matchbox Toolkit](#) developed by the Global Fund. Additional tools such as [HEAT](#) and [EQUIST](#) may also help determine equity dimensions for various health services including malaria and other services that are delivered at community level, health centres/hospitals and through outreach activities. The Roll Back Malaria Partnership to End Malaria has also published a matrix-format checklist to guide assessment of gender-related factors that impede or facilitate access to malaria services¹⁸. ‘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 phase¹⁹. Guidance is also available for assessment of populations excluded from malaria information and services in complex emergencies and other challenging operating environments²⁰.

After exploring the main risk increasing factors and barriers to access services, impacting on each of the populations identified, the next step is to identify and tailor malaria interventions/programs to overcome the barriers. The approaches chosen, may need to be different for the different populations, even if they face the same barriers (refer to examples in the [Malaria Matchbox toolkit](#) and sections below). This can include adaptations of existing interventions to better address

¹⁸ Roll Back Malaria Partnership and Kvinnoforum. *A guide to gender and malaria resources*. Stockholm, 2005, pp 29 ff.

¹⁹ VectorWorks. *Achieving gender integration in malaria prevention: VectorWorks project strategy*. Baltimore: Johns Hopkins Center for Communication Programs, 2015.

²⁰ 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

identified barriers and/or new interventions, partners, and approaches. National Malaria Control Programs should include details on any intervention adaptations and/or activities/actions in their funding requests and include appropriate budgets and arrangements (i.e. new partners, etc.) and evaluations for implementation.

The following descriptions of types of programs – with some examples of tools and real experiences – are meant to help planners and implementers of Global Fund grants to think through ways to improve program outcomes by assessing and 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. Additional illustrations of possible actions that can be undertaken to address human rights and gender-related vulnerabilities are available in the [Malaria Matchbox toolkit](#).

Overall programmatic approach

Notably, there are the five minimum human rights standards with which all Global Fund-funded programs must comply. These standards require that implementers:

1. Grant non-discriminatory access to services for all, including people in detention ^[L]_[SEP]
2. Employ only scientifically sound and approved medicines or medical practices ^[L]_[SEP]
3. Do not employ methods that constitute torture or cruel, inhumane or degrading treatment ^[L]_[SEP]
4. Respect and protect informed consent, confidentiality and the right to privacy concerning ^[L]_[SEP] medical testing, treatment or health services rendered, and ^[L]_[SEP]
5. Avoid medical detention and involuntary isolation, which, consistent with WHO guidance, are to ^[L]_[SEP] be used only as a last resort. ^[L]_[SEP]

Programmatic approaches to **address** inequities and remove human rights and gender-related barriers to primary healthcare services generally and malaria services specifically can be included in funding requests as part of RSSH and malaria modular frameworks. Some general programmatic approaches which enable malaria responses include:

3.1 Programs to monitor and reform laws, regulations and policies relating to malaria prevention and control

To-date, there have been successful policies and laws put in place to enable vulnerable populations access the needed services including removal of taxes from health products and free universal LLIN coverage. However, regular monitoring of existing laws/policies or establishment of new laws to address the identified human-rights and gender related barriers is essential. While some policies/laws may not appear to directly impact delivery of malaria services, they may inhibit or prevent populations at risk of malaria from accessing services. Multisectoral efforts may be needed to support policies and laws that protect vulnerable populations, such as refugees, prisoners etc., from discrimination, and support their access to malaria prevention and treatment. Malaria programs should ensure that policies and guidelines for malaria are non-discriminatory and advocate for improving access for populations that are vulnerable and at high risk for malaria.

3.2 Meaningful participation of high-risk and underserved populations

Communities' participation in decision-making about health policies and programs that affect them is an integral element of the right to health. Global Fund support for malaria 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 program review and evaluation. Malaria programs need to ensure representation from civil society and most affected communities in the development and planning of the funding application. Whenever needed, technical assistance for community engagement of under-represented groups impacted by the

disease should be facilitated²¹. Funding requests may include efforts to establish and support community and civil society organization initiatives to reach the marginalised and vulnerable groups through appropriate and effective service delivery and advocacy. It is important to ensure the participation of women and adolescent girls who understand the challenges of enabling access to antenatal services and the best ways to reach all women with information on prevention measures. The interests of refugees and internally displaced persons, migrants and other mobile populations should also be represented in key decision processes that affect them.

3.3 Strengthening of community systems for participation in malaria programs

Related to the point above, Community Systems Strengthening (CSS) may be especially useful to improve and monitor access to malaria services for underserved populations. This includes empowering and supporting communities, and especially the most vulnerable, to participate in national and local structures, platforms and processes, 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, as well as civil society organizations of patients and people living with or affected by specific diseases may be engines of such mobilization, and ensure that their representation is inclusive and reflect the views of their members.

