Gender Issues Influencing Zika Response in Guatemala
Acknowledgements

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Recommended citation

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Acronyms

ANC  Antenatal care
ASSIST  USAID Applying Science to Strengthen and Improve Systems Project
CDC  U.S. Centers for Disease Control and Prevention
CEDAW  Committee on Elimination of Discrimination Against Women
COCODE  Community Development Councils
CSaZ  Congenital Syndrome associated with Zika
ENSMI  National Maternal and Child Health Survey (ENSMI for the Spanish acronym)
FGD  Focus group discussion
FP  Family Planning
GBS  Guillain Barre Syndrome
GBV  Gender-based violence
GDP  Gross Domestic Product
HC3  Health Communication Capacity Collaborative
iDARE  Identify, Design, Apply/Assess, Record, Expand
IGSS  Guatemalan Institute for Social Security
INE  National Institute of Statistics (INE for the Spanish acronym)
IPV  Intimate partner violence
KII  Key informant interview
LAC  Latin America and the Caribbean
M&E  Monitoring and evaluation
MNCH  Maternal, newborn, and child health
MSPAS  Ministry of Health and Social Assistance
QI  Quality improvement
STI  Sexually transmitted infection
URC  University Research Co., LLC
USAID  United States Agency for International Development
WHO  World Health Organization
I. BACKGROUND

The USAID Applying Science to Strengthen and Improve Systems (ASSIST) Project has worked globally since 2012 to improve the quality and outcomes of health care and other services by enabling host country providers and managers to apply quality improvement evidence. ASSIST seeks to build the capacity of host country service delivery organizations in USAID-assisted countries to improve the effectiveness, efficiency, client-centeredness, safety, accessibility, and equity of the health and family services they provide.

As part of USAID’s emergency response to Zika, ASSIST has been implementing health systems strengthening efforts in Latin America and the Caribbean since 2016. ASSIST works to improve the capacity of Zika-related health services to deliver consistent, evidence-based, respectful, high-quality care with a focus on pregnant women, newborns, and girls and women of reproductive age.

ASSIST achieves this by supporting Ministries of Health and Social Security Institutions in the Dominican Republic, Ecuador, El Salvador, Guatemala, Honduras, Jamaica, Nicaragua, Paraguay, and Peru, and to:

- Increase health care provider and client knowledge about Zika risks and prevention measures, such as condom use to prevent sexual transmission during pregnancy;
- Improve clinical screening for signs and symptoms of Zika infections during pregnancy and implementation of recommended care;
- Improve clinical screening for microcephaly and other manifestations of congenital Zika syndrome in newborns and increase the number and proportion of affected infants receiving recommended care; and
- Strengthen the provision of high-quality psycho-emotional support services for women and families affected by Zika.

Since 2016, the USAID ASSIST Project has been working in Guatemala to support local actors to improve the capacity of health service providers to deliver consistent, evidence-based, respectful, high-quality Zika-related care with a focus on pregnant women, newborns, and women and youth of reproductive age. The project supports prenatal care, family planning services, delivery and newborn care, and assessment of the children’s physical growth and development.

WI-HER, LLC, a women-owned small business and international development consulting firm, provides technical leadership on integrating gender into the Zika emergency response under the USAID ASSIST Project. To integrate gender, WI-HER developed an innovative, results-oriented approach that draws directly from the science of quality improvement, called iDARE, which is an acronym for Identify, Design, Apply/Assess, Record, Expand [1].

The Identify and Design steps ensure that contextually appropriate interventions are implemented. These steps have a gender perspective that takes the different needs and behaviors of women, men, girls, and boys into consideration. The final three steps ensure that this approach is constantly examined, evaluated, and adjusted to ensure continued effectiveness and improved development and humanitarian outcomes. The iDARE approach has been proven effective at multiple levels and across 35 countries in Africa, Asia, Eastern Europe, Latin America, and the Middle East.

To improve the effectiveness of the program in reaching women and vulnerable populations, WI-HER conducted a gender assessment of the delivery of services in health facilities and sociocultural factors that create barriers to Zika prevention and care. Along with an extensive desk review, the assessment was comprised of 15 Focus Group Discussions (FGDs) (six with pregnant women, six with women of reproductive age, five with men, and one with midwives), and 14 key informant interviews (KII) with health providers (doctors, nurses, and community health promoters).
The gender assessment revealed issues that affect the quality and effectiveness of family planning, antenatal care, and male engagement in reproductive health. Some of these issues included: limited decision-making power of women and girls over their sexual and reproductive health; resistance to condom use by couples in long-term relationships, including during pregnancy; and low participation of males in antenatal care counseling.

These issues need to be addressed as part of quality improvement of the Zika response at health facilities and through community-based activities to reach populations with limited access to health facilities. It is critical to ensure that women, men, girls and boys can take the steps necessary to prevent and respond to Zika through access to comprehensive family planning services and education.

