MALARIA CONSORTIUM

LEARNING **BRIEF**

Mainstreaming gender and youth in malaria programming in Uganda

Key learning

- Gender and youth dynamics and norms play a key role in determining the health outcomes of women, men and the youth.
- Gender- and youth-related barriers to health seeking, decision-making and resource allocation can best be addressed through adequate training of healthcare staff, support to parents, youth and women's empowerment initiatives, and equal access to resources.
- The successful integration of gender and youth issues in malaria programming requires institutionalizing mainstreaming in policy planning and development.

Background

In Uganda, malaria accounts for over 20 percent of outpatient visits, 19 percent of inpatient admissions and over 3,000 deaths each year. More than 95 percent of the country has stable malaria transmission, with malaria infections occurring all year round.[1]

While malaria affects both men and women of all ages, gender and youth dynamics and norms play a key role in determining health outcomes. Women and girls are often unable to promote and protect their health in the same way as their male counterparts. According to the World Health Organization, gender norms, roles and behaviors significantly influence how women, men, girls and boys react to health challenges, access health services and how health systems respond to their needs. Gender roles and dynamics may give rise to different vulnerabilities, including exposure patterns to disease, response to ill health, access to support and services, and health outcomes and consequences.[2,3] A thorough understanding of youth- and gender-related dynamics of health seeking, decision-making and resource allocation within households and the wider society and their integration into programming is, therefore, critical for effective malaria control and prevention.[4]

Though much has been published on the need for gender and youth integration and mainstreaming, and how this may be achieved, there is still a gap between intention and practice — few national health programs have integrated gender into their objectivities and activities, and this is particularly true of malaria programming.[5] Similarly, research aimed at obtaining and generating gender- and youth-related data to improve health programming and health provider training remains limited. This learning brief, therefore, aims to provide guidance and share learning with malaria programs in Uganda and sub-Saharan Africa on integrating measures that address these barriers.

Program activities

In support of Uganda's National Malaria Control Strategy, USAID's five-year Malaria Action Program for Districts (MAPD) seeks to reduce maternal and childhood morbidity and mortality due to malaria. It also aims to develop the national and district health authorities' capacity to plan, manage and sustain efficient malaria control activities in focus districts. Core activities include promoting malaria in pregnancy (MiP) services at health facilities, and improving health workers' diagnosis and treatment practices to enable them to provide quality services to patients.

Malaria Consortium is providing overall technical direction and oversight, programmatic and representation leadership, as well as coordination of project partners to facilitate these aims. Within this role, and together with Banyan Global, we conducted a qualitative study to identify how gender- and youth-related norms might be hindering effective malaria control in Uganda. This comprised a literature review; key informant interviews at national, district and local levels; and focus group discussions with community members in six districts located in the West Nile, central and mid-western regions of Uganda.

Results

Our study revealed four critical gender- and youth-related norms and barriers and the mitigation approaches necessary to combat them.

1. Men are typically the heads of households, putting them in control of the decisions and resources needed to access malaria services. They are also less likely to perceive themselves to be at risk of contracting malaria and are, consequently, less likely to take the necessary precautions to prevent infection or to seek timely treatment. As key decision makers, it is imperative that men receive accurate malaria-related information (e.g. on transmission at the household level and their role in preventing it, the economic risk of malaria and the dangers of delayed health seeking) through effective and relevant channels, such as community dialogues. Exposing them to activities that foster joint decision-making at the household level and encouraging trust in women's ability to make decisions is key.
2. Because of the stigma surrounding teenage pregnancy, pregnant adolescents often experience discrimination or rejection at the hands of parents and health workers. As a result, young girls often conceal their pregnancies. This delays health seeking and, therefore, hinders their access to antenatal care (ANC) and MiP services. It is important to develop interpersonal communication skills among health workers to equip them to accept, counsel and support pregnant adolescents. Similarly, providing parents with information on how to support their children through pregnancy for better health outcomes, and on the dangers of malaria to mothers and unborn babies, is crucial to improving healthcare access among pregnant youths.
3. Healthcare services may not be affordable or appropriate to women and adolescents, which limits their access to preventive malaria services and delays treatment. Advocating for the availability of free medical supplies in public health facilities would not only improve access to those with limited resources, but also give them greater control over their health decisions. Another approach is integrated community case management, which could be an effective, equity-focused way to address gender- and age-related barriers, by extending core malaria services to individuals who may be unable to access facility-based care.
4. Parents or guardians, teachers, employers and spouses often act as gatekeepers of adolescents, controlling their mobility, access to information and decision-making. Additionally, not being viewed as productive members of society means adolescents are often not involved in planning, implementing or participating in community interventions, particularly those on malaria. Early mobilization around malaria events would give young people time to negotiate their participation and movement. Engaging in community initiatives would further allow them to tap into their potential as agents of change and empower them to make meaningful contributions to decision-making on malaria control in their communities.

Lessons Learnt

We incorporated the above results and mitigation approaches into planning and implementation of the USAID MAPD project. Here, we share what worked.

