



Technical Brief

Equity, Human Rights, Gender Equality and Malaria

Allocation Period 2023-2025

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Introduction

The new [Global Fund Strategy](#), “Fighting Pandemics and Building a Healthier and More Equitable World (2023-2028)”, puts greater focus on reducing health inequities, sustainability, program quality and innovation. It highlights the need to take action to tackle equity-, human rights- and gender-related barriers and make catalytic, people-centered investments to enable progress against malaria while contributing to the SDG target of achieving universal health coverage. It is aligned with global efforts set under:

- The World Health Organization Global Technical Strategy for Malaria (2016-2030)¹;
- The RBM Partnership Strategic Plan 2021-2025;² and
- The Action and Investment to Defeat Malaria (AIM) 2016-2030³

To accelerate progress toward the 2030 malaria goals, countries need to increase the efficiency and effectiveness of malaria interventions ensuring they are people-centered, human rights-based, gender-responsive, sub-nationally tailored, and adapted to local contexts. Understanding malaria epidemiology and population needs in a country or sub-region is a critical component in programming to enable proper selection and targeting of interventions for improved impact. Too often, the people most vulnerable to malaria are the same people with limited or without access to necessary health care because of varying population needs, geographic, socio-economic, and cultural differences, as well as equity-, human rights- and gender-related barriers. Similarly, malaria can also exacerbate inequality, impoverish people, make them more vulnerable to human rights violations, and most likely to suffer the catastrophic consequences of poor health.

The purpose of this technical brief is to provide guidance to Global Fund applicants in their efforts to ensure that malaria programs, interventions and activities include measures to remove equity-, human rights- and gender-related barriers to services. It can be used by Country Coordinating Mechanisms (CCMs), program managers, partners, implementers, advocates, civil society and communities.

In addition to this document, applicants are encouraged to consult the resources listed below for further guidance when developing Malaria funding requests:

- [Applicant's Handbook](#): How to develop a funding request.
- [Funding Request Instructions](#): To complete the Application Form.
- [Modular Framework Handbook](#): Global Fund supported interventions and indicators.
- [Malaria Information Note](#): Guidance on preparing Malaria Funding Requests.
- [Technical briefs](#): Additional guidance on critically enabling cross-cutting areas

¹ [Global technical strategy for malaria 2016–2030](#). World Health Organization, 2021.

² [RBM Partnership Strategic Plan 2021-2025](#). RBM Partnership to End Malaria, UNOPS, 2020.

³ [Action and Investment to Defeat Malaria](#). RBM Partnership to End Malaria, WHO, 2015.

1. Human Rights-based Approach

The highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, ethnicity, political belief, economic or social condition or any other status.^{4,5} A rights-based approach to malaria requires that malaria policy and programs prioritize the needs of those furthest behind first towards, greater health equity, ensuring that all people have access to the malaria prevention and treatment services they need, when and where they need them in line with the 2030 Agenda for Sustainable Development⁶ and Universal Health Coverage⁷.

To guide its investments, the Global Fund has developed an ambitious [new Strategy](#) to get progress back on track in the fight against malaria and contribute to the target of achieving universal health coverage. This new Strategy guides the Global Fund to take determined action to tackle human rights- and gender-related barriers and leverage the fight against the three diseases to build more inclusive, resilient and sustainable systems for health better able to deliver health and well-being and to prevent, identify and respond to pandemics.

This commitment means ensuring that programs supported by the Global Fund provide available, acceptable, accessible and high-quality services to all, and that they do not violate human rights. Malaria programs are encouraged to integrate human rights principles – participation, equity, accountability, and transparency – throughout the grant cycle, and into the policy-making process.

All grant agreements signed by the Global Fund are expected to meet the following [five human rights standards](#):

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

⁴ [WHO Constitution](#). World Health Organization, 1964.

⁵ [Human Rights Principles](#). UNFPA, 2005

⁶ [The 17 Sustainable Development Goals](#). United Nations, Department of Economic and Social Affairs.

⁷ [Universal Health Coverage](#). World Health Organization, 1 April 2019.

2. Program Essentials

For many countries, addressing equity, human rights and gender-related barriers to malaria prevention and treatment is a new focus. Aligning with the new 2023-2028 Global Fund Strategy and our collective goal of ending the malaria epidemic by 2030, the funding model has been refined to improve its focus on health equity, gender equality, and the removal of other human rights-related barriers to malaria services.

In the 2023-2025 allocation period, the Global Fund has incorporated Program Essentials within all aspects of its investment. Program Essentials are a set of standards for the delivery of services by programs supported by the Global Fund. They are based on the recommendations of the WHO and other technical partners and used to ensure the quality delivery of health services. Applicants are expected to consider the Program Essentials as important levels of success toward malaria elimination, and plan for taking them to scale throughout the grant lifecycle.

For Malaria Funding Requests, applicants must **ensure that sub-nationally tailored planning considers factors beyond malaria epidemiology such as equity- human rights-, gender-related barriers, and the important sociocultural, economic and political factors influencing individual and population-level risk, and access and engagement with health services.**

Applicants should consider how best to tailor strategies, interventions, implementation methodologies and surveillance to respond to vulnerable populations and address equity-, human rights- and gender-related barriers to services. Planning, design, implementation, monitoring and evaluation of malaria programs must integrate human rights and gender-equality norms and principles, including non-discrimination, transparency and accountability, with full participation of vulnerable populations. This approach calls on applicants to focus on:

- Delivering people-centered, integrated, inclusive and comprehensive interventions;
- Delivering interventions aligned to the needs of individual and their communities;
- Empowering affected and vulnerable populations; and
- Expanding access to quality services.

3. Assessments

When developing funding requests, applicants will be required to describe how Global Fund-supported programs will (a) maximize human rights; (b) maximize gender equality; (c) maximize health equity; and (d) maximize the engagement and leadership of most affected communities.

Responding to these questions will require an understanding of (i) malaria epidemiology and the populations most impacted by malaria and (ii) the equity, human rights, gender barriers to health services and health outcomes. If recent relevant assessments are not already available to support with a response to these questions, applicants should undertake an assessment using the **Malaria Matchbox** or similar tools,⁸ and are requested to attach country-specific human rights and gender assessments as annexes to the funding request, if available. Where not available, an assessment should be conducted as a foundational activity in the allocation period or aligned with the next National Strategic Plan (NSP) revision or malaria program review (MPR).

The Malaria Matchbox Toolkit

The [Malaria Matchbox](#) is an equity assessment tool, designed to support the identification of populations or individuals most affected by malaria and underserved by malaria interventions, as well as the key equity- human rights- and gender-related barriers disproportionately affecting malaria outcomes in those populations. Conducting the Malaria Matchbox assessment will enable countries to progress towards achieving equity in malaria programming across the continuum, from control to elimination, through identifying risk factors and key barriers impeding equitable, inclusive, and integrated people-centered malaria programs, as well as generating recommendations on how to address them.

It is important for malaria programs to ensure that after identifying and understanding existing barriers to malaria services, they collaboratively develop evidence-based actions to remove the barriers and fully integrate the costed actions within the national strategies, malaria programs and their implementation.

Where exploration on equity gaps is still needed, undertaking the Malaria Matchbox can be included in the Funding Request. Applicants requesting support to conduct these assessments should include plans in their application for how the findings from these assessments will be used during the period of the grant implementation to inform tailoring of interventions. Qualitative assessments and studies on underserved groups and access barriers to malaria interventions, including the use of the Malaria Matchbox, should be included under the RSSH module on “Monitoring and Evaluation” and the intervention “Analysis, evaluations, reviews, and data use.”

⁸ [Malaria Matchbox](#), [EQUIST](#), [WHO's Innov8 Technical Handbook](#), and [HEAT](#).

4. Programs to Reduce Barriers to Malaria Services

In order to reach the global malaria targets and end the epidemic, countries will need to scale-up sub-nationally tailored, gender-responsive and, where appropriate, gender-transformative programming, reduce inequities in access to services and health outcomes, and significantly expand coverage of comprehensive programs to remove human rights- and gender-related barriers.

Key programs to address equity-, human rights- and gender-related barriers include:

1. **Reducing gender-related discrimination and harmful gender norms**
2. **Promoting meaningful participation of affected populations**
3. **Strengthening community systems for participation**
4. **Monitoring and reforming laws, policies and practices**
5. **Improving access to quality services for underserved populations**

4.1 Reducing gender-related discrimination and harmful gender norms

Achieving gender equality, where everyone has an opportunity to attain their full health and wellbeing without being disadvantaged due to gender norms, roles and relationships, will enable countries to progress towards their malaria goals and accelerate malaria elimination.

Inequality and discrimination based on sex and gender identity influence an individual's access, engagement and experience with health services. The forms and effects of gender inequality are different for men, women, boys, girls and gender-diverse communities. Societal expectations of appropriate gender roles and power dynamics based on gender norms, can influence the risk of malaria infection, access to services, prevention and control interventions, and the distribution of the burden of malaria morbidity and mortality.⁹ Inequality is deeply entrenched in harmful cultural norms, attitudes, beliefs and practices, as well as in retrogressive laws.

- Examples of gender-specific vulnerabilities for women and girls include unequal access to educational and economic opportunities, spousal or parental consent to access health care, as well as occupational exposure to malaria.
- Boys and men also experience gender-related health vulnerabilities, with norms of masculinity often resulting in poor health-seeking behaviors, and engaging in social and occupational activities that put them at risk of malaria infection.

⁹ Addressing gender inequalities and strengthening responses for women and girls: Information Note. The Global Fund, 2014.

