



Responding to Gender Issues to Improve Outcomes in Zika-related Health Care

Background

Zika is a virus that can be transmitted through mosquito bites, from mother to child during pregnancy and breastfeeding, through sex, or through the exchange of other bodily fluids, such as blood, saliva, and urine [1]. As of mid-2017, 48 countries and territories in the Americas, Africa, Asia, and Europe have confirmed vector-borne transmission of the Zika virus, while five countries have reported sexually transmitted Zika cases [2]. The Latin American and Caribbean (LAC) region has seen the bulk of infections, where females account for the majority (61-75%) of all Zika cases. In fact, the rates of probable Zika cases were highest in women of reproductive age, between 20-49 years [3-4].

Pregnant women can be infected with the Zika virus throughout the pregnancy, and the virus is capable of spreading from a pregnant woman to her child [5]. While many people infected are asymptomatic or have mild symptoms, Zika infection is of particular concern for pregnant women because it has been linked to cases of serious birth complications such as microcephaly and other brain anomalies among infants [3,6]. One study found the estimated risk for microcephaly with Zika infections in the first trimester of pregnancy ranged from 1-13% in Brazil [7]. Currently, there is no vaccine or treatment for Zika; medications are only used to alleviate symptoms.



A couple receives counselling about Zika at the Teculután health center in Zacapa, Guatemala. Photo by Carolina Luna, URC.

Gender issues in Zika-related health services

International recommendations on Zika prevention and public health response efforts often do not take into account gender issues and social realities on the ground. Recommendations that encourage women to avoid or delay pregnancy or practice safe sex or abstain from sex during pregnancy assume that women have high levels of reproductive control and autonomy [8,9]. Yet the ability to comply with these recommendations often varies with a woman's socioeconomic context.

Disparities in access to reproductive and maternal health services persist within and between affected countries

in the LAC region. Some women have limited access to contraceptives and other reproductive health services, experience high rates of sexual violence, and face other reproductive health decision-making barriers that result in high rates of unintended pregnancies [10-12]. Gender norms and inequalities and gender-based violence affect health outcomes for all people. Understanding the unique needs and vulnerabilities of men, women, boys, and girls helps us identify target populations, tailor responses, and dedicate resources where they are most needed. This technical brief focuses on gender issues that affect Zika-related antenatal care, family planning, delivery, and newborn care.

JUNE 2018

This short report on integrating gender considerations in Zika-related health services was written by Taroub Harb Faramand, Megan Ivankovich, and Erin Taylor of WI-HER, LLC for the USAID Applying Science to Strengthen and Improve Systems (ASSIST) Project, which is funded by the American people through the United States Agency for International Development (USAID) Bureau for Global Health, Office of Health Systems. The USAID ASSIST Project is managed by University Research Co., LLC (URC) under the terms of Cooperative Agreement Number AID-OAA-A-12-00101. URC's global partners for Zika support under USAID ASSIST include: the American Academy of Pediatrics, FHI 360; Institute for Healthcare Improvement; and WI-HER, LLC. For more information on the work of the USAID ASSIST Project, please visit www.usaidassist.org or write assist-info@urc-chs.com. For more information on integrating gender considerations in Zika care, please contact tfaramand@wi-her.org.

Gender-related roles and values

Women and girls—especially in female-headed households—bear the main burden of productive and reproductive work. They tend to spend more time at home doing domestic chores and are therefore more likely to be exposed to *Aedes* mosquitos (which carry the Zika virus) [4]. Lack of adequate water and sanitation infrastructure—a particular concern for poor families and indigenous groups—leads to breeding grounds for mosquitos. For example, indigenous peoples are 10-25% less likely to have access to piped water and 26% less likely to have access to improved sanitation [13].

There are also traditional gender roles and values that influence patterns of sexual behavior and thus the spread of Zika. In Latin American cultures, men face fewer social sanctions for having sexual partners outside of marriage. In comparison, women are expected to be submissive to their male partner, to wait until marriage to initiate sex, to have only one sexual partner, and to be faithful to that partner [14].

