Building a gender responsive framework for malaria elimination in Asia-Pacific

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Since 2010, the Asia-Pacific region has made significant strides towards malaria elimination with a 63% decline in cases and 87% decline in deaths. Despite this, 300 million people continue to remain at high-risk.1 Increasingly, it is a disease of the rural poor and vulnerable communities. While history has shown that malaria can be eliminated without a gendered approach, applying the lens of gender in health programming can have the dual effect of improving outcomes while furthering gender equality. Across Asia-Pacific, collective understanding gender’s role in malaria programming is underdeveloped. A gender-based perspective to planning, monitoring, and implementation can help address potential biases in program design and evaluation.

Data reported by Asia-Pacific countries show that the malaria prevalence is higher among males due to the nature of their work in fields and forests.2 Given that outdoor transmission poses challenges for malaria elimination in Asia-Pacific,3 women, too, are at risk of contracting malaria through outdoor work such as cooking, collecting water, fuel, and agriculture-related activity. Gender-related social and cultural norms influence exposure to malaria and access to services. For example, women may lack information, agency, and the economic means to seek malaria services.4 Evidence also suggests that pregnant women face a disproportionately higher risk of malaria due to reduced immunity.5 Gender-based physiological differences underpin the need for gender responsive strategies, particularly in communities where both men and women are susceptible to malaria parasites. There are three areas which could benefit from a more intentional gender-based approach.

First, is data and research that informs programmatic design and delivery. Sex and age disaggregated data on malaria in the Asia-Pacific region is necessary to accurately identify vulnerable groups and inform targeted interventions. For example, in Papua New Guinea, incidence of morbidity is highest in children, and similar for men and women,6 whereas in the Greater Mekong Subregion, malaria is concentrated among mobile migrant workers, mostly young males.7 Malaria messages should be developed targeting different at-risk groups. Women are often primary caregivers; tailored messages for women, could lead to greater acceptance of community-based interventions. Bangladesh, plans to design Information Education Communication (IEC) activities to promote equity in accessing malaria services.8 Malaria programs in Asia-Pacific could consider including age and gender-specific indicators in dashboards and monitoring frameworks. There is a need to deepen our understanding of the intersection of gender, access, and interventional design.

Second, malaria programs should adopt interdisciplinary approaches across other health programs. Historically, malaria programs have remained vertical, where services are malaria specific. Malaria interventions such as Intermittent preventative treatment during pregnancy (IPTp), LLIN distribution and malaria screening for pregnant women can be better delivered in tandem with existing efforts. Malaria programs can leverage the maternal and child health services network to reach pregnant women and children. Several countries in the region have adopted this approach to protect pregnant women and infants better. Long Lasting Insecticidal Nets are distributed to pregnant women during Antenatal Care (ANC) visits. Pregnant women are also screened for malaria during ANC visits in some countries.9 Integration of malaria services with maternal and child health services in Bangladesh, Solomon Islands and Myanmar have led to an increase in ANC attendance.5,10,11 Bhutan is implementing Gender Responsive Planning and Budgeting to address gender gaps in the health, education and agriculture sector.12 These integrated approaches should be further documented.

Third, engage women in decision-making and malaria research. While women comprise 75% of the health workforce, they are underrepresented in leadership and research positions.13 Gender barriers to career

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development lead to the underrepresentation of women scientists in malariology, which in turn impacts the research agenda. Involvement of women in health research promotes inclusion of gender and sex analysis in research. #WomenInMalaria initiative celebrates the contributions of women in the field of malaria. Clinical trials have also seen limited enrolment of women due to socioeconomic and cultural factors; there has been active exclusion of pregnant women from clinical trials due to risks, complexities and cost. This results in limited options of safe and effective drugs for pregnant women. Medicines for Malaria Venture’s initiative ‘Malaria in Mothers and Babies’ focuses on promoting the safe inclusion of pregnant women into clinical studies. Such initiatives should be encouraged.

Improving service delivery means patient-centered care - understanding how to tailor solutions for the end user. By applying greater focus on gender responsive strategies, Asia Pacific can not only improve the region’s ability to reach the end goal of malaria elimination by 2030, it will advance achievement of SDG 5 by providing equitable access to health services for women in our collective efforts towards equity and inclusion.

Contributors
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Declaration of interests
All authors have no conflict of interest to disclose.

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