APLMA | Asia Pacific Leaders Malaria Alliance

TOOLKIT

Gender Equality, Disability and Social Inclusion (GEDSI) Implementation Toolkit for National Malaria Programmes in the Asia Pacific Region

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Acronyms and Abbreviations

ANC	Antenatal Care
APLMA	Asia Pacific Leaders Malaria Alliance
APMEN	Asia Pacific Malaria Elimination Network
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CHW	Community Health Worker
CLAW	Community-Led Accountability Working Group
CLM	Community Led Monitoring
CHW	Community Health Worker
CMV	Community Malaria Volunteer
COVID-19	Coronavirus (SARS-CoV-2)
CRVS	Civil Registration and Vital Statistics
CS4ME	Global Civil Society for Malaria Elimination
CSO	Civil Society Organisation
DHS	Demographic and Health Survey
G6PD	Glucose-6-phosphate dehydrogenase
GBV	Gender Based Violence
GEDSI	Gender Equality, Disability and Social Inclusion
HIV/AIDS	Human immunodeficiency virus/acquired immunodeficiency syndrome
HMIS	Health Management Information System
IDP	Internally Displaced Person
IEC	Information, Education, Communication
IPTp	Intermittent Preventative Treatment of Malaria in Pregnancy
IRS	Indoor Residual Spraying
ITN	Insecticide Treated Net
LLIN	Long-Lasting Insecticide Treated Net
MDA	Mass Drug Administration
MHV	Malaria Health Volunteer
MMP	Mobile and Migrant Population
NGO	Non-Governmental Organisation
NMP	National Malaria Programme
OPD	Organisation of People with Disabilities
PACD	Proactive Case Detection
PDR	People's Democratic Republic
P. falciparum	*Plasmodium falciparum*
PMC	Perennial Malaria Chemoprevention
PNG-SDP	Papua New Guinea Sustainable Development Programme
PSI	Population Services International
P. knowlesi	*Plasmodium knowlesi*
P. vivax	*Plasmodium vivax*
RBM	Roll Back Malaria
RDT	Rapid Diagnostic Test
SBCC	Social and Behaviour Change Communication
SDG	Sustainable Development Goal
SMC	Seasonal Malaria Chemoprevention
UCSF	University of California San Francisco
UN	United Nations
VHV	Village Health Volunteer
WHO	World Health Organisation

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1. CSO Platform for Health Equity and Inclusiveness (formerly known as the Malaria Free Mekong)
2. Lenny L. Ekawati, DPhil from Oxford University Clinical Research Unit Indonesia (OUCRU ID)

Executive Summary

This toolkit has been compiled to support national malaria programmes (NMPs) and their implementing partners in the Asia Pacific region to integrate a stronger focus on gender equality, disability and social inclusion (GEDSI) into their activities. The toolkit responds to a request for practical guidance from malaria policy makers and programme staff in the region. It complements other GEDSI resources such as the Malaria Matchbox equity assessment tool compiled by Roll Back Malaria and The Global Fund. This toolkit focuses not only on principles and commitments, but also on practical implementation, offering concrete entry points, tools, and prompts to support action within real-world resource, capacity, and system constraints.

Many NMPs have historically focused their resources on addressing biological susceptibility to malaria, with lower priority given to interventions that focus specifically on under-served populations. The toolkit highlights how this situation is changing in the Asia Pacific region where the use of targeted strategies to reach underserved groups is becoming more prominent. Opportunities to further strengthen NMPs to promote social inclusion and health equity, and maximise positive health outcomes, are highlighted.

The APLMA GEDSI toolkit aims to be a resource for all stakeholders involved in malaria control and elimination, including the staff of national malaria and/or vector borne disease programmes, malaria implementing partners, researchers, donors and funding agencies, communities, civil society organisations and representatives of vulnerable, discriminated, underrepresented and marginalised groups who are advocating for equitable access to services.

The toolkit has been designed to be practical and user-friendly, providing helpful operational guidance for users. It is structured around five key topics: the importance of GEDSI in malaria; community engagement and feedback mechanisms; GEDSI-sensitive service delivery; strengthening data collection and analysis from a GEDSI perspective; and integrating GEDSI into programme planning and budgeting. Short narratives provide a high-level overview of each topic. A variety of tools and resources such as checklists, case studies, infographics, section summaries and lists of useful resources provide hands-on operational guidance for NMPs and other toolkit users.

A draft of the toolkit was peer reviewed by a small group of malaria and GEDSI experts and modifications were made in response to feedback. The toolkit may be revised in future to ensure that it aligns with and addresses GEDSI challenges within a rapidly changing epidemiological context.

Section 1: Introduction

1.1 Rationale for Toolkit

This toolkit has been compiled to assist national malaria programmes (NMPs) and their implementation partners in the Asia Pacific region to integrate a stronger gender equality, disability and social inclusion (GEDSI) focus into their activities.

A 2024 baseline assessment carried out by APLMA looked at the extent to which countries in the region have incorporated GEDSI commitments in their national strategic plans for malaria and are collecting GEDSI-specific data (1). Many have taken impressive steps to collect data and target interventions to at-risk or hard-to-reach populations, including pregnant women, children, remote communities, migrant or displaced populations, or outdoor workers (e.g. forest workers).

At the 9th Asia Pacific Leaders' Summit on Malaria Elimination in June 2025, participants resolved to do more and requested practical guidance on how to further integrate GEDSI into malaria programming. This toolkit responds to this request.

The APLMA GEDSI toolkit complements other useful resources such as the Malaria Matchbox equity assessment tool created by Roll Back Malaria (RBM) and the Global Fund in 2020 (2). However, the toolkit covers topics specifically requested by malaria policy makers and programme staff in the Asia Pacific region

1.2 Malaria Overview

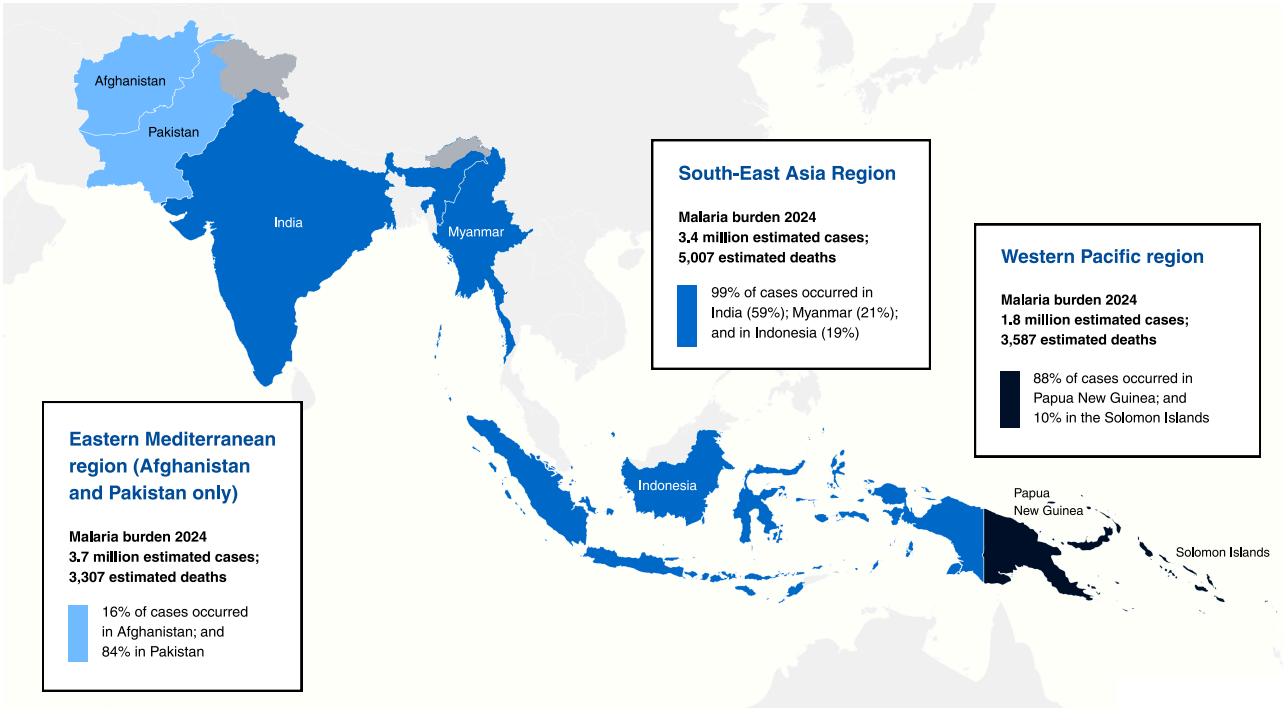


Figure 1: Snapshot of Malaria Burden in the Asia Pacific Region

Ongoing Challenges

South-East Asia Region

- 9x increase in cases in Myanmar 2019-2024
- High proportion of *P. vivax*
- *P. knowlesi* presence and transmission
- Resistance to Artemisinin-based Combination Therapies
- Decline in funding for malaria (64% from 2015-2024)

Western Pacific Region

- Reduction in malaria funding (46% from 2015-2024)
- High treatment failure rates
- *P. knowlesi* presence and transmission
- Suboptimal surveillance systems
- Lack of health care infrastructure and limited access to services
- Supply shortages

Eastern Mediterranean Region (Afghanistan and Pakistan only)

- 0 out of 2 countries on track to meet WHO Global Technical Strategy target of at least 70% reduction in estimated case incidence by 2025 compared with 2015
- 0 out of 2 countries on track to meet WHO Global Technical Strategy target of at least 70% reduction in malaria mortality rate by 2025 compared with 2015

*Figures in this section include Indonesian data, as they were obtained in 2024, and prior to Indonesia joining the Western Pacific region in 2025. Conversely, figures in the Western Pacific section do not include data from Indonesia.
Source of data: World Malaria Report 2025(3).

The Asia Pacific region made significant progress in reducing the malaria burden from 2010-2021, with a 45% decline in indigenous cases and an 89% reduction in deaths (4). However, recent data show that indigenous cases are increasing, from 2.5 million cases in 2015 to 4.4 million in 2024 (5). Progress in burden reduction in the WHO Western Pacific region is slowed by the lack of health care infrastructure, poor access to services, supply shortages and inadequate surveillance and response.

The success of malaria control and elimination efforts in both regions hinges on addressing health inequities, gender inequality and human rights-related barriers of access to information and services. This is because malaria disproportionately affects marginalised groups such as women and children living in rural areas, those with specific occupations such as forest workers, internally displaced populations (IDPs), refugees, individuals facing stigma or discrimination (e.g. disabled persons, drug users) or entire communities living in remote, hard-to-reach areas, and influences accessibility to services including SBCC, which may not be accessibility to people with disabilities, people with different languages and different literacy levels (3).

1.3 Approach and Structure

This toolkit has been designed to be practical and user-friendly and aims to provide helpful operational guidance for users. The document is structured around five key topics (Box 1). Guidance is provided on themes specifically requested by NMPs in the Asia Pacific region. This includes a section on community engagement and feedback mechanisms and another on GEDSI-focused data collection and analysis. The toolkit also offers practical guidance on how to integrate a GEDSI focus into malaria-related service delivery and into programme planning and budgeting.

GEDSI integration is enabled by a set of cross-cutting system factors, including leadership, governance, partnerships, political commitment, and accountability mechanisms. These enablers shape how effectively GEDSI principles are translated into practice across community engagement, service delivery, data systems, and planning and budgeting. Rather than treating these as a standalone theme, the toolkit integrates these enabling factors throughout all sections.

Throughout the toolkit, particular attention is paid to the role of leadership, governance arrangements, partnerships, and accountability mechanisms as critical enablers of sustainable GEDSI integration.

Box 1: Toolkit Topics

- Importance of GEDSI in malaria
- Community engagement and feedback mechanisms
- GEDSI-sensitive service delivery
- GEDSI-sensitive data collection and analysis
- GEDSI integration in programme planning and budgeting

In each section, short narratives provide a high-level overview of a topic. Plain English is prioritised over complex technical jargon. Practical tools and resources are included at the end of each section.

The toolkit includes the following:

- **Checklists** to aid planning and decision-making
- **Case studies** to provide practical examples of how countries in the region have tackled a specific GEDSI-related challenge or highlight gaps in implementation
- **Infographics** to aid visualisation of key issues
- **Resources and tools** such as case studies, checklists and monitoring tools to provide additional reference material to support the adoption of a GEDSI approach at the end of each section
- **Section summaries** to highlight key issues covered and points to remember

1.4 Audience

The toolkit aims to be a resource for all stakeholders involved in malaria control and elimination. The main audiences for the GEDSI toolkit are:

Staff of national malaria and/or vector borne disease programmes, including:

- Programme managers
- Monitoring and Evaluation (M&E) staff
- Technical Advisors
- Training Co-ordinators

Malaria implementing partners, including:

- Non-Governmental Organisation (NGO) / Civil Society Organisation (CSO) implementing partners and communities
- Private sector actors relevant to malaria transmission and service access (e.g. mining, agriculture, forestry, transport, construction, and other industries employing mobile or forest-exposed populations)
- Other implementing partners (e.g. bilateral or multilateral funded projects)

Other stakeholders involved in malaria control and elimination may also wish to use the toolkit, including:

- Ministry of Health (MOH) officials responsible for health policy and resource allocation
- Researchers developing research plans who wish to ensure that their findings and recommendations are GEDSI-sensitive
- Donors and funding agencies who are providing support for malaria programmes and who want to ensure that the programmes are equitable
- Representatives of key populations and other vulnerable and marginalised groups who are advocating for equitable access to services including Organisations of People with Disabilities (OPDs)

The toolkit also supports engagement with non-health actors, including through public–private partnerships, to address structural and occupational drivers of malaria risk among mobile, migrant, and forest-exposed populations. Selected tools, checklists, and summaries can also be used as briefing materials for non-health ministries, private sector partners, and community-based advocacy groups.

The toolkit can therefore be used at every level of the health system, including communities to the policy makers.

1.5 Process

A draft of the toolkit was peer-reviewed by a small group of malaria stakeholders. This included GEDSI and malaria technical experts, and representatives of development partners working on malaria. The toolkit was revised in response to feedback.

The toolkit will be updated intermittently to include new resources and information and additional case study material to ensure that it remains up-to-date.

Summary

- The GEDSI toolkit can be used by policy makers and programme stakeholders involved in malaria control and elimination
- The toolkit is designed to be practical and user-friendly. Short narratives provide a high-level overview of a topic. These are accompanied by various easy-to-use resources and tools
- A draft of the GEDSI toolkit was peer reviewed. The current version will be updated in response to user feedback

Section 2: Overview of GEDSI Issues in Malaria

2.1 Why GEDSI is Important in Malaria

Malaria is a disease of poverty and a driver of inequality. Poverty exacerbates malaria by increasing vulnerability and susceptibility to the disease and malaria causes poverty by impeding productivity and economic growth (6). In the Asia Pacific region and elsewhere, malaria has a disproportionate effect on isolated and poor populations who live and work in hard-to-reach and border areas that are poorly served by healthcare systems (7).

Over the last decade, scaling up of malaria prevention, diagnosis and treatment has helped to improve coverage. However, gaps and inequities in access to malaria information and services remain, often based on poverty and diverse forms of discrimination, leaving a proportion of people at risk (Box 2).

Box 2: Marginalised groups carry a disproportionate burden of malaria

India

20% of the population accounts for 80% of reported malaria cases. Populations residing in tribal, forested or hard-to-reach areas in five states (Chhattisgarh, Jharkhand, Odisha, Madhya Pradesh and Maharashtra) and the Northeast carry the heaviest burden (5).

Indonesia

93% of Indonesia's malaria cases come from lowland Papua, home to 2% of the national population. Rural Papuans, especially those working in poor, forested lowland districts are at higher risk of infection than other populations (8).

Papua New Guinea

In Papua New Guinea, Momase region reported the highest prevalence of malaria in 2023 (7.3% compared to 1.5% in the Southern region). The coastal areas that are prone to malaria outbreaks have many remote communities which are poorly served by transport infrastructure (9).

Cambodia

Forests and forest fringes in border areas are key sites for malaria occurrence and transmission in Cambodia. The populations most affected are forest goers located in hard-to-reach areas. Increased infection risk in these locations is associated with distance from a health facility (10).

Effective malaria control and elimination, and the prevention of re-establishment, cannot be achieved if at-risk and underserved population groups are left behind (3). These groups often face higher risks of infection, act as reservoirs of the disease, and are less likely to benefit from existing control measures. Understanding the characteristics of these groups using a GEDSI lens is therefore essential (11) (Box 3).

Box 3: Why GEDSI in malaria elimination efforts is important

GEDSI is crucial for effective malaria elimination. Rather than being an "add-on" to routine malaria programming, it is a fundamental approach to achieving effective and sustainable malaria elimination.

Reaching the Most Vulnerable:
A GEDSI lens helps to identify and address the specific barriers that different groups (e.g., women, people with disabilities, ethnic minorities, IDPs) face in accessing malaria information, prevention, diagnosis, and treatment.

Tailored Interventions:
Understanding gender dynamics, disability-related needs, and social norms allows targeted interventions that are more effective and acceptable to communities to be developed. Involving representatives of target groups in programme design, implementation and monitoring helps to ensure relevance and acceptability and is essential.

Equitable Resource Allocation:
GEDSI principles ensure that resources are distributed fairly, reaching those most in need and preventing further marginalisation, stigmatisation and discrimination.

Improved Programme Effectiveness:
Incorporating GEDSI into malaria programmes can improve coverage, surveillance, case reporting, and programme evaluation, leading to better outcomes and faster progress towards elimination and prevention of reestablishment.

Promoting Social Justice and Dignity:
Addressing GEDSI is not only a matter of public health but also a matter of human rights and social justice, ensuring that everyone can live a healthy life free from malaria.

2.2 Understanding Malaria Risk

Malaria risk is influenced by both biology and socio-economic factors:

- From a **biological perspective**, pregnant women, children under five years old, migrants moving from non-endemic to endemic areas and people living with HIV/AIDS, undernourished people, as well as older persons have reduced or limited immunity which increases their susceptibility to the disease.

- The risk of malaria infection and susceptibility to severe disease is also mediated by barriers of access to malaria information and services, which are, in turn, grounded in a range of **socio-economic factors** (Figure 2).

Populations most impacted by malaria can be **high risk populations** with low immunity or **underserved populations** who face barriers of access to prevention, diagnosis and treatment. Some individuals and populations fall into both categories (e.g. pregnant women from ethnic minorities – this is often called intersectionality).

Illustrative example: In eastern Indonesia, malaria burden is highly geographically concentrated. Approximately 93% of national malaria cases occur in lowland Papua, which is home to only around 2% of the population. This highlights how malaria risk can be shaped by the intersection of remoteness, ethnicity, poverty, linguistic diversity, and limited access to services.

In such settings, GEDSI-sensitive programming may need to consider how local cultural practices, customary leadership structures, and the roles of Indigenous and faith-based organisations influence trust, care-seeking, and community participation.

Figure 2: Malaria Risk Factors, Populations Impacted, Outcomes and Impact

<table>
<tr><th colspan="2">Risk Factors</th></tr>
<tr><td>Biological factors
Low immunity to malaria parasite</td><td>Socio-economic and other factors
Poverty
Malnutrition
Social exclusion
Gender inequalities
Financial barriers
Social and cultural norms
Ethnicity
Low education / literacy levels
Disability
Religion
Occupational risk
Migration / mobility
Legal or criminal status
Emergencies (floods, civil unrest, war, famine)
Adverse living conditions
Older age groups</td></tr>
<tr><th colspan="2">Populations Most Impacted</th></tr>
<tr><td>High risk populations
Pregnant women
Infants
Children under 5 years old
People living with HIV/AIDS
Non-immune groups
Migrants from non-endemic to endemic areas
Travellers
Older persons</td><td>Underserved populations
Populations living in hard-to-reach areas
Refugees / IDPs
Women and children affected by poverty/malnutrition
Ethnic minorities
Indigenous populations
People with disabilities
Undocumented workers
Groups affected by stigma and discrimination
Institutionalised groups</td></tr>
<tr><th colspan="2">Outcomes</th></tr>
<tr><td>Higher risk of contracting malaria
Higher risk of developing severe disease</td><td>Poor access to malaria information
Reduced access to Insecticide Treated Nets (ITNs) and other vector control tools
Low use of ITNs and other vector control tools
Low coverage of antenatal care (ANC)
Low uptake of Intermittent Preventative Treatment of Malaria in Pregnancy (IPTp)
Delayed or lack of access to diagnosis including for glucose-6-phosphate dehydrogenase (G6PD) deficiency testing
Delayed or lack of access to treatment and/or referral</td></tr>
<tr><th colspan="2">Impact</th></tr>
<tr><td colspan="2">Increase in malaria incidence and mortality rates</td></tr>
</table>

Source: Adapted from The Global Fund and RBM. Malaria Matchbox Tool: An Equity Assessment Tool to Improve the Effectiveness of Malaria Programs. 2020; Geneva: The Global Fund and RBM.

Resource 2.1 highlights some of the barriers of access to services experienced by marginalised groups who are at-risk of malaria.

Malaria risk may be increased by interacting socio-economic factors. For example, the combination of gender and disability, or ethnicity and living in a hard-to-reach area can drive malaria risk.

Resource 2.2 is a case study that looks at gender, disability and malaria risk in Lao PDR.

2.3 Global Policy Commitments to GEDSI

Globally, there is an extensive policy framework that supports health equity. The objective to strengthen health systems and reach the unreached is embodied in the Sustainable Development Goals (SDG). Target 3.8 of SDG 3 (ensure healthy lives and promote well-being for all at all ages) focuses on bringing bring universal health coverage (UHC) to every country. UHC aims to ensure that all people can access quality health services whenever and wherever they need them. A commitment to leave no-one behind and to reach the furthest behind first is central to the SDGs.

Other global policy commitments, such as the United Nations (UN) Convention on the Rights of the Child (1990) and the UN Convention on the Rights of Persons with Disabilities (2016) reinforce the right of potentially vulnerable and excluded population groups to equal access to services and opportunities, including health care. These broader policy commitments also provide a framework and justification for utilising malaria resources to address health inequities.

Resource 2.3 provides an overview of global policy commitments to GEDSI in health and malaria.

2.4 Progress to Date in National Malaria Programmes

To date, many NMPs have focused their resources on addressing biological susceptibility to malaria. This has resulted in the prioritisation of pregnant women and children under five years old in malaria programmes (2). In comparison, vulnerabilities linked to socio-economic factors are generally under-researched. Globally, and in the Asia Pacific region, very few countries are collecting detailed disaggregated data to enable a better understanding of how gender inequality, social exclusion and other socio-economic and cultural factors affect malaria risk and vulnerability (3). Historically, therefore, less priority has been given to designing targeted interventions that specifically focus on reaching under-served populations.