Specifically related to Zika, research suggests that women believe pregnancy prevention and Zika prevention (when pregnant) are their responsibility and that mothers are expected to take care of children and have a considerably larger role than participating males [15]. Some men also refrain from talking about health issues such as Zika, to demonstrate strength and avoid vulnerability in alignment with traditional gender roles in Zika-affected countries [15].

Limited access to and/or control over sexuality education, contraceptives, and other reproductive health services

Many people in Zika-affected countries have limited access to comprehensive sexual education and lack accurate information related to sexual health and Zika transmission, particularly that Zika can be transmitted through sexual contact. For example, in the Dominican Republic, only 30% of males and females surveyed were aware that Zika could be sexually transmitted [4].

Gender issues in Zika services

- Gender-related roles and values
- Limited access to and/or control over sexuality education, contraceptives, and other reproductive health services
- Women's lack of power to negotiate contraceptive use (including condoms)
- Stigma leading to mother and child abandonment

Women and couples that intend to follow recommendations to abstain from sex if pregnant or prevent pregnancy during the recommended timeframe may experience several challenges. 21% of women of reproductive age in LAC have an unmet need for modern contraception (24 million in 2017—an increase of 1.2 million since 2014), and an estimated 69% of all pregnancies in the region are unintended [16]. Rates of modern contraceptive use in the Zika-affected regions range from 34-76%, however, these rates tend to be lower among women in rural areas and poorer communities [10]. Although many of these countries provide family planning services for free in public facilities, frequent stock-outs force many women to pay out of pocket and prevent them from accessing their method of choice [17].

Although the modern contraceptive prevalence rate (mCPR) has increased in every country in the LAC region over the past 50 years, many disparities still persist in vulnerable populations, including indigenous, uninsured, and low-income women who face further discrimination in accessing education and health services. For example, a study of five countries in LAC found that mCPR was 20% lower among indigenous women than the general population, 5% lower among uninsured women than insured, and 7% lower among the poorest women than the wealthiest [17].

Women's lack of power to negotiate contraceptive use (including condoms)

The concept of *machismo*, where men are taught to be strong and aggressive to achieve their goals, often manifests as social domination over women in the LAC region. Men are expected to be dominant and sexually experienced, while women are expected to be submissive and faithful. In the context of HIV-transmission, and relevant to Zika, machismo culture influences norms of condom use [19]. Fewer women than men reported using a condom during their last sexual encounter [14], which is consistent with reports that women find it difficult to negotiate condom use with their partners [15]. In Latin America, condom use is associated with non-marital sexual relations, suggesting that either her or her husband has been unfaithful, thus challenging the female norm of fidelity and significantly threatening the authority of her husband and condoning his extramarital affairs [20]. This may be an explanation for the high number of women infected by their long-term partners [14].

An additional obstacle is the difficulty that men may have understanding why a condom should be used, given that the woman is “already pregnant”. Condoms are widely perceived as contraceptives. When they are presented as a barrier to sexual transmission of the virus, many men perceive that they are being accused of having caught the virus from another partner.

Due to high rates of gender-based violence in Latin America (with intimate partner violence ranging from 23.7-41% [21]), women fear violence at home and in transport to health facilities. Women also experience higher rates of mistreatment by health care professionals and can be particularly vulnerable to violence during a crisis [4]. This can make women fearful of negotiating contraceptive use as well as leading to unintended pregnancy or Zika infection.

Stigma leading to mother and child abandonment

There has been increased stigma against pregnant women—especially against *infected* pregnant women—throughout the epidemic. In addition, men have been stigmatized for fathering a ‘Zika baby’—further reinforcing stereotypical norms related to virility, fertility, and machismo—and in some cases leading to the abandonment of their partners and children [22].

Suggestions to integrate gender considerations in Zika-related health services

Different gender-related issues need to be taken into account when designing and implementing Zika-related health services. The following actions will help advance quality of care, improve patient outcomes, and reduce existing inequalities.