II. INTRODUCTION

The U.S. Centers for Disease Control and Prevention (CDC) identifies multiple Zika transmission pathways [2]:

- Through the bite of an infected Aedes mosquito;
- From a pregnant woman to her unborn child during pregnancy or around the time of birth. Zika transmission during pregnancy can cause Congenital Syndrome associated with Zika (CSaZ), which can include microcephaly and a range of other fetal brain defects and developmental delays;
- Through the consumption of breast milk, though it is important to clarify that there have been no reports of CSaZ in babies resulting from breast milk from a woman with Zika virus infection;
- Through sex, from a person who has Zika to his or her partners;
- Through blood transfusion;
- Through exposure to the virus in a laboratory and healthcare setting.

International recommendations on Zika prevention and public health response efforts rarely take gender and social context into account. Government recommendations that encourage women to avoid or delay pregnancy, practice safer sex using condoms, or abstain from sex during pregnancy assume that women have high levels of reproductive control and autonomy and universal access to contraception [2,3]. However, these recommendations ignore the realities in Latin America and the Caribbean, where there is often limited access to contraceptives and other sexual and reproductive health services, high rates of machismo and sexual and gender-based violence (GBV), and barriers to autonomous reproductive health decision-making that result in high rates of unintended pregnancies, particularly among youth [4].

Understanding the needs and vulnerabilities of women, men, girls, and boys helps us tailor responses and dedicate resources where they are most needed.

This is the first analysis of gender issues in the Zika response in Guatemala. Therefore, this report aims to fill an important gap. This document offers an overview of these issues, identifies critical gender concerns, and explains how to address these concerns with contextually appropriate interventions.

III. OBJECTIVES

The objective of this analysis was to understand gender issues that influence Zika prevention and care within the Guatemalan health system and the broader community. Specific objectives included:

1. Identify factors that affect condom use in couples in general and particularly when the woman is pregnant.
2. Identify sexual behaviors of couples in which the woman is pregnant:
   a. Perception of condom use during pregnancy.
   b. Frequency of sexual relations during pregnancy.
c. Risk perception of not using the condom during pregnancy.
d. Condom use in those who have attended antenatal care (ANC) and have already been recommended to use a condom.

3. Identify different strategies that women and men use to negotiate condom use.
4. Identify recommendations for condom promotion in couples of reproductive age and pregnant couples.

IV. METHODS

To achieve the objectives, the team used the following data collection methods: (1) in-depth desk review; (2) key informant interviews (KII) with 14 health providers; and (3) 15 focus group discussions (FGDs) with a total of 134 participants. These data were analyzed independently and compared across data collection modalities to triangulate the results.

A. Desk review

The team conducted an extensive desk review of relevant statistics, studies, and documents related to gender, sexual and reproductive health, and Zika in Guatemala and the Latin American and Caribbean region.

B. Tool development

FGD and KII guides (see Annex I and Annex II) were developed based on the objectives proposed by the ASSIST team in Guatemala and supplemented with findings from the desk review.

The FGD guide was piloted in Barberena with groups of men, women of reproductive age, and pregnant women, and the KII guide was piloted with two nurses. The same FGD guide was used in all three populations to try to understand their own perspective and their perception of what other groups thought. The guides were immediately improved upon and applied in all subsequent FGDs and KIIs. No substantive changes were made as a result of the pilot, and, therefore, the results of the pilot FGDs and KIIs were included in the final analysis.

C. Selection of assessment sites

For the assessment, ASSIST staff in Guatemala selected five health regions and six health facilities around the capital, Guatemala City, and in the eastern part of the country, based on site diversity and programmatic impact. According to the Ministry of Health, all included health facilities had confirmed Zika cases since the initial outbreak in early 2016. At the time of the assessment, ASSIST was already implementing quality improvement activities in these facilities, training health providers to counseling pregnant women on Zika prevention during antenatal care, and distributing condoms during their appointments.

As shown in Figure 1, the selected sites were:

1. **Amatitlán, Guatemala City**: a tertiary care hospital in an urban area, 43 kilometers outside of Guatemala City.
   a. **Llanos de Animas**: a small health post in a rural community outside of Amatitlán.
2. **Barberena, Santa Rosa**: a mid-level health center in a peri-urban area, 58 kilometers outside of Guatemala City.
3. **Nueva Santa Rosa, Santa Rosa**: a mid-level health center in a peri-urban area, 50 kilometers outside of Guatemala City.
4. **Zacapa, Zacapa**: a tertiary care hospital and an attached mid-level health center in an urban area in the regional capital of the eastern department of Zacapa.
5. **Teculután, Zacapa**: a mid-level health center in a peri-urban area, 26 kilometers outside of the regional capital in Zacapa.

This broad array of sites allowed for different perspectives from urban, peri-urban, and rural populations, in two different regions of the country, and at all three levels of the health system (health post, health center, and hospital).

