MAMaZ Against Malaria AT SCALE

EVIDENCE BRIEF

# Importance of gender empowerment to reducing malaria mortality in Zambia

Gender equality and women's empowerment are key to achieving universal health coverage. They are also important in their own right as a means to achieve sustainable development. Building on a successful gender mainstreaming approach used in three earlier projects, MAM@Scale integrated a focus on gender into the design of a severe malaria intervention in Zambia. Community health volunteers (CHVs) were trained to administer quality assured 100 mg rectal artesunate to children with severe malaria danger signs at community level and to refer patients to the health facility for further treatment. The project's gender strategy aimed to address the wide range of social norms and gender stereotypes that prevented rural households from responding promptly to severe malaria and other child health emergencies.

In April 2020, when the project pivoted to take on a COVID-19 focus, the gender strategy was adapted to include a campaign to highlight the added risk of gender-based violence (GBV) during emergencies. Changes in health-related decision-making and in health care seeking within intervention communities were monitored throughout the project. Shifts in the balance of power within gender relations, including violence against women and girls, changes that ultimately open up other development opportunities for women and girls, were also tracked.

## SUMMARY


- MAM@Scale mainstreamed a focus on gender into the design of a community level intervention to address severe malaria in Zambia.
- By the end of the project, considerable improvements in children's health care access and status were identified in intervention sites. There was also evidence of gender empowerment gains.
- Seven 'gender-smart' strategies were integral to delivering these results.
- As the severe malaria intervention is scaled up by Zambia's Ministry of Health, it will be important to maintain a strong focus on gender so that targets relating to malaria mortality reduction can be achieved within the shortest possible timeframe.


*CHVs often cover long distances to reach dispersed rural households*

## Background and context

MAM@Scale began in December 2018 with funding from Grand Challenges Canada and the Government of Canada, Medicines for Malaria Venture (MMV) and Transaid. Originally an 18-month intervention, additional funding from FIA Foundation, Grand Challenges Canada and a private donor extended the project by six months enabling MAM@Scale to participate in Zambia's national COVID-19 response. The project built on three earlier interventions, all with a strong community engagement and gender empowerment component.[1]

Over 7,500 malaria deaths occurred in Zambia in 2018[2] and children under six are the most susceptible due to their lack of immunity. MAM@Scale empowered Zambian families in five districts (Chitambo, Serenje, Chama, Manyinga and Vubwi) to reduce their mortality risk from severe malaria by introducing quality assured artesunate rectal capsules (known locally as rectal artesunate or 'RAS'), a cutting-edge pre-referral intervention given at community level to children aged six months to six years old. At the start of the project, a wide range of factors affected communities' ability to respond in a timely way to child health emergencies (*Box 1*).

Alongside these household and community constraints various supply-side constraints, including a weak referral system and shortages of essential drugs, consumables and equipment, limited uptake of child health services.

*Emergency Transport Scheme rider, Serenje District*

**BOX 1:** GENDER-RELATED AND OTHER CONSTRAINTS DELAYING THE RESPONSE TO CHILD HEALTH EMERGENCIES

- Low priority afforded to women's and children's health at community level, resulting in a lack of planning and preparedness for health emergencies.
- Various social and gender norms that undermined communities' early response to child health emergencies, including:
  - beliefs about the causes of sickness in children that led to life-threatening delays
  - low male involvement in children's health
  - women's lack of voice and capacity to make independent decisions about children's health
  - women's lack of access to finance / other resources that would enable access to care
  - normalisation of GBV
- Practical constraints of access to child health care (e.g. long distances, challenging terrain, poverty, lack of information, lack of social support).
- Low reserves of community social capital: few examples of communities working together to support families experiencing a health emergency.

