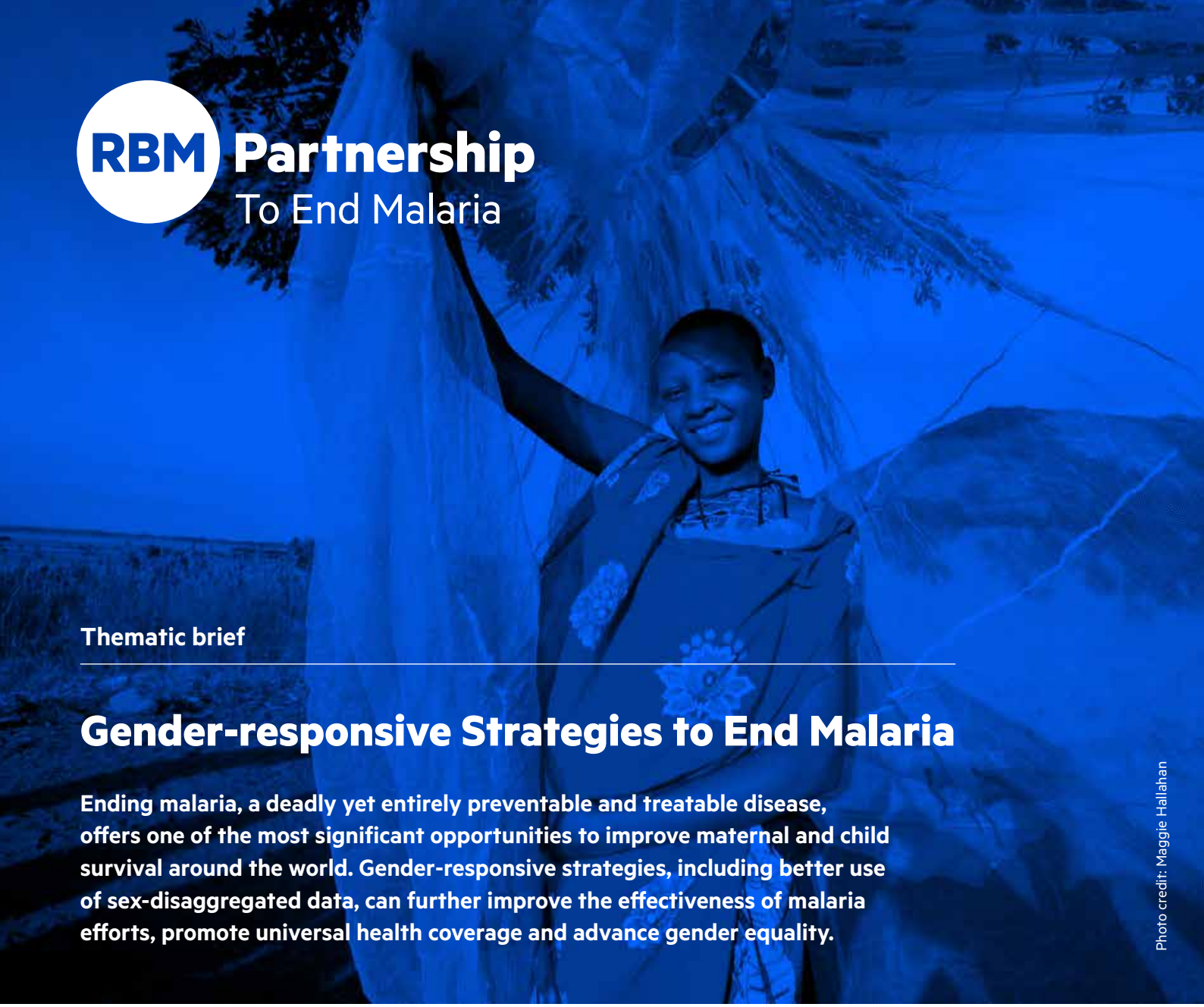


RBM Partnership To End Malaria

Thematic brief

Gender-responsive Strategies to End Malaria

Ending malaria, a deadly yet entirely preventable and treatable disease, offers one of the most significant opportunities to improve maternal and child survival around the world. Gender-responsive strategies, including better use of sex-disaggregated data, can further improve the effectiveness of malaria efforts, promote universal health coverage and advance gender equality.