**Figure 1. Map of data collection sites**

D. **Sample size**

Sample size was calculated based on data saturation estimation, when repetition and redundancy is observed in the data. We calculated that three FGDs per site, with 8-12 participants each, would be sufficient to elicit relevant variation in the themes of interest.

For KIIs, we calculated that interviewing at least two health providers, both doctors and nurses, per site would be sufficient to reach saturation.

E. **Participant selection**

FGDs with community members were stratified according to gender, pregnancy status, and community role. These strata included currently pregnant women, women of reproductive age (16-45) who self-reported that they were not currently pregnant, and men (ages 16-70). For the majority of FGDs, the local quality improvement team selected participants through convenience sampling, extending invitations to interested participants known to the project or to clients in the waiting room at the facility. Pregnant women were invited to participate in the FGDs before their antenatal care appointments, and some women of reproductive age were recruited in the hospital waiting room. FGDs with men in Llano de Animas and Zacapa were recruited through community leaders who referred potential participants to the
research team; men in Barberena were recruited in the health facility waiting room. All participants approached in the waiting rooms were asked if they were interested in participating and informed that their participation would not conflict in receiving the health service they came for. Midwives were invited to participate in the FGD before they had a training at the local health post.

Table 1 and Figure 2 provide detail about participant characteristics for the 15 FGDs.

**Table 1. Focus group discussion participants by community**

<table>
<thead>
<tr>
<th>Community</th>
<th>Pregnant Women</th>
<th>Women of Reproductive Age</th>
<th>Men</th>
<th>Midwives</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barberena</td>
<td>11</td>
<td>12</td>
<td>7</td>
<td>N/A</td>
<td>30</td>
</tr>
<tr>
<td>Amatitlán</td>
<td>8</td>
<td>7</td>
<td>11</td>
<td>N/A</td>
<td>26</td>
</tr>
<tr>
<td>Nueva Santa Rosa</td>
<td>9</td>
<td>9</td>
<td>N/A</td>
<td>10</td>
<td>28</td>
</tr>
<tr>
<td>Zacapa</td>
<td>10</td>
<td>6</td>
<td>9</td>
<td>N/A</td>
<td>25</td>
</tr>
<tr>
<td>Teculután</td>
<td>6</td>
<td>10</td>
<td>9</td>
<td>N/A</td>
<td>25</td>
</tr>
<tr>
<td><strong>Total (#)</strong></td>
<td><strong>44</strong></td>
<td><strong>44</strong></td>
<td><strong>36</strong></td>
<td><strong>10</strong></td>
<td><strong>134</strong></td>
</tr>
<tr>
<td><strong>Total (%)</strong></td>
<td><strong>33%</strong></td>
<td><strong>33%</strong></td>
<td><strong>27%</strong></td>
<td><strong>7%</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

KII participants were health providers who were quality improvement team members or were invited by project staff. Participants included:

- Doctors (3)
- Nurse Assistants (6)
- Nurse (1)
- Chief of External Maternal and Child Health (1)
- Environmental Health Inspector (1)
- Community Health Promoters (2)

All KII participants were women and had conducted Zika health promotion by directly counseling pregnant women during ANC care, sensitizing women and men on Zika prevention and condom use at the facility level, or through community outreach activities.

**F. Data collection**

From August 1-9, 2018, the WI-HER/ASSIST team conducted 15 FGDs and 14 KII. Data collection team members were experienced qualitative researchers, were fluent in Spanish, and were familiar with Zika. Spanish was the predominant language spoken by the participants in the assessment. Participants provided written informed consent before the beginning of the focus groups and interviews and signed a consent form before audio taping. Each participant was given a copy of the consent form for their records. All discussions were audio recorded.
The team used a structured FGD guide (see Appendix I), exploring general knowledge about Zika before asking questions about condom access, negotiation, and use, strategies to effectively sensitize men and involve them in Zika prevention and care, and closing with a discussion about sexual behavior during pregnancy. When discussing how to involve men in Zika prevention, facilitators wrote participants’ ideas on a flip chart and then used them in a prioritization exercise, where participants voted on each idea and commented on its perceived effectiveness, strengths, and challenges.

FGD data collection took place in a conference room in each health facility, and in a conference room at a nearby church in Nueva Santa Rosa. All rooms were private with only facilitators and participants present so participants could speak freely. FGD duration ranged from an hour and 15 minutes to two hours.

The KIIs also used a structured guide (see Appendix II) focused on condom use during pregnancy and male involvement in ANC. Interviews were conducted in private offices and lasted 30 to 45 minutes.

G. Data analysis

The team that collected and analyzed the data was fluent in Spanish and familiar with Zika and the Guatemalan context. The textual transcript data was analyzed by multiple coders, themes were compared, and aligning themes were more thoroughly examined.

V. DESK REVIEW

A. Guatemala sociodemographic overview

The Republic of Guatemala is located in Central America and bordered by Mexico, Honduras, El Salvador, Belize, the Pacific Ocean, and the Gulf of Honduras in the Caribbean Sea. The country has an area of 108,889 square kilometers [5].