## Strategy

CHVs were trained to mobilise their communities, administer RAS and refer severe malaria cases to the health facility for further treatment. Community-managed safety nets (e.g. food banks, emergency savings schemes and emergency transport systems) were established to tackle barriers and delays to use of health services.[3] Capacity building of front-line health providers helped to improve severe malaria case management. A community monitoring system, baseline and midline statistical surveys, and a gender empowerment study generated data to measure impact. At national level, MAM@Scale worked with the National Malaria Elimination Centre (NMEC) to prepare the ground for wider national scale-up of RAS.

Seven 'gender-smart' strategies were devised to facilitate increased access to health services and promote empowerment within the intervention communities.

As the project adapted to integrate a focus on COVID-19, the gender strategy was adjusted to include an anti-GBV campaign. This featured a series of community radio programmes and a poster campaign. Anti-GBV messages were reinforced by CHVs who interacted with traditional leaders and community members.

*RAS recipient Wiseman with his parents*

[1] Mobilising Access to Maternal Health Services in Zambia (MAMaZ, 2014-2016), funded by UK Department for International Development, MORE MAMaZ (2016-2018), funded by Comic Relief, and MAMaZ Against Malaria (MAM, 2017-2018), funded by MMV and Transaid.

[2] World Health Organization, 2019, **World Malaria Report** 2019. Geneva: WHO.

[3] In Chama MAM@Scale worked in partnership with the USAID Program for Advancement of Malaria Outcomes and in Vubwi and Manyinga, the Churches Health Association of Zambia.

| | GENDER SMART STRATEGY | RATIONALE |
|---|---|---|
| 1 | **Participatory community engagement approach** | Used to mobilise communities around a child health agenda and empower communities to establish and manage their own systems for addressing barriers and delays to use of health services. |
| 2 | **Address disempowering social norms** | CHVs facilitated community discussion groups. These provided opportunities to identify and counter harmful social and gender norms. |
| 3 | **Promote male involvement** | Women's access to health information and children's timely access to health services are contingent on supportive gender relations. Male involvement helped to redefine gender roles and decision-making processes. |
| 4 | **'Whole community' approach** | CHVs were trained to ensure that all women and girls were reached and empowered, including the least-supported. |
| 5 | **Train large number of CHVs** | The idea was to ensure that every household was reached; to create a network of male and female role models who could positively influence the community change process; and create a mutual support network to help sustain the CHVs' work. |
| 6 | **Involve traditional leaders** | Working with traditional leaders to encourage changes to local by-laws and directives helped create an enabling environment for women's and girls' empowerment. |
| 7 | **Train health workers in community engagement, gender and equity** | Training health workers as core community engagement trainers meant that they became champions for women's and girls' rights to access health information and quality services. |

## Results

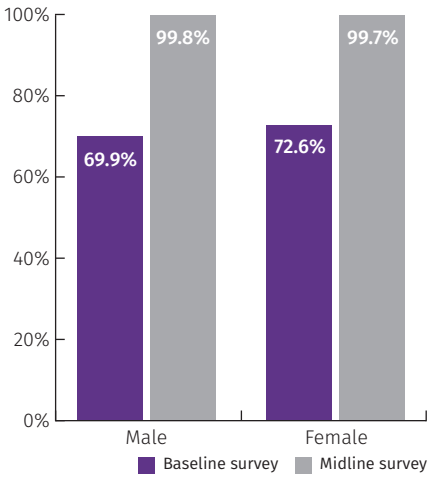
A qualitative gender empowerment study was carried out in January 2020, and baseline and midline surveys in February 2019 and July 2020 also captured gender-related data. CHVs' knowledge of the severe malaria danger signs improved dramatically between the two surveys (71% to 99.7%). More CHVs managed severe malaria cases (71% at baseline to 87% at midline). By midline, 3,216 severe malaria cases in children had been identified and managed by CHVs in the project's five intervention districts. This was lower than expected, but for positive reasons: the percentage of malaria cases progressing to severe malaria fell from 2.2% to 1.1%. This meant that malaria cases were identified and treated earlier. Case fatality rates from severe malaria fell from 3.1% to 0.9% resulting in an estimated 193 children's lives saved.

