MODULE 12:

GENDER IN MALARIA SURVEILLANCE, MONITORING, AND EVALUATION

MODULE 12: GENDER IN MALARIA SURVEILLANCE, MONITORING, AND EVALUATION

This module provides an introduction to gender and malaria, describing how gender influences malaria transmission, prevention, and treatment, and how gender data can help malaria programs better target populations and intervention approaches.

Module Objectives

By the end of this module, you will be able to:

- Explain gender influences on malaria transmission, prevention, care-seeking, and treatment
- Identify sources of gender data for malaria programs
- Identify gender analyses that can be used to make decisions for malaria programs

Gender and Health

According to the World Health Organization (WHO), gender refers to a culturally defined set of economic, social, and political roles, responsibilities, rights, entitlements, and obligations, associated with being female and male, as well as the power relations between and among women and men, boys and girls. The definition and expectations of what it means to be a woman or girl and a man or boy, and sanctions for not adhering to those expectations, vary across cultures and over time, and often intersect with other factors such as race, class, age, and sexual orientation. Transgender individuals, whether they identify as men or women, are subject to the same set of expectations and sanctions.

> "Gender is a culturally defined set of economic, social, and political roles, responsibilities, rights, entitlements, and obligations associated with being female and male, as well as the power relations between and among women and men, and boys and girls."
> World Health Organization, 2009

Gender norms influence household decision making and access to resources, which in turn influence the following:

- Access to and uptake of preventive behaviors and interventions
- If, when, and how individuals seek care and treatment for themselves and their children

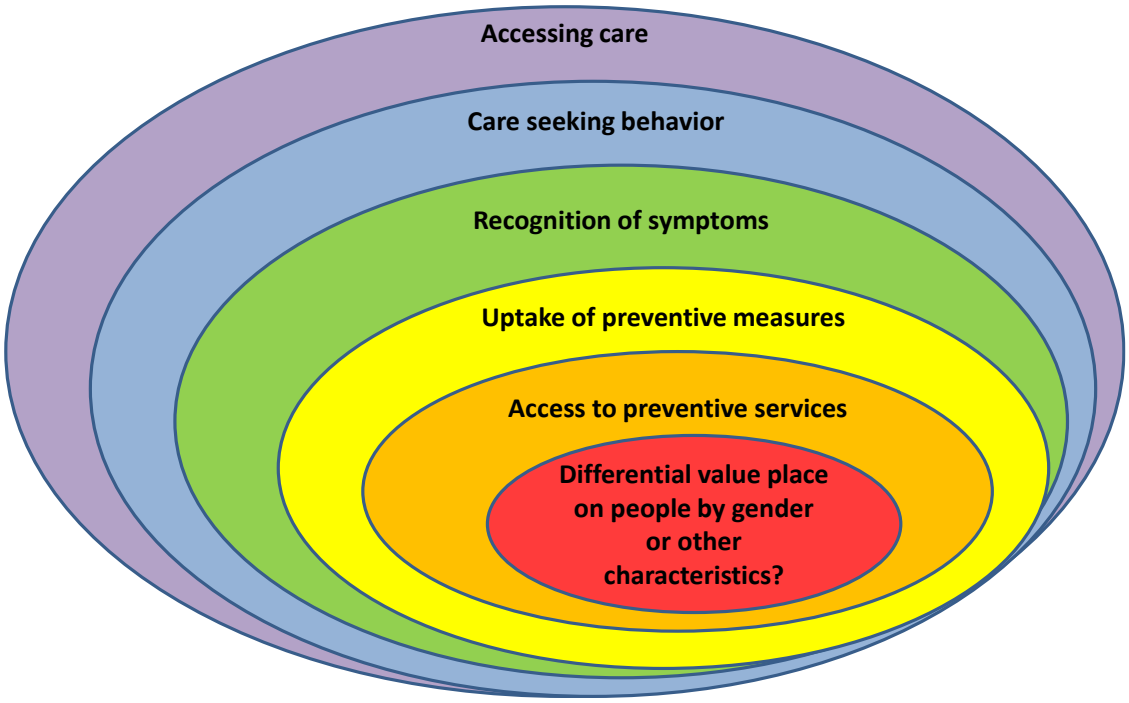
For example, travel requires resources and is often controlled by men who control household resources. Therefore, travel is a gendered barrier to accessing care and treatment outside of the home or community.

There are also gendered dimensions to consequences of illness. We will not discuss these issues in depth in this course, but it is important to note that these consequences can have long-term effects on individual, family, and community well-being and contribute to continued or deepened poverty. These consequences include attrition from school and inability to do work in or outside of the home.

Common Gender Influences on Malaria

Figure 37 illustrates the gendered dimensions of health. This graphic should be read from the center out, to see how different gender dynamics contribute to vulnerability to (risk of) disease infection, and how gender dynamics affect prevention, care-seeking, and access to quality care.

Figure 37. The gendered dimensions of health



Starting in the center, a basic question helps frame the context for how gender may influence the continuum of care: Is there a differential value placed on people by gender or other characteristics?

The term "differential value" refers to whether there is a difference in how people are valued in a society, community, or household, or whether there is a different social "worth" ascribed to different people.