With over 16 million people, Guatemala has the largest population in Central America and continues to grow at 2.0% a year, nearly double the average population growth rate of the region [6]. The population is predominantly young - the average age is 26 years for women and 25 years for men, and life expectancy is 75 years for women and 68 for men [7]. While the urbanization rate is increasing, 51.5% of the population still lives in rural areas [8]. Guatemala has a diverse cultural heritage and recognizes 25 sociolinguistic groups comprised of Mayan, Xinca, Garífuna, and Ladino (Spanish-speaking people of mixed Spanish and indigenous heritage) populations [5].

Despite significant improvements in the health of the general Guatemalan population over the past several decades, many key health indicators remain worse than the regional average (Table 2). Many studies have posited that economic and social inequalities in rural, poor, and indigenous populations contribute to these overall poorer health outcomes [9].

<table>
<thead>
<tr>
<th></th>
<th>Guatemala</th>
<th>Latin America and Caribbean Regional Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infant Mortality Rate</td>
<td>23.9 per 1,000 live births [10]</td>
<td>14.9 per 1,000 live births [10]</td>
</tr>
<tr>
<td>Total Fertility Rate</td>
<td>3.1 children per woman [12]</td>
<td>2.1 children per woman [12]</td>
</tr>
</tbody>
</table>

While Guatemala has been one of the strongest economic performers in Latin America in recent years, with a gross domestic product (GDP) growth rate of 3.2% in 2017 and an expected growth of 3.4% in 2018 (World Bank), the country still has one of the most unequal income distributions in the hemisphere [6]. An estimated 51% of people live below the international poverty line (earning less than 1.90 US$ per
person per day, using 2011 prices), and four in every ten children under the age of five are chronically malnourished [5,13]. Nearly three million (19%) Guatemalans lack access to safe water and about six million (38%) lack access to improved sanitation [13].

Since the signing of the Peace Accords in 1996, Guatemalan society has made significant progress towards becoming more equitable. The gender gap in primary education has drastically decreased, more people have access to primary health care services, the private sector is opening to social development, and natural resource management has improved significantly in protected areas [5]. However, this development has not been applied equally across Guatemala’s population, with rural and indigenous communities often left behind.

Most of Guatemala’s poor are rural indigenous people of Maya descent with a long history of discrimination and exclusion from full economic, political, and social participation [5]. Rural indigenous communities were the most seriously affected by the 36-year armed conflict (1960-1996) that claimed more than 200,000 lives, of which 83% were indigenous people [8]. The resulting exclusion and racism from that conflict have produced structural, legal, and institutionalized forms of violence and discrimination that are still pervasive in Guatemalan legal and health systems today [8]. For example, the 2011 illiteracy rate among indigenous women was 48%, compared to non-indigenous women 19% [8]. Furthermore, in the 2011 elections, out of the 158 seats in congress that were available, there were only 22 indigenous candidates, three of which were women (1.9%) [8]. These numbers show high levels of social and political exclusion.

In terms of gender relations, the 2017 Global Gender Gap Report ranked Guatemala 101 out of 144 countries (where the country with the smallest gender gap is ranked first). Women and girls have slightly lower educational attainment compared with men and boys, as demonstrated by the literacy rates of 76.4% among women and 86.8% among men [14]. On average, women earn approximately half as much money as men- with men earning over US$10,000 annually and women earning approximately US$5,000 [14]. According to the Global Gender Gap Report, 43.8% of women and 85.7% of men in Guatemala participate in the formal labor force, meaning that far more women are working in the home or in informal settings [14]. In a study that monitored Central America for a decade, Guatemala was the only country where women experienced reductions in labor force participation and a widening of the earnings gap. In 2015, 25.1% of households were headed by women, leaving female-headed households with a particularly significant disadvantage in earning a living wage [6].

Several new and evolving issues are influencing social and health outcomes. Emigration to Mexico and the United States is increasing due to lack of economic and employment opportunities and rising insecurity and violence stemming from primarily gang-related drug and human trafficking in Guatemalan cities [9]. In addition, Guatemala has been grappling with environmental instability including volcanic eruptions, storms, and droughts, which contribute to food insecurity and malnutrition and continue to impact indigenous communities disproportionately [9]. These issues continue to influence the health of the population and the ability of the health system to respond to disease. This report seeks to connect how these sociodemographic trends impacted the spread of Zika, who was most affected and how the health system responded.

B. The Zika virus outbreak: timeline and spread

In late November 2015, Guatemalan health authorities reported the first confirmed case of endemic Zika transmission in the eastern department of Zacapa [15].

By July 2017, Guatemala had reported suspected Zika cases in 20 departments. The highest incidence rates of suspected Zika cases were detected in Santa Rosa, Zacapa, and Chiquimula in 2016, with 61 – 106 cases per 100,00, whereas in 2017, Guatemala Central, Chiquimula, and Santa Rosa reported the highest incidence rates, with 5 – 14 cases per 100,000 people [15].