However, this is changing. In parts of the Greater Mekong Subregion, for example, occupational groups such as forest workers who live and work in areas of high malaria transmission are prioritised. In Thailand, migrants from Myanmar suffering from high malaria infection rates are receiving programmatic focus. These targeted interventions for mobile and migrant populations (MMPs) and forest workers are underpinned by a solid evidence base. However, within these tailored approaches there is scope to do more to strengthen the GEDSI focus and ensure that no-one is left behind.

Resource 2.4 is a case study that highlights how interventions targeted to male forest workers in Cambodia may be crowding out attention to other aspects of equity.

The 2024 APLMA GEDSI baseline assessment identified that none of the 15 countries included in the study had an explicit focus on disability within their NMPs. This is a gap.

Resource 2.5 looks at the disability context in Cambodia, Lao PDR and Vietnam and highlights national policy commitments to disability inclusive service delivery. The case study asks whether these commitments are reflected in the respective NMPs.

2.5 Steps Towards GEDSI Mainstreaming

There are several steps that NMPs can take to begin or strengthen the process of mainstreaming a GEDSI focus. This includes undertaking a review of national policy commitments to GEDSI, both within and outside the health sector such as establishing a taskforce to oversee the process of integrating GEDSI into the NMP, with representation from OPDs, women's organisations, other Ministries such as Culture, Social Welfare, Women's Affairs and other departments within the MOH, prioritising areas for GEDSI-focused interventions, testing new or improved approaches and generating evidence of outcomes and impact using a robust monitoring and evaluation framework, and planning for scaling up successful approaches (Table 1).

Table 1: Steps to Begin the Process of GEDSI Mainstreaming

Activity	Key Steps

Establish a taskforce to oversee the integration of GEDSI issues into the NMP	• Decide what should be included in the taskforce's terms of reference
	  ◦ Will the taskforce have a defined timeframe in which to deliver its work?
	  ◦ What is the process for recruiting, retaining and replacing members?
	  ◦ What will be the frequency of taskforce meetings?
	  ◦ Who will the taskforce report to?
	• Decide the mix of expertise required on the taskforce
	  ◦ Can the taskforce draw on GEDSI expertise from other government units, departments or ministries (e.g. ethnic affairs, women's affairs, social welfare, sexual and reproductive health)?
	  ◦ Can the taskforce draw on GEDSI expertise from outside government (e.g. development partners or academia)?
	• Decide how the taskforce will support the engagement of representatives of key marginalised or vulnerable groups.
	  ◦ Define how representatives of marginalised and vulnerable groups (e.g., women's organisations, organisations of persons with disabilities, ethnic minority and migrant groups) will be meaningfully engaged, including measures to address barriers to participation, ensure accessibility, enable safe and inclusive participation and decision-making.
	  ◦ What other ways are there to ensure that the GEDSI focused work of the taskforce is relevant to the needs of key high risk or underserved groups?

Review national policy and programme commitments to GEDSI and health equity and undertake a gap analysis	• Review existing policy commitments to GEDSI within the health sector and more broadly • Assess the extent to which existing legal and policy commitments to GEDSI are reflected in the malaria programme • Assess the available evidence in each gap area
Prioritise key areas for intervention	• Decide what steps can be taken now, in the medium-term and in the longer-term to improve the GEDSI focus of the NMP • Assess if further research is required to guide appropriate GEDSI-focused programming on malaria

Source: Adapted from The Global Fund and RBM. Malaria Matchbox Tool: An Equity Assessment Tool to Improve the Effectiveness of Malaria Programs. 2020; Geneva: The Global Fund and RBM.

Table 1: Steps to Begin the Process of GEDSI Mainstreaming

Activity	Key Steps
Test new or adapt existing approaches	• Pilot new approaches/interventions to improve the GEDSI focus of the NMP or adapt existing approaches • Measure the outcomes and impact of the pilot(s) using a robust GEDSI disaggregated M&E framework • Disseminate implementation experience, results and lessons learned, including to other countries in the region and to GEDSI linked organisations and communities
Scale-up new GEDSI-sensitive approaches	• Develop and implement a clear plan for the systematic scale-up of GEDSI-sensitive approaches across relevant programs, policies, and operations.
Plan for how to continue building GEDSI expertise within the NMP	• Consider how the NMP can continue to benefit from GEDSI expertise in the longer-term. ◦ What expertise is required? How will the NMP obtain this? ◦ What capacity-building activities and internal policy reforms are needed to institutionalize GEDSI within the NMP (e.g., inclusive recruitment, accessibility, anti-discrimination and harassment safeguards, and equitable access to professional development), and how will these be budgeted?
Institutionalise and sustain GEDSI integration	• Integrate GEDSI into national malaria policies, guidelines, and standard operating procedures • Embed GEDSI-related responsibilities into job descriptions, performance frameworks, and supervision systems • Invest in long-term capacity building and establish mechanisms for accountability, learning, and continuous improvement.

Source: Adapted from The Global Fund and RBM. Malaria Matchbox Tool: An Equity Assessment Tool to Improve the Effectiveness of Malaria Programs. 2020; Geneva: The Global Fund and RBM.

Tool 2.1 is a checklist that can be used by NMP personnel to assess national policy commitments to GEDSI.

Tool 2.2 is a scoring matrix that can be used by NMPs to help prioritise where to intervene from a GEDSI perspective.

Based on global policy commitments to health equity, some useful resources (e.g. technical briefs, evidence reviews, GEDSI assessment toolkits) have been produced to support the mainstreaming of GEDSI into malaria policy and programmes. **Resource 2.6** provides a list of key resources.

Summary

- In the Asia Pacific region vulnerable, hard-to-reach marginalised groups carry a disproportionate burden of malaria
- Effective malaria control and elimination cannot be achieved if these high-risk groups are not targeted
- The socio-economic factors associated with increased malaria risk require more attention
- There is a robust global policy framework that supports the attainment of health equity and adoption of a GEDSI lens
- Steps that NMPs can take to strengthen the GEDSI focus of their programmes include establishing a GEDSI taskforce, reviewing national legal and policy commitments to GEDSI, undertaking a gap analysis, prioritising key areas for intervention, testing new approaches, planning for scaling up GEDSI-sensitive approaches, and ensuring GEDSI is a focus within their own organizational arrangements and processes.

Section 2: Resources and Tools

Resource 2.1: Barriers of Access Faced by Marginalised Groups At-Risk of Malaria
This highlights some of the barriers (including awareness, physical access and affordability) faced by different marginalised groups that are at-risk of malaria

Resource 2.2: Case Study: Gender, Disability and Malaria Risk in Lao PDR
This describes how gender and disability intersect in Lao PDR to affect women's and girls' access to health services

Resource 2.3: Global Policy Commitments to GEDSI in Health and Malaria
This highlights some of the key international GEDSI policy commitments

Resource 2.4: Case Study: Are Female Forest Workers in Cambodia Being Missed?
This asks if the prioritisation of male forest workers in Cambodia is resulting in female forest workers not receiving services

Resource 2.5: Case Study: Malaria Risk and Disability in Lao PDR, Cambodia, Vietnam
This describes the lack of available evidence on disability and malaria risk in three countries in the Asia Pacific, despite the large population of disabled persons in each country

Resource 2.6: List of Useful Resources for NMPs
This provides useful resources for NMPs that are planning to strengthen the GEDSI focus of their malaria programmes

Tool 2.1: Checklist for Assessing National Policy Commitments to GEDSI
This can be used by NMPs to carry out a rapid assessment of national policy commitments to GEDSI that are relevant to the malaria programme

Tool 2.2: GEDSI Intervention Prioritisation Tool
This can be used by NMPs to help prioritise where to intervene from a GEDSI perspective based on epidemiology, GEDSI vulnerability and programmatic feasibility

Resource 2.1

Possible barriers faced by marginalised groups at-risk of malaria

Marginalised group	Barriers affecting access to and utilisation of malaria services
Women and girls	**Accessibility** • Mediation of women's and girls' access to information on malaria prevention by a male household head or other gatekeepers (e.g. older women) • Lack of autonomy to make decisions about health care access (requirement to obtain permission from husband/father/other gatekeepers to seek care) • Lack of independent access to funds to pay for the cost of health care • Lack of timely access to transport to a health facility **Acceptability** • Services are not delivered in culturally appropriate ways (e.g. IRS administered by male sprayers) • Cultural preference for female health providers • Inconveniently timed health services which disrupt women's and girls' other duties and responsibilities under the gender division of labour • Services do not cater to the needs of adolescents/young women • Stigma and discrimination faced by women and girls when accessing health care **Utilisation and Quality of Care** • Household responsibilities / gender division of labour may mean that repeat or additional visits to the health facility (e.g. for IPTp; G6PD testing; directly observed treatment for *P. vivax* radical cure) are challenging • Prioritisation given to men's and children's health at household level • Lack of integrated health care leading to inconvenient access for women and girls

Marginalised group	Barriers affecting access to and utilisation of malaria services
Persons with disabilities	**Accessibility** • Long distances to health facilities and lack of mobility • Physical access barriers linked to health care infrastructure (e.g. lack of ramps, lack of navigable walkways/clinic buildings) • Inability to reach centralised distribution points for ITNs • Physical barriers to access to community outreach • Lack of access to health information e.g Lack of health worker capacity to use sign language • Health facility signage that is difficult to read • Health worker communication that is difficult to hear or follow • Difficulties leaving residence during IRS campaigns **Acceptability** • Negative attitudes of health workers • Lack of dignity linked to service delivery modes (e.g. lack of accessible toilets when experiencing long waiting times for service) **Utilisation and Quality of Care** • Reliance on other family members to accompany patient to the health facility / opportunity costs to carers • Lack of affordability of malaria diagnosis and treatment • Discrimination leading to sub-standard care
Ethnic minorities	**Accessibility** • Long distances to health facilities • Inadequate community-based service delivery • Ethnic minority languages not spoken by health workers • Health facility signage that is in another language **Acceptability** • Discriminatory attitudes of health workers • Failure of health workers to acknowledge cultural preferences of ethnic minorities • Timing of services inappropriate to ethnic minority activities/calendars **Utilisation and Quality of Care** • Reliance on majority language speakers to accompany patient to the health facility / opportunity costs to carers • Lack of affordability of malaria diagnosis and treatment • Discrimination leading to sub-standard care

Marginalised group	Barriers affecting access to and utilisation of malaria services
Refugees	**Accessibility** • Lack of information on rights to health care in host country • Lack of awareness of malaria prevention if from a non-endemic country • Long distances to health facilities • Communication / language barriers • Limitations to freedom of movement based on refugee status • Lack of access to ITNs in mass campaigns due to temporary residence / lack of civil registration **Acceptability** • Discriminatory attitudes and stigmatising behaviours of health workers and other patients • Inadequate healthcare infrastructure to meet needs **Utilisation and Quality of Care** • Reliance on health advocates to accompany patient to the health facility / opportunity costs • Lack of affordability of malaria diagnosis and treatment • Discrimination leading to sub-standard care
IDPs	**Accessibility** • Inability to access ongoing care due to displacement (e.g. IPTp during pregnancy at ANC; radical cure for *P. vivax*) • Inability to benefit from IRS due to poor quality or temporary housing • Inability to access ITNs in mass campaigns due to temporary residence, lack of local registration and high mobility • Long distances to health facilities • Communication / language barriers **Acceptability** • Discriminatory attitudes and stigmatising behaviours of health workers and other patients • Inadequate healthcare infrastructure to meet needs • Health service delivery not culturally appropriate **Utilisation and Quality of Care** • Lack of affordability of malaria diagnosis and treatment • Discrimination leading to sub-standard care

Marginalised group	Barriers affecting access to and utilisation of malaria services
Undocumented workers	**Accessibility** • Lack of information on rights to health care in host country • Language / communication barriers • Long distances to health facilities • Lack of civil registration leading to denied access to ITNs during mass campaigns • Inadequate housing for IRS • Illegal residency status leading to barriers of access to IRS **Acceptability** • Discriminatory attitudes/stigmatising behaviours of health workers • Health service delivery not culturally appropriate **Utilisation and Quality of Care** • Fear of being apprehended when utilising public services • Lack of affordability of health care
Older people	**Accessibility** • Mobility challenges limit physical access to health facilities • Communication difficulties and difficulties reading signage when accessing health facilities **Acceptability** • Discriminatory attitudes and stigmatising behaviours of health workers **Utilisation and Quality of Care** • Reliance on family members to accompany patient to the health facility / opportunity costs • Lack of affordability of malaria diagnosis and treatment • Discrimination leading to sub-standard care • De-prioritisation of older people's healthcare at household level

Marginalised group	Barriers affecting access to and utilisation of malaria services
Populations living in hard-to-reach areas	**Accessibility** • Long distances to health facilities • Lack of affordable transport options • Inadequate qualified health personnel • Inadequate coverage of community-based services • Long distances to ITN distribution centres during mass campaigns • Lack of information on ITN and IRS campaigns **Acceptability** • Lack of convenient access to health care • Reliance on traditional remedies **Utilisation and Quality of Care** • Opportunity costs (to livelihoods or other household responsibilities) of accessing health facilities located at a distance

Resource 2.2

Case Study: Gender, Disability and Malaria Risk in Lao PDR

Gender, disability and malaria risk in Lao PDR

A 2018 USAID study on gender and disability in Lao PDR found the following (12):

- Females with disabilities face more stigma and harassment than males with disabilities. Social stigma can affect disabled women and girls' confidence.
- Men with disabilities are perceived as being more likely to access essential services than women with disabilities. A desire to prove that they can fulfil their role as household head and family provider may be a reason why disabled men are more likely to access (or be supported to access) essential services.
- Females with a disability may require two people to accompany them to a health facility – a female to take care of their personal needs and a male to speak to the health workers. This increases the opportunity costs to households of health treatment seeking.
- Information from external agencies about services and opportunities tends to flow through household heads, the majority of whom are male. Mediated access to health information may occur in contexts where families do not want to invest in women and girls with a disability because they are perceived as unlikely to get married.
- The threat of gender-based violence (GBV) affects the mobility and freedom of women with and without disabilities. This adds an additional barrier of access to essential health services and restricts access to development opportunities.
- Individuals with developmental or psychosocial disabilities face greater discrimination than individuals with physical disabilities. The former are more likely to be kept out of sight by their carers. Concerns about women with psychosocial disabilities being sexually assaulted or becoming pregnant can restrict their mobility, affecting their access to health services.

Gender and disability therefore work together to constrain women's and girls' access to health information and services in Lao PDR. This could potentially increase their risk of malaria and susceptibility to severe disease.

Resource 2.3

Global Policy Commitments to GEDSI in Health and Malaria

Global Policy Commitments to GEDSI in Malaria	
Document	**Relevance**
Sustainable Development Goals (2015)[1]	Adopted in 2015 by 193 countries, the Sustainable Development Goals (SDGs) are a call to action to end poverty, inequality, promote peace and protect the planet by 2030. There are 17 interconnected goals. Those that are particularly relevant to the promotion of GEDSI in health are: SDG3: Ensure healthy lives and promote well-being for all at all ages SDG5: Achieve gender equality and empower all women and girls SDG8: Promote inclusive and sustainable economic growth, employment and decent work for all SDG 10: Reduce inequality within and among countries The promotion of universal health coverage (target 3.8 of SDG3) is seen as integral to achieving health for all, ending poverty and reducing inequalities. SDG 10 commits signatories to empowering and promoting inclusion across all domains (social, economic and political), irrespective of age, sex, disability, race, ethnicity, origin, religion, economic or other status. Signatories should ensure equal opportunities and reduce inequalities of outcome by eliminating discriminatory laws, policies and practices and adopting inclusive legislation, policies and action.
Leave no one behind (2015)[2]	The commitment to leave no one behind is central to the SDGs, as is the emphasis on “reaching the furthest behind first.” Signatories to the SDGs have therefore committed to targeting the most vulnerable and marginalised individuals and groups, including those facing poverty and discrimination and those who lack access to health services. This could include children, older people, disabled individuals, refugees, migrants, displaced persons, individuals facing discrimination based on their sexual orientation or gender identity, prisoners, and people living in poverty.

[1] https://sdgs.un.org/goals.
[2] https://unsdg.un.org/2030-agenda/universal-values/leave-no-one-behind.

Global Policy Commitments to GEDSI in Malaria	
Document	**Relevance**
Political Declaration on Universal Health Coverage (2019)[3]	The Political Declaration on Universal Health Coverage was signed by all 193 of the United Nations member states in 2019. This recognises that all people, including the poorest, most vulnerable or marginalised parts of the population, should have timely access to health prevention and care and access to safe, affordable and effective quality medicines and vaccines. The Declaration requires signatories to proactively tackle health inequities and inequalities. It also recognises the need for accountable, integrated, community-based and people-centred health services.
Rio Political Declaration on the Social Determinants of Health (2011)[4]	The Declaration on the Social Determinants of Health was adopted by 125 United Nations member states in 2011 and endorsed by the World Health Assembly in 2012. Signatories, including many countries in the Asia Pacific region, have agreed to apply a social determinants of health approach to reduce health inequities. The declaration highlights the importance of increasing the participation of communities and civil society in decisions that affect their health. It requires signatories to prioritise a reduction in health inequity by addressing the underlying social and economic determinants of ill-health. Signatories must track progress towards the achievement of health equity and adopt accountability mechanisms that enable government and other key stakeholders to be held to account for the delivery of equitable health services.
United Nations Resolution on Ending Discrimination in Health Care Settings (2017)[5]	This joint statement commits UN agencies to support member states to tackle all forms of discrimination in health care settings. The statement recognises that discrimination is widespread and affects both the users of health services and health workers. Discrimination may be grounded in age, sex, race, ethnicity, health status, disability, vulnerability to ill-health, gender identity, sexual orientation, nationality, residence, legal status or criminal record. Discrimination is often directed towards individuals and groups who are already marginalised and stigmatised and runs counter to fundamental human rights, affecting access to health services and the quality of service received.

[3] https://www.un.org/pga/wp-content/uploads/sites/53/2019/07/FINAL-draft-UHC-Political-Declaration.pdf.
[4] https://www.who.int/publications/m/item/rio-political-declaration-on-social-determinants-of-health.
[5] https://www.who.int/news/item/27-06-2017-joint-united-nations-statement-on-ending-discrimination-in-health-care-settings.

Global Policy Commitments to GEDSI in Malaria	
Document	**Relevance**
United Nations Convention on the Rights of Persons with Disabilities (2016)[6]	The purpose of the Convention on the Rights of Persons with Disabilities is to: "promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity." This includes the right to attain the highest standard of health care. Persons with disabilities are defined as individuals who have long-term physical, mental, intellectual or sensory impairments which act as barriers to their full and effective participation in society. A key principle underpinning the Convention is that disabled persons should have a stronger say in the policies that affect their lives. By 2017, 43 of 50 countries in the Asia Pacific region had ratified the convention.
United Nations Convention on the Rights of the Child (1990)[7]	This covers all aspects of the child's life, including the right to health and health services. All countries in the Asia Pacific region are signatories to the United Nations Convention on the Rights of the Child.

[6] https://social.desa.un.org/issues/disability/crpd/convention-on-the-rights-of-persons-with-disabilities-crpd.
[7] https://www.unicef.org.uk/what-we-do/un-convention-child-rights/.

Global Policy Commitments to GEDSI in Malaria	
Document	**Relevance**
WHO Global Technical Strategy for Malaria 2016-2030 (updated 2021) (13)	The WHO Global Technical Strategy for Malaria is underpinned by a commitment to leave no-one behind. The strategy is built on three pillars, one of which is to ensure universal access to malaria prevention, diagnosis and treatment. The strategy highlights the importance of affordable health care for all those in need.
World Malaria Report 2024 (3)	The World Malaria Report 2024 highlights the importance of addressing vulnerabilities to malaria that are based on factors other than biology and the physical environment to address persistent health inequities and end malaria. This includes vulnerabilities that are grounded in socio-economic status, gender, disability, ethnicity, and migrant status. The report also highlights that the currently available disaggregated data does not provide the detail that is needed to fully understand the inequities faced by different population groups in relation to malaria prevention, diagnosis and treatment. It advocates for further data disaggregation.
The Global Fund Strategy: Fighting Pandemics and Building a Healthier and More Equitable World (2023-2028) (14)	The Global Fund's strategy (2023-2028) highlights that progress in malaria control and elimination has been uneven both between and within countries. It specifies that children under 5 and pregnant women, and rural and mobile populations are disproportionally affected by malaria and encounter a range of barriers when accessing malaria services. It also recognises that the poorest individuals face inequities in access to prevention and care. The strategy calls for intensified action to address inequities, human rights and gender-related barriers. It highlights the importance of involving the communities living with and affected by the disease in decision-making and promotes integrated, people-centred services. It emphasizes the need to equitably deploy innovations, making sure that these reach those most in need. The strategy also calls for a greater emphasis on data-driven decision-making and use of high-quality, disaggregated data.

Resource 2.4

Case Study: Are Female Forest Workers in Cambodia Being Missed?

Targeting forest workers in Cambodia: Are female forest workers being missed?

Cambodia's Malaria Elimination Action Framework (2021-2025) specifies that the highest risk groups for sustaining malaria transmission are MMPs, and within these, forest workers and visitors (15). Forest-goers engage in a range of activities including hunting, logging, fishing, and collecting forest products. Males of working age are at highest risk of malaria and are therefore targeted for key interventions.

However, various studies have highlighted that there are other groups who are involved in forest work and who can be at-risk:

- A 2017-2018 study in Mondulkiri province in the northeast of Cambodia (16) found an overall lower prevalence of all types of malaria among women compared to men (5.0% versus 13.3%) in forest areas. However, prevalence varied depending on the location of villages (i.e. located outside the forest; on the forest fringe; inside the forest). Prevalence rates for women were significantly higher in villages located inside the forest. These findings challenge the assumption that forest-going men of working age should be the primary target of malaria elimination efforts.

- Another study undertaken in Mondulkiri Province in 2021(17) found an overall malaria prevalence of 6.7%. Prevalence rates were 8.29% among men and 5.08% among women. All cases were asymptomatic. Although government policy is to target males aged 15 years and above for active case detection, the study found that forest-goers travel into the forest in mixed-sex and age groups. It is therefore important to ensure that the needs of women and children are addressed.