For example, are male children more desired? This can extend to different expectations. For example, men may be thought to be physically stronger than women, so a different value or judgement is placed on men according to that characteristic.

Transmission Patterns

Populations may have different susceptibilities to malaria based on gendered norms, such as division of labor, which drives different transmission patterns.

Specific populations may spend the dawn and dusk hours outdoors—prime biting time for malaria-transmitting mosquitos. Some populations may even sleep outdoors, prolonging their exposure. These populations may include migrant communities and other marginalized groups, such as sex workers and LGBT individuals, who are more likely to be homeless or sleeping outside.

Other populations may have increased exposure at certain times of year. Farming season in some places may mean that certain household or community members, oftentimes men, spend a period of time sleeping away from home and outside.

Uptake of Prevention Behaviors

Now that you have examined how different populations may have differential exposure to malaria infection, consider whether these different populations have equitable access to preventive services.

Do different characteristics (e.g., sex), and the different value placed on these people based on those characteristics, affect their access to preventive services?

For example, women may lack financial or decision-making power to acquire insecticide-treated nets (ITNs) or to attend antenatal care (ANC) visits to receive intermittent preventive treatment in pregnancy (IPTp).

If you are identifying barriers that are surprising or new to you, and which may result in gaps in coverage of preventive interventions, this indicates that you may need more data about these barriers and the populations facing them. This can inform thinking about ITN distribution strategies and points of care other than ANC to ensure universal ITN coverage.

Next, consider how gender or other differentials may affect uptake and use of available and accessible preventive services. In a household, gender norms may affect who sleeps under an ITN, particularly if households do not have enough ITNs for each person or bed.

Some specific groups may be left out of routine ITN distribution campaigns. New or additional strategies for ITN distribution may be necessary to ensure that all populations are able to access and use ITNs for malaria prevention.

Care-Seeking and Treatment

Answer the following questions. If you do not have data or information to answer these questions, this identifies some data needs.

Consider how symptoms are recognized and whether there is different importance ascribed to symptoms based on the person experiencing them. If a pregnant woman has a fever, is this recognized more quickly or considered more serious than if an adult man has a fever? Do men "ignore" symptoms of malaria based on gender norms and expectations that men are "tough" or cannot take time away from work to be sick or seek care?

Consider factors that affect whether care is sought for a person with symptoms of malaria. How might gendered expectations around loss of economic productivity or income affect decisions to seek care? Are women able to make decisions independently about whether and when to take a sick child to a health facility? Do they need permission from a husband or male family member?

Globally, gender factors that impact care-seeking and treatment for sick children are those faced by mothers., Evidence shows that, with few exceptions, there are no differences in care-seeking or treatment for children under five years of age in most settings. If women, typically primary caregivers of children, require permission from others to take children for care, this could delay care-seeking and treatment beyond the 48-hour period of fever onset in which appropriate malaria treatment should be given.

Differentials in care-seeking may manifest in differences in timely treatment. If all children are getting appropriate treatment, do we know whether it is timely treatment? Consider whether there are delays in seeking care for male children or female children.

Once a decision is made to seek care, barriers and facilitators to accessing quality care need to be considered. Are there gendered barriers or facilitators to accessing quality care? Travel, as discussed above, may be a gendered barrier, because travel requires resources, which may be controlled by a male head of the household.

Are women able to go to a health facility unaccompanied with a sick child? Is a pregnant woman able to go to a health facility unaccompanied? Or visit a pharmacy that sells artemisinin-based combination therapies? Or meet a community health worker (CHW) unaccompanied? Bringing care for children with malaria directly to communities through integrated community case management could reduce gender-related barriers—mothers may not need permission to access the care from female CHWs. However, male CHWs may pose a barrier if female caregivers are not permitted to access care unaccompanied.

What are the treatment policies in your country? How might these affect the ability of different groups of people to access timely treatment for malaria?

Lastly, consider the quality of care provided. Could the quality of care that an individual provider gives vary based on the person seeking care? For example, can you think of a context in which a woman accompanied by a male relative may get care faster, or get better care, than if she were alone or with a female relative? Does this differ by source of care (facility, pharmacy, CHW)? What barriers are there to completing treatment?

Gender Data

There are multiple sources of gender data. These include the following:

- **Sex-disaggregated data.** Examples of sex-disaggregated malaria indicators include:
    - Percentage of people reporting sleeping under an ITN, by sex and age
    - Number of people treated for malaria, by sex and age
- **Age-disaggregated data.** Examples of age-disaggregated malaria indicators include:
    - Percentage of women, by age group, that took more than three doses of sulfadoxine-pyrimethamine for IPTp
- **Gender data.** Examples of malaria gender indicators include:
    - Percentage of people who perceive they are at risk from malaria, by sex
    - Percentage of people who are confident in their ability to perform a specific malaria-related behavior (e.g., sleep under an ITN for the entire night), by sex
    - Percentage of married women who make decisions about their own health care
- **Data on key populations and vulnerable groups.** Examples of malaria indicators specific to key populations include:
    - Percentage of nomadic population that owns at least one ITN
- **Qualitative data.** Examples of qualitative malaria indicators include:
    - Perceptions of malaria risk among young adult males