According to available data, the highest Zika incidence rate was observed among women aged 15 to 39 years, particularly women aged 20 to 24 years. This statistic may be biased because pregnant women and women of reproductive age are more likely to be screened for Zika infection, which cannot be confirmed without relatively expensive and complex testing. For most age groups, the incidence rate
observed in women was higher than that among men, except for ages 0 to 9 years and 60 to 64 years [15].

As of August 2017, the Guatemala Ministry of Public Health and Social Assistance had reported 1,414 pregnant women with suspected Zika infection, including 341 confirmed cases. There were 81 cases of Guillain-Barré syndrome (GBS), including 9 confirmed and 65 suspected to be associated Zika virus infection [15]. As of January 2018, there had been 140 confirmed cases of congenital syndrome associated with Zika virus infection, but no deaths among Zika cases were reported to PAHO/WHO [16]. In the departments where ASSIST works (six out of the total 22 departments), 134 children were identified as having symptoms of CSaZ, even if laboratory confirmation was not possible, and 15 confirmed fatalities. These data affirm that due to difficulties in confirming the association of newborn’s disabilities with Zika, cases of children with CSaZ are underreported.

C. Zika response

1. Current Zika response programming

Currently, the Guatemalan Zika response is being led by the Ministry of Public Health and Social Assistance (MSPAS). Their coordination mechanism for dengue, chikungunya, and Zika, formerly named the Grupo Técnico (GT) Dengue, was renamed GT Aedes, referring to different vector-borne diseases. The group monitors various vector-borne disease related activities including vector control, the National Laboratory, various health promotion activities, and hospital administration. They have implemented a coordinated short- and long-term plan that addresses dengue, chikungunya, and Zika, and continue to closely monitor and analyze data collected by the national surveillance system [17].

ASSIST works in seven hospitals and 31 second level of attention health centers. When accounting for third-level health posts, ASSIST reaches a total of 263 health facilities in 31 municipalities.

2. Public perception of Zika

Previous qualitative studies beginning in 2016 by the Health Communication Capacity Collaborative (HC3) and RTI International exploring the saliency of Zika messaging and people’s perceived self-efficacy and feasibility to comply with Zika prevention behaviors in Guatemala has revealed several key insights. First, most participants (pregnant women, women likely to become pregnant, and male partners of pregnant women) conflated Zika with other mosquito-borne diseases. Dengue fever has been endemic for years and there was a recent, substantial outbreak of Chikungunya in 2014 [18,19]. Participants in these studies drew on experience with Dengue and Chikungunya as a baseline in understanding Zika and did not conceive of Zika as a new disease. However, Zika has the unique property of also being sexually transmitted, which people may not take measures to prevent if Zika is confused with other mosquito-borne diseases [18]. Additionally, Zika can lead to adverse effects on an unborn child, which is also unique among these diseases, and demands additional vigilance to prevent all types of transmission [2].

The study by HC3 conducted FGDs in Barberena, Santa Rosa, and Mazatenango, Suchitepequez found that participants thought using a condom to prevent sexual transmission of Zika had low cultural salience, ranking lower than mosquito nets, eliminating containers exposed to rain, using repellent, and cleaning the house. Participants in the same study considered condom use during pregnancy to prevent Zika transmission either ineffective or not feasible and reported low self-efficacy to comply. The HC3 researchers posit that infrequent or no condom use during pregnancy was also driven by other factors, such as silent Zika infections, identifying condoms as a birth control measure not applicable when one is already pregnant, considering pregnancy a special period during which women have less or no sex, or contraindication of having sex if a pregnancy were at risk of losing the baby [19]. Gender and partner power dynamics were also considered a driving factor, particularly that condoms are associated with infidelity and partners outside a stable relationship such as with a mistress or sex worker. Stable partners reported fear that proposing condom use would drive their partners to seek others partners in which they could have unprotected sex [19].
These studies show that Zika is still confused with other mosquito-borne diseases and that knowledge about sexual transmission of Zika is limited. There is a clear need to go further in depth into the issues raised in these inquiries.

3. Relevant laws and legislation that impact Zika response

Guatemala has committed to promoting a human rights perspective on health and has approved several international declarations of human rights. At the national level, Guatemala has enacted laws regarding social development, universal and equal access to family planning, healthy motherhood, against violence, and against child marriage, all which are critical to addressing the Zika epidemic [20].

It is pertinent to highlight the law against femicide and other forms of violence against women (Decreto 22-2008. Under Article 3, the law specifically classifies that partners or others who deny women right to utilize family planning methods or to adopt protection measures against sexually transmitted diseases as forms of sexual violence [20].

While this legal framework is critical to have in place on a higher level, there remain challenges translating commitments into implementation that reaches the community level. Many patients, and in some cases health providers, are unaware of the existing legal framework and therefore cannot advocate to the government to access these rights.