- Another study conducted in Oddar Meanchey Province in the northwest of Cambodia (18) examined the forest-going activities of loggers. Even in this sub-group of forest-goers, and contrary to assumptions about who undertakes strenuous work, some adult women, especially widows and women whose husbands could not work, were engaged in logging activities.

In some locations, therefore, high risk forest-going activities involve a broader range of the population, including women and children. Hence malaria elimination activities need to target entire villages within the forest. Within this approach, understanding the gender dimensions of preventive behaviours, health decision-making and access to diagnosis and treatment is essential.

Although prioritisation is important where resources are constrained, a narrow emphasis on male forest-goers may be crowding out attention to other aspects of equity thereby compromising malaria control and elimination efforts.

Resource 2.5

Case Study: Disability and Malaria Risk in Cambodia, Lao PDR and Viet Nam

Lack of evidence on disability and malaria risk in Cambodia, Lao PDR and Viet Nam

The prevalence of disability is 2.8%, 7% and 21% respectively in Lao PDR, Vietnam and Cambodia. Cambodia has one of the highest rates of disability in the world. In Lao PDR and Vietnam, the official prevalence rates are considerably below the global prevalence rate of 16%, as specified by WHO (19). Under-reporting is therefore likely.

All three countries are signatories to the UN Convention on the Rights of Persons with Disabilities. In addition, all have reasonably comprehensive national legal and policy frameworks on disability. These provisions provide for the equal rights of persons with disabilities to services and opportunities, including health care.

In practice, many barriers of access to health services exist for disabled persons in all three contexts. This includes a lack of access to information, financial access barriers, physical access barriers (e.g. long distances to services, or lack of accessible roads or ramps), other barriers such as a lack of materials in braille or staff able to use sign language, and personal and social barriers such as stigma and low confidence. Some disabled persons need to be accompanied to a health facility by a carer. This can increase the opportunity costs to households of accessing services and may result in reduced use.

Evidence on the relationship between malaria and disability is missing in all three countries. With 161,000, 3.4 million and six million disabled persons respectively in Lao PDR, Cambodia and Vietnam, higher priority needs to be given to the provision of inclusive malaria services.

The UN Convention on the Rights of Persons with Disabilities specifies that disabled persons should have a stronger say in the policies that affect their lives. This means that signatories to the convention are required to consult with disabled persons to ensure equity in the design and delivery of national malaria programmes. Within the respective NMPs, consultation with representatives of disability organisations will be an important starting point for the three countries to strengthen service delivery to be more inclusive of disabled persons.

Resource 2.6

Useful GEDSI Resources for NMPs

GEDSI Resources for NMPs		
Resource	**Author/Date**	**Description**
Disability-Inclusive Health Services Toolkit: A Resource for Health Facilities in the Western Pacific Region (20)	WHO (2020)	This toolkit provides practical guidance on how to improve access to health information and services and ensure quality service delivery for disabled persons. It contains hands-on operational guidance on how to promote disability-inclusive attitudes among health workers, how to address physical access barriers that affect the health care access of disabled persons, and factors to consider when providing disability-inclusive health information. It also looks at how to ensure that health information systems are disability inclusive.
Technical Brief: Equity, Human Rights, Gender Equality and Malaria (11)	The Global Fund (2022)	This technical brief provides guidance on how to ensure that malaria programmes, interventions and activities include measures to remove equity, human rights and gender-related barriers to information and services. Although aimed at applicants to The Global Fund, the brief is relevant to NMPs more generally.
How to Strengthen Gender Approaches within the Malaria Response (21)	The Global Fund (2025)	This resource provides further practical guidance from The Global Fund on integrating gender approaches into malaria programming. It focuses specifically on three key areas: (1) women's economic empowerment and the importance of their decision-making and bargaining power within the household (2) using ANC as an entry point for gender-focused malaria interventions and (3) promoting gender equality in the health care workforce.
Achieving a Double Dividend: The Case for Investing in a Gendered Approach to the Fight Against Malaria (22)	RBM, Malaria No More (2021)	This sets out the case for gender-based investments in malaria prevention, control and elimination as a pathway to achieving the eradication of malaria and improvements in women's and girls' status.

GEDSI Resources for NMPs		
Resource	**Author/Date**	**Description**
Gender Equality, Disability and Social Inclusion (GEDSI) in Malaria Elimination in the Asia Pacific Region (1)	APLMA (2024)	This report sets out the findings of a GEDSI baseline assessment and data audit of NMPs in the Asia Pacific region. The report summarises where progress has been made in integrating GEDSI perspectives across malaria programmes and where there are gaps.
Gender and Malaria Evidence Review (23)	Bill and Melinda Gates Foundation (2020)	This report provides a synthesis of the current evidence on the role of gender in mediating access to malaria prevention, diagnosis and treatment. It provides an overview of the evidence on how addressing gender inequalities in malaria endemic settings can accelerate burden reduction and disease elimination.
Access Barriers to Malaria Services for Migrant and Indigenous Populations - a GEDSI Review in Tak Province, Thailand	PlanCatalyst Team (2025)	This report examines barriers to malaria services faced by migrant, ethnic minority, and other marginalised populations along the Thailand–Myanmar border through a GEDSI lens. Using participatory methods, it identifies systemic, social, and health-system gaps and provides actionable recommendations to institutionalize inclusive, equitable malaria programming.

HOW TO USE THE TOOLS

Tools in this toolkit are designed for use by different audiences and levels of the health system. Where relevant, tools may be labelled as:

- Foundational – suitable for district or facility-level teams
- Intermediate – for provincial or national programme planners
- Advanced – for strategic reform, grant applications, or policy development

TOOL 2.1

CHECKLIST FOR ASSESSING NATIONAL POLICY COMMITMENTS TO GEDSI

While Tool 2.1 is primarily designed for national-level malaria programme teams, it can also be adapted for use in decentralised health systems where planning and implementation responsibilities sit at provincial, district, or local levels. In such contexts, the tool can be used to translate national GEDSI commitments into locally relevant operational priorities.

Checklist for Assessing National Policy Commitments to GEDSI	
Policies, Laws, Strategies	**Assessment Questions**
Wider Policy Environment	
National disability laws, strategies, plans	• Is the country a signatory to the United Nations Convention on the Rights of Persons with Disabilities? • Does the country have a national law on the rights of persons with disabilities? • What does the national law says about the rights of persons with disabilities to health?
National gender equality laws, strategies, plans	• Is the country a signatory to the Convention on the Elimination of All Forms of Discrimination Against Women 1979 (CEDAW)? • Is the country a signatory to the Beijing Declaration and Platform of Action 1995? • Does the country have a Gender Equality Law? • Does the country have a law on gender-based violence prevention and control?
National Socio-economic development plan	• What does the national socio-economic development plan say about inequities in access to opportunities and services? • Does the national socio-economic development plan include targets that focus on women, children, all genders, the disabled, ethnic minorities, refugees or IDPs?
Refugee and IDPs policies and laws	• Does the country have a policy to protect refugees or IDPs? • What do these say about the rights of refugees or IDPs to health care?

Checklist for Assessing National Policy Commitments to GEDSI	
Policies, Laws, Strategies	**Assessment Questions**
Health Policies	
National Health Strategy	• Is there a commitment to universal health coverage in the national health strategy? • What else does the national health strategy say about health inequities? • Does the national health strategy specify any groups that are particularly disadvantaged, vulnerable to health risks or who face barriers of access to health services? • What does the national health strategy say about the need for GEDSI focused data disaggregation?
National health insurance policy	• Does the country have a national health insurance policy? • Does this contain any provisions for the poorest or other vulnerable sections of society?
National Malaria Strategic Plan	• What does the NSP say about universal health care access and health inequities? • What groups are defined as high risk for malaria in the NSP? • Does the NSP mention disabled persons as being at high risk of malaria or as facing barriers of access to information and services? • Does the NSP consider vulnerability linked to socio-economic status, gender, disability, refugee/migrant status, ethnicity etc? • Does the NSP include any targets that relate to tackling health inequities? • What does the NSP say about the collection, analysis and use of GEDSI disaggregated data?

USING THIS TOOL IN DECENTRALISED SETTINGS

In decentralised systems, this tool may be adapted by:

- Replacing national policy references with provincial or district plans
- Using local service delivery data and community feedback
- Focusing on decisions that fall within subnational authority (e.g. outreach modalities, staffing, partnerships)
- Facilitating the tool through district planning workshops or routine review meetings

This allows subnational teams to align local action with national GEDSI commitments.

TOOL 2.2

GEDSI INTERVENTION PRIORITISATION TOOL

Population Group	Epidemiological Risk	Social Vulnerability	Programmatic Feasibility	Total Score
	Score 1-5, where 1=least risk / lowest vulnerability / least programmatically feasible			***Maximum score = 15***
Pregnant women				
People with disabilities				
MMPs				
Ethnic minority (1)				
Ethnic minority (2)				
Forest workers				
Artisanal workers				
[add here]				

HOW TO USE THE TOOL

NMPs can use this scoring matrix to prioritise population groups for intervention. Groups that are important in specific country contexts can be added.

When scoring (1 = lowest; 5 = highest), NMPs can take the following issues into account:

Epidemiological risk: Which population groups carry the highest biological risk for malaria? What is the estimated size of each group? What are the risks of not intervening?

Social vulnerability: Which population groups are at high risk of malaria, and of lacking timely access to malaria services, due to single or multiple vulnerabilities? What population groups were identified as being highly vulnerable by the Malaria Matchbox (or other equity assessments)?

Programmatic feasibility: What existing structures (e.g. ANC or CHW services) can be modified to support service delivery targeted to a specific population group – either within the NMP or that could allow integration of malaria services into their programme e.g. prison health, refugee health etc.? Are there known gaps in service provision to specific high-risk population groups that could affect the feasibility of intervening (e.g. MMPs)? Can these gaps be addressed by modifying or extending existing programmes in NMP or in other health programmes? What are the resource implications of making these changes?

The maximum score is 15. NMPs may decide to intervene to support those population groups with the highest scores initially. A plan can also be devised for intervening in medium priority areas as soon as resources become available or solutions to feasibility constraints are identified. Remember to monitor and evaluate any unforeseen consequences of marginalisation or discrimination, and ensure access is improved for the populations prioritised. Community led monitoring can assist NMPs to more deeply monitor and evaluate accessibility.

Section 3: Community Engagement and Feedback

3.1 Rationale for Community Engagement

Community engagement is a central component of the WHO Global Technical Strategy for Malaria 2016-2030 and is considered essential for the achievement of malaria control and elimination (13). WHO defines community engagement as "a process of developing relationships that enable stakeholders to work together to address health-related issues and promote well-being to achieve positive health impact and outcomes" (24).

The terms 'community participation' and 'community engagement' are often used interchangeably, although they are not the same (Box 4).

Box 4: Community Participation and Community Engagement

Community engagement is an intentional, strategic and comprehensive approach that involves an external party (e.g. district health office, local health facility or CSO partner) building a relationship with the community and working collaboratively to address issues and achieve shared goals. Community participation usually refers to individuals or groups taking part in a one-off or series of activities and may not involve a high level of decision-making on the part of the community.

The main differences between community participation and community engagement are examined in more detail in **Resource 3.1**.

Actively engaging communities and seeking their feedback is important in the context of malaria for several reasons. It is a process that enables programmes to better understand local needs, to tailor interventions to suit the cultural context, and build trust, which, in turn, helps to improve and sustain programme effectiveness. Feedback from communities can also help to shape research agendas, lead to the refinement of malaria interventions, or to policy changes. Switching top-down approaches for tailored and locally relevant approaches is key to finding sustainable solutions for malaria prevention, control and elimination (Box 5).

Box 5: Why community engagement in malaria is important

Community engagement is important in the context of malaria for several reasons:

Tailored Interventions:
Understanding community knowledge and attitudes and health-seeking behaviours is essential for designing effective strategies. Community engagement allows interventions to be tailored to suit the local context, beliefs and practices.

Understanding Barriers of Access:
Community engagement can reveal barriers of access to services that health authorities would otherwise not be aware of, creating opportunities to intervene. This could include lack of affordable transport options or women self-excluding from health services because of gender-based violence.

Increased Participation and Adherence:
When communities are involved in planning and implementing malaria control activities, they are more likely to participate and accept key interventions and advice, such as using bed nets, using preventive chemotherapies, or participating in environmental management for vector control.

Addressing Safety Concerns and Misinformation:
Community engagement provides opportunities to address concerns, correct misinformation, and build confidence in malaria interventions, including vaccines and other preventative measures.

Addressing Equity:
Community engagement can help ensure that interventions reach socially excluded and hard-to-reach populations, minimizing potential negative impacts and promoting equitable access to healthcare. Building knowledge and awareness among key stakeholders (e.g. communities, health workers, health authorities) of different forms of social exclusion and how to reach and include those affected, will be important.

Building Trust and Ownership:
Involving communities in decision-making helps build ownership of the interventions, leading to improved results. Community engagement can also improve trust between the community and health authorities.

Promoting Sustainability:
By promoting community ownership and participation, engagement efforts can help ensure the long-term sustainability of malaria control and elimination programmes.

Informing Research and Policy:
Community feedback and engagement can be helpful in shaping research priorities, refining intervention strategies, and informing and advocating for policy decisions related to malaria control and elimination.

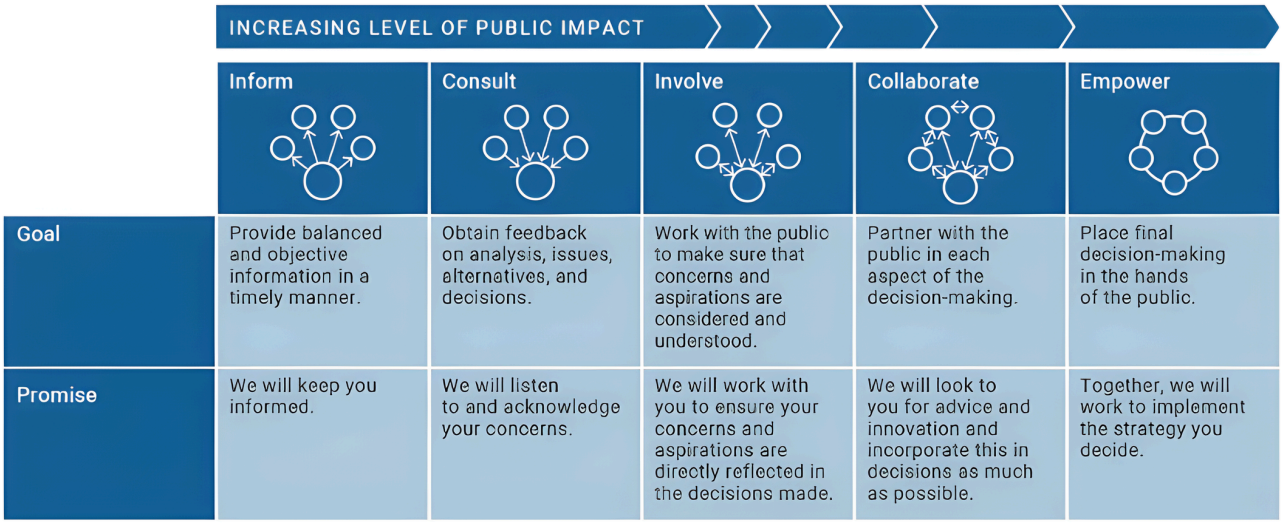
The importance of community engagement and feedback in health has been recognised since the late 1970s when the Alma-Ata declaration on Primary Health Care was agreed. Since then, numerous studies have described how community engagement has contributed positively to different aspects and components of disease-specific interventions. Yet a lack of robust empirical evidence of the public health benefits of community engagement within the context of malaria has made it challenging for malaria programmes to lobby for increased funding for this component (25). As a result, community engagement has been marginalised within malaria control and elimination programmes over the years (26).

Community engagement will become increasingly important as countries get closer to elimination and public perceptions of malaria risk lessen. In an elimination context, active rather than passive participation of communities in malaria prevention, surveillance and treatment is required (26). An example is building community support for the radical cure of *P. vivax*, which may require community members to complete a lengthy course of treatment despite experiencing asymptomatic malaria. Another example is the active participation by communities to map larval habits and assist with their destruction.

3.2 Levels of Community Engagement

The concept of a 'Ladder of Participation' was devised by Sherry Arnstein in 1969 (27). This offers a hierarchy of community participation in civic activities progressing from non-participation to tokenistic participation to full community control. This concept has been widely used in and adapted for the health sector. For example, the University of California San Francisco's (UCSF) continuum of community engagement shows how the public health impact of an intervention increases with increasing levels of community engagement from passive forms (being informed about a health intervention) to more active forms (communities collaborating to deliver the intervention or being in full control of decision-making) (Figure 3).

Figure 3: Continuum of Community Engagement, UCSF



Source: APLMA. Community Engagement for Vector Borne Disease Control in Asia Pacific. 2023; Singapore: APLMA

WHO has devised four approaches to community engagement which range from the lowest level of community engagement (informing and mobilising the community) to the highest (where an intervention is community-owned) (28) (Figure 4). Decisions about the most appropriate approach to use will depend on the social and epidemiological context.

Figure 4: Approaches to Community Engagement, WHO

			
Community-oriented	**Community-based**	**Community-managed**	**Community-owned**
The community is informed and mobilised to participate in addressing immediate short-term concerns with strong external support.	The community is consulted and involved to improve access to health services and programs by locating interventions inside the community with some external support.	There is collaboration with leaders of the community to enable priority settings and decisions from the people themselves with or without external support of partners.	Community assets are fully mobilised, and the community is empowered to develop systems for self-governance, establish and set priorities, implement interventions and develop sustainable mechanisms for health promotion with partners and external support groups as part of a network.

Source: APLMA. Community Engagement for Vector Borne Disease Control in Asia Pacific. 2023; Singapore: APLMA, adapted from WHO. Community Engagement: A Health Promotion Guide for Universal Health Coverage in the Hands of the People. 2020; Geneva: World Health Organization

In practice, there is both a conceptual and practical gulf between community engagement (a local, iterative process that relies on good communication, feedback loops and adaptation) and the way in which the health sector functions (from both biomedical and administrative perspectives) (29). It is therefore important to learn from NMPs and their partners that have managed to navigate these differences.

3.3 Enabling Factors for Community Engagement

There is a large literature on community engagement in global health. Implementation experiences spanning decades, and a distillation of lessons learned, suggest that there are some important enablers of effective community engagement. These include involving communities - including diverse subgroups within them as early as possible in the engagement process; providing supportive leadership; recognising power imbalances between communities and external bodies (i.e. health authorities, health facilities, CSOs); proactively identifying and addressing exclusion; and ensuring that women, people with disabilities, ethnic minorities, migrants, and other marginalised groups are meaningfully heard and engaged. Identifying early tangible wins remains important for building trust and momentum. Further information on enabling factors for community engagement can be found in **Resource 3.2.**

3.4 Entry Points for Promoting Community Engagement

Many potential entry points for community engagement exist within the programme or project cycle. Some examples can be found in Table 2.

Table 2: Community Engagement Opportunities in the Project or Programme Cycle

Phase	Community Engagement Opportunities
Identification	• Carry out a participatory needs assessment (of gaps in services, unmet needs, barriers of access, opportunities) with target communities • Undertake participatory stakeholder analysis to identify all the people who will be affected by the programme or intervention • Engage the community in problem analysis and identify the root causes • Work with target populations or their representatives to define the potential scope, scale and boundaries of the intervention
Design	• Establish a mechanism for ongoing community input to the design process to ensure relevance and responsiveness to community needs • Involve the community in a risk assessment, identifying potential obstacles to implementation and how these can be mitigated
Implementation	• Establish a process for ongoing communication and feedback with traditional or other community leaders • Create opportunities for the wider community to feedback on implementation experiences • Strengthen community health committees so that they can oversee implementation • Ensure that CHWs receive training on community engagement and mobilisation (in addition to service delivery) • Identify ways to involve community members in service delivery • Partner with local CSOs to support different aspects of service delivery
Monitoring, Evaluation and Learning	• Build the monitoring capacity of community health committees so that they can hold health authorities to account • Engage a CSO (ideally one with a track record of working with at-risk/ underserved groups) to undertake Community Led Monitoring of service delivery • Train CHWs to collect data useful for wider programme / intervention monitoring • Feedback to target communities on adjustments to programme activities in response to monitoring data • Involve CSOs or representatives of underserved or at-risk groups for malaria on evaluation teams • Capture community insights on the intervention/programme to inform lesson learning and future intervention design • Involve community representatives in programme dissemination activities so that they can share their first-hand experience

To take advantage of these potential community engagement opportunities, NMPs need to:

- Consider what **technical skills and capacity** are needed to implement and support a community engagement approach. Are these available internally or will they need to be obtained outside the NMP? For example, are there CSOs that specialise in community engagement in health that can be contracted to work with the NMP?

- Consider what **resources** will be needed to support community engagement in different parts of the project or programme lifecycle. Countries that are eligible for Global Fund grants can explore what funding for community engagement is available through the resilient and sustainable health and community systems grant funding component. For example, funds may be available to support Community Led Monitoring.

- If resources are constrained, **prioritise** the most important community engagement entry points. Community engagement at the problem identification phase will almost always be a priority since without this, it will be impossible to appropriately tailor interventions to the implementation context. NMPs will need to decide what other entry points can be supported to promote community engagement.

- Build on existing **systems, processes and structures**. For example, if CHWs are already working in the target communities, the NMP may need to consider what additional skills will be required by CHWs to effectively engage with and mobilise their communities. Alternatively, if community health committees exist, NMPs may wish to consider how these can be strengthened as a mechanism to enhance community engagement.

Community engagement opportunities linked to malaria prevention, diagnosis and treatment and surveillance are highlighted in **Resource 3.3.**

3.5 Community Engagement Approaches

A variety of community engagement approaches have been used effectively in the health sector and to support NMPs. This includes ethnographic research, community discussion groups, the Role Model Approach, use of innovative change and delivery agents, participatory monitoring and evaluation, and support for strengthening local health committees. Further information on these approaches can be found in Table 3.