Photo credit: Maggie Hallahan

Key messages

Malaria disproportionately impacts pregnant women and children under five, putting their lives, education and future potential at risk. **Malaria in pregnancy contributes to 10,000 maternal deaths each year. It is also responsible for up to 200,000 newborn deaths globally**[i] and up to 20% of all stillbirths in sub-Saharan Africa.

Access to health care services for malaria can be affected by gender issues, including gender inequality. Women often have to ask for their husband's permission to access treatment for themselves and their children. Cultural reasons, such as reluctance to see male health workers, may contribute to underreporting of malaria cases among women.

There is limited knowledge on the gender dimensions of malaria. Furthermore, there are currently no sex-disaggregated data being systematically collected and reported on global malaria burden and access to treatment, beyond malaria in pregnancy prevention.

From community health workers to country leaders, women around the world are playing a critical role in the fight against malaria. **Women comprise 70% of the global health workforce but only make up 25% of the top leadership positions**[ii].

Malaria in pregnancy

125 million pregnancies occur annually in areas with transmission of *P. falciparum* and/or *P. vivax*. In malaria-endemic areas, as much as **10% of maternal deaths** are caused by malaria in pregnancy, as well as 11% of newborn deaths and **20% of stillbirths** in sub-Saharan Africa[iv]. However, only **1 in 5 eligible women** currently receive at least 3 recommended doses of intermittent preventive treatment in pregnancy (IPTp)[v].

Pregnancy reduces a woman's immunity to malaria, making her more susceptible to malaria infection and increasing the risk of illness, severe anemia and death.

Adolescent girls are particularly vulnerable to malaria. In many sub-Saharan settings, adolescents are often parasitaemic and anaemic when they first become pregnant. Moreover, societal stigma results in pregnant adolescents being least likely to use antenatal care (ANC)[iii].

The World Health Organization (WHO)'s recommendations on ANC provide an important platform to increase a pregnant woman's touchpoints with the health system and additional opportunities for frequent IPTp uptake, beginning as early as possible in the 2nd trimester.

While countries have made important strides in promoting anti-malaria prevention in pregnancy, most countries are well below targets. Among 33 African countries that reported on IPTp coverage levels in 2017, an estimated 22% of eligible pregnant women received the recommended 3 or more doses of IPTp, compared with 17% in 2015 and 0% in 2010[vi].

Spotlight on: TIPTOP Project

Funded by Unitaid, and implemented by Jhpiego and its partners in the **Democratic Republic of the Congo, Madagascar, Mozambique and Nigeria**, the Transforming Intermittent Preventive Treatment for Optimal Pregnancy (TIPTOP) Project is working to break down barriers between pregnant women and the malaria medicines they need.

Working closely with community health workers, the project provides eligible pregnant women with quality assured anti-malaria prevention, including IPTp and mosquito nets, in both the community and at antenatal care centers. This approach is being tested to generate evidence for WHO to review and make a policy recommendation regarding community IPTp in 2022.

Several other countries are testing this approach, including **Burkina Faso, Malawi, Senegal** and **Sierra Leone** with support from the President's Malaria Initiative, the Global Fund, UNICEF and other partners.

Community health workers

Women combatting malaria are most visible on the frontlines. They make up 90% of the community health workers who have helped significantly drive down malaria cases and deaths—a major contribution to some 7 million lives saved and over one billion of malaria cases prevented since 2000.

In 2017, India launched its five-year plan, aiming to eliminate malaria by 2030. India is the only high-burden country to achieve a 23% decline in malaria cases in 2017 over 2016 and is on track to reduce malaria cases by 20-40% by 2020[vii]. An innovative program for Accredited Social Health Activists (ASHAs) supports India's public health delivery system.