A lesson from the long history of malaria control is that there is no “one size fits all” strategy²²; 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 is an accepted goal. Elimination strategies represent an opportunity for rights-based action to reach traditionally excluded and geographically marginalized populations with 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 measures as involuntary screening, including at borders or points of internal displacement to prevent importation of cases²⁴, which constitute human rights violations. There may be cases where coercive measures are applied, as fines against people who do not comply with prevention directives or who fail to seek treatment²⁵. Such coercive measures alienate rather than engage communities, and hamper efforts to stamp malaria out. Rights-based, respectful approaches and meaningful participation of affected communities are crucial in malaria elimination efforts. One example is Civil Society for Malaria Elimination (CS4ME), a civil society network that is committed to advocate for more effective, sustainable, people-centered, rights-based, equitable, and inclusive malaria programmes.

Applicants are encouraged to explore the potential of community-based monitoring (CBM) as part of efforts to improve accessibility, responsiveness, and quality of services. CBM is a process by which community engagement can be increased through collaborative approaches to identifying and addressing bottlenecks and gaps in service provision, providing feedback using short, local

²¹ Please, refer to <https://www.theglobalfund.org/en/funding-model/throughout-the-cycle/technical-cooperation/> for technical assistance for country dialogue. For technical assistance on community engagement, please refer to the Community, Rights and Gender Short-term Technical assistance, available on <https://www.theglobalfund.org/en/funding-model/throughout-the-cycle/community-rights-gender-technical-assistance-program/>

²² 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.

²³ 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.

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.

feedback loops. CBM can focus on general health, disease specific or intervention specific services (e.g. monitoring of correct usage of LLIN or geographic and other structural barriers). Examples of CBM tools that applicants should consider include scorecards, complaints mechanisms and monitoring of human rights and gender-related barriers to services. For more information, refer to the Global Fund's webpage on [Community Response Systems](#).

Specific Program approaches to address inequities and remove rights and gender-related barriers, as part of malaria module interventions

3.4 Addressing barriers in ITN use

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 ITNs²⁶. 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.

Working with women's groups, men's groups, young peoples' groups and community health committees to find ways to address 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.

Where there is limited access to ITNs among vulnerable populations (including refugees, IDPs, migrants, prisoners, socially and legally excluded), altering distribution strategies of ITNs to reach remote areas (such as adding additional distribution points, distributing door to door, using continuous distribution strategies rather than a mass campaign should be considered). Additional actions include targeted distribution to refugees or IDPs if living in camps or geographically identifiable locations; altering registration techniques to encourage individuals/populations to register without fear of reprisal; including refugee, IDP, migrants, socially/legally excluded populations as staff for household registration, distribution and SBCC; planning specific distributions to prisons; and providing targeted distribution to specific populations – (for example, distribution of LLINs through HIV clinics). In mobile populations comprehensive migrant mapping is essential to guide and support implementation of IRS or LLIN distribution. A more frequent distribution to areas with mobile populations, prisons, etc. could also be considered as the population may change and people may go with their nets and/or there is increased probability of loss and increased wear and tear due to challenging living conditions.

To address limited use of nets due to low literacy/language barriers, gender/age-related issues in household, physical structure of household, sleeping habits and occupation-related issues, applicants may include funding support towards developing pictograms and/or translating relevant materials into local languages/languages of specific populations served and adapting messages to the cultural context(s); adapting messaging to take gender and age into consideration and/or; evaluating reasons for insufficient nets in household requiring families to prioritize who has access to a net.

To enhance ITN use, it is important to procure nets appropriate for occupational or sleeping conditions for example: hammocks for forest workers or dumuria nets for nomadic populations

²⁶ 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.

(used in South Sudan and Kenya) or smaller nets for housing used by the Batwa population in Burundi. Nomadic communities use of dumuria nets in Garissa County, northeastern Kenya worked as a good option for outdoor sleepers and harsh environments. These types of examples highlight the importance of context-specific LLINs which take into consideration the nuanced needs and preferences of communities ²⁷.

Community-based monitoring of mass campaigns may also help to ensure improved access to vulnerable or excluded/underserved populations and ensure equitable distribution across households and communities.

The Global Fund has defined challenging operating environments (COEs) as countries which have weak governance and poor access to health services due to warfare, civil disturbance, natural disaster or large-scale movement of people. In COE contexts, modified and flexible strategies are needed to reach the affected populations. It is important that funding applications where applicable include vector control options which are context-specific and can be easily deployed to targeted areas and households, as well as used by those targeted. For example, the COE policy enables countries to consider reprogramming existing grants or requesting emergency funds to allow for flexible LLIN service delivery²⁸. Extensive guidance on distribution of ITNs in COE is provided in the [Alliance for Malaria Prevention toolkit – operational guidance for ITN distribution in complex operating environments](#).