Table 3: Community Engagement Approaches Used to Support Malaria Programmes[4]

Approach	Description
Ethnographic research / qualitative research	Ethnographic research and other qualitative research methodologies can be used to understand the needs and preferences of communities that are at risk of malaria. Ethnographic research uses a cultural lens to understand the behaviours, perspectives and interactions that shape the way of life of a particular group. The approach utilises direct observation, interviews, field notes or diary studies (where research subjects document their experiences and perspectives over time). This information can be used to co-design locally appropriate malaria interventions. NMPs may decide to commission an academic partner to undertake ethnographic research.
Community discussion groups / community dialogues	Community discussion groups or dialogues have been successfully used to promote malaria-related attitudinal and behaviour change. The approach involves a series of discussion sessions, facilitated by an individual with appropriate training (this could be a CHW, a health worker or a CSO representative). Participants are encouraged to examine a particular health issue (e.g. severe malaria) based on their own experience or the experience of someone known to them, to consider the factors that acted as barriers and delays to a successful outcome, and to devise actions that can be taken in future in order to improve the outcome. The approach places considerable emphasis on challenging myths and misconceptions that prevent appropriate health-seeking behaviour and supporting communities to translate their new knowledge into action. Community discussion group participants usually 'graduate' from a group once they have completed all sessions.
Role Model Approach	The role model approach is grounded in the idea of 'positive deviance.' This is where individuals who have positive but uncommon behaviours are recruited to share their experiences with other community members.
Use of innovative change and delivery agents	Non-traditional change and delivery agents can be used to support health promotion or service delivery to reach under-served or difficult-to-reach populations. Examples are targeting malaria health promotion activities to school children and encouraging local dissemination or use of community rangers to distribute forest packs, which contain LLINs and other malaria preventive products, to individuals working in forest areas that have high malaria transmission.

Approach	Description
Participatory monitoring and evaluation	Participatory monitoring and evaluation involves a diverse range of community members in programme or project monitoring and evaluation. It is therefore different to routine M&E in that the community plays a much more visible and significant role in measuring performance. The process helps to build ownership of health interventions and ensures that qualitative and quantitative performance data accurately capture the local situation and reflect community perspectives on the performance of an intervention. Community-based monitoring (CBM) and Community-Led Monitoring (CLM) are different forms of participatory monitoring and evaluation. CBM involves communities in an assessment of the services that they use from the perspective of effectiveness, quality, accessibility, acceptability and affordability. CBM includes any type of monitoring that involves communities. However, although communities participate in CBM, they may not lead or control it. In contrast, CLM places communities – or the CSOs that represent them – in charge of monitoring. Communities design the monitoring system, collect and analyse data and advocate for service improvements, thereby holding service providers to account for gaps or service delivery failures.
Strengthening community health committees	Many communities have a local health committee. If supported to operate effectively, these committees can help communities to hold local health workers and health authorities to account for service delivery gaps or failures. They can also be a means by which a community can oversee or help shape implementation of a malaria intervention and hence can offer a useful means by which to promote community engagement.

Source: Adapted from APLMA. Community Engagement for Vector Borne Disease Control in Asia Pacific. 2023; Singapore: APLMA

Resource 3.4 looks at the ways in which the Ministry of Health, Thailand is incorporating a stronger focus on community engagement in the NMP. This includes a focus on Community Led Monitoring.

Resource 3.5 examines the factors that contributed to effective community engagement in Lao PDR in the context of a mass drug administration intervention.

Resource 3.6. highlights some useful general resources and reference materials relating to community engagement in malaria.

Summary

- Community engagement is essential for the achievement of malaria control and elimination and will become increasingly important as countries get closer to elimination
- Community engagement enables NMPs to better understand local needs, tailor interventions to the cultural context, and build trust with communities, which is good for sustainability
- A variety of approaches can be used to engage with communities, including ethnographic research, community discussion groups, the Role Model Approach, and participatory monitoring and evaluation, including Community Led Monitoring
- There are many potential entry points for community engagement within the project or programme cycle. NMPs can select priority entry points based on their available capacity and resources and building on existing systems, processes and structures

Section 3: Resources and Tools

Resource 3.1: Comparison of Community Participation and Community Engagement
This highlights the main differences between community participation and community engagement

Resource 3.2: Enabling Factors for Community Engagement
This highlights some of the key enablers of effective community engagement based on decades of community engagement experience

Resource 3.3: Community Engagement Opportunities in Prevention, Diagnosis and Treatment and Surveillance
This provides examples of community engagement opportunities in different parts of the malaria programme, namely prevention, diagnosis and treatment and surveillance

Resource 3.4: Case Study: Strengthening Community Engagement Within Thailand's National Malaria Programme
This provides an overview of the various ways in which the Ministry of Public Health in Thailand is strengthening its focus on community engagement within the NMP

Resource 3.5: Case Study: Community Engagement within Context of Mass Drug Administration Intervention in Lao PDR
This examines the factors that contributed to successful community engagement within the context of a Mass Drug Administration intervention in Lao PDR

Resource 3.6: Useful Resources on Community Engagement and Feedback
This highlights useful resources and reference materials relating to community engagement and feedback

Resource 3.1

Comparison of Community Participation and Community Engagement

Domain	Community Participation	Community Engagement
Meaning	• Involves individuals or groups taking part in an activity • Activities are often part of a pre-defined plan or programme	• An intentional, strategic and comprehensive approach • Involves an external party a building relationship with the community, encouraging dialogue, and working collaboratively to address issues and achieve shared goals
Focus	• Emphasis on delivery of tangible actions by individuals or groups	• Emphasis on relationship-building • Collaborative problem-solving • Focus on mutual understanding • Shared decision-making
Examples	• Survey participation • Attending community outreach • Participating in environmental management for vector control	• Working with a community to devise a locally and culturally appropriate SBCC strategy • Partnering with a CSO to ensure that malaria services reach underserved populations • Co-creating a locally appropriate plan for community-based service delivery
Characteristics	• One-off event or series of activities • May not involve a high level of decision-making on the part of participants	• Ongoing process • Emphasis on building trust • Shared decision-making prioritised
Impact(s)	• Increased awareness • Increased involvement in activities	• Potential to empower communities • Potential for sustained change

Resource 3.2

Community Engagement Enablers

Enabler	Description/Rationale
Provide supportive leadership to target communities based on transparency	It is important that external organisations avoid being too directive or restrictive when supporting communities to participate in community engagement processes. An emphasis on being a good facilitator is key as is a commitment to good communication.
Create trusted and supportive environments for community engagement	Ensuring that communities can participate comfortably, conveniently and easily is essential to effective community engagement. This means holding meetings when and where convenient to communities, ensuring that there are no impediments to communication (e.g. language barriers / use of highly technical language), and recognising community preferences for different meeting formats.
Promote early involvement of communities	Communities need to be involved in identifying their own health care needs and potential solutions to address access and other barriers to utilisation of services. This not only helps to identify contextually appropriate interventions but also builds community ownership.
Shared decision-making and governance control	Communities need to be supported to take on decision-making and governance roles within a community engagement process. This could include strengthening community health committees so that they can call health facility staff or local health authorities to account. Representatives of GEDSI target groups could also be included on governance mechanisms (i.e. task forces, oversight committees etc).
Recognise power imbalances between communities and institutions	Perceived hierarchies of power and decision-making between communities and professionals working in local health authorities, health facilities or CSOs can undermine effective engagement. External bodies need to recognise communities' right to engage and to make independent, informed decisions. A participatory approach can help to ensure that communities have a voice in decision-making.

Source: Adapted from Weger, E., Van Vooren, N., Luijkx, K.G. et al. Achieving successful community engagement: a rapid realist review. BMC Health Serv Res 18, 285 (2018). https://doi.org/10.1186/s12913-018-3090-1.

Enabler	Description/Rationale
Pursue equity of engagement	Supporting the participation of individuals or groups who lack the skills, capacity or confidence to engage is important. This can help improve outcomes. An example is empowering socially excluded individuals to become successful peer educators.
Create and celebrate tangible, early wins	Communities are likely to be motivated if they see early changes because of their engagement. Early wins (e.g. a child with severe malaria whose life is saved) can help to sustain community engagement.
Be transparent about the motivations of both the target community and the partner organisation	It is important to clarify what motivates the community and the local health authority, health facility or CSO to work together to improve health. Motivations may differ, but clarifying common ground is important for transparency and ensuring community support. Clear and transparent communication is important.

Source: Adapted from Weger, E., Van Vooren, N., Luijkx, K.G. et al. Achieving successful community engagement: a rapid realist review. BMC Health Serv Res 18, 285 (2018). https://doi.org/10.1186/s12913-018-3090-1.

Resource 3.3

Community Engagement Opportunities in Prevention, Diagnosis, Treatment and Surveillance

Intervention Area	Community Engagement Opportunities
Prevention	• Involve whole communities in malaria health promotion activities using community engagement approaches such as community discussion groups/dialogues that facilitate two-way communication • Contract local CSOs to deliver malaria prevention activities • Train CHWs to raise community awareness on how to prevent malaria • Train CHWs to recognise Anopheles larvae, larval habitats, and engage communities in their destruction, where feasible • Involve CHWs, traditional leaders or CSOs in planning and implementing LLIN distribution • Train peer educators from the community (e.g. from ethnic minorities) • Partner with organisations that provide health services for high risk or underserved groups to support LLIN distribution through their services • Hire community members as IRS sprayers (ensuring a gender balance) • Work with traditional leaders to prepare the community for IRS
Diagnosis and Treatment	• Train CHWs to facilitate referral of community members for suspected severe malaria, G6PD testing or radical cure of P. vivax • Support communities to establish community-managed systems to address barriers and delays to use of malaria services • Train CHWs to undertake directly observed therapy for *P. vivax* radical cure or community IPTp • Involve communities in the design of mass drug administration interventions to ensure acceptable, convenient and responsive service delivery
Surveillance and response	• Train CHWs to undertake malaria surveillance (e.g. gather data on malaria cases, vector populations and environmental conditions) • Partner with local CSOs to undertake malaria surveillance within areas with known high-risk or underserved populations • Involve local health committees in malaria surveillance and response activities

Resource 3.4

Case Study: Community Engagement and Community-Led Monitoring in Thailand's Malaria Programme

Community Engagement in Thailand's Malaria Programme

Thailand's National Malaria Elimination Strategy 2017-2026 specifies that community engagement is a central pillar of effective malaria elimination in the country (30). The Ministry of Public Health is fulfilling this commitment in several ways. This includes:

- Recognising the central role of CSOs in supporting malaria elimination efforts.
- Investing in various community health worker cadres (i.e. Village Health Volunteers, Malaria Post Workers, Migrant Health Volunteers and Migrant Health Workers) to ensure that malaria services are available as close to the community as possible and meet the needs of specific at-risk or vulnerable groups (e.g. mobile and migrant populations).
- Undertaking social inclusion, gender and other assessments with the intention of identifying appropriate ways to engage with key risk groups for malaria.
- Introducing Community Led Monitoring. This approach will engage mobile and migrant populations in assessing the accessibility, appropriateness and quality of malaria services and opportunities for improvement. Evidence generated through this mechanism will be used by service providers, malaria programme personnel and policy makers to develop and implement solutions to problems identified by the community. This is expected to improve the cultural appropriateness, social inclusiveness and equity of malaria services.

Resource 3.5

Case Study: Community Engagement within a Mass Drug Administration Intervention in Lao PDR

Community Engagement within a Mass Drug Administration Intervention in Lao PDR

A mass drug administration (MDA) intervention for malaria implemented in Lao PDR from 2015-2016 was supported by a comprehensive community engagement approach (31). The intervention was implemented in four *Lao Theung*-speaking villages in Nong District, Savannakhet Province. These were remote sites and located close to the border with Vietnam. The community engagement strategy contributed to a high level of community participation in the intervention – above 85% population coverage was achieved.

Key elements of the community engagement strategy that supported the effective implementation of MDA were as follows:

- **Formative research** was carried out prior to the intervention. This was undertaken to gain insights into the local socio-economic, cultural and governance contexts and data on the knowledge, attitudes and perceptions about malaria and MDA. Tools used included a quantitative survey, focus group discussions, meetings and observations. The data generated by the research informed the design of the community engagement strategy.

- Time was taken to **sensitise, build consensus and collaborate on an ongoing basis with government authorities** at different levels. This helped to create an enabling environment for the implementation of MDA.

- **Building the capacity of local human resources in support of a community-directed approach.** Local volunteers were trained in MDA and allotted responsibility for its implementation. This helped to build community ownership and trust of the intervention. The volunteers listened to villagers' concerns, and the feedback was used to adjust the community engagement approach in line with expressed community needs.

- **Adopting a responsive approach.** The community's response to the MDA intervention was monitored on an ongoing basis. This meant that the community engagement strategy could be adjusted in real-time in response to any opportunities or challenges.

- **Sharing control / leadership with the community.** Joint decision-making between the wider MDA intervention team and the community volunteers on the timing of MDA, surveys and community engagement activities helped build community ownership of the intervention. Timeframes and other aspects of implementation were adjusted in response to volunteer feedback which, in turn, was based on their consultation with the wider community. The community volunteers were also empowered and motivated to trouble-shoot implementation challenges.

Resource 3.6

Useful Resources on Community Engagement and Feedback

Resources for NMPs: Community Engagement and Feedback		
Resource	**Author/Date**	**Description**
Community Engagement: A Guide to Opportunities Throughout the Grant Lifecycle (32)	The Global Fund (2022)	This technical brief provides a rationale for placing communities at the centre of development programmes. It highlights entry points to strengthening community engagement in malaria, TB and HIV/AIDS programmes and stumbling blocks to effective engagement. The resource focuses on The Global Fund grant lifecycle, but contains guidance and lessons learned that are relevant to malaria programmes.
Community Engagement for Vector-Borne Disease Control in Asia Pacific (33)	APLMA, APMEN, Malaria Consortium (2023)	This resource provides a rationale for community engagement and participation in vector control and highlights various approaches that can be used to engage communities (e.g. ethnographic research, community dialogue approach, role model approach, use of innovative change and delivery agents, and participatory monitoring and evaluation). It also shares lessons from community engagement experiences in the Asia Pacific, focusing on testing, treatment and surveillance, vector control and social and behaviour change communication.
Community Engagement: A health promotion guide for universal health coverage in the hands of the people (34)	WHO (2020)	This guide highlights the rationale for and benefits of community engagement within the context of health promotion. It provides an overview of theoretical models of community engagement and considers different levels of community engagement (i.e. inform, consult, involve, collaborate and empower). Community engagement principles, enabling factors and applications are highlighted. The guide introduces four approaches to community engagement: community-oriented, community-based, community-managed and community-led. Each involves a different level of community involvement. The guide contains practical tools such as a checklist for developing a community engagement strategy and case study material from around the world.

Resource	Author	Description
The architecture and effect of participation: a systematic review of community participation for communicable disease control and elimination: Implications for malaria elimination. Malaria Journal (25)	Atkinson *et al* (2011)	This article reports on a review of 60 years of literature on community engagement and participation. It highlights that community engagement and participation have been important for disease control and elimination in many countries. However, the benefits of these approaches have not yet been realised in the context of malaria programmes. The article concludes that it is important to invest appropriate resources in the 'people' component of health systems and look for ways to maximise community participation.
Community-led Monitoring Guide for Key Malaria Programs for Civil Society Organisations (35)	CS4ME (2022)	This practical guide provides an overview of CLM: what it is, why it is important and how it works. It introduces readers to the data collection and analysis processes that lie at the centre of CLM, provides guidance on data quality assurance, and the effective use of data to improve decision-making.
Best Practices for Community-Led Monitoring (36)	CLAW (2022)	This document, compiled by the Community-Led Accountability Working Group, documents best practices relating to the implementation of community-led monitoring. It looks at implementation arrangements and approaches that help deliver CLM more effectively. The document draws on experience and lessons learned from many countries that have implemented CLM.
A Global Exchange on the Role of Community-Led Monitoring in Malaria Programming: Meeting Report, June 1-2, 2023, Cape Town, South Africa (37)	The Global Fund (2023)	This meeting report highlights how CLM has proved to be an effective intervention in the context of HIV/AIDS and tuberculosis and discusses its potential within the context of malaria. Examples of how different countries have adopted CLM, including from Thailand and Pakistan, are highlighted.
CLM Hub Available at: https://itpcglobal.org/2022/11/28/resources-to-help-you-fund-implement-clm-community-led-management-project/	ITPC	This online resource provides access to numerous useful resources on CLM, including advice on how to budget for CLM.

Section 4: GEDSI-Sensitive Service Delivery

4.1 Overview

GEDSI-sensitive service delivery helps to address structural inequalities by ensuring that marginalised and underserved groups benefit equally from investments in the health sector. This includes women, children, disabled persons, refugees, internally displaced persons, ethnic minorities or indigenous people.

This section introduces the GEDSI Continuum, a tool that can be used to determine whether, and the degree to which, service delivery is GEDSI-sensitive. It also highlights issues to consider from a GEDSI perspective when designing malaria interventions, whether an IRS campaign, SBCC activities or malaria chemoprevention activities.

Three key strategies that can be used to improve GEDSI outcomes and impacts from malaria-related service delivery are briefly discussed. These are:

- CHW programmes that bring services closer to communities
- Addressing demand-side barriers and delays to the use of malaria services
- Training in social inclusion for front-line health providers

4.2 GEDSI-Sensitivity Framework

The GEDSI Continuum is a useful tool for assessing the extent to which service delivery is GEDSI-sensitive. The Continuum has four levels: two are unresponsive to GEDSI issues and two are responsive.

Based on the Continuum, service delivery can be **GEDSI blind** if it ignores GEDSI and does not acknowledge the existence of power imbalances and harmful social norms and stereotypes. Examples are:

- Constructing health facilities that are inaccessible to disabled persons
- Placing health workers who do not speak the local language in a health facility frequented by ethnic minorities
- Channelling information on malaria services through male household heads who may view women's and children's health as a low priority

Service delivery can be **GEDSI insensitive** if policy makers, planners and programme staff are aware of inequalities, but do not take action to address these. It can also be GEDSI insensitive if service delivery reinforces or takes advantage of GEDSI inequalities. Examples of the latter include:

- Encouraging women to work as volunteer CHWs, reinforcing the unpaid work that they do at household level in domestic labour, as carers or as community actors
- Designing SBCC materials in languages that are inaccessible to ethnic minorities
- Using printed materials in low literacy contexts when language or literacy barriers are known to be a barrier to health service access or where people sight impairments cannot access

Service delivery can be **GEDSI sensitive** if barriers, delays, stigma and discrimination, stereotypes and power imbalances are acknowledged, and steps are taken to address the practical needs of marginalised groups. Examples include:

- Ensuring that health services are physically accessible to disabled persons or that health workers can use sign language
- Training health workers on how to recognise and include socially excluded individuals in a safe non-discriminatory manner

Finally, service delivery can be **GEDSI transformative** if it challenges unhelpful social and gender norms and empowers marginalised and excluded groups. Examples include:

- Breaking down unhelpful gender norms and stereotypes that prevent women and girls from accessing malaria diagnosis and treatment promptly (e.g. men and other gatekeepers giving higher priority to women's health within the household, or men taking on responsibility for childcare so that women can access healthcare unhindered)
- Achieving a gender balance in CHW recruitment thereby providing both women and men in the community with role models who demonstrate new health behaviours, break down social, gender and other barriers and delays, and enable wide social approval for behaviour change
- Supporting women, men and people with disabilities to be engaged in vector control activities e.g. IRS, vector surveillance

NMPs can use the GEDSI Continuum as a tool to review existing and new malaria interventions. The tool will help to highlight opportunities to strengthen the GEDSI focus of key interventions and improve GEDSI outcomes and impacts.

Resource 4.1 provides more information on the GEDSI Continuum.

4.3 Working with a GEDSI Lens

Working with a GEDSI lens involves consistently analysing decisions and interventions to ensure that they promote equal rights, capabilities and opportunities for all. Tools 4.1 – 4.6 are checklists that can be used to support the GEDSI-sensitive design of the following:

- Regular SBCC activities
- IRS campaigns and activities
- LLIN campaigns and activities
- Malaria diagnosis and treatment services
- Severe malaria services
- Chemoprevention interventions

The checklists highlight questions that are important from a GEDSI perspective for different marginalised groups (e.g. refugees, women and girls, disabled persons, ethnic minorities). NMPs can use the checklists in the GEDSI toolkit as a starting point to apply a GEDSI lens, adding their own questions, based on the local and country context. NMPs will need to draw on GEDSI expertise to compile their own checklists. This expertise may already exist within the NMP or Ministry of Health. If not, it may be possible to access this expertise in other government departments, or from outside government (e.g. through development partners, CSOs or academia). Over time, however, it will be important to build the skills and capacity of NMP staff so that they can carry out their own GEDSI analysis.

4.4 Strategies for GEDSI-sensitive Service Delivery

This section looks at three strategies that can help to promote GEDSI-sensitive service delivery.

Community Health Workers

There is an extensive and growing evidence base to suggest that community health workers (CHWs) are effective in the delivery of a range of preventive and curative health services, enhance access to care, ensure continuity of service, and contribute to reducing inequities in access to care. The evidence also suggests that CHWs can help to narrow the gap between communities and the health sector, enhancing communication, understanding and trust (38-40).

By bringing services closer to communities, CHWs help to reduce some of the barriers and delays to utilisation. They can also be deployed specifically to reach underserved groups and communities. For instance, on the Thai-Myanmar border, CHW cadres called Village Health Volunteers (VHVs) and Migrant Health Volunteers (MHVs) are bringing information on malaria prevention and supporting referral for diagnosis and treatment to locations with large numbers of MMPs and where malaria transmission rates are high. The MHVs are purposely selected from within the MMP population with the aim of providing role models who can demonstrate healthy behaviours to their peers in culturally familiar ways. This is helping to break down barriers and delays to malaria information and services within this underserved sub-population.

In Papua New Guinea, CHWs recruited under the Home-Based Management of Malaria Programme are increasing the access of very isolated communities to malaria information, diagnosis and treatment. There are many other examples of CHWs being deployed to reach underserved communities in the Asia Pacific region, for example, forest workers in Cambodia and Vietnam.

Resource 4.2 looks at the work of CHWs working in remote and hard-to-reach communities in Papua New Guinea.

Resource 4.3 looks at the work of the VHVs in addressing malaria among MMPs along the Thai-Myanmar border.

To ensure that community-based malaria services are inclusive from a disability perspective, there may be scope to deploy CHWs to identify, reach and include disabled persons in their activities. A broad-based training on social inclusion for CHWs, which includes a disability focus, would help to build their knowledge, capacity and confidence to identify and reach under-supported individuals within the community. The social inclusion training can also cover topics such as how to reach and include individuals who face stigma and discrimination when accessing health information and services.

Addressing Demand-side Barriers and Delays

NMPs work hard to ensure that malaria services are high quality, that essential drugs and consumables are procured on time and available where needed, including in remote locations, and that human resources for health are effectively deployed, have the appropriate skills and capacity, including communication, counselling and cultural competence and are provided with supportive supervision. To increase demand for services, SBCC are implemented to increase knowledge and awareness of preventive behaviours for malaria and timely treatment seeking within communities that are at risk of malaria. However, it is also important that NMPs consider how to address the other barriers that exist at household and community level to ensure that communities can utilise services. The SBCC should be appropriate to the diverse groups within the population who need access to the SBCC and should be evaluated to ensure no-one was left behind.