- We drew on gender- and youth-related issues to inform our drafting of information briefs and actions specific to malaria control, which we integrated into project materials and standard operating procedures. Information briefs and actions were also shared with key stakeholders at district level, and with community leaders, community health workers and district health management teams (DHMTs) for inclusion and use in routine tasks. These activities were critical for standardizing processes, and creating awareness and buy-in of mainstreaming among stakeholders.

- Various tools were developed to support, monitor and measure the progress of gender and youth mainstreaming in the project. One example is the Gender and Youth Responsive Community Dialogue Guide, which tackles issues of masculinity and decision-making and attitudes towards adolescent pregnancy through community discussions. Conversation starters — in the form of stories and pictures — highlight the negative effects of inequitable gender and youth practices on decision-making and resource access relating to malaria. At the end of the sessions, participants agree on actions to change the malaria situation in their community.

  We found that conversation starters facilitated transformative discussions around norms on masculinity that would otherwise be challenging to talk about, and showed participants how these norms lead to suboptimal health decisions that affect all family members. In several dialogues, male participants aimed to become more actively involved in the health of their households and to give women greater agency in decision-making, to avoid delays in seeking malaria care. Participants also agreed that it was important to empower women, increasing their control and decision-making over resources. In community dialogues with parents of adolescents, participants' discussions focused on giving pregnant adolescents a second chance and helping them access ANC and other malaria services. These dialogues often resulted in universal agreement to support pregnant adolescents, end child marriages, combat malaria and encourage their daughters' ambitions.

- Advocating for the availability of key malaria commodities at health facilities to increase access to free quality malaria prevention, diagnosis and treatment services to women and youth in need was facilitated through engagement with technical working groups at the Ministry of Health, National Medical Stores and DHMTs. We further supported health facilities and districts to make more accurate medicine and commodity quantifications and requests.

- Training project staff on how to integrate issues of gender and youth into malaria programming was essential to mainstreaming activities. This enabled them to form a common understanding of these issues, underlying concepts and theories, allowing for standardized implementation across regions. Training included real-life case studies and modules exploring the thought processes behind teenagers' decision-making. Such insights inform approaches to interpersonal communication between people in authority and the youth. A similar approach was used to train and sensitize health workers, community leaders and DHMTs in the project districts. Participants were receptive of the training and expressed willingness to integrate youth and gender components into their routine work.

- Through the project, we worked with the DHMTs to form community-based malaria youth initiatives to mobilize, organize and motivate young people to tackle malaria in their communities. These initiatives help identify and mentor 'youth champions', providing them with skills, knowledge and resources on malaria prevention and control in their households and communities. Participants also organize community events like village football tournaments, which function as arenas for discussion. These initiatives have given young people a platform to voice their opinions, lead on identifying malaria issues and drive community solutions.

A female participant shares her thoughts on the effects of early marriage on malaria in pregnancy during a USAID MAPD community dialogue in Lyantonde district

Recommendations

We believe the following recommendations will be useful for malaria control programs and practitioners alike in Uganda and sub-Saharan Africa to improve access to interventions among vulnerable women, men and young people and — ultimately — to reduce malaria morbidity and mortality.

Ministries of Health should:

- address gender and youth integration in national strategic plan development to allow for adequate resourcing of related interventions
- develop, adapt and disseminate a supportive policy, including appropriate tools, on the mainstreaming commitments in strategic plans
- ensure proper segmentation of the population so that national-level social and behavior change (SBC) messages aimed at men, women and the youth are disseminated using relevant channels
- involve relevant government sectors, departments and ministries in the planning and implementation of gender- and youth-related activities in malaria control.

Implementing partners should:

- adhere to and ensure delivery of gender and youth mainstreaming commitments provided for in the strategic plans
- develop the capacity of staff, government and private health service planners and providers to competently deliver gender and youth mainstreaming in malaria programming, in line with national and district plans and mainstreaming best practices.

Districts should:

- provide sensitization training and mentorship to health workers at all levels, including midwives, to help them better understand, accept, support and provide services to young people, pregnant adolescents and parents/caregivers
- routinely identify local norms and behaviors that expose men, women or young people to malaria infection and use these to develop SBC communication strategies and messaging
- demand accountability from partners and other stakeholders regarding planning and implementation of gender and youth integration interventions
- prepare gender- and equity-responsive budgets to ensure resources are available to address gender- and youth-related barriers to malaria service provision and access in accordance with financial regulations.

Health facilities, local health workers, key influencers and other community workers should:

- educate men visiting outpatients and other clinics on issues relating to gender and youth, such as the economic costs (financial and time) of malaria, and malaria prevention and control
- collect relevant data (e.g. sex, age, residence, etc.) to inform progress in malaria control intervention programming and implementation relating to gender and youth
- visit households where pregnant women and adolescents reside and encourage them to utilize ANC services
- engage women and other decision makers (including parents, spouses, employers, siblings, etc.) on women's and adolescent health — in particular, the role of ANC and preventing malaria during pregnancy.

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UK Registered Charity No: 1099776

Contact: info@malariaconsortium.org

Cover image: A woman and child reached by the USAID MAPD project.

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