To improve health outcomes and access to malaria services, it is essential that countries develop or adapt approaches throughout the entire grant cycle. As part of the next Funding Request, Global Fund applicants are advised to describe how:

- Gender inequalities, norms, roles and relations have been considered, including intersectional forms of discrimination based on age, ethnicity and sexual orientation, and what measures have been taken to actively address them.
- Interventions will be implemented, monitored and evaluated using disaggregated data ([see M&E](#)) and data on how all genders at risk of infection or severe health outcomes, and with identified barriers to service access and use.
- Programs and interventions are designed to be, at a minimum, **gender responsive**, and ideally **gender-transformative** to transform gender-related barriers.

Gender-responsive approaches: a minimum expectation for malaria programming

Gender-responsive programs are programs where gender inequities, norms, roles, relations, power dynamics and inequalities have been considered and measures have been taken to actively address them. This means tailoring programs to ensure that everyone is reached with quality and appropriate prevention, treatment and care services with full participation and consideration of vulnerable groups. It also means that programs include a set of feasible, measurable and disaggregated targets and indicators ([see M&E](#)). Examples of gender-responsive programming and actions can be found in the Global Fund's [Gender Equality Technical Brief](#).

Transforming Intermittent Preventive Treatment for Optimal Pregnancy (TIPTOP)¹⁰:

Adolescent girls are particularly vulnerable to malaria. In many sub-Saharan settings, adolescents are often parasitaemic and anemic when they first become pregnant. Moreover, societal stigma results in pregnant adolescents being least likely to use antenatal care (ANC). A gender responsive program, for example, would aim 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 second trimester to enable adolescent girls access the services.

Multiple countries including the Democratic Republic of the Congo, Madagascar, Mozambique and Nigeria successfully piloted community delivery of intermittent preventive treatment during pregnancy, aiming to reach the hardest to reach, reduce missed opportunities for eligible pregnant women to receive IPTp and to provide evidence on its safety and effectiveness, while maintaining or increasing ANC attendance.

Subsequently, the updated WHO (2022) recommendation no longer limits the delivery of IPT-SP to antenatal care (ANC) contacts. Where inequities in access to ANC services exist, other delivery methods, such as the use of community health workers, may be explored¹¹.

¹⁰ [TIPTOP: Advancing prevention of malaria in pregnancy.](#)

¹¹ [Updated recommendations for malaria chemoprevention among children and pregnant women.](#) World Health Organization, 2022.

Addressing Gender Norms in ITN Use¹²

All people have a right to protection from malaria through the full range of prevention methods, including use of ITNs. 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 ITNs. As a further example, it was found in one location in western Kenya that in the middle of their pregnancies, women would sleep on the floor with the children rather than in bed with their husbands and would thus lose the benefit of the ITN on the couple's bed¹. In this case, antenatal service providers were trained to promote ITN use and were equipped with free ITNs to distribute to pregnant women.

Gender-transformative approaches: a necessary next step for malaria programming

In many cases, programs will need to go further and take a gender-transformative approach to effectively address the underlying factors that contribute to malaria. Gender-transformative approaches recognize how harmful gender norms and stereotypes, inequalities in power and control over resources, discriminatory laws, policies and practices impact people of all genders' vulnerability, and take concrete actions to counter or change them. Transformative approaches address the causes of gender-based health inequity and include ways to transform harmful gender norms, roles and relations and foster equal power relationships between people of all genders by promoting meaningful participation, decision making and empowerment. Examples of gender transformative programming can be found in the Global Fund's [Gender Equality Technical Brief](#).

Addressing Gender Aspects of Indoor Residual Spraying (IRS)¹³

The success and coverage of IRS programs for malaria control depends partly on gaining the trust and acceptance of households and communities. 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 teams. Mainstreaming gender equality in vector control through training and employing women as sprayers and IRS promoters was an effective program conducted in 24 sub-Saharan African countries with support from PMI. This intentional approach resulted in improving access in several countries where the female sprayers had greater access to households than male sprayers, previously limited by cultural norms preventing access to a household by a male sprayer when the male head is away from the home. In many cases, the women also served as credible sources of malaria prevention information for other women in the communities, resulting in increased uptake of IRS and other malaria-prevention measures.

¹² [A Guide to Gender and Malaria Resources](#). RBM Partnership to End Malaria.

¹³ [The Case for Investing in a Gendered Approach to the Fight Against Malaria](#). RBM Partnership to End Malaria, 2021.

4.2 Promoting meaningful participation of affected populations

A key feature of rights-based approaches is meaningful participation. Participation means ensuring that national stakeholders – including communities, health service users and non-state actors – are meaningfully involved in all phases of programming: assessment, analysis, planning, implementation, monitoring and evaluation. It is critically important that the most vulnerable and disadvantaged populations are engaged, as their perspectives and lived experiences can provide useful insight into what works and how to effectively cover those who have been left behind.

Community participation is an essential element in malaria programming for both malaria control and malaria elimination. Communities are often best positioned to not only identify barriers to their health outcomes, but to also guide and implement health programs to effectively respond to their diverse needs. Applicants need to explicitly specify how they will proactively identify and comprehensively include high-risk and underserved populations and their leadership in decision making and prioritization. Community participation should ensure fairness and inclusivity, provide legitimacy to the decision-making process, and ensure sustainability.

Barriers that may prevent meaningful participation of communities should be identified and addressed, including efforts made to ensure that known hard-to-reach stakeholders have reasonable opportunities to participate. Although there is no “one-size-fits-all” community engagement strategy, community engagement must be a bidirectional activity, and community members must be at the heart of malaria control and elimination efforts.¹⁴

Applicants should demonstrate community engagement on their Country Coordinating Mechanisms (CCMs) which can be through inclusion of CCM members who represent targeted communities, establishment of CCM sub-committees for at risk and underserved populations and engagement by the CCM with high risk and underserved populations.

[The Funding Request Priorities from Civil Society and Communities Annex](#) must list the needs and requests identified during funding request development, and whether these were prioritized for inclusion under Allocation Funding or the Prioritized Above Allocation Request (PAAR).

¹⁴ [The 2019 Isdell:Flowers Cross Border Malaria Initiative Round Table: community engagement in the context of malaria elimination.](#) Malaria Journal, 19 December 2019.

Table 2: Common Features of Effective Community Engagement¹⁵

Underlying principles	Descriptions	Operational Strategies	Descriptions
Trust and transparency	Trust is critical to community engagement. To build trust, there needs to be a prolonged interaction between health promotion professionals and the community to enhance empathy and understanding. The accumulation of beneficial acts and results may also strengthen trust. Community engagement puts the community first and central to the planning and implementation of activities.	Decentralized program management and service delivery	Effective community engagement involves moving decision-making away from centralized control and closer to the users of health services. This requires strengthening the links between communities and the local health units. Feedback loops that go from communities, through local health units, to national-level policy making and back to communities can support this process.
Proactive, continuous, and integrated engagement	Proactive and continuous community engagement that is integrated with other health and development priorities makes a bigger impact and it should not be conducted as a one-off activity.	Alternative, community-centered delivery pathways	CHWs, including volunteers, and private providers, are in a unique position to facilitate community engagement strategies and strengthen linkage between communities and the health system.
Adaptable, responsive and local action	To be effective, community engagement and associated tools should be flexible and responsive to local populations' needs, concerns and local context.	Social and behavior change communication (SBCC)	SBCC and community engagement are mutually supportive processes. Responsive and accessible SBCC facilitates bi-directional dialogue, participation and engagement among stakeholders to support social and behavior change.
Collaboration and shared decision-making	Effective community engagement treats the community as partners and works with stakeholders to identify problems and implement solutions. Communities are involved in decision-making processes including program planning, implementation, monitoring and evaluation.	Participatory methods	Participatory approaches are based on shared ownership of decision-making and encompass a range of different methods and activities. There are a range of methods, including participatory action research (PAR) and human-centered design (HCD), that can guide program strategies and activities.
Inclusion and representation	Community engagement is a multi-stakeholder process. To identify under-represented issues, perceptions, barriers to participation and solutions, efforts should be made to establish balanced community representation, including of minority and/or marginalized sub-groups.		

¹⁵ Adapted from [Implementing effective engagement for malaria control and elimination](#). Malaria Elimination Initiative, May 2020.

Malaria programs should not confuse meaningful participation of communities with providing information to the community or implementing community-based interventions. For community participation to be successful, it should ensure early involvement and dialogue with underserved and high risk-populations, frequent feedback and active community participation.

Malaria interventions are effective only if they are accessible, acceptable, available, of good quality, and properly used within communities. Therefore, the meaningful participation of communities is critical and an essential component as countries shift to creating local and site-specific solutions towards achieving malaria elimination. In countries that have successfully decreased their malaria burden, cases often start to cluster in smaller geographic foci and among subpopulations with unique risk characteristics. Active community engagement is critical to ending malaria in all settings, and of even greater importance where programs are working with populations that have historically been seen as marginalized or 'hard-to-reach' by programs and in communities where the perceived risk of malaria diminishes.

Case Study: Community Engagement to Address IRS Barriers in Uganda¹⁶

In Uganda, IRS has proven to be a very effective malaria prevention strategy and has rapidly reduced malaria out-patient attendances, in-patient case admission and malaria test positivity rates. However, successful IRS requires high coverage emphasizing the importance of community acceptance.

A rapid assessment revealed potential barriers such as spreading of misinformation regarding IRS, and inadequate duration of engagement with the community at each phase, resulting in communities and families resisting spraying of their homes, particularly during COVID-19.