In rural and remote areas especially, a variety of household and community level barriers and delays prevent community members from accessing malaria information and services. Although some of these barriers and delays derive from a lack of awareness, others are practical and include lack of access to affordable transport or lack of childcare. Others still have their roots in gender inequality and involve women's lack of scope for independent decision-making about their own or their children's health, women's ability to travel alone, or a lack of male involvement in children's health. Common barriers and delays are highlighted in Table 4. Still others may be linked to poor accessibility of services for people with disabilities.

Understanding and working to remove barriers and delays to appropriate treatment-seeking and adherence is essential, especially in contexts where malaria transmission rates remain stubbornly high. In some low-income country contexts, CHWs have been successfully trained to address these issues.

Table 4: Household and Community Barriers and Delays to Use of Malaria Services

Barriers and Delays	Description
Lack of Awareness	
Lack of awareness of malaria prevention, diagnosis or treatment or danger signs of severe malaria	Community members may not be aware of how to protect themselves from malaria infection, or of the signs and symptoms of malaria and therefore fail to act.
Lack of awareness of the need to complete the full treatment for malaria, including radical cure of *P. vivax*	Individuals with malaria and caregivers may not complete the full treatment for malaria because there has been a temporary improvement in their condition. In addition, community members with asymptomatic malaria may not understand the importance of beginning treatment for radical cure of *P. vivax*.
Preference for local remedies	Community members may hold particular beliefs about the cause of fever and may prefer traditional remedies to treat sick patients. They may have better access to informal health providers and/or they may feel they are treated with more respect by someone of their own culture.
Lack of prioritisation of health based on competing needs / priorities	Malaria may not be given priority in contexts where there are multiple pressures on families.
Lack of knowledge of role of CHWs	Community members may lack information on the role of CHWs (e.g. where they reside; their availability; whether they charge for services etc).
Stigma and Discrimination	
Lack of trust in local health facility	Some community members may not feel comfortable using the local health facility, perhaps because of a disappointing visit in the past, due to feedback from other members of the community, or because they have experienced discrimination. Women may feel uncomfortable socio-culturally (or even not allowed) to be seen by men providers.
Lack of confidence to use the health facility	Refugees, undocumented workers, or internally displaced persons may feel unwelcome at the health facility due to their irregular legal status.

Barriers and Delays	Description
Gender-based Barriers	
Lack of scope for independent decision-making on health issues	Women may not be able to take independent action without the permission of their husband or another member of the household. People with disabilities are often also not able to take independent action due to social norms.
Lack of access to money	Women and people with disabilities may lack an independent source of money and therefore not be able to afford to travel to the health facility without financial support.
Gender-based violence (GBV)	Survivors of GBV may experience significant and long-term impacts on their mental health, wellbeing, and ability to care for themselves and others. GBV is frequently accompanied by stigma, discrimination, and social exclusion. Persons with disabilities are at increased risk of GBV due to intersecting barriers related to gender, disability, social norms, and unequal power relations.
Financial Access Barriers	
Lack of money to go to the health facility	Some community members may lack the funds required to travel to and stay at the health facility.
Opportunity costs of travelling to the health facility	Some community members may forgo work to travel to the health facility or arrange for child care. They may not be able to afford to do this.

Barriers and Delays	Description
Physical Access Barriers	
Lack of affordable transport	Some communities lack transport with which to travel to the health facility. Other communities may have transport options that are unaffordable or not safe for women or people with disability to use.
Other physical access barriers	Some communities may be located a long distance from the health facility. The terrain may be challenging to navigate by foot or even by some modes of transport. These barriers may be especially challenging for people with disability and older persons.
Seasonal physical access barriers	Some communities may be cut off seasonally due to flooding (e.g. crossing points on rivers may be washed away), landslides and other natural events.
Other Practical Barriers	
Reliance on carers	People with disabilities may need to rely on other family members to accompany them to the health facility. The timeliness of visits may therefore be compromised.
Lack of childcare	Families may decide not to go to a health facility for malaria diagnosis or treatment because there is no-one to look after their other children.
Inability to leave farming tasks	Families reliant on subsistence agriculture may feel unable to leave their fields at certain times of the year in case their absence compromises planting or yields.
Lack of appropriate clothing in which to travel to the health facility	Some community members will feel unable to travel to the health facility in clothes that are dirty, old or torn.
Lack of food to eat while at the health facility	Some community members may not be able to feed themselves and/or their child when at the health facility.

Encouraging community members to reflect on the factors that prevent or delay people with signs of malaria from going to the health facility, and engaging with them to collaboratively find solutions, is the purpose of community engagement (see Section 3).

GEDSI Training for Health Workers

The provision of GEDSI training to front-line health workers is an important strategy for improving GEDSI outcomes. It can help to improve health workers' understanding of different types of vulnerability and social exclusion and the underlying factors that contribute to this. This can help to deepen health workers' empathy and encourage them to think of ways in which they can better identify, reach and include vulnerable and excluded individuals and groups.

An important topic in a GEDSI training for front-line health workers is consideration of the variety of factors that contribute to an individual's or groups' vulnerability or marginalisation, and which result in these individuals carrying a high burden of mortality and morbidity. This requires health workers to move beyond discriminatory and stigmatising perceptions that community members are "lazy", "uneducated", or "unable or unwilling to follow medical advice" to explore other contributing social, cultural, economic and environmental factors and processes that lead to barriers and delays to use of health services. Examples can be found in Table 5.

Table 5: Factors That Lead to Social Exclusion or Vulnerability

Factors Contributing to Social Exclusion or Vulnerability	Description
Community fragmentation	The fragmentation of communities due to migration for farming or internal displacement due to conflict has the potential to separate women, ethnic minorities, refugees, and indigenous people from important social and economic safety nets.
Historical political and social marginalisation	Some ethnic minorities or indigenous groups have faced historical disadvantage, discrimination, and power imbalances, leading to disparities in access to key services and opportunities and lack of trust in government services.
Gender based violence (GBV)	Being subjected to violence can affect a person's capacity to care for themselves and their dependents (if they have). It can lead to a lack of self-confidence, depression and stigma and social exclusion. People with disability often face higher levels of GBV than their people without disability.
General lack of support of women and girls	There may be many other reasons why women or girls lack the support of their partners, family and community. Socially accepted gender norms like inability to make independent decisions, being blamed for anything that goes wrong, community disharmony e.g., disputes over land, can all affect the extent to which women and girls are supported within the household.
Pregnancy	An early or unintended pregnancy can lead to lack of support for a woman and her child. This can be especially the case with pregnant adolescents or unmarried women. .
Polygamy	Co-wives can sometimes be neglected in contexts where men have several wives.
Widowhood	In some countries, becoming a widow can push women into a state of destitution. Some widows may also face a general lack of social and practical support from their families or from the community.
Disability	People living with disabilities may be particularly vulnerable, lack support within the household, face discriminatory social norms and experience poor access to health information and health services.
Stigma and discrimination	Drug users, sex workers, gender diverse persons or individuals with diverse gender identities or sexual orientations, often face stigma and discrimination when accessing health services, simply for not following established social norms.

GEDSI training for health workers needs to highlight the importance of looking beyond poverty as the main or only determinant of vulnerability. For example, women in better-off households may be under-supported if they are subjected to GBV. Similarly, a woman living with a disability woman in a better-off household may the lack support of family members who see her as a burden on the family, assume she cannot make decisions for herself and unable to get married. This could affect her access to health information and services.

A key aim of a GEDSI training for front-line health workers is to improve their understanding that the way that they choose to communicate with their clients has an important impact on the latter's experiences of using health services, their willingness to continue using the service, and the willingness of other community members to utilise the health facility as information about how people attending their services are treated is often shared within the community.

It has long been assumed that health workers do not always know how to communicate well with people who attend services and hence that they require communications training (e.g. training in interpersonal communications). However, experience in some low-income country contexts suggests that health workers choose with whom they communicate well or badly and that increasing awareness of the impact of these choices can help to improve their communication and empathy (41).

Resource 4.4 provides an outline of a GEDSI training curriculum for front-line health workers. This encourages health workers to consider who are the excluded and vulnerable individuals and groups in the local community and to devise strategies for reaching and including them using locally available resources. The training also looks at the impact on patients and the wider community of poor communication by health workers. It encourages health workers to communicate well with all their patients, regardless of their social situation.

To enhance learning outcomes, a participatory training in which health workers actively participate in their learning is preferred. This can be delivered using methodologies such as:

- Brainstorms
- Small group discussions
- Role play
- Personal commitments

It is also important to provide a supportive learning environment. This can be done by ensuring that trainers have strong facilitation skills. These help to create a positive learning environment for training participants and encourage a high level of participation by everyone in the group.

Resource 4.5 highlights the key facilitation skills that will be needed by trainers.

Summary

- The GEDSI Continuum is a useful tool to measure the extent to which existing and potential new malaria interventions are GEDSI-sensitive
- NMPs should routinely apply a GEDSI lens to ensure that all interventions are designed to promote social inclusion
- Three key strategies that can help to enhance the GEDSI focus of malaria programmes are: introducing or expanding CHW programmes; addressing demand-side barriers at household and community level that affect the uptake of malaria diagnosis and treatment services; and training front-line health workers on GEDSI issues
- Participatory training in social inclusion for front-line health workers is ideal since this will help to ensure that training participants play an active role in their learning

Section 4: Resources and Tools

Resource 4.1: Introducing the GEDSI Continuum
This provides further information on the GEDSI Continuum

Resource 4.2: Case Study: Community Health Workers Supporting Malaria Control and Elimination in Papua New Guinea
This looks at how CHWs are delivering malaria information and services in remote, hard-to-reach communities in Papua New Guinea

Resource 4.3: Case Study: Community Health Workers Supporting Malaria Control Along the Thai-Myanmar Border
This looks at the role of Village Health Volunteers in supporting malaria control among mobile and migrant populations along the Thai-Myanmar border where transmission rates are high

Resource 4.4: Outline of GEDSI Training Plan for Health Workers
This provides an outline of the topics to include, and methods to use in the delivery of, a GEDSI training for front-line health workers

Resource 4.5: Key Characteristics of a Good Facilitator
This outlines the key facilitation skills required by effective trainers

Tool 4.1: Checklist for Integrating a GEDSI Focus into Social and Behaviour Change Communications Activities
This lists questions to ask from a GEDSI perspective when designing SBCC activities for malaria

Tool 4.2: Checklist for Integrating a GEDSI Focus into Indoor Residual Spraying
This lists questions to ask from a GEDSI perspective when designing IRS campaigns

Tool 4.3: Checklist for Integrating a GEDSI Focus into LLIN Programmes
This lists questions to ask from a GEDSI perspective when designing LLIN campaigns

Tool 4.4: Checklist for Integrating a GEDSI Focus into Diagnosis and Treatment
This lists questions to ask from a GEDSI perspective when designing malaria diagnosis and treatment services

Tool 4.5: Checklist for Integrating a GEDSI Focus into Severe Malaria
This lists questions to ask from a GEDSI perspective when designing severe malaria interventions

Tool 4.6: Checklist for Integrating a GEDSI Focus into Malaria Chemoprevention
This lists questions to ask from a GEDSI perspective when designing malaria chemoprevention interventions

Resource 4.1

Introducing the GEDSI Continuum

Figure 5: GEDSI Continuum

NOT GEDSI-RESPONSIVE	**GEDSI Blind**	• Ignores gender inequality, social exclusion, and disability exclusion • Ignores discriminatory or harmful social and gender norms • Ignores power imbalances based on gender, gender identity, social status or grouping, disability etc
	GEDSI Aware (Insensitive)	• Aware of inequalities based on GEDSI, but fails to take action to address these • Reinforces or takes advantage of GEDSI inequalities, stereotypes, harmful social norms
GEDSI-RESPONSIVE	**GEDSI Aware (Sensitive)**	• Acknowledges GEDSI, and takes action to reduce inequality • Takes action to address the practical needs of for example socially excluded groups, women and non-binary gender, people with disability, but does not tackle the root causes of their inequality
	GEDSI Aware (Transformative)	• Shifts harmful social norms, discriminatory practices and stereotypes thereby transforming the lives of women, people with disability and other socially excluded groups • Challenges power imbalances and transforms roles for diversity of genders, people with disability and other socially excluded peoples. • Promotes equal decision-making, participation, and access

Source: Based on the Inter-agency Working Group on Gender's (IGWG) Gender Integration Continuum, 2017. See: https://prevention-collaborative.org/knowledge_hub/gender-integration-continuum/

Resource 4.2

Outline of a GEDSI Training for Health Workers

Topic	Content	Methodology
Background and training objectives	• Participant introductions and expectations-setting • Rationale for integrating GEDSI into health service delivery • Overview of participatory and inclusive training approach • Establishing group norms (respect, confidentiality, non-judgement)	• Icebreaker focused on diversity of identities and roles • Short presentation • Anonymous expectations questionnaire • Group agreement-setting exercise
Understanding marginalisation and exclusion	• Who are under-served and marginalised groups in our communities? • Intersectionality (e.g., gender, disability, ethnicity, migration status) • How exclusion is shaped by systems, norms, and power	• Small group mapping exercise • Post-it wall of identities and barriers • Facilitated discussion • Short conceptual input
Burden of mortality and morbidity among marginalised groups	• Inequities in health outcomes • Structural drivers of poor health • Local examples of clustered vulnerability	• Short presentation • Small group discussions • Community-based case studies • Facilitator synthesis
What people need to achieve good health	• Social, economic, cultural, and psychological determinants of health • Safety, dignity, autonomy, and access as enablers of health • Differentiated needs across population groups	• Small group discussion • Post-it wall • Gallery walk • Facilitator summary
Power, stigma, and discrimination in healthcare	• How power operates in health systems • Implicit bias and stereotyping • Stigma related to gender, disability, ethnicity, GBV, HIV, migration	• Implicit bias reflection exercise • Case study analysis • Paired discussions • Facilitated debrief

Topic	Content	Methodology
Communication: what goes wrong and why?	• What is respectful, inclusive communication? • How language, tone, and body language include or exclude • Impact of poor communication on trust and care-seeking	• Brainstorm • Role play • Group feedback • Facilitator synthesis
Improving interpersonal communication	• Barriers to inclusive communication • Trauma-informed and survivor-centred approaches • Practical strategies for respectful engagement	• Skills-building role play • Group coaching • Personal commitment reflection
Gender-based violence, safeguarding, and survivor-centred care	• Gender-inclusive and disability-inclusive framing of GBV • Health impacts of violence and trauma • Confidentiality, consent, and referral pathways	• Short presentation • Scenario-based group work • Guided reflection
Community and system-level supports for marginalised groups	• Formal and informal support systems • Barriers to access • What “good support” looks like from the perspective of marginalised groups	• Guest speakers from marginalised groups (where feasible) • Recorded testimonies or interviews • Facilitated Q&A • Small group reflection
Health workers as agents of inclusion	• Professional responsibility and ethics • Everyday actions that create inclusive spaces • Accountability and advocacy	• Small group problem-solving • Personal action planning • Peer feedback
Reflection, consolidation, and next steps	• Key learning points • Personal and institutional commitments • Sustaining inclusive practice	• Individual reflection • Pair sharing • Written commitments • Evaluation form

Topic	Methodology
How we manage our service user and community consultations and interactions • How do we manage our client consultations? • What could we do better? • What external factors would support us to manage consultations better?	• Small group discussions • Feedback to group • Group work to compile advocacy statement to policymakers • Facilitator summarizes
Orienting other health workers on GEDSI • How can we orient other health workers on GEDSI issues? • What steps can we as individual health workers take to orient our colleagues on GEDSI issues?	• Small group discussions • Facilitator summarizes
Closing • Topics covered in training • Review of trainee expectations of training • Personal commitments	• Facilitator summarizes topics covered • Review of trainee questionnaires and whether objectives were met • Personal commitment to supporting GEDSI in our work as health workers

Resource 4.3

Core Facilitation Skills Required by Trainers

Characteristics of a Good Facilitator

- Good listener
- Supportive of trainees and encourages them
- Creates a non-judgemental environment for discussion
- Guides rather than leads
- Encourages the participation of everyone in the group – especially quiet individuals
- Makes sure that they thank trainees for their contributions
- Uses a range of techniques to keep activities fresh and interesting
- Asks many questions to 'get to the bottom' of a problem
- Supports trainees to find solutions to problems
- Good at summarising what has been said and agreed
- Concerned that trainees enjoy and benefit from the sessions
- Flexible – happy to change direction/review old topics/answer questions if requested

Additional Skills for GEDSI-Sensitive Facilitation

A GEDSI-sensitive facilitator:

- Responds calmly, firmly, and constructively to biased, discriminatory, or hostile attitudes (including those related to gender, disability, ethnicity, migration status, sexuality, or other identities)
- Recognizes that some participants may express internalized stigma or bias about themselves or others
- Has strategies to prevent and address bullying (including cyberbullying), sexual harassment, peer pressure, and intimidation
- Is attentive to participants' physical needs, safety, and family or social responsibilities
- Uses de-escalation techniques, including reflective listening, respectful paraphrasing, and calm, measured speech
- Reinforces group agreements and standards of respectful behaviour
- Addresses harmful behaviour privately when needed, issuing clear warnings and if necessary, asking participants to leave to protect the dignity and safety of others

Resource 4.4

Case Study: Community Health Workers Supporting Malaria Control and Elimination in Remote Communities in Papua New Guinea

Community Health Workers Supporting Malaria Control and Elimination in Remote Communities in Papua New Guinea

In Papua New Guinea, the National Malaria Control Programme's vision is to ensure that malaria case management is available at community level in all endemic areas located more than two hours walk from a primary health care facility (42). Different cadres of volunteer CHW have existed in PNG for decades. These lay health workers are an essential part of the health system, filling a gap especially in remote, rural areas where there are acute shortages of trained health workers.

Between 2013-2015, Population Services International (PSI) supported the NMCP to pilot integrated community-based case management in remote areas in three provinces. The pilot reported some positive results, including high usage of trained community-based distributors (CBDs) for the diagnosis and treatment of febrile illnesses compared to other treatment options. Building on the results, the NMCP has channelled resources into the Home-based Management of Malaria programme (HMM) since 2020. This trains Community Malaria Volunteers (CMVs) to provide malaria diagnosis and treatment at the community level. The programme covers 12 of PNG's 22 provinces, supported in 11 provinces by the Global Fund and in one province by a local organisation, the PNG Sustainable Development Program (PNG-SDP).

Despite a number of challenges, the HMM programme carries significant potential to increase the coverage of malaria case management in remote areas and to reduce some of the household and community level barriers that have historically impeded access to and use of malaria services.

A 2023 evaluation carried out in East Sepik and Sandaun provinces found that 99.4% of community members understood that the HMM programme focused on malaria and 87% had sought care from a CMV. In comparison, the 2022/23 Malaria Indicators Survey indicates that less than 50% of community members in the region sought health care outside the home in response to malaria symptoms (7). The evaluation also identified that a high proportion of clients presenting with fever were managed appropriately by CMVs (43).

The convenience of a service that is readily available 'on the doorstep', culturally appropriate, and affordable drive the high usage rates within the HMM programme. A further feature of HMM is its emphasis on achieving a gender balance in CMV recruitment. This responds to women's and girls' preferences for female providers. It also provides rural men with role models who are able to demonstrate positive health-seeking behaviours, thereby challenging some of the gender stereotypes that can delay men's treatment seeking.

Based on current scale-up plans, HMM will be available in three-quarters of the remote communities that stand to benefit the most from the intervention by the end of 2026.

Resource 4.5

Case Study: Village Health Volunteers Supporting Malaria Control Among MMPs on the Thai-Myanmar Border

Village Health Volunteers Supporting Malaria Control Among MMPs on the Thai-Myanmar Border

In recent years Thailand has experienced an upsurge in malaria cases along its 2,400-kilometre-long border with Myanmar. This has compromised the country's progress towards malaria elimination over the last two decades. Mobile and migrant populations who reside and work in the border area are at high risk for malaria but face considerable barriers of access to essential health services.

As part of the government's malaria control and elimination strategy Village Health Volunteers (VHVs) are playing a role in the proactive case detection (PACD) of malaria among at-risk groups, including mobile and migrant populations in border areas where transmission rates are high. VHVs are also being trained to carry out therapeutic efficacy surveillance, helping to ensure that patients adhere to treatment regimens, thereby supporting the radical cure of both *P. falciparum* and *P. vivax* cases.

The VHV scheme has been an integral part of Thailand's primary health care system since 1978 when the government signed the Alma Ata Declaration. By 2025, over a million VHVs were operational throughout the country. As members of the local community, VHVs are able to provide culturally appropriate services and hence are widely accepted and respected.

VHVs play a vital role in their communities in health promotion, disease prevention and acting as intermediaries between the community and the formal health system. During the COVID-19 pandemic, VHVs implemented malaria prevention and outreach activities and also carried out surveillance activities which proved to be vital to pandemic control. This included collecting data on COVID-19 cases and monitoring the movements of villagers in and out of communities (44). This extended role for VHVs has been maintained in order to support the country's implementation of intensified malaria elimination activities.