D. Factors to consider in Zika response

1. Gender norms and sexual behavior

One of the factors influencing the spread of Zika in Guatemala is the different behavioral and social expectations for men and women proliferated by traditionally conservative gender norms and “machismo”. In the LAC region, “machismo” dictates that men act strong, aggressive, both socially and sexually, and stoic, and are the primary providers and protectors of the family. This often manifests as male social domination over women. Women are expected to be submissive and faithful, produce and raise children, and to manage domestic duties. “Machismo” perpetuates gendered power relationships and reflects and reinforces inequalities in the social, political, and economic realms. It imposes specific ways of acting and thinking, limiting female agency over their lives and bodies, including family planning decision making, and results in negative health and social outcomes for women and girls but also boys and men [21,22].

In the Latin American region in general, “machismo” creates an environment that promotes and values men who demonstrate their virility and aggressiveness by having multiple sexual partners and who dominate decision-making in the relationship. It is common for men to have a spouse or committed partner and then have extramarital affairs or pay commercial sex workers on the side, which is considered acceptable among some in LAC due to the belief that men have both the right and the need to have multiple sexual partners and the belief that there is a difference between the women they marry and the women they can enjoy sex with [21].

According to the 2014-15 Guatemalan National Maternal and Child Health Survey (ENSMI for the acronym in Spanish), women had an average of 1.5 sexual partners in lifetime, while men had an average of 6.1. Only 0.4% of women had multiple concurrent sexual partners, while 6.1% of men did. A total of 16.2% of men reported having ever paid for sex [23]. Since Zika can be sexually transmitted, having more than one simultaneous sexual partner can contribute to greater infection rates and reinforces existing gendered systems of power, limiting the ability of women in committed relationships to demand condom use when they know their partner is not monogamous. The 2014-15 ENSMI indicates that though almost all women and men have knowledge of at least one method of FP (97.7 percent and 98.3 percent, respectively), only 60.6 percent are using a method; 14.1 percent cite an unmet need for FP. Some of the reasons women do not use FP are related to social factors: gender and social norms, including pressure from family, in-laws, and community to become a mother; husbands’ disapproval of FP (such as the belief
that contraception leads to infidelity, and their desire to bear children to show strength and dominance; and fear of marital problems and abandonment \((49), (50)\).

2. **Gender norms and family planning**

“Machismo” influences how people perceive, access, and use condoms and other methods of contraception. In 2015, nearly two thirds of married women in Guatemala used some form of contraception; 48.9% used a modern method and 18.5% used a traditional method. Of the 11% of women who reported having a non-marital, non-committed partner, only 29.6% of them used a condom during their last sexual encounter. Of the 31.2% of men who had a non-marital, non-committed partner, 67.7% of them used a condom during their last sexual encounter, which may suggest that men have more access to condoms, more power to negotiate condom use, and more knowledge about safer sex. In addition, of the 16.2% of men who had ever paid for sex, 75.4% had used a condom during the last paid intercourse \([23]\).

Qualitative studies in Guatemala have helped to explain this phenomenon. Typically, condoms have been viewed as suitable for use with partners outside a stable relationship, such as with a mistress or sex worker, or for individuals who do not have a committed partner. The concept of stable partners using condoms evoked many themes of infidelity and trust. Female partners reported considerable fear that requesting to use condoms might drive their partner to search for another partner, as he may expect to have unprotected intercourse with his stable partner. Furthermore, the use of condoms in stable relationships was viewed primarily for family planning rather than prevention of sexually transmitted diseases, like Zika. On the other hand, men reported additional barriers to condom use such as cost, lack of access, and embarrassment in purchasing condoms \([19]\).

Despite existing barriers to condom use, men and women do have knowledge about family planning: 98.1% of men and 97.7% of women knew about any modern contraception method. The methods that men were aware of included condoms (96%), injections (91.3%), oral contraception (89.5%), female sterilization (87.8%), and male sterilization (72.3%). Methods of which men were least aware included intrauterine devices (IUD) (57.1%), implants (53.7%), female condoms (52.4%), and emergency contraception (43.7%) \([23]\). Women were most aware of the injection (94.8%), the contraceptive pill (91.8%), and female sterilization (91.1%), and were least aware of female condoms (44.7%) and emergency contraception (34.3%) \([23]\).

Contraception is critical for preventing and delaying pregnancy due to the potential negative consequences of contracting Zika during pregnancy, yet there is a 13.9% unmet need for family planning among Guatemalan women of reproductive age \([23]\). This figure is twice as high among indigenous women \([8]\). FGD participants in the Health Communication Capacity Collaborative (HCCC) study did not consider family planning to delay pregnancy a prevention method for Zika. While participants identified a lack of accessibility, stock-outs in health facilities, costs, and fear of the methods, they also indicated that many men did not permit their partners to use such methods, and some women who used them did so in secret. This highlighted that there is often a lack of equity in decision-making among couples about family planning, and that women resort to secrecy to control their fertility, despite their partners’ objections \([19]\).