Recognizing that religious leaders have the potential to promote and sustain positive change in the community through their well-established outreach and community programs, PMI Vector Link Project organized community dialogues and meetings with key religious, cultural, and opinion leaders. A total of 102 faith leaders in Uganda were engaged to improve acceptance of malaria control interventions including IRS. These leaders were trained on the benefits of IRS and ITNs, community mobilization and advocacy techniques, and enlisted for their support in promoting IRS and supervising its implementation in their respective communities.

In collaboration with District Health Educators and District Health Team members, district dialogues were conducted in selected communities that had previously achieved low IRS coverage. Dialogues enabled the community to ask questions about IRS, understand its benefits and discuss their concerns and fears. As a result, fears and concerns around IRS were allayed and SBC materials were adapted, increasing IRS acceptability.

¹⁶ [Ugandan Faith Leaders Promote Insecticide Spraying Amidst COVID-19](#). U.S. President's Malaria Initiative, 9 September 2020.

4.3 Strengthening community systems for participation

Community systems strengthening (CSS) supports the development of informed, capable, and coordinated communities, and development of community-led and community-based organizations, groups, and structures, to advance health and equity in efforts against malaria. In the 2023-2025 funding cycle, the Global Fund prioritizes funding for four interventions of community systems strengthening, as described in the [CSS Technical Brief](#):

- **Community-led monitoring:** independent accountability mechanisms designed, led, and implemented by local community organizations that work closely with recipients of care and key and vulnerable populations.
- **Community-led research and advocacy:** activities to inform and support advocacy designed and led by community organizations, networks, and civil society actors, especially advocacy led by marginalized, criminalized, under-served and vulnerable populations.
- **Capacity building and leadership development:** activities that support the establishment, strengthening, and sustainability of community-led organizations to provide and improve health services and other programming to address HIV, TB, and malaria
- **Community engagement, linkages and coordination:** Activities to create an interlinked and coordinated system of community-based and community-led programs and services that engage, inform, and deliver services to people in key and vulnerable populations and others not benefitting from health programs

CSS in malaria is aimed at engaging and establishing roles for the most-at-risk and underserved populations and community organizations or networks. Community action through raising awareness of equity-, human rights- and gender-related barriers is fundamental. In the Funding Request, applicants should indicate how community systems will be strengthened to empower communities to meaningfully engage in planning and delivering equitable, rights-based and gender-responsive programs. Proposed interventions and activities should be included under the “Removing human rights- and gender-related barriers” module of the Modular Framework. An additional [Decision-Making Tool for Community Systems Strengthening Interventions in Global Fund Grants](#) has also been developed to support the conceptualization and design of effective CSS interventions for malaria to include in your Funding Request.

Case Study: Peer Learning and Education Approach on Malaria Prevention (PLEA-malaria) Through Primary Schools' Communities in Rural Ethiopia¹⁷

The development of the SBCC program was informed by evidence from formative qualitative research conducted in the area to explore the local malaria situation, community needs and to map key stakeholders in the area. Various data collection techniques including in-depth interviews (IDIs) and a document review were employed to collect rich data. The purpose was to explore malaria-related beliefs, threat perceptions, preventive practices, opportunities, organizational appropriateness and barriers for malaria preventive practices in the community and schools. The findings were then used as the baseline to design the school-based malaria SBCC strategy. The goal of the program was to empower schools, local stakeholders and the community to cooperatively design, implement and evaluate the key malaria preventive actions that include sustained use of ITNs, appropriate and timely access to malaria services, appropriate use of anti-malaria drugs, acceptance of IRS, and mosquito breeding habitat modifications.

A key success was the empowerment of students to act as health messengers to disseminate malaria preventive information to parents and neighbors. Students reached by the school-based malaria education program took a post-test before they were sent to teach their parents, neighbors, and community members. The peer education activities were aided by manuals and various health learning materials such as flip charts, leaflets, and posters with persuasive messages. Further, various educational and communication activities such as social dramas, campaigns, and role-plays were conducted within schools and in the nearby communities. The school-based malaria PLEA-malaria was people-centered and integrated well into the existing primary health care activities, increasing acceptability of the program by peer educators. This study recognized that embracing child-centered and child-empowering approaches through meaningful participation provides children an opportunity to express their interests and play active roles in impactful malaria control and elimination efforts.

While all four areas should be included in Funding Requests, applicants are specifically encouraged to explore the potential of [community-led monitoring](#) (CLM) as part of efforts to improve accessibility, responsiveness and quality of services. The Global Fund supports CLM as it is an effective way to learn from communities on how to improve health services and respond to equity-, human rights- and gender-related barriers to health. CLM is a collaborative approach to identifying and addressing bottlenecks, gaps in service provision, and poor service quality, providing feedback using local feedback loops. CLM can focus on general health, disease specific or intervention specific services (e.g., monitoring of correct usage of ITNs, alerting on recurrent stock-outs or geographic and other structural barriers).

Effective community monitoring initiatives are often based on existing community accountability mechanisms, or local decision-making structures. However, it is important to keep in mind that existing structures may reinforce the exclusion of already underserved or

¹⁷ [Acceptability of peer learning and education approach on malaria prevention \(PLEA-malaria\) through primary schools communities in rural Ethiopia: peer educators' perspectives](#). Malaria Journal, 15 November 2021.

marginalized populations. Programs aiming to support underserved or marginalized populations should consider this reality when deciding which type of monitoring mechanism to develop.

Case Study: Community-led Monitoring Using the Community Scorecard in Ghana¹⁸

The Ghana Ministry of Health (MoH) and the Ghana Health Service (GHS), with support from the African Leaders Malaria Alliance (ALMA), initiated an innovative Community Scorecard (CSC), which provides an opportunity to close the gap in communication and collaboration between the providers and consumers of community-based health services, including malaria services. It offers a systematic way to gather data, monitor and act on the demand side of service delivery in contrast to the conventional approach focused primarily on the supply side of the health sector. The CSC is an accountability tool completed on a quarterly basis by community representatives to provide qualitative and quantitative feedback to local health providers and MoH/GHS officials on the quality of care experienced by users of the public health system.

The CSC is a mechanism that gives the community more influence and autonomy in relation to how health services are provided. Use of the CSC is leading to greater community involvement and contributions to improve local infrastructure and service delivery. For example, in the Adaklu district, security concerns led most Community Health Officers to live outside of the Community-based Health Planning and Services (CHPS) compound. CHPS were therefore not available after the regular workday. This was identified using the Community Scorecard and so the community contributed to hire a security guard for the CHPS. The staff have moved back into the CHPS compound and health services are now available 24/7.

4.4 Monitoring and reforming laws, policies and practices

In the context of health care, poorly designed or harmful laws, policies and practices impede effective responses, as does a lack of enforcement of effective laws and policies. Examples of areas to strengthen, amend and/or enforce include:

- Policies and practices on informed consent and confidentiality;
- Policies preventing bribes, and unexpected or prohibitively higher user fees;
- Policies that currently prohibit the use of Rapid Diagnostic Test kits by non-medical personal, or limiting their use to government staff only;
- Underfunded health systems and high out-of-pocket costs deterring people from accessing healthcare, or causing catastrophic costs to service users;
- Policies allowing for discriminatory treatment including exclusion from the health system, particularly for migrants, mobile and other undocumented populations;
- Laws requiring health care providers to report certain groups to law enforcement; and

¹⁸ [Ghana community scorecard: achievements](#), ALMA Scorecard Hub.

- Laws and policies limiting access to sexual and reproductive health services for adolescents and young women (e.g., age-of-consent laws and parental consent requirements) and other spousal consent laws.

To-date, there have been successful policies and laws put in place to enable vulnerable populations to access the needed services including removal of taxes from health products and free universal ITN coverage. However, countries need to identify, remove or amend laws, policies and practices that may prevent or delay access to malaria services as well as develop laws, policies and practices that advocate for non-discrimination and for improving access to quality malaria services. While some policies or laws may not appear to directly impact delivery of malaria services, they may inhibit or prevent populations at risk of malaria from accessing services.

Applicants should evaluate and document in their applications whether there exists a policy environment that guarantees inclusivity of all, including undocumented migrants, refugees, the poor, socially disadvantaged, persons with disabilities, legally, and geographically marginalized, asylum-seekers and prisoners and whether the laws governing availability and use of data enables timely and responsive subnational tailoring of malaria programs. Applicants should also evaluate and document whether the laws, policies and guidelines enable malaria interventions to meaningfully engage and include people of all genders.

Where appropriate laws, policies and guidelines exist, it is essential to ensure their implementation. Beyond stating the existence of policies strategies, countries in their applications should include the evidence or plans for their operationalization including dissemination, implementation, coordination, monitoring and evaluation. Multisectoral efforts including collaboration with community-led groups, and civil society organizations 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.

Case Study: Introduction of Community-based Health Insurance (CBHI) for Low-income Populations¹⁹

In Rwanda, health care-related costs are mostly covered by health care insurance, which comprises public and private insurance schemes. However, not all of the population were covered, as uninsured individuals had to purchase their insurance privately. In November 2016, the government of Rwanda introduced a new policy that stipulated, individuals classified in the lowest income classification, denoted as the first and second Ubudehe category, receive free access to CBHI coverage. This meant that this low-income group became exempted from the 10% co-payment normally required for the CBHI insurance scheme. This new policy granted free malaria prevention, diagnosis and treatment services to individuals classified as being in the lowest income and most economically vulnerable populations at risk of catastrophic financial impact when accessing healthcare.