Tool 4.1

Checklist for integrating a GEDSI focus into SBCC

Marginalised group	Checklist for Integrating a GEDSI Focus into Malaria SBCC
Women and girls	• What communication methods and messages best suit women and girls? • Are there gender-based differences in access to radio, television, internet, mobile phones? • How can SBCC activities be timed to fit with women and girls' other responsibilities? • How ensure the gender stereotypes are not reinforced in the SBCC • Is it possible to achieve a gender balance among CHWs? (This will help to ensure that men and women both have role models for demonstrating new behaviours) • What are the most effective ways to involve gatekeepers to health (e.g. men, in-laws, older women) in malaria-focused SBCC activities? This will help to create an enabling environment for women's and children's health
Ethnic minorities	• What are the appropriate languages to use when communicating with ethnic minorities? • What are the most appropriate communication methods to use with different ethnic minorities? Which methods and channels are favoured from a socio-cultural perspective? • To what extent can ethnic minority communities access radio, television, internet, mobile phones etc? • What are the most culturally appropriate ways to address different aspects of malaria? How can misinformation and incorrect cultural beliefs be addressed in sensitive and effective ways? • How ensure the social or cultural stereotypes are not reinforced in the SBCC

Marginalised group	Checklist for Integrating a GEDSI Focus into Malaria SBCC
Persons with a disability	• Are there people with sight impairments, hearing impairments, learning impairments that needs specific adjustments to ensure accessibility to the information? • What communication methods and messages are most appropriate to meet the needs of people with disabilities in target communities? • What strategies can be used to facilitate the safe participation of people with disabilities in community discussion groups? • Is any form of adaptive technology needed to facilitate the access of people with disabilities to malaria SBCC? • How can people with disabilities participate in and influence the design of SBCC campaigns to ensure that these are relevant to their needs? • How ensure the social or cultural stereotypes are not reinforced in the SBCC
Refugees / IDPs	• What are the most socially and culturally appropriate ways to engage refugees or IDPs in malaria SBCC? • What are the most appropriate methods of communication? • How can SBCC messages be appropriately tailored to meet the needs of and access for refugees or IDPs? • Could peer educators or CHWs be an effective way to communicate with refugees or IDPs? • How to ensure the safety of undocumented workers in these activities?
Older persons	• Do older people face barriers to participation in SBCC activities (e.g. hearing, sight, learning, physical access)? How can these be addressed? • Is the gatekeeping role played by older persons in relation to children's and women's health in some contexts acknowledged in the design of SBCC activities?
Undocumented workers	• What are the most appropriate information channels and methods to reach undocumented workers? • What role can peer educators or CHWs play in relation to increasing the knowledge and awareness of malaria prevention, diagnosis and treatment among undocumented workers? • How to ensure the safety of undocumented workers in these activities?
Populations living in hard-to-reach areas	• What are the most appropriate communication methods to use in populations in remote or hard-to-reach areas (where access to mass media, education, may be constrained)? • What role can CHWs play in supporting SBCC activities? What training will they need to do this?

Tool 4.2

Checklist for integrating a GEDSI focus into Indoor Residual Spraying

Marginalised group	Checklist for integrating a GEDSI focus into Indoor Residual Spraying
Women and girls	• Are there any cultural restrictions on women-headed or other households being visited by men sprayers? • Does the timing of IRS suit the workloads of women and girls? • What do women and girls know about the value and efficacy of IRS? Are there any barriers to their knowledge and acceptance of IRS? • Are there any barriers to women and girls being informed about IRS campaigns? • Is there scope to employ local women as spray operators, IRS co-ordinators or peer educators? • What steps are needed to ensure wide community support for hiring local women as spray operators? Is the support of local community leaders and/or men in general needed? How can this be secured? • How will the NMP ensure the physical safety of women sprayers (e.g. provision of adequate protective equipment)? • Are there safeguarding protocols in place to ensure the personal safety and security of women sprayers?
Ethnic minorities	• What do ethnic minorities know about the value and efficacy of IRS? Are there any barriers to their knowledge and acceptance of IRS? • What are the best ways to ensure that information about IRS campaigns reaches target ethnic minority communities? What are the preferred languages / preferred methods of communication? • Are there any cultural or other barriers that could prevent ethnic minorities communities from participating in an IRS campaign (e.g. lack of trusting relationship with health workers at the local health facility)? • How can ethnic minorities input to the planning of an IRS campaign to ensure that their needs are met? • Is there scope to employ individuals from ethnic minorities/ethnic minority women as spray operators, IRS co-ordinators or IRS peer educators?

Marginalised group	Checklist for integrating a GEDSI focus into Indoor Residual Spraying
People with disabilities	• What do people with disabilities know about the value and efficacy of IRS? Are there any barriers to their knowledge and acceptance of IRS? • What strategies can be used to ensure that people with disabilities can access information about IRS campaigns? • What communication methods are best suited to the people with disabilities in the community? • What steps can be taken to ensure that all households with a person with disability are included in IRS campaigns? • Will people with disabilities with a psychosocial disability, learning disability or neurocognitive disability require extra support in order to ensure their personal safety during household spraying? • Will people with disabilities require support in order to exit their house prior to the start of spraying? How can this be done? Will they require shelter while their home is being sprayed? • How can people with disabilities input to the planning of an IRS campaign to ensure that their needs are met?
Refugees / IDPs	• What do refugees/IDPs know about the value and efficacy of IRS? Are there any barriers to their knowledge and acceptance of IRS? • Are the homes of refugees or IDPs suitable for IRS? If not, what other vector control interventions will be suitable? • Are temporary dwellings included on the list of eligible households for IRS? • Will refugees or IDPs face any language/communication barriers when accessing information about IRS? How can these be resolved? • Can refugees or IDPs be hired to support awareness raising about an upcoming IRS campaign or as spray operators or co-ordinators? • How will the NMP ensure the physical safety of refugee or IDP sprayers (e.g. provision of adequate protective equipment)?
Older persons	• What do older persons know about the value and efficacy of IRS? Are there any barriers to their knowledge and acceptance of IRS? • Are older people likely to face any barriers of access to information about IRS campaigns (e.g. hearing and sight impairments, neurological and cognitive disability)? • Are older people likely to require any assistance to leave their homes during an IRS spraying campaign? How can this be done? Will then need shelter whiles their home is being prayed?

Marginalised group	Checklist for integrating a GEDSI focus into Indoor Residual Spraying
Undocumented workers	• Do undocumented workers live in properties that are included on the list that are eligible for IRS? • Do undocumented workers face any barriers of access to information about IRS? What are the best ways to reach these workers? • What is the knowledge and level of acceptance of IRS among undocumented workers? • What are the most appropriate messages and communication methods to use to improve undocumented workers' knowledge and support for IRS? • How will the NMP ensure the physical safety of undocumented workers engaged in vector control activities?
Populations living in hard-to-reach areas	• What are the best ways to ensure that hard-to-reach populations are able to access timely information on IRS? • How can the local health authorities build support within remote communities for IRS? • Can CHWs be trained to share information on upcoming campaigns and/or to address any awareness barriers? • How can IRS campaigns be timed to suit the livelihoods and other activities of populations living in remote areas?

Tool 4.3

Checklist for Integrating a GEDSI Focus into LLIN Programmes

Marginalised group	Checklist for Integrating a GEDSI Focus into LLIN Programmes
Women and girls	• Are there gender-based differences in knowledge of the value and efficacy of LLINs? • Are women and girls able to access timely information about LLIN mass campaigns? • Are LLIN mass campaigns timed to suit the livelihoods and other responsibilities of women and girls? • Are women able to access LLINs through ANC? What barriers do they face? Is the coverage rate of ANC universal or are some women left behind • Do women and girls have equal access to LLINs within the household? • How do cultural practices (e.g. sleeping arrangements and preferences) affect women's and girls' access to and use of LLINs? Do these practices change based on the season? • What knowledge do women and girls have of LLIN care and maintenance practices? • What are the constraints faced by women and girls in appropriately maintaining LLINs?
Ethnic minorities	• What is known about the knowledge, attitudes and practices of ethnic minorities in relation to LLIN use? • Do ethnic minority communities face any practical, financial or other barriers to accessing LLINs? What are these? • Do LLIN campaign outreach teams reach ethnic minority communities? Are the communication methods and key messages used by these teams culturally appropriate? • Do women, children and men within ethnic minority households have equal access to an LLIN? • What are the household level barriers to using an LLIN? How can these be addressed? • How do household sleeping patterns affect LLIN use and distribution within the household? • What is known about the LLIN care practices at household level? Are LLIN's used and maintained in the correct way? • How can ethnic minority communities be included in the planning of LLIN campaigns so that these are appropriate and responsive to their needs?

Marginalised group	Checklist for Integrating a GEDSI Focus into LLIN Programmes
People with disabilities	• What is the level of knowledge of LLINs as a preventive intervention for malaria among people with disabilities? Are there any gaps in knowledge? • Can people with disabilities access timely information on LLIN mass campaigns? • What are the most appropriate communication methods and messages to use in order to reach people with disabilities with information on LLIN mass campaigns? • Do people with disabilities face physical access or other barriers of access to LLINs during mass campaigns? What are these? • Do people with disabilities face any challenges in installing LLINs? What assistance might they need? • Do people with disabilities face any challenges in using LLINs? What assistance might they need? • How can people with disabilities be included in the planning of LLIN campaigns so that these are appropriate and responsive to their needs?
Refugees / IDPs	• ·What is the level of knowledge and awareness of LLINs among refugees or IDPs? • ·Do refugees or IDPs face any barriers of access to LLINs during mass campaigns? For example, are they living in houses that are registered as eligible for LLIN distribution? • ·Are there any cultural or other practices that affect the access of refugee/IDP household members (e.g. women or children) to an LLIN? • ·Do refugees or IDPs face any challenges with installing LLINs (e.g. if in temporary shelters, forest dwelling etc)? What alternative vector control may be needed for them? • ·Do refugees or internally displace persons face any challenges with maintaining LLINs?
Older persons	• What is the level of knowledge and awareness of LLINs as a preventive measure among older persons? • Can older people access information about LLIN mass campaigns in a timely way? • Do older persons face any challenges with accessing LLINs? • Do older persons face any challenges with installing or using LLINs? How can these be overcome?

Marginalised group	Checklist for Integrating a GEDSI Focus into LLIN Programmes
Undocumented workers	• What are the knowledge, attitudes and practices of undocumented workers in relation to LLINs? • Are there any cultural barriers to use of LLINs among these groups? How can these be addressed? • What are the appropriate messages and communication channels to use in order to reach undocumented workers with information on LLINs? • Can undocumented workers access LLINs during mass campaigns? Is their legal status a barrier? • ·What other distribution mechanisms can be used to reach these workers (e.g. workplace distribution)?
Populations living in hard-to-reach areas	• Do remote or hard-to-reach populations face challenges in accessing information on LLIN mass campaigns? • Do remote or hard-to-reach populations face any physical access barriers to accessing LLINs during mass campaigns? What are the best ways to ensure convenient access to LLINs for these communities? • Are there any cultural or other barriers to use of LLINs in remote or hard-to-reach communities?

Tool 4.4

Checklist for Integrating a GEDSI Focus into Malaria Diagnosis and Treatment

Marginalised group	Checklist for Integrating a GEDSI Focus into Malaria Diagnosis and Treatment
Women and girls	• Are there gender-based differences in knowledge and awareness of the signs and symptoms of malaria and the actions to take? • Do women and girls need to seek permission to go to the health facility for malaria diagnosis and treatment? • Are there gender-based differences in access to money or transport for malaria diagnosis and treatment? How do these affect women's and girls' timely access to services? • How are women and girls affected by the opportunity costs of accessing health care for malaria diagnosis and treatment? • To what extent do women and girls carry the care burden for other family members affected by malaria? • Is G6PD testing accessible and convenient for women and girls considering their multiple responsibilities? How can this be provided as close as possible to communities? • Are radical cure treatments for P.vivax acceptable and convenient for women and girls? Can treatment adherence be observed by CHWs close to the community, thereby reducing repeat visits to the health facility? • To what extent do health worker attitudes towards women and girls affect their use of health services? Do women and girls feel that they receive good quality of care at the health facility?
Ethnic minorities	• Are there any knowledge barriers or cultural constraints that prevent timely access to malaria diagnosis and treatment by ethnic minorities? • Are health services acceptable to and welcoming of ethnic minority patients? • Do ethnic minorities experience language or communication barriers when accessing the health facility for malaria diagnosis and treatment? • Can CHWs recruited from within ethnic minority communities provide malaria diagnosis and treatment in culturally sensitive ways?

Marginalised group	Checklist for Integrating a GEDSI Focus into Malaria Diagnosis and Treatment
People with disabilities	• Do people with disabilities face physical access barriers to use of facility-based health services (e.g. lack of transport, long distances to the health facility, challenges moving around the health facility infrastructure?) • Do people with disabilities face communication challenges when accessing malaria diagnosis and treatment services at the health facility (e.g. inability of health workers to use sign language; inability of the patient to read facility signage, posters or pamphlets?) • Are there other access and affordability barriers that prevent people with disabilities from using malaria diagnosis and treatment services? • Do people with disabilities face stigma and discrimination when accessing malaria diagnosis and treatment at the health facility? • Can people with disabilities access the diagnosis and treatment services provided by CHWs?
Refugees / IDPs	• Are refugees or IDPs aware of their rights to malaria diagnosis and treatment services? • Are there any gaps in the knowledge of refugees or IDPs on the need to act promptly in relation to malaria signs and symptoms? • Are there other access and affordability barriers that prevent refugees or IDPs from using malaria diagnosis and treatment services? • Do refugees or IDPs face stigma or discrimination when using malaria diagnosis and treatment services at the health facility? • Is continuity of treatment compromised (e.g. of radical cure of *P. vivax*) if refugees or IDPs are highly mobile?
Older persons	• Do older persons face physical access barriers to malaria diagnosis and treatment? • Do older persons face affordability barriers of access to malaria diagnosis and treatment? • Are older persons reached and included in the activities of malaria CHWs? • Do older persons face stigma or discrimination at the health facility when accessing malaria diagnosis and treatment? • Do older persons face communication challenges when accessing malaria services at the health facility?

Marginalised group	Checklist for Integrating a GEDSI Focus into Malaria Diagnosis and Treatment
Undocumented workers	• Do undocumented workers know about their rights of access to malaria diagnosis and treatment? • Do undocumented workers fear being discriminated against when accessing the health facility for malaria diagnosis and treatment? • Are there other access and affordability barriers that prevent undocumented workers from using malaria diagnosis and treatment services? • Do undocumented workers benefit from the services of CHWs?
Populations living in hard-to-reach areas	• What are the main barriers, including physical access barriers, to use of malaria diagnosis and treatment services by communities living in remote or hard-to-reach areas? • Can CHWs be trained to bring malaria diagnosis and treatment closer to communities? • What opportunities are there to provide G6PD testing close to communities in order to reduce access barriers? • Can directly observed therapy be provided at community level in the context of radical cure for *P. vivax*? This will help ensure that this treatment is convenient and accessible for remote or hard-to-reach populations.

Tool 4.5

Checklist for Integrating a GEDSI Focus into Severe Malaria Interventions

Marginalised group	Checklist for Integrating a GEDSI Focus into Severe Malaria Interventions
Women and girls	• Are there gender-based differences in knowledge and awareness of the signs and symptoms of malaria and the actions to take? • Do women and girls need to seek permission to go to the health facility for malaria diagnosis and treatment? • Are there gender-based differences in access to money or transport for malaria diagnosis and treatment? How do these affect women's and girls' timely access to services? • How are women and girls affected by the opportunity costs of accessing health care for malaria diagnosis and treatment? • To what extent do women and girls carry the care burden for other family members affected by malaria? • Is G6PD testing accessible and convenient for women and girls considering their multiple responsibilities? How can this be provided as close as possible to communities? • Are radical cure treatments for P.vivax acceptable and convenient for women and girls? Can treatment adherence be observed by CHWs close to the community, thereby reducing repeat visits to the health facility? • To what extent do health worker attitudes towards women and girls affect their use of health services? Do women and girls feel that they receive good quality of care at the health facility?
Ethnic minorities	• Are there any knowledge barriers or cultural constraints that prevent timely access to malaria diagnosis and treatment by ethnic minorities? • Are health services acceptable to and welcoming of ethnic minority patients? • Do ethnic minorities experience language or communication barriers when accessing the health facility for malaria diagnosis and treatment? • Can CHWs recruited from within ethnic minority communities provide malaria diagnosis and treatment in culturally sensitive ways?

Marginalised group	Checklist for Integrating a GEDSI Focus into Severe Malaria Interventions
People with disabilities	• What is the level of knowledge of the signs and symptoms of severe malaria and of the actions to take among people with disabilities in the community? • What are the main barriers at household and community level to timely referral of a person with disabilities with suspected severe malaria to a health facility? • What affordable and accessible transport options exist at community level to support the timely transfer people with disabilities with suspected severe malaria to the health facility? • Are there economic constraints of access to health care for severe malaria among households with a person with disability? • Do households with a person with disabilities with suspected severe malaria face opportunity costs when accompanying them to the health facility (e.g. work forgone)? • Are there other barriers (e.g. language/communication) to use of health services faced by people with disabilities in the context of suspected severe malaria?
Refugees / IDPs	• What is the level of knowledge of the signs and symptoms of severe malaria and of the actions to take among refugees or IDPs? • What are the main barriers at household and community level to timely referral of refugees or IDPs with suspected severe malaria to the health facility? • Are there any language/communication barriers to use of health services faced by refugees or IDPs in the context of suspected severe malaria?
Undocumented workers	• Do undocumented workers have a legal right of access to health care? What do these workers know about their right of access to health care? • What is the level of knowledge of the signs and symptoms of severe malaria and of the actions to take among undocumented workers? • What are the main barriers that undocumented workers face in relation to timely referral to a health facility in the context of suspected severe malaria?

Marginalised group	Checklist for Integrating a GEDSI Focus into Severe Malaria Interventions
Older persons	• What is the level of knowledge of the signs and symptoms of severe malaria and of the actions to take among older persons in the community? • Are older people in the community gatekeepers to other family members' health care? How can older people be supported to become advocates for prompt referral in the context of suspected severe malaria? • What are the main barriers at household and community level to timely referral of an older person with suspected severe malaria to a health facility? • What affordable and accessible transport options exist at community level to support the timely transfer of older people with suspected severe malaria to the health facility? • Do older people face economic constraints of access to health care for severe malaria? • Do households with an older person with suspected severe malaria face any opportunity costs when accompanying them to the health facility (e.g. work forgone)? • Are there other barriers (e.g. language/communication) to use of health services faced by older persons in the context of suspected severe malaria?
Populations living in hard-to-reach areas	• Are there any constraints of access to information in hard-to-reach communities on the signs and symptoms of severe malaria and the actions to take? • What are the most effective ways to improve knowledge and awareness of severe malaria within hard-to-reach communities? What role could CHWs play in increasing awareness? • What are the main physical access barriers affecting the timely referral of patients with suspected severe malaria? • What role can CHWs play in supporting referral for suspected severe malaria in hard-to-reach communities? • Is there scope to introduce a pre-referral treatment for severe malaria in children in hard-to-reach communities that are far from the health facility?

Tool 4.6

Checklist for Integrating a GEDSI Focus into Malaria Chemoprevention

Marginalised group	Checklist for Integrating a GEDSI Focus into Malaria Chemoprevention
Women and girls	• What are women's knowledge and beliefs about IPTp as a preventive intervention? Are there gaps in their knowledge? • Are there any household level constraints to women completing the full course of IPTp (e.g. lack of time, opportunity costs, lack of permission from gatekeepers to care, lack of affordability)? How can these be addressed? • To what extent would women benefit from community IPTp as a mechanism that would bring this service closer to their homes? • What knowledge and beliefs do women have about the role and purpose of seasonal malaria chemoprevention (SMC) or perennial malaria chemoprevention (PMC)? Are there gaps in their knowledge or do they have misconceptions? • Are there any household or community level constraints to women taking children for SMC or PMC (e.g. lack of standing permission; lack of affordability; lack of transport; lack of support for childcare)? • What are the barriers to women and girls accessing mass drug administration (MDA)? How can this be provided conveniently considering the demands on women's and girls' time?
Ethnic minorities	• What knowledge do ethnic minority communities have of different types of malaria chemoprevention? Are there gaps in their knowledge or any misconceptions? • Are there any cultural factors or other barriers of access that could prevent the timely access of ethnic minorities to different types of malaria chemoprevention? • How can malaria chemoprevention be provided close to communities in culturally appropriate ways? Could CHWs support this process?
People with disabilities	• Are there any barriers faced by people with disabilities to information about different types of malaria chemoprevention? • What physical barriers of access to IPTp are faced by people with disabilities who are pregnant? • Can children with a disability access malaria chemoprevention? What are the barriers of access? • Can malaria chemoprevention be provided close to the community to reduce the physical access barriers faced by people with disabilities?

Marginalised group	Checklist for Integrating a GEDSI Focus into Malaria Chemoprevention
Refugees / IDPs	• Do refugees and IDPs have all the required information about different forms of malaria chemoprevention? How can this information be provided in culturally appropriate and convenient ways? • Are refugees and IDPs included in SMC and PMC campaigns? • Is the access of women refugees and IDPs to IPTp affected by high levels of mobility? What strategies are needed to promote treatment adherence?
Older persons	• What barriers do older persons face in relation to MDA? Are they able to physically access this intervention? How can MDA be provided conveniently for older persons? • What role do older people in the community play in relation to facilitating children's access to malaria services, including SMC and PMC? • What information and other types of support will older persons require in order to fulfil this role?
Undocumented workers	• What are the best ways to get information about different types of malaria chemoprevention to undocumented workers? How can workplaces, peer educators or CHWs assist with this? • What are the barriers that pregnant undocumented workers face in relation to IPTp access? How can these be addressed?
Populations living in hard-to-reach areas	• What are the most appropriate ways to communicate the benefits of malaria chemoprevention to remote and hard-to-reach communities that may be poorly served by mass media? • How can different types of malaria chemoprevention be provided in convenient and accessible ways for populations living in remote or hard-to-reach areas? • Can CHWs play a role in the delivery of community IPTp?

Section 5: GEDSI-Sensitive Data Collection

5.1 Rationale

GEDSI-sensitive data collection ensures that the activities of NMPs are effective, inclusive and sustainable. The use of GEDSI metrics enables malaria programme staff to identify disparities in access to resources, opportunities and services, and also different outcomes from core malaria interventions across different social groups. This information can be used to tailor malaria activities so that they address the specific needs and priorities of high risk or underserved population groups.

As highlighted in Section 2, ensuring that all members of society benefit from malaria investments is not only vital to achieve malaria elimination but also important from a sustainable development perspective. Collecting GEDSI-sensitive data is also important from an accountability perspective: countries can measure their own performance in promoting inclusion and citizens can hold governments accountable for addressing inequalities (Box 6).

Box 6: Benefits of GEDSI-sensitive data collection

- Highlights the challenges faced by specific population groups, and enables NMPs to tailor malaria interventions to address precise needs and priorities
- NMPs can monitor what is working well, gaps in implementation and the extent to which key interventions are reaching intended beneficiaries
- Individual countries can measure their own performance in promoting inclusion
- Citizens can hold government accountable for addressing inequalities
- Contributes to sustainable development by ensuring that no groups are left behind

5.2 Current Situation

The baseline assessment undertaken by APLMA in 15 countries in the Asia Pacific region in 2024 identified that positive steps are being taken by NMPs to collect GEDSI-focused data (1). However, the assessment also identified some gaps:

- Most NMPs collect data on high-risk groups such as pregnant women and children under five
- A small number of countries collect extensive data on rural communities
- Two countries collect detailed data on a specific occupational group (i.e. forest workers)
- Data disaggregated by disability is not collected by any of the study countries

These findings resonate with WHO's concern that NMPs are not collecting adequate disaggregated data to understand the inequities faced by specific vulnerable and marginalised groups (3).