1. Assess the unique needs of men, women, boys, and girls in Zika-affected areas related to Zika infection and reproductive health.

- Conduct a gender analysis, preferably before the start of a program, to identify gender-related issues relevant to Zika infection and the reproductive health needs of women, men, girls, and boys. For example, it is crucial to determine who in a family makes decisions about contraceptive use.

2. Optimize contact with clients to educate them on how to minimize Zika virus infection and its consequences

- Ensure messaging for Zika-related clinical guidelines, processes, counseling, and training materials are tailored for men, women, boys, and girls, as appropriate, to reflect sociocultural realities and the shared responsibility for reproductive outcomes.
- Expand health education related to Zika beyond antenatal clinics, in the event the male partner does not attend.
- Determine the best opportunities to reach both men and women. For example, consider offering Zika

prevention counseling to both partners during antenatal care visits.

- Train family planning counselors to screen for gender-based violence and strengthen the provision of support services (e.g., counseling, pregnancy testing, emergency contraception).
- If possible, ensure both male and female providers are available for counseling.

3. Improve access to a wide range of contraceptive methods

- Expand access to a full range of high-quality, voluntary, and user-friendly contraceptive methods (e.g., long-acting reversible contraception, female condoms, male condoms, emergency contraception, vasectomy) that will be acceptable and feasible (e.g., cost, logistics).
- Ensure all men, women, boys, and girls have access to these goods and services, as appropriate, particularly among poor and vulnerable groups. Engage community health workers to reach women and couples who face barriers in accessing care.

4. Engage male partners and other influential actors, when appropriate

- Sensitize clients on the essential role men play in decision making and behaviors related to Zika transmission, preventing unintended pregnancies, and related health outcomes of their families. Staff should promote gender equality, open communication, and shared decision-making (e.g., about fertility, pregnancy, and contraception) between males and females. Involving men in these discussions could help make them more supportive of contraceptive use.
- Involve men in program design to ensure that services and products address their concerns and needs.
- Engage community champions and influencers to support members of the community, especially ones affected by Zika.
- Design activities to address stigma against pregnant women, infants, and children affected by Zika. Specific messaging should be geared towards

reducing the stigma fathers may have against their infected partner or child.

5. Sensitize and provide continuous support to health care providers and community health workers to address gender issues affecting Zika-related health services

- Sensitize health care workers on gender issues surrounding Zika and gender integration.
- Educate staff on all recommended contraceptive methods, how they can be accessed, and the risks and effectiveness of each method.
- Train health workers to welcome male partners, when agreed upon by the female client, in clinical visits and health discussions. Health care workers should also be sensitized against projecting their own beliefs on clients that may generate socially-driven, negative attitudes (e.g., stigma against pregnancy while infected with Zika).
- Observe the “do no harm” principle while designing and implementing activities to avoid harmful practices against women and men, boys, and girls.

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Resources to learn more

Zika Virus: Promoting Male Involvement in the Health of Women and Families (2016)

Accessed at: <http://doi.org/10.1371/journal.pntd.0005127>

This article discusses the role of men in Zika virus infection and reproductive health care and offers recommendations and suggestions on how to promote male involvement in the Zika virus outbreak.

A Guide to Integrating Gender in Improvement (2017)

Accessed at: https://www.usaidassist.org/sites/assist/files/assist_gender_integration_guide_final_aug2017.pdf

This guide aims to support gender integration in quality improvement activities by helping the reader to understand gender and gender integration, details how to integrate gender in improvement activities, encourages additional areas for consideration, and provides resources that improvement teams can use to integrate gender.

Engaging men in sexual and reproductive health and rights, including family planning (2017)

Accessed at: <https://www.k4health.org/topics/engaging-men-boys>

This resource is designed to assist program designers or managers in constructively engaging men as clients of sexual and reproductive health services, as supportive intimate partners, and as agents of change to address gender norms in their communities. It provides basic programming guidance as well as practical tools which can be used to accomplish such goals.

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