¹⁹ Rwanda Malaria Strategic Plan 2020-2024.

Case Study: Introduction of Policies and Strategies to Reduce Barriers to Malaria Prevention and Treatment Services for Migrant Populations in Thailand²⁰

Thailand is a malaria-endemic country that has been able to dramatically reduce its malaria burden, now aiming for malaria elimination. Most confirmed cases are now confined to provinces bordering neighboring countries, often in geographically hard-to-reach areas with regular formal and informal migration. Thailand hosts up to 5 million non-Thai migrants, both documented and undocumented, including those displaced due to conflict and those crossing borders to seek healthcare. To consolidate recent gains and progress towards malaria elimination, prioritizing migrant populations become a key strategy of the National Program. The Program became more proactive identifying barriers and exploring and validating innovative strategies including policy changes as listed below.

- The national strategy called for specific programs to control malaria in migrant populations and considers this a key group for containment of the spread of artemisinin-resistant malaria parasites.
- Thailand's Workmen's Compensation Act established rights for migrant workers to access medical treatment in the event of work-related injury or illness. According to the Act, the associated medical expenses must be covered by employers, who are also obliged to compensate workers for lost income. Employers can use the Workmen's Compensation Fund (to which they have the duty to pay contributions) to cover all costs providing them with the same rights as Thai nationals.
- Rather than simply trying to screen incoming migrants for disease, in 2001, the Thai Ministry of Public Health further introduced an insurance policy on migrant health. It enables access to health care at public facilities including services for prevention, diagnosis, and treatment of malaria, and reduces catastrophic health expenditures for undocumented migrants and their dependents. This scheme allows both documented and undocumented migrants and their dependents to purchase health insurance membership. With this system, Thailand is a pioneer in providing access to health services for migrants.
- The Ministry of Public Health commenced migrant-sensitive health care services. A range of migrant-friendly services, including trained community health volunteers, were also introduced in community and workplace settings.
- The government also introduced a multisectoral policy on migrants, coordinated across the Interior, Labor, Public Health and Immigration ministries.

²⁰ [Strategy To Address Migrant and Mobile Populations For Malaria Elimination In Cambodia](#). Malaria Consortium, March 2013.

4.5 Improving access to services for underserved populations

A. Identifying high-risk and underserved populations most impacted by malaria, and the equity, human rights and gender barriers they face

Although malaria prevention and treatment interventions have been scaled up, coverage gaps and inequities in access to these proven tools remain.²¹ A proportion of people at risk of malaria are still not being protected, therefore insufficient levels of access to and uptake of lifesaving malaria tools and interventions are being achieved. The fight against malaria requires substantial emphasis on the specific country and subnational contexts where malaria programs are deployed, including the policy and program context, and the characteristics of different population groups in order to leave no one behind.

While some progress has been made in reducing barriers to malaria prevention, for example, through the targeted distribution of ITNs²², many barriers to prevention and treatment still remain, often associated with poverty and discrimination on the basis of income, education levels including literacy, ethnicity, social, cultural differences; legal marginalization; adverse living conditions including inadequate housing and water and sanitation systems, mobility and migration that may inhibit adherence practices, people affected by humanitarian emergencies and natural disasters and occupational exposure that put people at risk and yet, often these factors are not considered in the development of national policies. Rural populations globally are amongst the most exposed to the risk factors for malaria and face greater challenges in accessing services.

Using the Malaria Matchbox or a similar tool, programs should evaluate and document who are the most vulnerable populations to malaria both in terms of who may develop severe disease but also who may not have access to malaria services. If a population is at risk of malaria, it is essential for programs to understand how equity-, human rights- and gender-related barriers affect their ability to access and utilize prevention, diagnosis and treatment of malaria, and how interventions will address their specific needs.

²¹ [World Malaria Report 2022](#). World Health Organization, 8 December 2022.

²² [State of inequality: HIV, tuberculosis and malaria](#). World Health Organization, 9 December 2021.

Table 3: Examples of high-risk and underserved populations, potential inequities, as well as equity, human rights and gender-related barriers.

Populations	Potential inequities, human rights- or gender barriers
Potential high-risk populations <ul style="list-style-type: none"> • Pregnant women • Infants • Children under 5 years of age • People living in remote/rural areas • People living with HIV/AIDS • Non-immune groups 	<ul style="list-style-type: none"> ▸ Cultural and gender norms or age of consent related barriers that may limit access to services ▸ Literacy and language barriers ▸ Negative attitudes and perceptions to ITNs ▸ Limited access to ITNs, including access to distribution channels such as ANC ▸ Limited use of ITNs ▸ Limited access to accessible information ▸ Limited knowledge on ITN benefits and subsequent use ▸ Gender norms dictate who sleeps under ITNs
Potential underserved populations <ul style="list-style-type: none"> • Migrant, mobile or displaced populations • Travelers • People impacted by conflict and complex emergencies • Populations living in rural/remote areas • Women and children from poor settings • Undocumented workers • Indigenous and ethnic minority populations • Prisoners • Persons with disabilities 	<ul style="list-style-type: none"> ▸ Legal barriers ▸ Physical, financial and security (real and perceived) barriers ▸ Equity, human rights and gender-related barriers ▸ Social and cultural barriers ▸ Literacy and language barriers ▸ Limited acceptance of male CHW, IRS sprayers, ITN or SMC distributor or SBCC information providers ▸ Unavailability of household occupants thus households unavailable for interventions such as IRS. ▸ Varying acceptance according to affiliation of sprayers with government, military or communities. ▸ Policies limiting access to prisons

B. Designing programmatic approaches and interventions to address identified equity, human rights and gender barriers in malaria programs

After identifying high-risk and underserved populations and the barriers to accessing malaria services, programs should design concrete, evidence-based programmatic changes or new interventions to address the identified barriers and inequalities with full participation of the disadvantaged groups. Programming should be designed with a people-centered approach and, while there are commonalities across groups, the one-size-fits-all model is not appropriate and must be guided by country and subnational context. It is also critical that interventions are implemented at appropriate scale, with high quality and include a monitoring and evaluation component.

Applicants may request for funding towards specific and realistic interventions that are in-line with national country policies and strategies, current best practices, and global recommendations and; aligned to prioritized interventions to be funded by the Global Fund as outlined in the [Malaria Information Note](#). Interventions can be included in funding requests as part of [RSSH or Malaria Modular Frameworks](#). Applicants may use the updated [Modular Framework](#) to guide them on modules to include in the Funding Request.

- Applicants should include specific details on any new or adapted interventions in their funding requests and include appropriate budgets and implementation arrangements.
- Applicants may include in their application, support to conduct consultative reviews to identify and tailor malaria interventions/programs to address equity-, human rights- or gender-related barriers.

When contemplating the scope of proposed actions, these questions may be useful:²³

- Are there proposed improvements to the standard-setting, regulation, or legislation aspect of the malaria program? Does the assessment team see the need for revised or new protocols, standards, or guidelines? Likewise, are changes to regulation or legislation (e.g., regulation of costs for services offered by private sector providers, legislation for population-based interventions involving other sectors) foreseen to create a more enabling environment for health equity?
- Is there a need to change the malaria program strategy? That is, does the proposed change involve incorporation of a new intervention, service, awareness-raising platform, etc.? If so, at what level will it be implemented?
- Are there specific program intervention approaches to address specific inequities and remove rights- and gender-related barriers in vector control, chemoprevention, malaria case management etc.?
- Are there proposed changes to the structure and organization of the program that influence execution or delivery? Do the proposed adjustments to the program entail shifts in delivery channels and/or implementation mechanisms? If so, how will subnational variations in program capacity (and wider health system capacity) influence this?
- Are there proposed changes to the management processes and financing mechanisms? Do the proposed adjustments involve changing the ways needs assessments, planning, budgeting, resource allocation, payment of providers and other management and financing tasks are done? For example, are there new partners (e.g., like other sectors or those with expertise in work on gender equality and/or ethnic minority health) with which some interventions/activities should be jointly conducted? Are there resources (financial, human) dedicated to addressing needs of specific underserved communities and identified community, human rights and gender-related barriers?
- Are there proposed changes to the human resources? Do the proposed adjustments entail changes to pre-service or continuing education for health professionals, task-shifting, use of community mediators/volunteers in activities,

²³ Adapted from [The Innov8 approach for reviewing national health programs to leave no one behind](#). World Health Organization, 2016.

or changes to human resources policies (e.g., for recruiting and retaining staff in rural areas)? Do the proposed adjustments involve having both male and female team members at all decision-making and /or implementing levels?

- Do the changes involve any mechanism to empower the prioritized subpopulation to know and act on their rights and entitlements in relation to the program? Are there changes to ensure meaningful participation of affected populations? Are there program changes to strengthen community systems for participation in malaria programs?
- Do the changes involve ways to identify, address and/or transform harmful gender norms, roles and relations?
- Do the changes involve other sectors beyond the health sector to find solutions to health inequities and more effectiveness of the program?
- Are there ways to monitor/ensure accountability for addressing equity-, human rights- and gender-related barriers, and leaving no one behind in the malaria responses?

The following descriptions of types of activities – with some examples of tools and real experiences – are included to help malaria programs and implementers of Global Fund grants to think through ways to improve outcomes by assessing and removing equity-, human rights- and gender-related barriers to malaria services in their specific settings. These lists are not exhaustive.