There is therefore scope for NMPs in the region to scale-up their GEDSI-sensitive data collection activities, building on progress made so far.

This section provides practical guidance for NMPs and their implementing partners on how to incorporate a stronger focus on GEDSI in routine and periodic data collection and use.

5.3 Steps in Measuring Programme Performance from a GEDSI Perspective

There are three key steps in ensuring that NMPs have a robust system for the measurement of equity gaps. These are:

1. Identify underserved populations and barriers to malaria information and services
2. Select a core set of indicators to measure malaria equity gaps in priority populations
3. Undertake data analysis, devise a plan for addressing identified equity gaps and monitor progress

Each step is discussed below.

5.3.1 Identification of Underserved Populations

Malaria Matchbox Equity Assessment

Equity assessment tools such as the Malaria Matchbox Tool developed by The Global Fund and Roll Back Malaria (RBM) provide practical guidance on how to identify groups that are at risk of malaria (2). Malaria Matchbox assessments focus on the socio-economic, cultural, geographical, gender and other factors that contribute to malaria risk. The tool encourages NMPs to look beyond the groups that are biologically at risk of malaria due to their low immunity to the malaria parasite (i.e. pregnant women and children) and consider other risk factors. However, the tool also recognises that biologically vulnerable groups may face additional malaria risks based on the social, cultural, political, economic and physical environment in which they live.

Malaria Matchbox assessments examine the following:

- Who and where are the populations that are most impacted by malaria
- Risk factors and barriers affecting health equity in the context of malaria
- Intra-household inequities that contribute to malaria risk

In addition, the tool provides advice on how to undertake data analysis and how to translate findings into actionable recommendations to guide the malaria response in an individual country.

A number of countries in the Asia Pacific region have undertaken Malaria Matchbox assessments. A case study summarising Papua New Guinea's assessment can be found in **Resource 5.1.**

Planning a Malaria Matchbox Assessment

To date, funding to carry out a Malaria Matchbox assessment has usually been provided by a development partner or donor (e.g. The Global Fund). The assessments are normally contracted out to a local or regional research organisation or other body with a track record of undertaking GEDSI assessments. However, it is usual for NMPs to form a technical steering committee to oversee the design and implementation of the study. The committee's role is to compile terms of reference for the study, agree a timeline for implementation, and a process for reviewing and validating the findings and recommendations. It is good practice for steering committees to consult widely with malaria and GEDSI stakeholders to inform the focus of the study. Some countries may co-opt members of the NMP onto the Malaria Matchbox research team to ensure that recommendations are actionable from policy and programming perspectives.

The size of the budget needed to implement a Malaria Matchbox study will depend on a number of factors (see Box 7). For budgeting purposes, however, a ballpark figure would be between US$ 50,000 to 100,000.

Box 7: Issues to Consider When Budgeting for a Malaria Matchbox Assessment

The following factors will be important when deciding what funds to allocate to a Malaria Matchbox study:

- Geographical scope of the study: will the study focus on a specific geographical area or the entire country?
- Inclusion of population groups: will the study focus on one or two known vulnerable and at-risk groups for malaria, or on all vulnerable and at-risk groups across the country?
- New or follow-up study: is this the first Malaria Matchbox assessment that has been undertaken in the country, or is it a follow-up study?
- Information availability: how much data can be gathered using secondary sources, and how much primary data collection is required?
- Stakeholder engagement: how will domestic and other malaria and GEDSI stakeholders be involved in the study? Will they be consulted about the study terms of reference or the study design? Will they be invited to participate in a review of preliminary findings and in devising recommendations?

The findings and recommendations of the Malaria Matchbox assessment can help to influence how the national malaria programme is delivered and targeted. NMPs can therefore time the implementation and completion of the study to fit with other planned activities. For example:

- The assessment findings may be needed in advance of a planned revision of the national malaria strategy.
- Some of the issues raised in a Malaria Matchbox assessment could potentially be explored in more detail in upcoming thematic reviews or periodic programme evaluations. Timing the assessment to take place in advance of planned reviews/evaluations may make sense.
- There may be opportunities to add new indicators into periodic surveys (e.g. malaria indicator survey or DHS) based on the issues identified in the Malaria Matchbox assessment. This, too, could influence the timing of the study.

5.3.2 Selection of GEDSI Indicators

Global Normative Guidance on Appropriate Malaria Metrics

Global normative guidance on appropriate metrics for measuring the impact and outcomes of malaria programmes can be found in **Resource 5.2.** Applicants to The Global Fund are encouraged to select indicators from this list. Some of the indicators measure malaria impacts and outcomes from the combined effect of prevention, diagnosis and treatment activities. Others are specific to vector control, case management and other preventive activities. Recommended data collection frequencies, data sources and minimum levels of data disaggregation are highlighted.

From an equity perspective, the Global Fund indicators encourage NMPs to do the following:

- Report data on a sub-national basis. This means that **geographical variations in the malaria burden** and access to malaria resources and services can be reported. Many of the indicators in **Resource 5.2** are recommended for disaggregation below national level.
- Disaggregate selected programme outcomes by **age.**
- Disaggregate selected programme outcomes by **gender.**
- Measure the distribution of benefit of an activity within a **specific high-risk or vulnerable group** (e.g. children; pregnant women; people with disabilities; prisoners etc).
- Report on **equity of access** at household level to a particular resource (e.g. ITNs).
- Measure the proportion of services that are **delivered at community level.** Community-based service delivery can help to reduce GEDSI and other barriers of awareness, access and affordability to use of malaria services in remote and underserved areas.

Table 6 below provides some examples of GEDSI-focused indicators that are included in the global normative guidance, drawing from the list in **Resource 5.2.**

Table 6: Examples of Equity-focused Indicators

Indicators that provide data on geographical disparities in the malaria burden/access to services	Indicators that measure results based on age	Indicators that measure results based on gender	Indicators that measure results within a target high-risk or underserved population	Indicators that measure results based on location of service delivery
• Malaria test positivity rate by national/province/district/ sub-district • Proportion of confirmed malaria cases that received first-line antimalarial treatment at public sector health facilities by national/province/district/ sub-district	• Malaria mortality: rate per 100,000 people/year among children and adults aged <5, 5-14, 15+ • Malaria admissions: rate per 100,000 pop/year among children and adults aged <5, 5-14, 15+	• Malaria parasite prevalence among men / women • Proportion of men/ women who slept under an ITN the previous night	• Proportion of pregnant women attending ANC who received three+ doses of IPT for malaria • Number of ITNs distributed to targeted risk groups (e.g. pregnant women/migrants/prisoners) through continuous distribution	• Proportion of suspected malaria cases that receive a parasitological test in the community • Proportion of confirmed malaria cases that received first-line antimalarial treatment in the community

Although the global normative guidance on appropriate indicators to measure the performance of national malaria programmes is helpful, there are gaps from a GEDSI perspective:

- Two indicators focus on malaria in pregnancy (gender-specific indicators)
- Two further indicators are recommended for disaggregation by gender
- One indicator (i.e. proportion of targeted risk groups covered by ITN distribution) focuses on high risk groups such as prisoners and IDPs
- Indicators that focus on people with disabilities, vulnerable groups such as transgender or gender diverse persons, or ethnic or religious minorities are not included

NMPs are encouraged to review the indicators in **Resource 5.2** to see where additional indicators can be further disaggregated. For example, the two indicators that are recommended for disaggregation by gender are malaria parasite prevalence and proportion of the population that slept under an ITN the previous night. Examples of additional indicators that could be disaggregated by gender include the following:

- Malaria case fatality rate (by male/female)
- Malaria admissions rate (by male/female)
- Proportion of confirmed malaria cases that received first-line antimalarial treatment at public sector health facilities (by male/female)
- Proportion of confirmed malaria cases that received first-line antimalarial treatment in the community (by women/men)

Many countries in the Asia Pacific region already collect gender-specific data at health facility level. NMPs may have scope to report more of these data at national level.

Resource 5.3 provides some examples of indicators that can be disaggregated by disability.

Strengthening GEDSI-sensitive Data Collection

In order to strengthen malaria performance frameworks from a GEDSI perspective, NMPs can compare a standard population level indicator with the same indicator for a sub-population. This will allow countries to measure if they are making faster progress within the sub-population compared to the overall population. Reducing malaria-related inequities requires NMPs to achieve faster progress within an underserved sub-population compared to the population as a whole.

A sub-population could be demarcated based on place of residence, race, ethnicity, language, occupation, gender, religion, disability, age or sexual orientation for example. Undertaking a GEDSI assessment (see **Section 5.3.1**) will highlight which population groups and issues need to be monitored as a priority.

A comprehensive list of socially inclusive indicators for malaria elimination can be found in **Resource 5.4.** This shows how each indicator can be disaggregated by stratifiers such as age, gender, pregnant women, people with disabilities, mobile groups, occupational groups, tribal or ethnic groups, rural dwellers, or prisoners. NMPs will need to decide which indicators to disaggregate and by what stratifiers. This, in turn, will depend on the programme objectives outlined in a country's National Strategic Plan for Malaria.

It may make sense for NMPs to disaggregate malaria data based on a number of stratifiers (Box 8). For example, there may be both age- and/or gender-based disparities in LLIN use among specific minority ethnic groups living in a high malaria transmission area. Alternatively, men with a disability may find it easier to access LLINs than women with a disability.

Box 8: Disaggregating Malaria Data by Multiple Stratifiers

Malaria indicators can be designed to collect comprehensive data on GEDSI if they include several stratifiers. Some examples are:

- Number of LLINs distributed to (1) people with disabilities through continuous distribution disaggregated by (2) gender and (3) age
- Proportion of (1) forest workers/goers who slept under a LLIN last night by (2) gender
- Malaria case fatality rate by (1) gender (2) age and (3) disability
- Proportion of (1) ethnic minority population who slept under a LLIN last night by (2) gender and (3) age

Output-based indicators can also be used to measure operational performance from a GEDSI-perspective. Using the example of malaria SBCC, **Resource 5.5** shows how these activities can be monitored from a GEDSI perspective. The indicators cover ethnic minorities, people with disabilities, hard-to-reach communities, a specific occupation group (forest workers), prisoners and IDPs.

Resource Implications of Strengthening Malaria Metrics to Incorporate GEDSI

Adding new data elements to performance frameworks comes at a cost. If additional data can be collected through the routine reporting system, health staff and programme personnel will need to spend extra time on data collection, entry and analysis. In some cases, additional surveys or studies may need to be commissioned to provide the GEDSI-sensitive data. These will need to be budgeted for.

It may also be possible to add new indicators into an existing periodic survey such as Malaria Indicator Survey (MIS) or a Demographic and Health Survey (DHS).[8] It is therefore important to clarify whether a new data element addresses a specific performance gap and aligns with the strategic priorities of the malaria NSP.

[8] It is recognised that countries approaching elimination are unlikely to carry out an MIS.

5.3.3 Data Analysis, Use and Monitoring

GEDSI-sensitive data need to be systematically examined, interpreted and presented in a way that is comprehensible and accessible to decision-makers within the national malaria programme. Timely analysis is crucial since it:

- Enables NMPs to track progress towards reducing inequities in the malaria burden and access to services
- Enables programme staff to track trends and compare results against targets. This, in turn, enables informed decision-making on how to allocate scarce resources or to change course, if required
- May reveal issues with data quality (i.e. gaps; discrepancies; anomalies) that can then be corrected or further explored
- Highlights topics and issues that would benefit from being incorporated into periodic data collection activities (e.g. surveys; evaluations; studies) to fill gaps in the evidence base

Adequate resources need to be allocated to support the data analysis phase. It is also important that NMPs cultivate an organisational culture that embraces data-driven decision-making.

GEDSI-sensitive data collected routinely through the HMIS need to be reviewed and analysed at regular intervals to support decision-making within the malaria programme. These quantitative data can be contextualised and triangulated with reference to qualitative data that is available in research reports and other studies.

GEDSI-sensitive data that are collected periodically in household surveys, programme evaluations and other assessments can complement routine data, filling gaps in the evidence base. It is therefore vital that routine and periodic GEDSI-data collection are considered as complementary and interrelated. Full ownership of a GEDSI assessment by a NMP will help to ensure that the recommendations emerging from these studies are taken forward (Box 9).

Box 9: Ensuring that GEDSI Assessments Inform Policy and Practice

Involving NMP staff and other senior policy makers in Malaria Matchbox research teams, especially at the data analysis phase, can help to ensure that actionable recommendations are taken forward. The existence of a GEDSI Taskforce can also help to ensure that the findings of the Malaria Matchbox influence policy and practice. Development partners and civil society organisations also have an important role to play in championing GEDSI-focused studies and advocating for the findings and recommendations to be taken forward by the NMP.

Summary

- GEDSI-sensitive data collection is crucial for malaria elimination since it highlights the groups that are left behind
- NMPs in the Asia Pacific region recognise that there is scope to do more to strengthen their malaria performance frameworks from a GEDSI perspective
- Establishing a system to measure equity gaps involves three steps: (1) identify underserved populations (2) select a core set of indicators to monitor priority populations and (3) analyse data, devise a plan for addressing equity gaps and monitor progress
- Equity assessments like Malaria Matchbox assessments help to guide decisions about which indicators would benefit from being disaggregated based on GEDSI stratifiers

Section 5: Resources and Tools

Resource 5.1: Case Study: Papua New Guinea Malaria Matchbox Assessment
This provides a summary of the key findings and recommendations of the PNG malaria matchbox assessment

Resource 5.2: Global Fund Malaria Indicators
This lists malaria indicators recommended by The Global Fund and highlights where and how they are disaggregated by GEDSI

Resource 5.3: Examples of Disability Focused Indicators for Malaria
This provides examples of outcome and impact indicators that can be used to measure the effect of the malaria programme on people with disabilities

Resource 5.4: Disaggregating Malaria Indicators Based on GEDSI
This illustrates how malaria indicators for different programme components can be disaggregated by GEDSI stratifiers (e.g. disabled persons, refugees, IDPs etc)

Resource 5.5: How to Disaggregate Malaria Outcome Indicators by GEDSI
This uses the example of a SBCC component to show how outcome indicators can be disaggregated by GEDSI stratifiers

Resource 5.1

Case Study: Papua New Guinea Malaria Matchbox Assessment

Papua New Guinea Malaria Matchbox Assessment

A Malaria Matchbox assessment was undertaken in Papua New Guinea (PNG) in 2020. The study was designed by the National Department of Health and the PNG Institute of Medical Research and had a country-wide focus. Key findings included:

- Rural communities commonly only respond to malaria symptoms and seek assistance when traditional remedies and self-medication fail. Significant physical access barriers to use of health services contribute to these delays.
- IEC on malaria prevention, diagnosis and treatment is inadequate in rural areas. Health workers also lack training on how to communicate effectively with patients on these issues.
- Women sex workers, people living with HIV and transgender women experience stigma and discrimination when seeking any type of health service, including malaria services.
- Significant language and cultural barriers are experienced by refugee, migrant and displaced communities when accessing malaria services.
- Health workers lack knowledge and experience of working effectively with marginalised groups such as people who use drugs, women sex workers and transgender persons.
- Health workers also lack the knowledge and skills that would allow them to offer disability-inclusive service delivery.
- People with disabilities are being missed in community-based LLIN distribution. This is due to physical access barriers and because information about the distribution fails to reach them.

Some of the key recommendations from the study were:

- Improve the capacity of health workers to communicate with clients and communities on malaria prevention, diagnosis and treatment, acknowledging local beliefs but ensuring that communities have the correct information.
- Ensure that communication approaches and materials utilise local / preferred languages and vernacular speech.
- Ensure that representatives of marginalised communities are involved in sharing information on malaria issues to avoid language barriers and stigma and discrimination.
- Provide GEDSI (including disability awareness) training for health workers so that they can better meet the needs of marginalised and vulnerable clients and communities.
- Work with and through organisations that already work with marginalised groups to increase their access to malaria services.
- Explore the feasibility of providing home testing kits for malaria in remote communities and train community health workers to support this intervention.

The recommendations were reviewed at a workshop in 2022 and a plan for taking forward the recommendations (e.g. GEDSI training for health workers) was devised (45).

Resource 5.2

Recommended Malaria Indicators for Measuring the Performance of NMPs (The Global Fund)

The following indicators are recommended by The Global Fund. The final column shows how the indicators can be disaggregated.

Indicator Type	Indicator	Data Collection Frequency	Data Source	Scope of Target & Recommended Disaggregation
Impact	Reported malaria cases (presumed and confirmed)	Monthly	HMIS	• National; sub-national • Age (<5, 5-14, 15+) • Malaria case definition (Confirmed/Presumptive)
	Confirmed malaria cases (microscopy or RDT): rate per 1,000 persons/year	Monthly	HMIS	• National; sub-national • Age (<5, 5-14, 15+) • Species (*P. falciparum, P. vivax*, mixed, other)
	In-patient malaria deaths: rate per 100,000 persons per year	Monthly	HMIS	• National; sub-national • Age (<5, 5-14, 15+)
	Malaria test positivity rate	Monthly	HMIS	• National; sub-national • Type of testing (microscopy, RDT)
	Malaria parasite prevalence: Proportion of population with malaria infection	Every 2-3 years	Population-based survey	• National; sub-national • Age (<5, 5-14, 15+) • Gender (female, male)

Indicator Type	Indicator	Data Collection Frequency	Data Source	Scope of Target & Recommended Disaggregation
Impact	Annual parasite incidence: Confirmed malaria cases (microscopy/RDT): rate per 1000 persons/year (elimination settings)	Monthly	HMIS	• National; sub-national • Source of infection (imported, locally acquired)
	Proportion of districts reporting locally transmitted cases of malaria	Monthly	HMIS	• National
	Malaria mortality: rate per 100,000 people/year	Annual	HMIS/CRVS/ WHO estimates	• National/sub-national • Age (<5, 5-14, 15+)
	Malaria case fatality rate: Percentage of deaths among confirmed malaria cases (elimination settings)	Monthly	HMIS	• National/sub-national • Age (<5, 5-14, 15+)
	Malaria admissions: rate per 100,000 pop/year	Monthly	HMIS	• National/sub-national • Age (<5, 5-14, 15+)
	Number of locally acquired malaria cases	Monthly	HMIS	• National/sub-national • Species (*P. falciparum*, *P. vivax*, mixed, other)
	Number of malaria free districts (elimination settings)	Annual	HMIS	–

Indicator Type	Indicator	Data Collection Frequency	Data Source	Scope of Target & Recommended Disaggregation
Outcome	Proportion of population that slept under an insecticide-treated net the previous night	Every 2-5 years	Household survey	• National/sub-national • Gender (female, male)
	Proportion of children under five years old who slept under an insecticide-treated net the previous night	Every 2-5 years	Household survey	• National/sub-national
	Proportion of pregnant women who slept under an insecticide-treated net the previous night	Every 2-5 years	Household survey	• National/sub-national
	Proportion of population with access to an ITN within their household	Every 2-5 years	Household survey	• National/sub-national
	Proportion of households with at least one insecticide-treated net for every two people	Every 2-5 years	Household survey	• National/sub-national
	Proportion of population at risk potentially covered by distributed ITNs	Annual	Routine reporting system/NMP records	• National/sub-national
	Percentage of districts achieving national target for the proportion of population at risk potentially covered by distributed ITNs	Annual	Programme records for ITN distribution/ census projection	• National

Indicator Type	Indicator	Data Collection Frequency	Data Source	Scope of Target & Recommended Disaggregation
Outcome	Proportion of targeted risk groups covered by distributed ITNs	Periodic	Routine reporting system/NMP records	• National/sub-national • Targeted risk groups (migrant/refugees/IDPs, prisoners, others)
	Annual blood examination rate: per 100 population per year (elimination settings)	Monthly	HMIS	• National/sub-national • Case detection (active, passive)
	Proportion of malaria cases detected by the surveillance system	Periodic	HMIS/WHO estimate	• National
	Proportion of children aged < 5 years with fever in previous 2 weeks who had a finger or heel stick	Every 2-5 years	Household survey	• National/sub-national
	Proportion of (estimated) malaria cases that was detected by parasitological testing	Periodic/annual	HMIS/WHO estimate	• National

Indicator Type	Indicator	Data Collection Frequency	Data Source	Scope of Target & Recommended Disaggregation
Vector control	Number of insecticide-treated nets distributed to populations at risk of malaria transmission through mass campaigns	Monthly	NMP records	• National/sub-national
	Number of insecticide-treated nets distributed to targeted risk groups through continuous distribution	Monthly	HMIS/NMP records	• National/sub-national
	Proportion of population at risk receiving at least one round of IRS within the last 12 months in areas targeted for IRS	Annual	NMP records	• National/sub-national
	Percentage of districts achieving national target for proportion of population at risk receiving at least one round of IRS within the last 12 months in areas targeted for IRS	Annual	NMP records	• National

Indicator Type	Indicator	Data Collection Frequency	Data Source	Scope of Target & Recommended Disaggregation
Case management	Proportion of suspected malaria cases that receive a parasitological test at public sector health facilities	Monthly	HMIS	• National/sub-national • Age (<5, 5+) • Type of testing (microscopy, RDT)
	Proportion of suspected malaria cases that receive a parasitological test in the community	Monthly	HMIS	• National/sub-national • Age (<5, 5+) • Type of testing (microscopy, RDT)
	Proportion of suspected malaria cases that receive a parasitological test at private sector sites	Monthly	HMIS	• National/sub-national • Age (<5, 5+) • Type of testing (microscopy, RDT)
	Proportion of confirmed malaria cases that received first-line antimalarial treatment at public sector health facilities	Monthly	HMIS	• National/sub-national • Age (<5, 5+)
	Proportion of confirmed malaria cases that received first-line antimalarial treatment in the community	Monthly	HMIS	• National/sub-national • Age (<5, 5+)
	Proportion of confirmed malaria cases that received first-line antimalarial treatment at private sector sites	Monthly	HMIS	• National/sub-national • Age (<5, 5+)

Indicator Type	Indicator	Data Collection Frequency	Data Source	Scope of Target & Recommended Disaggregation
Case management	Percentage of confirmed cases fully investigated and classified as per national guidance	Monthly	HMIS	• National/sub-national • Source of infection (imported/locally acquired)
	Percentage of malaria foci fully investigated and classified	Monthly	HMIS	• National/sub-national
	Percentage districts achieving national target for proportion of susp malaria cases who receive parasitological test	Monthly	HMIS	• National/sub-national • Type of provider (public, private, community)
	Percentage of districts achieving national targets for the proportion of confirmed malaria cases who received first-line antimalarial treatment	Monthly	HMIS	• National • Type of provider (public, private, community)
	Proportion of detected malaria patients who contacted health care provider within 48 hours of onset of symptoms (elimination settings)	Monthly	HMIS	• National/sub-national
	Proportion of cases reported at national reporting system within 24 hours of treatment (elimination settings)	Monthly	HMIS	• National/sub-national

Indicator Type	Indicator	Data Collection Frequency	Data Source	Scope of Target & Recommended Disaggregation
Other prevention activities	Proportion of pregnant women attending ANC who received three or more doses of IPT for malaria	Monthly	HMIS	• National/sub-national
	Percentage of children who received the full number of courses of seasonal malaria chemoprevention (SMC) per transmission season in targeted areas	End of transmission season	HMIS/mass campaign registers	• National/sub-national
	Proportion of infants who received the full number of courses of perennial malaria chemoprevention (PMC)	Annual	HMIS/mass campaign registers	• National/sub-national
	Percentage districts achieving national target for the proportion of pregnant women attending ANC who received =>three doses of IPT for malaria	Monthly	HMIS	• National
	Percentage targeted districts achieving national targets for % children who received full number of SMC courses	Annual	HMIS/mass campaign registers	• National

Resource 5.3

Examples of Disability-Focused Outcome and Impact Indicators

Outcome Indicators	Impact Indicators
• % people with disabilities receiving malaria treatment within 24 hours • Rate of severe anaemia among children with disabilities under 5 years • Percentage people with disabilities sleeping under LLIN • % families with person with a disability covered by IRS • % people with disabilities reporting a measure of malaria-related behaviour change in response to a SBCC campaign • % people with disabilities with fever tested with an RDT • % confirmed malaria cases among people with disabilities that received first-line antimalarial treatment	• % people with disabilities with fever for whom treatment was sought • % children with disabilities with fever for whom treatment was sought • % malaria mortality in pregnancy in people with disabilities • % malaria mortality in people with disabilities • Malaria prevalence among people with disabilities

Resource 5.4

Disaggregation of Malaria Indicators based on GEDSI Stratifiers

The table below shows how malaria indicators can be disaggregated based on various stratifiers (i.e. age, gender, disability, ethnic minority group etc). An equity assessment (e.g. Malaria Matchbox study) will help to inform decisions about which indicators would benefit from being disaggregated.