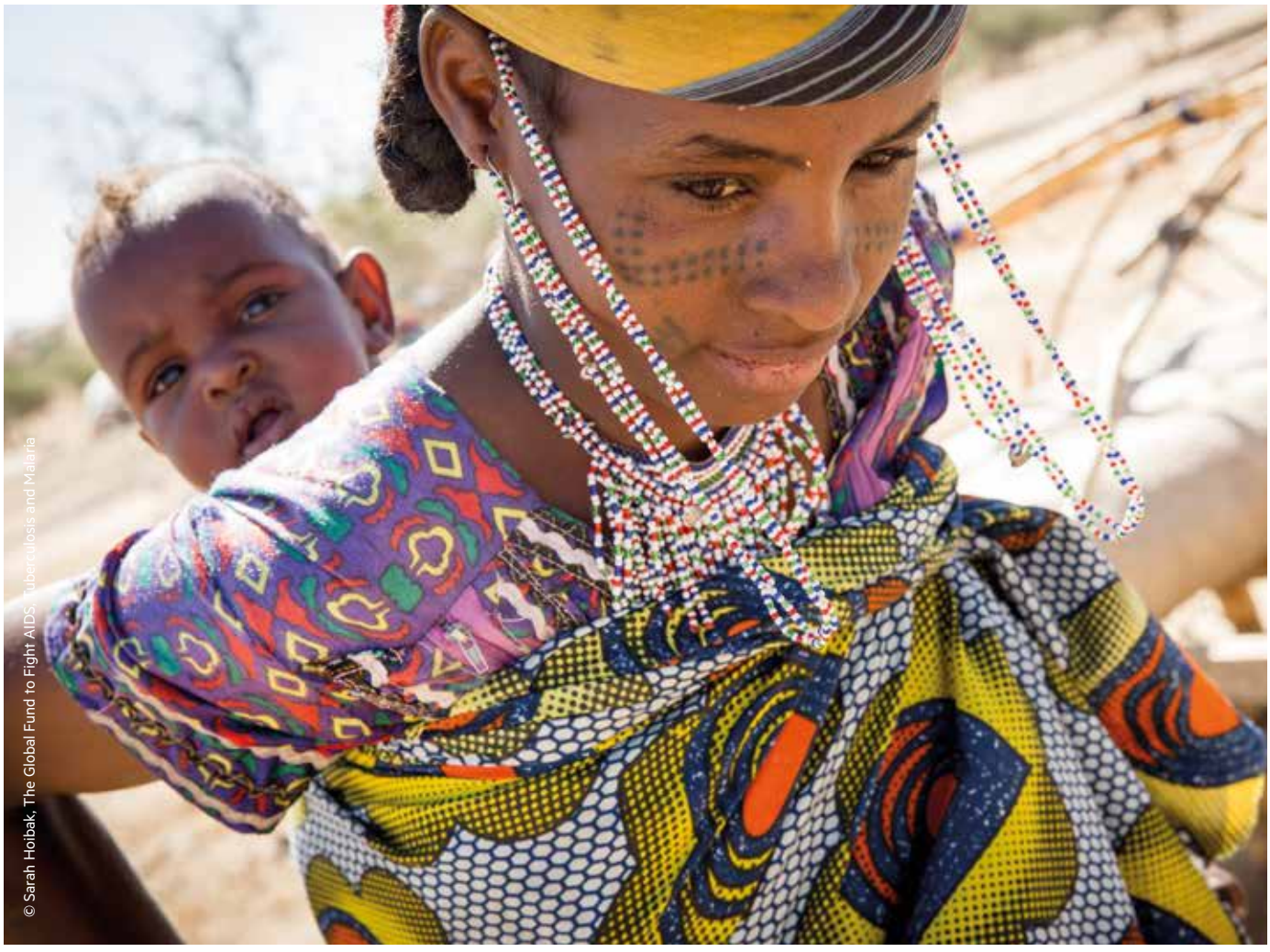
Odisha, India's highest burden state, contributing 45% of total cases albeit with only 3% of population, is setting the pace of success in the country's battle against malaria. Since 2010, over 45,000 trained ASHAs were progressively involved in malaria control activities in Odisha, providing mass screening and treatment for malaria along with interventions for anemia and malnutrition to remote tribal villages on the eve of the monsoon season. This led to a dramatic reduction in the malaria burden[viii].