Although female CHVs had less formal education than male CHVs (69% of female CHVs and 55% of male CHVs finished their education at primary level) severe malaria knowledge levels were the same (*Figure 1*). The CHV training, designed for a low literacy context, had therefore helped to level out an uneven playing field.

*"Because I'm a man, I try to set an example. I tell other men that you can copy what I do.... I'm sensitizing other men to be more involved at home. Men should also take their children to the health centre."*

Male CHV, Serenje

***Figure 1: Knowledge of Severe Malaria Danger Signs by Gender***




***Source:** MAM@Scale Midline Survey, July 2020*

By July 2020, the project had trained 1,800 CHVs in partnership with district health teams. Just under half (47%) of CHVs were female, slightly below the project's target of 50%. A third of bicycle ambulance riders were female, exceeding expectations. This was positive since there were concerns within communities about women's time and capacity to operate bicycle ambulances at the start of the project.

A number of gender empowerment-related gains were also evident. Some of the disabling social norms that had discriminated against women and girls, and which had prevented or delayed children's health care access, were eroded. For instance, there was evidence of a significant increase in male involvement in children's health which lessened the childcare burden on women, helping to share responsibility for children across the household (*Box 2*).

### BOX 2: CHANGING MALE ATTITUDES TOWARDS CARE OF SICK CHILDREN

*"In the past it wasn't common for a man to take much notice of whether his children were sick. These days, if the wife isn't at home, they are checking children, recognising signs and bringing the children to the CHV if they think they are sick. This is an amazing change. It never used to be like this."* **Male CHV, Chitambo**

"In the past it was the mother who would take the sick children to the CHV. Now it's both the mother and the father in case the child needs to be rushed to the health facility." **Male ETS rider, Serenje**

***Source:** MAM@Scale Gender Empowerment study, January 2020*

Gains for women extended beyond improvements in children's health. Advances in women's status were evident: many women reported a greater say in household decision-making on health issues, and, in some cases, on other issues. Many women indicated that they were more confident to challenge husbands if they did not agree with a decision.

Some small but significant shifts in the gender division of labour were also evident, with some men taking on tasks that had previously been seen as women's responsibility (e.g. cooking, childcare and cleaning). Some male CHVs saw themselves as role models and influencers and were confident of their ability to help change disabling social norms and behaviours among fellow men.

*"I have inspired many other men in my community, and they are now changing too. They are taking part in what we thought were women's jobs like taking children for under-five clinic sessions, cleaning their surroundings and fetching water."*

Male community member, Serenje

Women in the study communities showed signs of increased voice, influence and agency in relation to health issues (*Box 3*). This stands them in good stead for being able to draw down other services, resources and opportunities in future. The greatest empowerment gains were found among the female CHVs who had learnt to operate very effectively in the public domain, including in areas that were once the preserve of men (*Fig 2*). The CHVs' work gave them credibility and authority within their communities, with positive impacts on their social status.