Participants in the same FGD perceived abstinence to have low feasibility in preventing sexual transmission of Zika. The study summarized that asking adults to be abstinent is unrealistic as both and women have sexual desire. In addition, some participants indicated that men had a larger role in determining whether and when sexual intercourse occurs, which limits control female participants have to practice abstinence as a preventative behavior. Some participants indicated that they had not had a dialogue with their partner about this method \([19]\).
3. Gender-based violence (GBV) and its connection with Zika and other STIs

Sexual- and gender-based violence has been increasing throughout Central America. Guatemala has extremely high rates of violent deaths among women (9.7 in 100,000), known as femicide, which are approximately five times higher than overall homicide rates among men and women in most Northern, Western, and Southern European countries [8]. In 2017, there were over 670 reported cases of femicide (UN Women). The perpetrators of femicide in Central America and generally gangs and other armed criminal groups, or intimate partners or family members [24].

Guatemala has high rates of intimate partner violence (IPV), with 20% of ever married women reported experiencing physical violence committed by their husband or partner and 7% experiencing sexual violence [23, 25]. According to ENSMI (2014 – 2015), 23.4% of women reported experiencing some form of violence—verbal (21.6%), physical (7.8%), or sexual (4.8%)—in the last 12 months [26].

The same survey asked men if their wives or partners needed their permission to perform certain activities, an indicator of women’s independence. A total of 81.6% men answered that their partners needed permission to leave the house, 58.9% to use of contraception, 67.0% for managing household funds, and 77.8% to perform other activities, such as working or studying outside the house. Additionally, 82.7% of men answered that family problems should only be discussed with family members and 49.2% believed that a man needs to show that he is in command of the household [26]. These limitations affect women’s financial independence, educational attainment, impact their access to health care, and lead to higher rates of maternal and infant mortality, among other consequences [8].

Many of these controlling and violent attitudes towards women were reinforced by Guatemala’s 36 years of internal armed conflict. The Guatemalan Commission for Historical Clarification (CHC) found that sexual violence, including the use of rape as a weapon, was prevalent during the three decades of the conflict but was severely underreported [8]. Gender-based violence (GBV) was used as a tool to control women’s bodies and lives and was rooted in Guatemala’s patriarchal and conservative culture [8].

Several studies demonstrate that high rates of IPV limit women’s control over their bodies and their ability to negotiate sexual activity and a method to prevent pregnancy and STIs. Women’s fear of violence when requesting condom use is a pathway that links IPV to inconsistent condom use. Since the Zika outbreak is quite recent, there are not yet studies examining the association between IPV and Zika infections. However similar comparisons have been drawn between HIV and IPV and given that both diseases are transmitted sexually, it is relevant to examine existing studies that link HIV and IPV [27, 28, 29]. A 2013 WHO systematic global review and analysis of studies across different HIV epidemic settings found that IPV increases the risk for HIV infection among women and girls by more than 50%, and in some instances up to four-fold [27]. There is a two-way link between IPV/GBV and STIs: victims of GBV are more likely to acquire STIs and having an STI makes women more vulnerable to violence [28]. The WHO also reported that forced sex is directly linked to HIV infection and highlighted that the younger women are at the time of their first sexual intercourse, the higher probability that the sexual encounter was non-consensual or forced [29].

In the region, studies also associate IPV during pregnancy with a limited number of prenatal care visits. For example, in one of the major maternal perinatal hospitals in Peru, patients that are survivors of IPV are eight times more likely to attend fewer than six prenatal care visits compared to patients that do not experience violence [30]. There are no studies in Guatemala that investigate this phenomenon, and more research is needed to determine whether this is also relevant to Guatemala. In the context of Zika, it is possible that dynamics could be similar, where those experiencing IPV might be less likely to receive perinatal care, and therefore less likely to receive education about Zika, which they could use to prevent transmission during pregnancy.
4. Challenges in the health system

Health financing and coverage:

The Government of Guatemala, through the Ministry of Health and Social Assistance (MSPAS) and the Guatemalan Institute for Social Security (IGGS), is committed to universal, free health care for its citizens. However, limited resources, infrastructure, and personnel, and inadequate supplies of medicines and materials pose profound challenges to healthcare access, especially for rural and indigenous Guatemalans [5]. It is estimated that basic health and nutrition services meet only 54% of the needs of Guatemala’s rural and indigenous population [31].

There is low public financing in healthcare, leading to inadequate quality and commodity availability, and therefore many people pay high out-of-pocket expenditures (OOP). The limited capacity of public facilities, including frequent stock-outs of supplies and medicines, force people to seek services in the private sector, which account for more than half (52%) of total health spending in the country [32].