3.5 Addressing barriers to 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 teams²⁹. Efforts to address this gender barrier, may include employing women as sprayers and community-level IRS promoters³⁰. Similarly, it may be useful to assess women's and community concerns about IRS and design information efforts to address those concerns and to reach women where they are. Also consider engaging community leaders both male and female (or female community health workers) to visit female-headed households with spray personnel to facilitate acceptance. Adjustment of working days/hours of sprayers (such as conducting the spraying on weekends) could improve availability and access to those working outside the home.

It is important to consider the living conditions and accessibility of refugees, IDPs and migrants and whether IRS may be more suitable than LLINs given living conditions and mobility of the population (shared migrant housing with individuals moving in and out may be better for IRS that is fixed as individuals may move with their nets and/or each individual will have his/her own sleeping space). Prisons may also be better served by IRS for similar reasons.

3.6 Addressing barriers to IPTp (Chemoprevention)

All malaria programs should be concerned with ensuring that all women and adolescents have access to basic health services to fulfil their right to health. Pregnant women should be informed about and have regular access to IPTp through antenatal services (see related Global Fund

²⁷ Georgia R. Gore-Langton, et al. Investigating a Non-Mesh Mosquito Net among Outdoor Sleeping Nomadic Communities in Kenya

²⁸ The Global Fund *Challenging Operating Environments Policy* GF/B35/05. Available [online](#).

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/>

information notes)³¹. To address barriers faced by women and adolescent girls accessing IPTp, programs could provide health education and messaging targeting specific cultural and gender norms, literacy and language barriers that may hinder access to ANC. Specific targeting of men and local leaders to improve understanding of importance of accessing ANC early and regularly, as well as malaria-specific prevention measures should also be considered. Community based IPTp is currently being piloted in several countries. Should evidence prove the effectiveness of this strategy it could be piloted/scaled up. Funding applicants are encouraged to develop innovative outlets to reach specific populations, and consider how to manage resistance.

3.7 Addressing barriers through IEC/SBCC

In the funding application countries should include initiatives to strengthen malaria communication strategies to address identified human-rights and gender barriers, including barriers to accessibility of information. Development of communication programs using various approaches including advocacy, behaviour change communication, community and social mobilization, as well as social marketing is critical to address the barriers to services. Those should consider specific gender aspects when defining their key messages, and when planning how those messages will be delivered to community members.

Applicants may refer to [the RBM Strategic Framework](#) for malaria communication guidance, as they develop or update their national malaria communication plans aimed to enhance program implementation. For example, it would be beneficial to develop and implement evidence based social and behavioural change communication (SBCC) strategies to address gender norms. In the Gambia, peer educators encouraged men as household heads to become involved in community health discussions by using short dramas to attract them. The discussions demonstrated to men the critical role that they can play in supporting women both morally and financially to go for IPTp, ITNs and other malaria prevention measures. A program evaluation showed that ITN usage increased threefold in the area where this intervention was implemented³².

Programs should tailor IEC/SBCC messages to address barriers to access or use within specific vector control interventions, chemoprevention and/or access to health services for diagnosis and treatment or messages that may apply across all interventions. Tailoring should consider: specific population groups (such as refugees, internally displaced persons, mobile populations, migrants, prisoners, socially and legally excluded populations); different literacy levels; different local languages used; gender and age dynamics. Communication tools and methods (e.g. radio, interpersonal communication, etc.) should be adapted to the needs of the context or population. Communication focused on healthcare providers and community health workers should aim to promote non-discriminatory and culturally-sensitive malaria services.

Funding applications can also include initiatives to make available malaria IEC materials/resources where particular at risk/vulnerable populations will have better access such as transport hubs or border checkpoints where migrants/mobile workers tend to gather. In situations of gender-influenced occupational risks, for instance where men are at disproportionate risk because they migrate to work in an area of high malaria transmission, 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

³¹ 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.

³² Global Fund to Fight AIDS, TB and Malaria. *Community Systems Strengthening Information Note*. Geneva, 2014.

information on malaria transmission, especially where girls are disproportionately denied formal education and would not have learned about malaria in school³³.

Coordination with experienced emergency service providers for refugee populations can be crucial, and applicants should include emergency/response plans in their funding requests. Information on malaria prevention and care should be provided to emergency-affected communities in their own language and in practical and understandable terms.