**BOX 3:** INCREASED VOICE, CONFIDENCE AND SELF-ESTEEM AMONG FEMALE CHVS

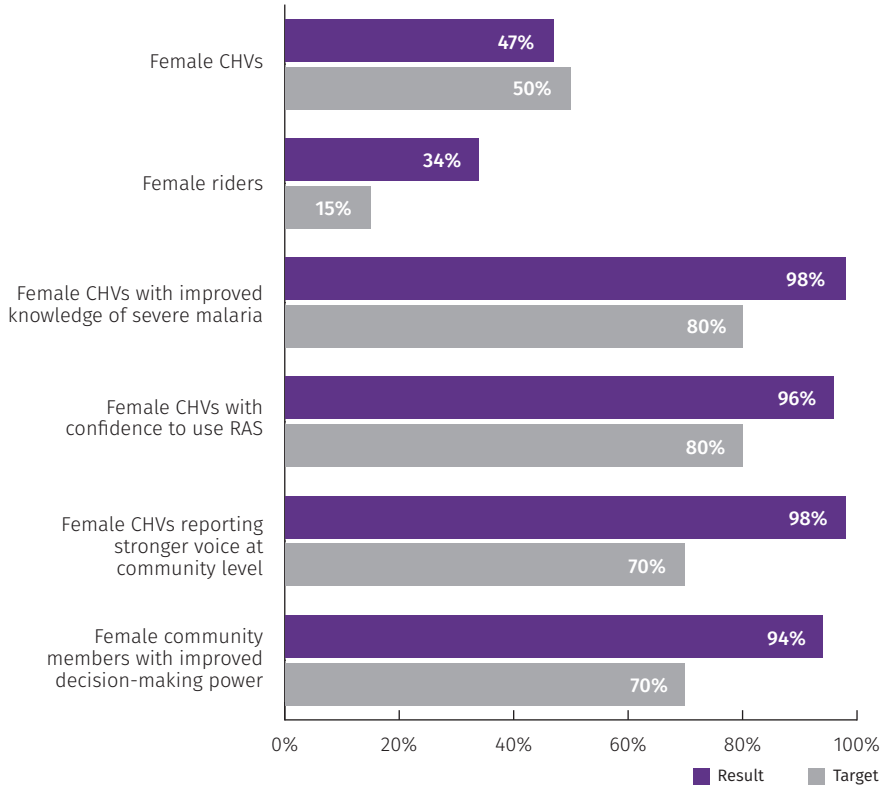
*"Traditionally men were the ones who conducted meetings. But now with female CHVs conducting meetings, it has encouraged us to aspire for more responsibility in the community and encouraged women to stand for positions in cooperatives or religious groups..."* **Female community member, Chitambo**

*"The CHV who was here earlier, she never used to talk....She used to keep herself to herself but now she goes out and talks to others. She has an openness and freedom to do things."* **Female CHV, Chitambo**

*"I've got a voice in my home now. I make a decision and my husband respects it. It's really changed from the situation before."* **Female CHV, Chitambo**

***Source:*** *MAM@Scale Gender Empowerment Study, January 2020*

***Figure 2: Gender Empowerment Results***




***Source:*** *MAM@Scale Midline Survey, July 2020*

The midline survey found that 83% of CHVs reported that GBV had fallen in their community. Of these, 85% of female CHVs and 75% of male CHVs indicated that GBV had 'disappeared' or 'reduced a lot' in recent years. This can be attributed to the anti-GBV work of both MAM@Scale and earlier programmes. However, five percent of CHVs indicated that GBV had increased due to COVID-19. It is probable that the project's community engagement approach, with its emphasis on gender equality and women's empowerment, had helped to prevent an escalation in GBV in a context where cases were rising in many other countries.

## Lessons Learned and Policy Implications

- The gender-smart strategies that underpinned MAM@Scale's community engagement approach were integral to the positive child health outcomes and the empowerment gains seen in the project's intervention sites. As Zambia's MOH begins to scale up RAS across the country through the integrated community case management (i-CCM) platform, it will be important to ensure that a gender focus is fully integrated into the national response. This can be done by adding two extra training days to the existing i-CCM training approach.
- In two MAM@Scale intervention districts (Chitambo and Serenje) the project worked with district health teams to ensure a gender balance of CHVs selected for training. In these districts 52% of trainees were women. In three other districts there was less opportunity to influence the selection process, and, as a consequence, only 20% of trainees were women. As RAS is scaled up across the country, ensuring that equal numbers of male and female CHVs are selected for training will be vital. This will enable the MOH to achieve the desired level of engagement with communities and, ultimately, help deliver national malaria mortality reduction targets.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Funded by Grand Challenges Canada and the Government of Canada, Medicines for Malaria Venture, FIA Foundation and Transaid.

December 2020 | **Design:** holmqvistdesign.co.uk