B.1 Addressing barriers to vector control interventions

Activities to address any distinct barriers and inequities related to vector control interventions should be included under the Module on “Vector Control” and the applicable interventions in the Modular Framework handbook. Examples of Vector Control interventions include:

To achieve optimal, universal coverage and maximum impact, applicants need to ensure that coverage of vector control interventions reaches all targeted populations at risk, at a sufficient level of coverage and usage, ensuring universal approaches are equitable. In malaria elimination countries where the focus is on enhancing and optimizing vector control identification of specific barriers to accessing remaining targeted foci and specific areas of on-going transmission is vital.

Insecticide-treated Nets (ITNs)

Addressing barriers to both ITN access and use should be sub-nationally tailored based on at risk populations, and the equity- human rights- and gender-related barriers they face²⁴. This includes consideration of ITN distribution methodology, quantity, selection of ITN distributors and SBCC strategies targeting social, cultural and gender norms that influence ITN use, and increased monitoring and evaluation. It is essential that applicants provide the data used to inform these strategies. Some examples of ITN distribution include:

²⁴ See the [Malaria Information Note, Allocation Period 2023-2025](#). The Global Fund, 2022.

- Universal (mass) distribution targeted to a specific population group, including refugees, internally displaced persons, migrants, mobile populations, prisoners and other underserved populations.
- Continuous delivery of ITNs through antenatal care (ANC)/Expanded Program on Immunization (EPI) in schools and outreach to out-of-school children.

Case Study: School-based ITN Distribution in Ghana Reaching Both Public and Private School-going Children²⁵

School-based ITN distribution in Ghana is a collaboration between the Ghana Health Service (GHS) NMCP and Ghana Education Service (GES) School Health Education Program (SHEP). It is supported by the U.S. President's Malaria Initiative (PMI) VectorLink as donors and implementing partners. Strong interministerial collaboration between the GHS and GES contributes to the successful implementation of school-based ITN distribution, including monitoring, supervision and reporting activities.

Improvements to the Ghana Education Management Information System (EMIS) was required to strengthen the quality of school enrollment data. Engagement with national and subnational EMIS officials ensured that school enrollment data were available and accessible in real time or updated early in the school year to avoid the need to use enrollment data from the previous academic year for ITN macro-quantification and micro-quantification. The availability of timely school enrollment data helped reduce the oversupply and undersupply of ITNs to schools. School-based ITN distribution data collection and reporting by School Inspectorate Support Officers (SISOs) was digitized through a collaboration between the NMCP and PMI VectorLink. ITN issuing data were available to national and subnational health and education officials in near real time.

The inclusion of private schools in school-based ITN distribution further increased the number of students reached. It was realized that Private schools would be disenfranchised if only EMIS data are used for macro- quantification and micro-quantification because some private schools were not captured in the EMIS. Consultation with SISOs and district education officials during the microplanning process was conducted to ensuring that eligible private schools were included in the school-based ITN distribution. PTA meetings were important channels for ensuring community support for school-based ITN distribution and disseminating information before, during and after school. Using existing education structures enabled the successful implementation of school-based ITN distribution in **Ghana, ensuring the targeted children were included including those attending private schools. In 2020 a total of 1,175,249 LLINs were distributed in 26,488 schools.**

²⁵ [School-based ITN Distribution Step-by-step Exemplar](#). The PMI VectorLink Project, 8 December 2020.

Case Study: Characterizing Types of Human Mobility to Inform Differential and Targeted Malaria Elimination Strategies in Northeast Cambodia²⁶

Several countries in the Greater Mekong Subregion are aiming to achieve malaria elimination within the next few years. However, residual transmission foci persist in forested areas such as the north-eastern Cambodian province of Ratanakiri, that is largely populated by ethnic minority communities, often located near international borders and on the fringes of society, with increasing rural to rural migration to exploit new economic opportunities such as rubber plantations, gem mining and agriculture. Human population movements challenge malaria elimination in low transmission foci in this Greater Mekong Subregion. The aim of this study was therefore to characterize the different mobile groups in one such context and consider their vulnerability to malaria.

Different structural types of human mobility were identified, showing differential risk and vulnerability. Among local indigenous populations, access to malaria testing and treatment through the village malaria workers-system and LLIN coverage was high, but control strategies failed to account for forest farmers' prolonged stays at forest farms/fields (61% during rainy season), increasing their exposure. The Khmer migrants, with low acquired immunity, active on plantations and mines, represented a fundamentally different group not reached by LLIN-distribution campaigns since they were largely unregistered (79%) and unaware of the local village malaria workers-system (95%) due to poor social integration. This study highlights the importance of understanding different mobility types. Targeting mobility without an in-depth understanding of malaria risk in each group can lead to wasted efforts and resources and challenges further progress towards elimination.

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. It is important that barriers that hinder achievement of IRS coverage levels necessary for attaining the maximum community protective effect are identified and addressed in NSPs and Funding Requests where applicants are requesting for IRS support.

Applicants should describe how they will ensure that targeted communities are part of the dialogues and other key decision-making processes regarding the IRS implementation design of innovation strategies developed to address identified barriers.

It is also important to consider the living conditions and accessibility of refugees, IDPs and migrants, and whether IRS may be more suitable than ITNs given living conditions and mobility of the population (e.g., shared migrant housing and high mobility). Prisons may also be better served by IRS for safety and similar reasons.

²⁶ [Characterizing Types of Human Mobility to Inform Differential and Targeted Malaria Elimination Strategies in Northeast Cambodia](#). Nature, 23 November 2015.

Case Study: Identifying and Addressing Barriers to Accessing Timely IRS in a Refugee Camp in Rwanda²⁷

Rwanda has been hosting refugees from the Democratic Republic of the Congo (DRC) since 1996, in addition to Burundian refugees who have fled insecurity and unrest since 2015. The vast majority live in refugee camps, while about 20% live in urban areas. Primary health services are provided by humanitarian actors in refugee camps through health centers that are also accessible to the local host communities. Refugees are referred to local health facilities for secondary and tertiary health.

When malaria cases increased in Rwanda from 400,000 cases in 2014 to 4.7 million in 2017, an initial analysis identified multiple districts contributing to this increase, including Kirehe district. A further analysis on the populations at high risk of malaria in Kirehe district identified the refugee population in the camp at most high risk, accounting for 50% of all malaria cases reported. A further assessment identified that implementation of IRS in the refugee camp had been delayed and the refugees were not included in the mass LLIN campaigns thus rendering the population underserved and resulting in high cases of malaria.

In response, Rwanda developed a plan to conduct IRS every September in the refugee camps prior to the high transmission season using an effective insecticide. The Ministry of Health, through the Rwanda Biomedical Centre (RBC), worked in close collaboration with UNHCR and the President's Malaria Initiative Africa Indoor Residual Spraying Project to implement IRS at the refugee camps, ensuring that the quality of insecticide was maintained, and timeliness of spraying observed.

Actions identified by countries may directly require programmatic changes such as introduction of additional interventions in line with WHO recommendations and country policies, or modifications in the design of interventions which would then need to be indicated in the grant application. They may include adaptations of the implementation approach or activity design (e.g., adjustment of working days/hours of sprayers) which will need to be taken into consideration during coordination, planning, budgeting, and procurement, and therefore should be considered when developing the budget for the grant.

²⁷ [Characterizing Types of Human Mobility to Inform Differential and Targeted Malaria Elimination Strategies in Northeast Cambodia](#). Nature, 23 November 2015.

Table 4: Examples of barriers to use or access to vector control interventions with possible actions to address these barriers

Barriers identified	Actions
<p>Limited access to vector control interventions in hard-to-reach populations due to geographical barriers, insecurity, operational barriers such as limited vehicles and mobility challenges.</p>	<p>Adequate budgeting, planning and use of alternative, accessible transportation options to address geographically challenging areas.</p> <p>Advocacy, communication and social mobilization activities related to universal equitable access to vector control</p> <p>Engage communities when planning/implementing campaigns.</p> <p>Select ITN distributors and IRS sprayers from local populations within the hard-to-reach communities.</p> <p>Alter distribution strategies, for example shifting from traditional point distribution of ITNs to door-to-door distribution.</p> <p>Consider more frequent distribution in insecure areas/areas affected by natural disaster.</p>
<p>Gender, age and other sociocultural barriers to vector control interventions</p>	<p>Develop gender- and age-specific behavior change communication strategies and peer education programs</p> <p>Ensure adequate number of nets are provided to each household to cater for cultural, gender or age-related behaviors</p> <p>Consider age, gender and representation when building an appropriate health workforce (e.g., sufficient women for mass campaigns and men for male-dominated migrant communities)</p> <p>Inclusion of community leaders or female community health workers in conducting IRS in female-headed households to facilitate acceptance.</p> <p>Assess women's and community concerns about IRS and develop accessible information to address those concern</p> <p>Dialogue with men, boys and community leaders to address gender norms and other traditional sociocultural norms.</p> <p>Introduce gender transformative programs such as training and employing women as IRS sprayers.</p> <p>Targeted ITN distribution to reach children within and outside of formal education.</p>
<p>Age, gender and cultural norms and influencing attendance at ANC services.</p>	<p>Raise awareness and support identification of solutions to increase early ANC attendance.</p> <p>Community engagement targeting men to promote male involvement in ANC visits and male support towards</p>