Conventional media may not be suitable for semi-literate/illiterate groups therefore using multiple channels to disseminate information including the use of inter-personal communication may be more effective.

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 services³⁴. A number of measures to address barriers to information and services faced by migrant workers in Thailand, Cambodia and Myanmar were undertaken by malaria partners in this greater Mekong region.

Through a Presidential Malaria Initiative (PMI) supported project, 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 services³⁵. Some clinics provide more complete mobile services. A telephone hotline provides malaria service information in the language of the workers. Efforts were also made to work 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.³⁶

The Global Funds Regional Artemisinin-resistance Initiative (RAI) also has several strategies to address the needs of remote, mobile and minority populations in the greater Mekong region. These include establishing malaria posts to serve mobile and remote populations, innovate approaches to work with private companies employing migrant workers and establishment of regional steering committees to enhance cross-border and intercountry coordination of malaria prevention and treatment services.³⁷

³³ 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.

³⁴ USAID CAP-Malaria. Reducing malaria among mobile and migrant populations in Southeast Asia: technical brief. Phnom Penh, 2014

³⁵ Ibid.

³⁶ 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>

³⁷ The Global Fund Regional Artemisinin-resistance Initiative at https://www.theglobalfund.org/media/6509/publication_regionalartemisininresistanceinitiative_focuson_en.pdf

3.8 Addressing barriers to appropriate case management:

For populations such as hard to reach, mobile populations and, migrants etc. programs may include strategies in their funding request that aim to expand access to care (through community, private sector, mobile services, etc.).

Funding applications may include support to mobile health worker visits to migrant work sites to give information and conduct testing/treatment or refer people to nearby services.

Refugees and others who have lost their homes or have been severely affected by emergencies face significant barriers to health services, and ways to address them may be similar to those used to overcome barriers 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 indicated³⁸. In some cases, training of health workers on the importance of respectful and culturally-appropriate service provision for refugees and IDPs may be warranted.

Support to integrated community case management, through selection of community health workers who understand and/or identify with the population to be assisted should be considered. Selecting and training refugees and/or nomads to serve as community health workers (CHW) in their respective communities, can ensure that language and cultural barriers are addressed. Strategies to mobilize and enable women to become female community health workers are also important, especially in countries where literacy rates for women are significant low. The provision of remuneration and support for CHWs should be fair and equitable, rather than reinforcing unequal gender norms. Malaria programs can also engage private sector providers who may be the preferred option for particular populations based on access and real and perceived security.

To ensure that people in state custody can realize their right to health, including through access 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. Prisoners frequently lack access to basic health services, with women also likely to face barriers in accessing sexual and reproductive health services. Programs to serve prisoners 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 Crime³⁹, may also be warranted.

Programs targeting barriers to malaria services for pregnant women and adolescents living with HIV are of vital importance given their vulnerability 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, Neonatal, Child and Adolescent Health and the Information Note on Resilient and Sustainable Systems for Health⁴⁰. Malaria program designers and managers and HIV program managers should work together on strategies for integration of malaria services in HIV programs.

Programs can also design innovative strategies to support multisectoral efforts to enable working with relevant Ministries to address issues related to barriers to care, including indirect barriers

³⁸ WHO, UNHCR, UNICEF et al., *Inter-agency field handbook*, op.cit.

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 UNAIDS. Key programmes to reduce stigma and discrimination and increase access to justice in national HIV responses. Geneva, 2012.

such as financial barriers, through strengthening referral systems to address direct barriers such as user fees.

Additional illustrations of possible actions that can be undertaken to address human rights and gender-related vulnerabilities are available in the [Malaria Matchbox toolkit](#).

In summary, 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 implemented and rigorously monitored and evaluated, including aspects of cost and cost-effectiveness.

4. Further reading

Assessing risk for malaria infection and disease progression involves simultaneous consideration of epidemiological, entomological, and social factors. Populations may be at high risk of infection due to exposure, high risk of developing severe disease if infected because of their biological conditions, and/or higher risk of mortality with severe disease both due to biological conditions and/or lack of access to adequate care. Underserved populations are populations facing

- Malaria and Gender Global Fund RSSH Information Note (2019)
- Global Fund to Fight AIDS, TB and Malaria. Addressing gender inequities in the context of the three diseases (2019)
- 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>
- The Global Fund: Malaria Matchbox toolkit, 2019 At: https://endmalaria.org/sites/default/files/Malaria_Matchbox_v4.pdf
- 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>
- AMP Operational guidance for ITN distribution in complex operating environments. At: https://allianceformalariaprevention.com/amp-tools/tools-resources/ifrc_lin_distribution_en/
- 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, 2019. 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/>