Malaria through a gender lens

With the help of ***Malaria Matchbox*, an equity assessment tool** designed by the Global Fund and the RBM Partnership to End Malaria and piloted in **Niger** and **Guinea Bissau**, public health professionals are encouraged to consider the vulnerabilities related to gender norms that result in men and women as well as boys and girls being disproportionally exposed to, and vulnerable to malaria, based on the division of labour, decision-making power, access to education, and broader contextual factors like gender-related access to economic resources and land use[ix].

Despite limited knowledge on the gender dimensions of the social and economic consequences of malaria within households, studies point out that although **the disease burden was greatest amongst adult males, the indirect economic burden of the disease was greater for women.**

- A study in rural **Colombia** found that the workload of women was significantly increased as they had to take care of sick household members as well replace men in farm production, with 64% if all tasks normally undertaken by the sick person then performed by women[x].
- Another study in **Cameroon** found that the burden of illness due to malaria rested disproportionately on economically disadvantaged women and on women with low social status[xi].
- Furthermore, a study in **Benin** revealed that when women earned an income and had control over this income, they were much more likely than men to purchase a long-lasting insecticide treated bed net (LLIN) for their household[xii].



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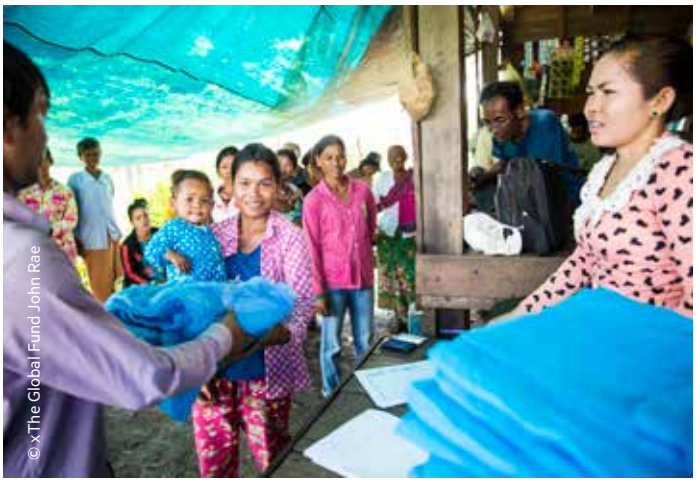
Solutions: Mainstreaming gender in malaria efforts

- **Integrate gender-responsive approaches in all aspects of malaria programming.** Collect and analyze sex-disaggregated data on malaria to better understand gender disparities related to malaria and malaria interventions and roll out tools such as *Malaria Matchbox* to promote more equitable and inclusive malaria strategies.

- To achieve universal health coverage, **women's primary health care needs, including addressing malaria in pregnancy, must be at the forefront** of comprehensive country policies and strategies that reach all women at risk for malaria — no matter where they live.



- **Ensure access to free treatment for children under five and pregnant women** including support to enhanced coverage of community case management.

- **Promote early and comprehensive antenatal care** where eligible pregnant women can access LLINs and receive IPTp. Measure and incentivize IPTp coverage at the facility level as a performance indicator.

- **Reduce, or eliminate wherever possible, antenatal care user-fees** to overcome cost as a barrier to the uptake of IPTp and other antenatal care services.

- **Include a policy framework and earmark specific funding for procurement of drugs**, including from local sources, that will be used in IPTp and delivered through antenatal care in both the public and private sector to prevent drug stock-outs.[xiii]

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For more information

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