	<p>ensuring that their partners or family members have access and utilize ITNs during pregnancy.</p> <p>Identification of women/adolescent champions to engage and educate pregnant women about the benefits of ITN use.</p>
<p>Low literacy or language barriers to vector control use.</p> <p>Unsuitable IEC materials and strategies</p>	<p>Preparation of advocacy materials in consultation with communities</p> <p>Development and distribution of accessible SBC materials tailored to the needs of the different population groups</p> <p>SBC materials consider potential inequities including language and accessibility barriers and ensure that messages take into consideration language diversity, use pictorial messaging in the case of limited literacy, or adapt for persons with disabilities</p> <p>Conventional media such as mobile technology, television, radio etc. may not be suitable or accessible for those lacking access to the technology and/or electricity. Therefore, use multiple channels and formats to disseminate information, including the use of inter-personal communication.</p>
<p>Underserved populations like prisoners, religious or ethnic minority groups, communities, refugees and IDPs who are not included in ITN mass campaign distribution programs or who fear to access these services.</p>	<p>Conduct targeted ITN distribution to specific vulnerable or underserved groups such as refugees, internally displaced persons, migrants, mobile populations, prisoners (where appropriate) and other socially or legally excluded populations.</p> <p>In communities with high population mobility, consider continuous distribution strategies to ensure no one is left out.</p> <p>Activities to empower and engage communities in vector control, such as sensitization meetings for opinion leaders at the community and village level.</p> <p>Ensure inclusive and non-discriminatory registration techniques to encourage all individuals to register without fear of reprisal</p> <p>Information on malaria prevention and care should be provided to communities in their own language and in practical and understandable terms, as well as in locations likely to improve access such as transport hubs or border checkpoints.</p> <p>SBC activities aimed at ensuring access to- and use of vector control for refugees, internally displaced persons, migrants, mobile populations, prisoners and other underserved and socially legally excluded populations.</p> <p>Community-based and community-led monitoring of access to- and quality of vector control interventions</p> <p>Activities to promote meaningful participation of affected populations, including efforts to engage underserved</p>

	<p>populations in Country Coordinating Mechanisms, in planning and delivery of vector control interventions and in assessing and addressing barriers.</p> <p>Select ITN distributors from target communities</p>
<p>Populations for whom conventional ITNs may not be suitable including nomads, pastoralists, forest workers, mobile and migrant populations impacting ITN use</p>	<p>Activities to empower and engage communities in vector control such as sensitization meetings for opinion leaders at community and village level.</p> <p>Development of tailored and accessible SBCC messaging.</p> <p>Adapt vector control interventions and consider non-conventional nets that may be more suitable for these populations such as long-lasting insecticide treated hammock nets (LLIHN), dumuria nets, ITNs with modified specifications (sizes and shapes of nets).</p> <p>Innovative community-based and community-led approaches</p> <p>Collaboration and coordination with non-health actors.</p>
<p>Religious beliefs and cultural practices may result in communities and individuals refusing IRS spraying</p>	<p>Involvement of community and religious leaders in community sensitization on the efficacy and safety of the chemicals</p> <p>Collaboration with a trusted implementing partner who is known by the community to deliver interventions.</p> <p>The use of a technically competent team comprised of community members who are familiar with community.</p>
<p>Barriers to vector control access at the household level including unavailability of household occupants during interventions</p>	<p>Adjustment of working days/hours of sprayers could improve availability and access to those working outside the home.</p>

Promoting Equity in Vector Control: Case Studies from Ghana and Rwanda²⁸

Ghana: Reaching the Unreached

Ghana's malaria strategy involves reaching all populations at risk of malaria including the country's most vulnerable groups such as children living in orphanages, migrant workers and people living with disabilities. To reach people living with disabilities, the NMCP has worked with the Ghana Society of the Physically Disabled and similar groups, both to engage people living with disabilities in these efforts and to get reliable figures for planning campaigns. As an example, the NMCP reached people living with disabilities through existing platforms, such as regular meetings of the Federation of Disability Organizations, to understand population needs and to gain valuable feedback about IRS and ITN campaigns.

Some people living with disabilities take on specific roles in these efforts, serving as community mobilizers, for example and ensuring a two-way flow of information. Some people living with disabilities may require support from 'packers'—people tasked with packing up and moving household goods out of homes while insecticide spraying occurs; others may need help in ensuring correct hanging of ITNs.

Rwanda: IRS for Prisoners and Refugees

In Rwanda, the Ministry of Health identified prisons and refugee camps as needing targeted strategies to implement IRS. The structures and the people living within them have different challenges than the general population served by malaria control efforts. For example, access to prisons and refugee camps is strictly controlled. Authorization from the ministries involved with prisons and refugees was first needed; then the Ministry of Health identified key stakeholders and involved them in all phases of the IRS campaign, including planning and intervention, supervision, monitoring and evaluation and adaptation. In addition, to protect the health of residents after the IRS was completed, the spray teams had to identify convenient sites for soak pits—outdoor areas to safely dispose of the wash water used as part of the spraying process—that were not too close to sites used by residents within these locations.

B.2 Addressing barriers to chemoprevention

Activities to address any distinct barriers and inequities related to specific chemoprevention²⁹ interventions should be included under the Module on "Specific Prevention Interventions (SPI)" and the applicable interventions in the Modular Framework handbook.

²⁸ [Promoting Equity in Vector Control: Examples from Ghana, Rwanda, and Senegal](#). The PMI VectorLink Project, 6 June 2022.

²⁹ [WHO Guidelines for malaria](#). World Health Organization, 3 June 2022.

Intermittent Preventive Treatment of Malaria in Pregnancy (IPTp) use

Applicants should ensure that all pregnant women and adolescent girls have access to IPTp services, and that this is reflected in NSPs and associated policies. A women- and adolescent-centered approach is recommended. To address barriers faced by women and adolescent girls accessing IPTp, applicants should include innovative evidence-based strategies in their requests, including strategies that promote integration of different services at ANC. Community IPTp (cIPTp) is an example of a new strategy of delivering IPTp to address observed access barriers in the delivery of IPTp at ANC.

Case Study: Addressing Policy and Male Involvement Barriers to IPTp Services in Uganda³⁰

A study in Uganda on a policy requiring men to accompany women to their first ANC visit revealed unintended negative consequences, including acting as a barrier to IPTp uptake. To encourage men's engagement in ANC, the Ministry of Health in Uganda implemented a national policy requiring men to accompany women to their first ANC visit. As an incentive, couples who attended together were prioritized.

In order to explore supply and demand-side barriers that impede uptake of IPTp in Uganda and recommend potential intervention strategies, a study was conducted in two regions of Uganda (Eastern and West Nile) that had low uptake of IPTp compared with the national average. The study found that the policy led some women to delay ANC attendance while they are waiting for their partners, who are often not available or not supportive. It also resulted in health workers giving preferential treatment to women attending with their partners, prioritizing them over single mothers.

Remedial actions taken:

Development of the National Strategy for Male Involvement/Participation in Reproductive Health, Maternal, Child Adolescent Health and Rights to provide guidance to stakeholders and implementers of the male involvement policy.

Empowering male partners with knowledge about ANC services to increase their participation, including the introduction of the male action groups to train and deploy men at the community level to teach their peers about maternal and reproductive health services.

Guidelines about male involvement in ANC were clarified and communicated to district and facility-level staff to ensure no women who attended ANC without their spouses were turned away nor prevented from receiving ANC services, including IPTp.

Promotion of community engagement and sensitization involving community, religious and political leaders, community health workers and community/faith-based organizations to encourage male participation.

Alternative IPTp delivery strategies in the strategic plan and piloting community-based IPTp.

³⁰ [Male partner attendance of skilled antenatal care in peri-urban Gulu district, Northern Uganda](#). BMC Pregnancy and Childbirth, 2010.

Table 5: Examples of barriers to use or access to IPTp with possible actions to address these barriers

Examples of Barriers	Potential Actions
Negative health-care worker attitudes and sociocultural biases resulting in abuse and disrespect of ANC clients such as adolescent girls and unmarried women, as well as poor service quality	<p>Collaboration and coordination with reproductive health departments and training schools to conduct pre-service and in-service training and sensitization to address cultural and social biases and uphold patients' rights</p> <p>Communication by health-care providers, including CHWs, should be non-discriminatory and culturally sensitive</p>
Delayed or lack of ANC attendance	<p>Community engagement to raise awareness and support identification of solutions to address late ANC attendance and low IPTp uptake.</p> <p>Outreach ANC services to rural and hard to reach areas</p> <p>Introduction of innovative and inclusive strategies including community IPTp</p> <p>Promote male-partner engagement in ANC visits.</p> <p>Integration of IPTp with other activities targeting pregnant women within reproductive, maternal, newborn, child and adolescent health services, sexual and reproductive health, and rights, and HIV services for pregnant women.</p>
Cultural and gender norms including intrahousehold dynamics.	<p>Community sensitization with targeted SBCC material tailored for local leaders, religious leaders, and men, to address specific cultural and gender-related barriers,</p> <p>Identification of women/adolescent champions to engage and educate pregnant women about the benefits of early ANC attendance and use of SP for prevention during pregnancy.</p>
The cost of procuring SP and delivering IPTp	<p>With support from partners, malaria programs can advocate for and actively monitor budgeting, timely procurement and delivery of SP to public health facilities.</p> <p>Local procurement of quality SP</p>
<p>Economic barriers, for example:</p> <p>Hidden cost by health-care providers, as well as related to transportation.</p> <p>Women may delay going for ANC visits until the pregnancy is advanced due to lack of money and in some cases financial control by a family member, narrowing the window of opportunity to receive at least 3 doses of IPTp.</p>	<p>Community engagement targeting men to promote male involvement in ANC visits and male support towards ensuring that their partners receive IPTp services.</p> <p>Active community participation, including establishment of community accountability mechanisms.</p> <p>Advocacy to ensure no stockouts of SP at national, subnational and health facility levels.</p> <p>Sensitization of employees and introduction of work policies and strategies to enable time off for female employees and accompanying partners to attend ANC visits.</p>

<p>Commitments to employment, household chores, farming and childcare are barriers to ANC attendance resulting in women incomplete IPTp.</p> <p>Inability to purchase drugs on the private market when/if there are stockouts at public health facilities.</p>	
<p>Language and literacy barriers</p>	<p>SBCC materials should consider potential inequities including language and accessibility barriers and ensure that messages take into consideration language diversity, use pictorial messaging in the case of limited literacy, or adapt for persons with disabilities</p>

Seasonal Malaria Chemoprevention (SMC)

SMC activities are focused in areas with highly seasonal malaria transmission. In their requests, applicants including SMC need to not only document an understanding of barriers to access and uptake of SMC, but also show how they will address the barriers by modifying their SMC strategies in order to achieve optimal coverage and maximum impact for all people in SMC coverage areas.