Data Sources

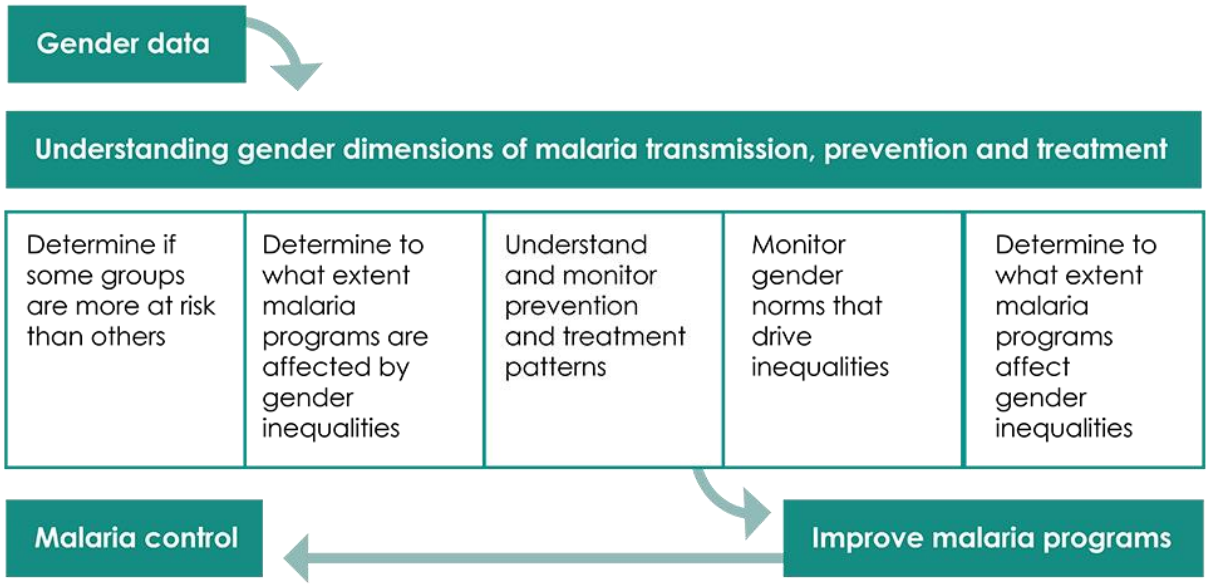
You learned about data sources for malaria SME in previous. Here are examples of gender data collected from multiple data sources.

Figure 38. Sources and types of gender data

Use of Data for Decision Making

You now have an idea of how gender influences risk of malaria transmission and access to and uptake of malaria prevention and treatment. To better control malaria and continue moving toward eradication, gender must be taken into account when designing and implementing malaria prevention and treatment interventions. Gender data can help malaria programs target populations and intervention approaches.

Figure 39. How gender data support malaria programs



Like all data, gender data should be used to make decisions and guide programming. Here are some examples of questions that can be generated and answered by gender data:

- Are the "right" populations being targeted for prevention and treatment services? Who is being missed?
- Might there be malaria transmission occurring among populations that are not targeted?
- Are the "right" populations accessing malaria prevention and treatment services?
- Do different characteristics (sex, age, etc.) necessitate different prevention intervention approaches?
- Do different characteristics (sex, age, etc.) necessitate different treatment intervention approaches?

If you have malaria gender data, use these data along with your work in the tables in the previous sections to help you answer these questions for your context.

If you do not have adequate data, make a list of the gender data you need to help you answer these key questions.

Module 12 Assessment

Questions

Correct answers are provided on the next page.

1. Gender is best defined as:

    a. The biological difference between females and males
    b. A culturally defined set of roles, responsibilities, rights, entitlement, and obligations associated with being female and male
    c. Power differences between men and women
    d. The characteristics of women and girls vis-à-vis men and boys

2. Gender influences which aspects of malaria control:

    a. Risk of malaria transmission
    b. Quality of diagnostics
    c. Use of ITNs
    d. a and c
    e. a, b, and c

3. Which of the following is an example of a gender indicator?

    a. Proportion of children under five with fever treated with artemisinin-based combination therapy within 48 hours
    b. Proportion of mothers of children under five who make decisions independently about when to seek care for a sick child
    c. Percentage of mothers of children under two who received at least two doses of IPTp at antenatal care
    d. Percentage of households with at least two ITNs

4. *True or false:* Women in village X must get permission from their husband or head of household to travel outside of the village. This is a gender-related barrier to access to malaria treatment.

    a. True
    b. False

Correct Answers

Correct answers are noted in bold.

1. Gender is best defined as:

   b. A culturally defined set of roles, responsibilities, rights, entitlement, and obligations associated with being female and male

2. Gender influences which aspects of malaria control:

   d. a and c

3. Which of the following is an example of a gender indicator?

   b. Proportion of mothers of children under five who make decisions independently about when to seek care for a sick child

4. *True or false:* Women in village X must get permission from their husband or head of household to travel outside of the village. This is a gender-related barrier to access to malaria treatment.

   a. True

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