Indicator Group	Indicator	Age	Sex	Pregnant women	Persons with disability	Mobile populations	Outdoor workers	Ethnic/ tribal groups	Rural dwellers
Malaria in pregnancy	n/% women in 1st/2nd/3rd trimester who tested positive for of malaria	✓	–	–	✓	✓	✓	✓	✓
	% pregnant women who received 1 or more doses of IPTp	✓	–	–	✓	✓	✓	✓	✓
	% pregnant women who received 2 or more doses of IPTp	✓	–	–	✓	✓	✓	✓	✓
	% pregnant women who received 3 or more doses of IPTp	✓	–	–	✓	✓	✓	✓	✓
	% women who attended 4 ANC visits during their last pregnancy	✓	–	–	✓	✓	✓	✓	✓

Indicator Group	Indicator	Age	Sex	Pregnant women	Persons with disability	Mobile populations	Outdoor workers	Ethnic/ tribal groups	Rural dwellers
Malaria in children <5	% children <5 years with fever in last 2 weeks for whom advice or treatment was sought	–	✓	–	✓	✓	✓	✓	✓
	% children <5 years of age with fever in last two weeks who were tested with RDT	–	✓	–	✓	✓	✓	✓	✓
	Children <5 with parasitemia (all species) by RDT, microscopy or PCR	–	✓	–	✓	✓	✓	✓	✓
	n/% of children <5 years with malaria	–	✓	–	✓	✓	✓	✓	✓
	% children <5 who slept under a LLIN during the previous night	–	✓	–	✓	✓	✓	✓	✓
	% children < 5 living in villages <2 km from forest who slept under an LLIN during previous night	–	✓	–	✓	–	✓	✓	✓

Indicator Group	Indicator	Age	Sex	Pregnant women	Persons with disability	Mobile populations	Outdoor workers	Ethnic/ tribal groups	Rural dwellers
Surveillance	Annual parasite index	✓	✓	✓	✓	✓	✓	✓	✓
	n/% of cases	✓	✓	✓	✓	✓	✓	✓	✓
	n/% of cases of each species	✓	✓	✓	✓	✓	✓	✓	✓
	n/% severe cases of each species	✓	✓	✓	✓	✓	✓	✓	✓
	n/% malaria-related deaths	✓	✓	✓	✓	✓	✓	✓	✓
	n/% malaria-related deaths of each species	✓	✓	✓	✓	✓	✓	✓	✓
	n/% of each classification (indigenous/locally transmitted/imported)	–	–	–	–	✓	✓	✓	✓
	n/% severe cases of each classification	✓	✓	✓	✓	✓	✓	✓	✓
	% patients with fever in last 2 wks for whom advice/treatment sought	✓	✓	✓	✓	✓	✓	✓	✓

Indicator Group	Indicator	Age	Sex	Pregnant women	Persons with disability	Mobile populations	Outdoor workers	Ethnic/ tribal groups	Rural dwellers
Surveillance (cont.)	Proportion of tests done by passive case detection, active case detection or forest outreaches						✓	✓	
	Number of fevers, anaemia, severe anaemia, splenomegaly cases	✓	✓	✓	✓	✓	✓	✓	✓
	n/% P vivax cases tested for G6PD	–	✓	✓	✓	✓	✓	✓	✓
	n/% malaria cases in mobile populations (<6 months living in their home), in migrant populations (6-12 months living in current home), in sedentary populations (12+ months living in current home)		✓	✓	✓	–	✓	✓	–
	% suspected malaria cases that receive a parasitological test at public sector health facilities, in the community, in the private sector	✓	✓	✓	✓	✓	✓	✓	✓

Indicator Group	Indicator	Age	Sex	Pregnant women	Persons with disability	Mobile populations	Outdoor workers	Ethnic/ tribal groups	Rural dwellers
Exposure to IEC/SBCC	Proportion of each social stratifier attending malaria community engagement events	✓	✓	✓	✓	✓	✓	✓	✓
	Proportion of h/hold in which at least 1 person attended malaria health education event in last 6 months in active foci	✓	✓	✓	✓	✓	✓	✓	✓
	Proportion of h/hold in which at least 1 attended malaria health education event in last 12 months in residual foci	✓	✓	✓	✓	✓	✓	✓	✓
	Proportion of h/hold in which at least 1 person attending malaria health education event in last 12 months in malaria-free areas	✓	✓	✓	✓	✓	✓	✓	✓

Indicator Group	Indicator	Age	Sex	Pregnant women	Persons with disability	Mobile populations	Outdoor workers	Ethnic/ tribal groups	Rural dwellers
Risk factors	n/% people who have gone to forest/away from home and slept overnight in last 6 months	✓	✓	✓	✓	–	–		
	n/% people living in endemic areas, active and residual foci	✓	✓	✓	✓	✓	✓	✓	✓
	n/% people living <2km from forest	✓	✓	✓	✓	–	–	✓	✓

Indicator Group	Indicator	Age	Sex	Pregnant women	Persons with disability	Mobile populations	Outdoor workers	Ethnic/ tribal groups	Rural dwellers
Vector control	n/% people who slept under any type of mosquito net previous night	✓	✓	✓	✓	✓	✓	✓	✓
	n/% people who slept under ITN previous night	✓	✓	✓	✓	✓	✓	✓	✓
	% of each risk group who slept under ITN previous night	✓	✓	✓	✓	✓	✓	✓	✓
	n/% h/holds who received at least 1 LLIN in past 12 months	–	–	–	–	✓	✓	✓	✓
	% h/holds with sufficient LLINs (1 LLIN per 1.8 people)	–	–	–	–	✓	✓	✓	✓
	% h/holds with at least 1 LLIN	–	–	–	–	✓	✓	✓	✓
	n/% h/holds with sufficient hammock LLINs (1 per forest goer)	–	–	–	–	–	✓	✓	✓
	n/% h/holds in targeted villages treated by IRS in last 12 months	–	–	–	–	✓	✓	✓	✓

Indicator Group	Indicator	Age	Sex	Pregnant women	Persons with disability	Mobile populations	Outdoor workers	Ethnic/ tribal groups	Rural dwellers
Vector control (cont.)	% forest goers who reported sleeping under ITN last time in forest	✓	✓	✓	✓	–	✓	✓	✓
	Proportion of pregnant women who slept under ITN previous night	✓	–	–	✓	✓	✓	✓	✓
	n/% people living in endemic areas, active and residual foci who slept under ITN previous night	–	–	–	–	–	✓	✓	✓
Testing/ diagnosis	% patients with fever in last 2 weeks tested by RDT or microscopy	✓	✓	✓	✓	✓	✓	✓	✓
	n/% cases of each species fully investigated	✓	✓	✓	✓	✓	✓	✓	✓
	n/% cases of each species fully investigated within 24 hours	✓	✓	✓	✓	✓	✓	✓	✓
	n/% cases of each species fully classified	✓	✓	✓	✓	✓	✓	✓	✓

Indicator Group	Indicator	Age	Sex	Pregnant women	Persons with disability	Mobile populations	Outdoor workers	Ethnic/ tribal groups	Rural dwellers
Testing/ diagnosis (cont.)	n/% cases of each species fully classified within 24 hours	✓	✓	✓	✓	✓	✓	✓	✓
	n/% cases still positive on day 28 disaggregated	✓	✓	✓	✓	✓	✓	✓	✓
	n/% cases still positive on day 42 disaggregated	✓	✓	✓	✓	✓	✓	✓	✓
	n/% *P vivax* patients recording side effects of Primaquine	✓	✓	✓	✓	✓	✓	✓	✓
	% *P. vivax* cases fully supervised during treatment with Primaquine	✓	✓	✓	✓	✓	✓	✓	✓
	% cases detected/confirmed by RDT	✓	✓	✓	✓	✓	✓	✓	✓
	% cases detected/confirmed by microscopy	✓	✓	✓	✓	✓	✓	✓	✓
	% cases detected/confirmed by PCR	✓	✓	✓	✓	✓	✓	✓	✓

Indicator Group	Indicator	Age	Sex	Pregnant women	Persons with disability	Mobile populations	Outdoor workers	Ethnic/ tribal groups	Rural dwellers
Treatment	Drug regimen given by species to simple/severe malaria cases/deceased patients	✓	✓	✓	✓	✓	✓	✓	✓
	Drug regimen given to malaria+ pregnant women in 1st trimester	✓	–	✓	✓	✓	✓	✓	✓
	% fevers in last 2 weeks who received treatment according to national treatment guidelines (NTGs)	✓	✓	✓	✓	✓	✓	✓	✓
	% fevers in last 2 weeks who received treatment according to NTGs within 24 hrs of fever onset	✓	✓	✓	✓	✓	✓	✓	✓
	% malaria-positive patients of all species, simple, severe or death who received treatment according to NTGs within 24 hours of fever onset	✓	✓	✓	✓	✓	✓	✓	✓

Indicator Group	Indicator	Age	Sex	Pregnant women	Persons with disability	Mobile populations	Outdoor workers	Ethnic/ tribal groups	Rural dwellers
Treatment (cont.)	% confirmed malaria cases that received 1st-line antimalarial treatment at public sector health facilities/community/private sector	✓	✓	✓	✓	✓	✓	✓	✓
	% patients receiving an ACT among patients with a fever in last 2 weeks who received any antimaterial drug	✓	✓	✓	✓	✓	✓	✓	✓

Indicator Group	Indicator	Age	Sex	Pregnant women	Persons with disability	Mobile populations	Outdoor workers	Ethnic/ tribal groups	Rural dwellers
Elimination	n/% districts reporting zero indigenous cases out of all districts targeted for zero indigenous cases	–	–	–	–	–	–	✓	✓
	% districts reporting zero indigenous cases out of all districts	–	–	–	–	–	–	–	✓
	n/% villages qualified as high risk that are active foci	–	–	–	–	–	–	✓	✓
	n/% villages qualified as high risk that are residual foci	–	–	–	–	–	–	✓	✓
	n/% villages qualified as high risk that are cleared foci	–	–	–	–	–	–	✓	✓
	n/% villages qualified as high risk that transitioned from active to residual foci in the last 12 months	–	–	–	–	–	–	✓	✓

Resource 5.5

Using Outcome Indicators to Measure GEDSI Gaps

The table below illustrates how outcome indicators can be used to measure GEDSI gaps. The example of a SBCC programme component is used. The same approach can be used for any programme component.

Indicator	Disaggregation by GEDSI stratifiers
% communities in intervention area with at least one malaria-focused community engagement (CE) event in last 6 months	• % ethnic minority communities in intervention area with at least one malaria-focused CE event in last 6 months • % hard-to-reach communities in intervention area with at least one malaria-focused CE event in last 6 months
% community members reporting attendance at least one malaria-focused CE event in last 6 months	• % women/men community members reporting attendance at malaria-focused CE event in last 6 months • % people with disabilities • Reporting attendance at malaria-focused CE event in last 6 months • % women/men community members in ethnic minority communities reporting attendance at malaria-focused CE event in the last 6 months
% community members reporting access to malaria information in the last 6 months	• % women/men prisoners reporting access to malaria information in last 6 months • % women/men IDPs reporting access to malaria information in last 6 months • % women/men with disabilities • reporting access to malaria information in last 6 months • % women/men forest workers reporting access to malaria information in last 6 months
% community members accessing malaria-related health information from health worker/community health worker/mass media	• % women/men community members who accessed malaria-related health information from a health worker/community health worker/mass media • % ethnic minority community members who accessed malaria-related health information from a health worker/community health worker/mass media • % disabled community members who accessed malaria-related health information from a health worker/community health worker/mass media

Indicator	Disaggregation by GEDSI stratifiers
% community members who correctly report main symptoms of severe malaria	• % women/men community members who correctly report main symptoms of severe malaria • % women/men ethnic minority community members who correctly report main symptoms of severe malaria
% women community members who know that three doses are needed to complete IPTp	• % women in ethnic minority communities who know that three doses are needed to complete IPTp • % women IDPs who know that three doses are needed to complete IPTp

Section 6: Integration of GEDSI in Planning and Budgeting

6.1 Integrating GEDSI into Programme Planning

The successful integration of GEDSI issues into malaria programme planning requires the adoption of a structured and stepwise approach. This toolkit has highlighted the importance of undertaking an initial analysis to explore the GEDSI context. The Malaria Matchbox tool was highlighted as a useful resource to this end (see Section 5). A GEDSI analysis is a vital first step in GEDSI-sensitive programme planning since it generates crucial information on malaria needs, priorities, barriers and opportunities. This can be used to develop a GEDSI strategy and subsequently an action plan for the NMP. In turn, a GEDSI strategy provides a framework to guide the development and implementation of socially inclusive malaria activities.

Malaria monitoring systems will also need to be adapted so that they can track performance from a GEDSI perspective. Data generated by these systems will enable NMPs to adjust intervention strategies in response to implementation experience.

Lastly, NMPs will need to put in place an accountability framework for GEDSI. This will enable key stakeholders, including programme beneficiaries, to hold government to account for the delivery of a malaria programme that leaves no-one behind.

Key steps in the integration of GEDSI into programme planning are highlighted in Table 7.

Table 7: Key Steps in Integrating GEDSI into the Malaria Programme

Step	Actions
1. Undertake GEDSI analysis	• Undertake a comprehensive analysis to understand the specific malaria-related needs, barriers and opportunities of different social groups, including women, men, people with disabilities, ethnic minorities, and other vulnerable and marginalised populations (e.g. IDPs, refugees, prisoners, drug users). • Collect and analyse data that is disaggregated by sex, age, disability, ethnicity, and other relevant characteristics to reveal differential impacts and inform inclusive programming.
2. Develop GEDSI strategy	• Develop a GEDSI strategy to outline how the malaria programme will address GEDSI and achieve equitable outcomes for all • Operationalise the GEDSI strategy by developing an action plan which specifies activities, timeframes/phasing, responsibilities etc
3. Design and implement socially inclusive interventions	• Design interventions to be empowering, ensuring that people with disabilities and other vulnerable and marginalised groups are included and empowered. • Design programme activities and materials to be accessible to people with a disability or individuals facing language and other barriers to ensure equitable access to programme information and benefits. • Promote participation and leadership of women, girls, people with disabilities, and other vulnerable and marginalised groups in decision-making processes relating to design and implementation. • Provide GEDSI training and build the capacity of relevant personnel to understand and implement GEDSI principles effectively throughout the programme cycle.
4. Monitor GEDSI outcomes and impact	• Develop GEDSI indicators to monitor progress, measure outcomes, and track improvements in equality and inclusion. • Identify gaps in the GEDSI evidence base and decide how to fill these. • Promote participation and leadership of women, girls, people with disabilities, and other vulnerable and marginalised groups in monitoring and evaluation
5. Strengthen and promote accountability	• Review, monitor, and adapt programmes based on GEDSI principles to address bottlenecks and ensure progress towards equitable outcomes. • Promote participation of development partners and government stakeholders to ensure cohesion, co-ordination and integration of activities. • Establish accountability mechanisms that enable programme beneficiaries to monitor the relevance and impact of key activities.

6.2 Integrating GEDSI into Programme Budgeting

Sub-national tailoring, increasingly implemented in the Asia Pacific region, uses local data and contextual information to customize the mix of malaria interventions for optimal impact. Adoption of this approach can lead to resource efficiencies, thereby helping to free up funds that can be used to promote social inclusion and equitable service delivery.

The budget required to implement a GEDSI-sensitive malaria programme will depend on many factors, including the:

- Proposed population coverage of target marginalised and excluded groups
- Service delivery modality (e.g. will delivery be facility- or community-based? Will services be delivered through the public, private or CSO sector?)
- Logistical factors, including the extent to which target communities are hard-to-reach
- Whether GEDSI expertise will need to be contracted in to support the NMP
- Extent of gaps in the GEDSI evidence base, and decisions about how to fill these
- Extent to which malaria M&E systems need to be adjusted to accommodate GEDSI and any related training requirements
- Track record of partnership working between the NMP and target groups

Tool 6.2 provides a checklist of issues to consider when compiling a GEDSI-sensitive budget for malaria activities.

When integrating GEDSI into programme budgets, NMPs may wish to consider diversifying budget teams to bring new and varied perspectives into the budgeting exercise. This could include, for example, persons with a disability or representatives of specific marginalised ethnic groups. Budget teams may also require training to enhance their understanding of GEDSI issues.

It will also be important to adapt budget frameworks to include specific indicators and analyses that measure expenditure on gender equality, disability and social inclusion.

Summary

- The process of integrating GEDSI into malaria programming involves a number of steps: production of a GEDSI analysis, compilation of a GEDSI strategy, development and implementation of socially inclusive malaria activities, adaptation of the malaria M&E system to accommodate GEDSI issues, and establishment of an accountability framework
- NMP may wish to consider diversifying budget teams to bring new and varied perspectives into budgeting exercises
- Many variables will affect the size of the budget required to implement a GEDSI-sensitive malaria programme
- Budget frameworks will need to be adapted to include specific indicators to measure expenditure on GEDSI

Section 6: Resources and Tools

Tool 6.1: Checklist to Guide Preparation of a GEDSI-sensitive Budget
This tool is a checklist of questions that will be useful to guide the preparation of a GEDSI-sensitive programme budget

Tool 6.1

Checklist for Compiling Budget for GEDSI Integrated Programming

Area	Questions
GEDSI Expertise	• Will the NMP require external technical support to integrate GEDSI into the NMP? How will this be obtained and what will this cost? • What are the set-up and ongoing costs of establishing a Technical Working Group to support GEDSI integration? • How will Women's organisations, organisations of Persons with Disability and other Organizations representing different marginalised groups be involved for their lived experience expertise?
Consultation and Participation	• What mechanisms will be used to consult with key vulnerable and marginalised target groups in intervention design? What will these cost? • What mechanisms will be used to ensure ongoing participation of vulnerable and marginalised groups in malaria activities? What will these cost?
Service Delivery	• What is the NMP's strategy for providing GEDSI training for front-line health workers (facility- and community-based)? What will this cost? • How will supervisory systems for health workers be modified to ensure that GEDSI is mainstreamed in service delivery? What will these modifications cost? • Will health workers require any training to ensure disability inclusion (e.g. diversity and inclusion training , training in sign language?) What will this cost? • Will any modifications need to be made to health infrastructure to accommodate the needs of people with disabilities? What will this cost? • Will any adaptations need to be made to service delivery modalities to ensure GEDSI inclusion? What will these cost?

Area	Questions
M&E and Learning	• Will modifications be required to routine data collection to ensure GEDSI inclusion? What will these cost? Will training be required to ensure that health workers can implement the modified system? What will this cost? • Will additional indicators be integrated into periodic surveys to fill GEDSI evidence gaps? What will this cost? • Will additional research studies be commissioned to fill GEDSI evidence gaps? What will these cost? • How will communities, Women's organisations, organisations of Persons with Disability and other Organizations representing different marginalised groups be involved in monitoring and evaluation? • Will intermittent programme reviews and evaluations be used to monitor GEDSI issues? What are the budget implications? • What is the NMP's strategy for dissemination and learning on GEDSI integration? What are the budget implications? • Does the NMP plan to include representatives of vulnerable and marginalised groups in learning and dissemination activities? What are the budget implications?

Section 7: Endnote

This toolkit aims to provide practical information and advice for NMPs in the Asia Pacific region to support their efforts to mainstream a GEDSI focus into malaria activities. The toolkit prioritises topics and issues identified by NMPs as areas where they require further information and support. Additional useful resources are signposted throughout the document.

It is hoped that the toolkit will increase the understanding and capacity of NMP staff in some key areas, including:

- Why GEDSI is important in malaria
- Strategies for strengthening community engagement in malaria programmes
- Adapting service delivery to be more socially inclusive
- Strengthening M&E systems to incorporate GEDSI metrics
- Integrating GEDSI into malaria planning and budgeting

The toolkit will be updated in future to incorporate additional feedback from, and any good practices identified by, NMPs in the region and to ensure that the guidance reflects changes and developments within the global and regional malaria control and elimination context.

NMP staff and other users of this toolkit are encouraged to share their feedback with the APLMA team so that the resource can be updated and improved as a living document (see Box 9 for contact details).

Box 9: Where to send feedback on the Toolkit

If readers would like to share their feedback on the toolkit, please contact the APLMA GEDSI team at: info@aplma.org

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