Case Study: Introduction of a Geographic Information System (GIS) to Ensure Successful Delivery of SMC in Hard-to-reach Areas in Cameroon³¹

In the northern regions of Cameroon where malaria parasite transmission is seasonal and prone to frequent epidemiological changes, seasonal chemoprevention was introduced as is an effective way to control malaria in children. However, due to security challenges and poor road infrastructure, commodities had not been reaching several targeted destinations and therefore children in these hard-to-reach areas were not accessing SMC. With the use of trucks for delivery, many roads are inaccessible, making deliveries almost impossible for hard-to-reach areas.

In 2018, the U.S. President's Malaria Initiative (PMI) supported the NMCP to procure smart phones and introduced a GIS tracking system to make sure commodities were delivered to the right place, in a timely manner and in the right condition. Cameroon, was able to develop a distribution plan, identify the hard-to-reach areas and track deliveries successfully delivering 3.4 million treatments for 1 million children between the ages of 3 months to 5 years within 10 days.

Funding and support from PMI and collaboration with Cameroon's NMCP has allowed for improved visibility and delivery thus creating a significant impact on malaria control and prevention. GIS systems can help improve other public health interventions for hard-to-reach populations.

³¹ <https://www.pmi.gov/gis-tracking-system-ensures-a-successful-smc-campaign-in-cameroon/>

Perennial Malaria Chemoprevention (PMC)

In areas of moderate to high perennial malaria transmission, children in age groups at high risk of severe malaria can be given antimalarials at predefined intervals to reduce disease burden. PMC should be integrated with other strategies targeting the same age group populations, such as EPI or deworming.

Other Chemoprevention Strategies

The WHO has broadened the spectrum of chemoprevention strategies that are now recommended. These include:

- Intermittent preventive treatment of malaria in school-aged children (IPTsc)
- Post-discharge malaria chemoprevention (PDMC), which provides a full therapeutic course of an antimalarial at predetermined times following hospital discharge to reduce re-admission and death and targets children admitted with severe anemia; and
- Mass drug administration (MDA), which can be used for transmission reduction in elimination areas, high burden, or for burden reduction in emergency settings (malaria outbreaks, malaria control in emergency settings).

When implementing these chemoprevention strategies, special attention should be paid to ensuring equitable access to all populations. Applicants implementing these chemopreventive interventions in their requests should indicate evidence of understanding potential barriers to access and uptake and include strategies to address them. For example, in IPTsc, applicants should assess strategies to reach children in the same age group that do not attend schools.

Elements of Effective Community Engagement: Lessons from a Targeted Malaria Elimination Study in Lao PDR³²

Mass drug administration (MDA) was implemented in Southeast Asia as part of a package of interventions referred to as targeted malaria elimination (TME) (*now intensified activities for elimination*). This intervention relies on effective community engagement that promotes uptake and adherence in target communities.

The community engagement strategy that accompanied TME in Lao PDR was successful in terms of contributing to high levels of participation in mass anti-malarial administration (above 85%). Five key elements were identified as enabling factors:

- Stakeholder and authority engagement, which proceeded from national level, to subnational and local level;
- Local human resources, particularly the recruitment of local volunteers who were integral to the design and implementation of activities in the study villages;
- Formative research, to rapidly gain insight into the local social and economic context;
- Responsiveness, whereby the approach was adapted according to the needs of the community and their responses to the various study components; and
- Sharing leadership with the community in terms of decisions on the organization of TME activities.

³² [Elements of effective community engagement: lessons from a targeted malaria elimination study in Lao PDR \(Laos\)](#), Global Health Action, 2017.

Table 6: Examples of barriers to use or access to chemoprevention strategies with possible actions to address these barriers

Examples of Barriers	Potential Actions
Hard to reach areas due to poor infrastructure, insecurity, political unrest, floods etc.	Provision of accessible and safe transport options for CHWs. Alternative and accessible transportation and distribution strategies for SMC, MDA and other chemoprevention.
Economic barriers: Repeated travel to hospital for PMDC to collect medicine can be costly and time consuming Use of SMS reminders may create inequity as not all guardians have access to a phone	Consider integrating SMC and other stand-alone chemoprevention strategies with other already established and accepted health programs. Community-based and community-led delivery. Institutional capacity building for CSOs, social mobilization, community-led advocacy and research. Community mobilization and sensitization.
Language and literacy barriers	Enhance SBCC for parents of targeted children. SBCC materials should consider potential inequities including language and accessibility barriers and ensure that messages take into consideration language diversity, use pictorial messaging in the case of limited literacy, or adapt for persons with disabilities.
Cultural and gender norms including intrahousehold dynamics.	Consider activities to promote meaningful participation of affected populations and specific efforts to engage underserved populations in CCMs, in planning and delivery of interventions and in assessing and addressing barriers. Recruit and train more female distributors and supervisors, recognizing that care givers are mostly women and, in some settings, social norms may not permit men to enter the households of other men. Sensitization of political, cultural and religious leaders before the SMC campaigns to foster community engagement. Use community leaders as community mobilisers. Community-based and led monitoring of interventions.

B.3 Addressing barriers to timely malaria case management

Activities to address any distinct barriers and inequities related to case management interventions should be included under the Module on “Case Management” and the applicable interventions in the Modular Framework Handbook.

Malaria case management interventions including facility-based treatment, integrated community case management (iCCM), private sector case management, epidemic preparedness, as well as intensified malaria elimination activities are affected often by health seeking behaviors and the delivery of health care services, both of which are impacted by gender, cultural, disability, socioeconomic and geographic factors which often result in unequal access and utilization of these services by the targeted populations.

Applicants need to identify innovative approaches to providing accessible, acceptable, inclusive and quality malaria services to all populations at risk, particularly the resulting underserved and high-risk populations through. Applicants should demonstrate how subnational and community level variations in barriers and subsequent access and uptake of case management services have been evaluated and understood and how innovative interventions included in the application are evidence based and people centered.

For populations such as hard-to-reach, mobile populations and migrants, programs may include strategies in their funding request that aim to expand access to care through community, private sector or mobile services, as well as scale-up of well-resourced, incentivized CHWs and quality iCCM.

Case Study: Identification of Barriers iCCM in Zambia³³.

Zambia adopted iCCM strategy in May 2010, targeting populations in rural communities and hard-to-reach areas. However, evidence suggested that iCCM implementation in local health systems had been suboptimal. This study sought to explore enablers and barriers to implementation of iCCM in the health system in Kapiri Mposhi District.

The study findings highlighted key sociocultural and religious enablers and barriers that should be considered by policymakers, district health managers, iCCM supervisors, health facility managers and co-operating partners, in designing context-specific strategies, to ensure successful implementation of iCCM in local health systems.

Case Studies: Establishing Mobile Clinics to Ensure Access to Malaria Treatment Services for Flood Victims

Somalia: In 1997, in the Jilib/Marere area, an estimated 4000 people were trapped by floodwaters for over a month. An assessment by the International Committee of the Red Cross reported that the area was infested with mosquitoes and the population were at high risk of malaria infection.

A mobile clinic was set up to provide malaria treatment services to the population at risk. A series of trips by motorboat to reach other stretches of dryland where people had taken refuge were initiated to provide timely

³³ [Facilitators and barriers to implementation of integrated community case management of childhood illness: a qualitative case study of Kapiri Mposhi District](#). BMC Health Services Research ,14 April 2022.

Program incompatibility with socio-cultural and religious beliefs limited implementation of iCCM. Myths and misconceptions about blood withdrawal were identified, including religious beliefs of forbidding church members to have their blood withdrawn, and low user acceptance. The findings highlighted the need to understand the compatibility of iCCM with the community in which it's implemented.

iCCM implementation teams must systematically assess potential enablers and barriers in preparation for implementing of iCCM. This approach may help enhance implementation effectiveness of the iCCM program as well as identify improvements to implementation strategies.

antimalaria treatment to the flood victims.

Malawi: Similarly in Malawi in March 2015 heavy rains and floods following Tropical Cyclone Idai resulted in displaced populations living in camps near large swamps, the perfect breeding grounds for malaria-carrying mosquitoes. Through collaboration between the government, USAID's Organized Network of Services for Everyone's (ONSE) Health Activity and the President's Malaria Initiative (PMI), mobile integrated health outreach clinics were conducted once or twice a week. During these clinic visits, malaria testing using rapid diagnostic tests was available and all positive cases were treated with the recommended antimalarial treatment.

Table 7: Examples of barriers to use or access to malaria case management with possible actions to address these barriers

Examples of Barriers	Potential Actions
<p>Delayed access to quality diagnosis and treatment services at health-care facilities by populations living in hard-to-reach areas.</p> <p>Complex environmental or humanitarian emergencies, including violence, natural disaster and restrictions on movement.</p>	<p>Use of well-resourced and incentivized CHWs for early diagnosis and prompt treatment in hard-to-reach areas and for mobile and migrant populations.</p> <p>Scale-up of community-based care through iCCM.</p> <p>Provision of accessible transportation for referred malaria cases (severe/complicated malaria) health facilities.</p> <p>Provision of accessible and safe transport options for CHWs</p> <p>Introduction of mobile malaria clinics to providing malaria diagnosis treatment services to hard-to-reach populations including populations affected by environmental or humanitarian emergencies.</p>
<p>Limited or restricted access to health care services by vulnerable populations including migrants, mobile and displaced persons, prisoners and other people in closed settings, as well as other underserved, socially and legally excluded populations.</p>	<p>Policies and plans in place to enable all populations to receive equitable care in local facilities without discrimination.</p> <p>Inclusion of underserved populations in the quantification and distribution of malaria commodities, and in understanding other barriers faced by these populations.</p> <p>Sensitize communities and health workers to ensure non-discrimination in malaria service design and delivery.</p> <p>Training and deployment of CHWs (from the refugee community) within campsites on malaria case management.</p>
<p>Language and accessibility barriers</p>	<p>Development and distribution of accessible SBC materials tailored to the needs of different populations.</p> <p>Targeted training and employment of health facility workers and CHWs who speak the language of the target community.</p>
<p>Economic barriers including out of pocket expenditure, transport, and loss of employment.</p>	<p>Use of CHWs to bring services closer to communities.</p> <p>Introduction of mobile or outreach services.</p> <p>Policies to ensure no catastrophic health expenditure.</p>
<p>Gender, cultural and physical barriers to community-based services</p>	<p>Training of health-care workers in provision of gender-responsive, cultural and socially acceptable services.</p> <p>Community involvement and empowerment through community-led services.</p> <p>Selection and training of CHWs from within the hard-to-reach communities, recognizing age, gender and other sociocultural characteristics of the target population.</p> <p>Provision of accessible and safe transport options for CHWs.</p>

B.4 Cross-cutting areas

Social and behavior change (SBC)

Where equity-, human rights- and gender-related barriers to access and uptake of malaria services have been identified, malaria programs should develop communication strategies that are evidence-based and theory-informed, tailored for the specific barriers, and implement them according to the needs of the different population groups. As shown in some of the examples provided above, tailoring may consider specific population groups, different literacy levels and communication ability, different local languages used, age, and gender norms. Accessible SBC strategies should be identified at different programmatic levels to maximize impact. Various approaches, including advocacy, behavior change communication, community and social mobilization, as well as social marketing can be used.

SBCC strategies must also be gender-transformative, ensuring they don't reinforce existing gender roles and gender norms. Reference to the RBM Strategic Framework for Malaria Social and Behaviour Change Communication 2018-2030³⁴ can provide guidance to the country in the development of updated communication plans to include the SBC strategies addressing the identified barriers.

In their funding application, applicants should include initiatives to strengthen malaria communication strategies to address identified human rights- and gender-related barriers.

Examples of questions that can be used to guide the discussions on how to identify SBC activities/actions needed to address reducing the barriers:

- Is there a need to adapt existing SBC strategies to address gender and/or socio-cultural inequalities?
- Is there a need to develop new SBC strategies to address gender and/or socio-cultural inequalities?
- Is there a need to advocate for action to be taken to address the barrier(s)?
- Is there a need to advocate for the adoption of new policies or removal of existing policies?
- Is there a need to increase/raise awareness targeting a specific underserved or high-risk population?
- Is there a need to change perceptions or cultural beliefs?
- Is there a need to increase demand for malaria services in a specific underserved or high-risk population?
- Is there a need to increase acceptance for malaria services in a specific underserved or high-risk population?
- Is there a need to change perceptions, improve motivation and /or build awareness of health care providers?

Applicants may also include in their Funding Requests support or technical assistance to develop or update communication strategies, where a need is identified. Activities to address any distinct barriers and inequities related to specific SBC interventions should be included under the relevant “Vector Control”, “Case Management” or “Specific prevention

³⁴ [RBM Strategic Framework for Malaria Social and Behaviour Change Communication 2018-2030](#). RBM Partnership.

interventions (SPI)” Modules and the associated “Social and behavior change (SBC)” intervention.

Monitoring and Evaluation (M&E)

It is fundamentally important for malaria programs to strengthen M&E systems to measure identified equity-, human rights- and gender-related barriers and their impact, as well as the impact of the interventions and activities introduced to address the barriers faced by high risk and underserved populations, and to what extent inequalities, discriminatory practices, and the exclusion of communities in decision making and has been corrected. M&E is also key to ensure accountability and transparency.

Where malaria programs have requested support for pilot projects to address equity-, human rights- and gender-related barriers, Funding Requests should include plans to evaluate, document and share experiences, and to identify sustainable approaches that can be institutionalized and scaled up. Mechanisms should also be established that ensure results and findings are used for decision making.

As part of a high-functioning M&E system, it is important that national programs and implementers collect, analyze and utilize disaggregated data. The timely use of disaggregated data will allow for a better understanding of programmatic challenges, population needs and appropriate responses to inequities related to malaria and malaria interventions. Without collecting and analyzing disaggregated data, the full impact on access and utilization of malaria services will remain unknown. Data should be disaggregated according to relevance to the intervention and based on the most appropriate stratification factors. **Stratification factors may include age, sex, gender, place of residence, displacement status, economic status, nationality, ethnicity, disability, occupation, religion, and other information specific to targeted groups based on contextual vulnerability.**

Malaria programs should also use multiple types and sources of data, including routine program (administrative) data, documentation on equity-, human rights- and gender-related barriers to accessing services, experiences of clients, public health surveillance data, statistical estimates (modelling), vital statistics and census data, participatory surveys and research studies, partner reports, evaluation studies, mid-term and end-term evaluations, and formal research studies.

Appropriate equity, human rights, gender-focused indicators should be identified and incorporated into M&E plans. These may include indicators to assess community participation in malaria decision making, planning and implementation as well as indicators to evaluate the impact of interventions and disease outcomes. Disaggregated data from other indicators that are not specifically equity, gender nor human rights indicators can also be analyzed from an equity, gender, and/or human rights perspective to assess which groups continue to be marginalized and left behind, and who is facing barriers in the availability, accessibility, acceptability and quality of malaria services. Data that are regularly collected, such as by national statistics offices, could be useful to analyze and assess whether human rights are being respected, protected, and promoted within the Malaria response, even if the data go beyond the indicators included in the national malaria monitoring and evaluation plan.

5. Resources

The Global Fund

1. [Community Systems Strengthening Technical Brief](#), 2022.
2. [Decision-Making Tool for Community Systems Strengthening Interventions in Global Fund Grants](#), 2022.
3. [Fighting Pandemics and Building a Healthier and More Equitable World: Global Fund Strategy \[2023-2028\]](#), 2022.
4. [Gender Equality Technical Brief](#), 2022.
5. [Malaria Information Note](#), 2022.
6. [Modular Framework Handbook](#), 2022.
7. [Strengthening Community Engagement Technical Assistance](#) (webpage).
8. [Sustainability, Transition and Co-financing Guidance Note](#), 2022.
9. [Undertaking a rapid assessment of information on human rights-related barriers to HIV and TB services: guidance and tools](#), 2022.
10. [Value for Money Technical Brief](#), 2022.

Global Strategies, Commitments and Reports

11. [Action and Investment to Defeat Malaria](#). RBM Partnership to End Malaria, WHO, 2015.
12. [Global Report on Health Equity for Persons with Disabilities](#). World Health Organization, 2 December 2022.
13. [Global Strategy on Integrated People-centred and Integrated Health Services: Interim Report](#). World Health Organization, 2015.
14. [Global Technical Strategy for Malaria 2016–2030](#). World Health Organization, 2021.
15. [RBM Partnership Strategic Plan 2021-2025](#). RBM Partnership to End Malaria, 2020.
16. [The 17 Sustainable Development Goals](#). United Nations, Department of Economic and Social Affairs.
17. [The Comprehensive Multisectoral Action Framework: Malaria and Sustainable Development](#). UN-Habitat, September 2022.
18. [Universal Health Coverage](#). World Health Organization, 1 April 2019.

Partner Guidance, Tools and Lessons Learned

19. [Conduct a Community Diagnosis for Malaria Interventions – A Practical Guide for Civil Society Organizations](#). Civil Society for Malaria Elimination (CS4ME), July 2021.
20. [EQUIST: Equitable Strategies to Save Lives](#). UNICEF
21. [Gender Scan of UNDP HIV, TB and Malaria Programmes Funded by the Global Fund to Fight AIDS, Tuberculosis and Malaria](#). United Nations Development Programme, 2020.
22. [Gender and Malaria Discussion Paper](#). United Nations Development Programme, 2015.

23. [Health Equity Assessment Toolkit \(HEAT\): Software for exploring and comparing health inequalities in countries](#). World Health Organization, 2021.
24. [Innov8 Technical Handbook](#), World Health Organization, 2016.
25. [The Case for Investing in a Gendered Approach to the Fight Against Malaria](#). RBM Partnership, 2021.