In addition, physicians are scarce in Guatemala, with 0.93 physicians per 1,000 people. This is startling considering the WHO prediction that countries with fewer than 23 healthcare workers (including physicians, nurses, and midwives) per 10,000 population will likely fail to achieve adequate coverage rates for primary healthcare, as defined by the Millennium Development goals[24]. Therefore, the number of doctors in Guatemala is likely insufficient to achieve sufficient coverage to meet the population’s primary healthcare needs [24].

Compounding these gaps, health care from private providers is limited, health insurance coverage is low, and Guatemalans living in poverty are unable to afford the costs associated with accessing these services. Many rural and underserved populations may seek care from traditional healers, such as curanderos, or folk healers, to bridge this gap and to address conditions believed to be outside the purview of modern medicine [33].

Family planning and maternal health:

Despite efforts to ensure sufficient and sustainable financing for maternal health and family planning in Guatemala, gaps and challenges in the health sector have resulted in insufficient access to family planning commodities, such as condoms. In urban areas, family planning is not integrated sufficiently into the IGSS package of services to reduce pressure on MSPAS for the provision of family planning services [32].

Despite political commitments to provide family planning services for free in public facilities, a large proportion of women pay out-of-pocket for family planning services and methods, which presents a significant barrier to access for lower income women. MSPAS provides 38% of total family planning in the country, and should stock and provide condoms, injectables, and oral contraception at the primary level of care. Some secondary and tertiary facilities also provide IUDs, implants, and sterilization services. However, commodity stockouts are frequent in MSPAS facilities, and clients frequently must pay out-of-pocket for commodities in the private sector [31]. Therefore, 22% of family planning services are obtained through private, for-profit clinics, hospitals, and pharmacies, with social marketing organizations (primarily APROFAM) providing 16% at subsidized prices based on income levels [32].

In terms of maternal health care, which is crucial to Zika prevention and screening, 64% of pregnant women seek ANC from a doctor, 27.3% from a midwife, 5% from other sources, and 3.8% do not receive any ANC. The median month of pregnancy at first ANC visit is 3.2 months [23]. This is troubling considering that Zika infection is most damaging in the first trimester and entering later into ANC care could be depriving women of essential preventative knowledge and care. In addition, only 65.5% of women delivered with a skilled provider (doctor, nurse, midwife and auxiliary nurse or midwife), which is critical to ensure infants are screened for CSaZ and receive prompt and proper referrals to care [23].
Weaknesses in healthcare financing, the low availability of skilled medical providers, and widespread unmet contraception demand, all hinder the health system’s response to the Zika outbreak, particularly for poor, rural, and indigenous populations. Women must commit time, energy, and scarce financial resources to obtain contraceptive supplies. As mentioned above, women face low independence and autonomy in their sexual relationships and decision making, meaning that any additional barriers could prevent women from obtaining contraceptives, which the law says they have the right to access.

E. Vulnerable populations

1. Youth

According to the Guatemalan National Institute of Statistics (INE for the acronym in Spanish), adolescents aged 10–19 account for 23.4% of the country’s total population [9]. The median age of first intercourse is 18.6 years, and more than one-third of women aged 18–24 have had sex before age 18. This proportion is significantly higher among the poorest women (46%) and those living in rural areas (43%) [33]. Eight percent of girls and 13.4% of boys had their first sexual encounter before the age of fifteen [23].

The adolescent fertility rate is 81 births per 1,000 girls aged 15-19, much higher than the 66 in the neighboring countries of El Salvador and Honduras [24]. The 2014–2015 ENSMI found that 20.7% of females between 15 and 19 years old had been pregnant at least once and 16.2% had children [23]. Although no differences related to ethnicity were found, there were differences related to education, area of residence, and socioeconomic level. Adolescent pregnancy is higher in the northern and northwestern regions. Some 88% of sexually active adolescents aged 15–19 with more than one sexual partner did not use a condom in their most recent sexual encounter [9]. Of those who carry their pregnancies to term, 60% of mothers under 20 report that they most recently gave birth at a health facility and 75% report having made one or more prenatal care visits [34].

While legal framework in Guatemala guarantees family planning services for adolescents (over the age of 14), particularly girls, face additional challenges in accessing and utilizing contraception, including protecting themselves from sexual transmission of Zika. Many face barriers when trying to access contraceptives and condoms to prevent pregnancy and STIs, including Zika, such as stigma from health providers, conflicts with parental consent, and financial constraints. For example, 39% of sexually active (had sex in past three months), never-married women and 33% of married women aged 15–19 use a contraceptive method. Fifty-five percent of sexually active, never-married girls and women aged 15–19, and 26% of married girls and women the same age, have an unmet need for contraception, meaning they wish to avoid having a pregnancy in the next two years but are not using contraception [34]. According to the ENSMI (2014–2015), 11.6% of unmarried young women had sex in the last year and 35.2% used a condom, while 35.8% of unmarried young men had sex in the past year and 68.6% used a condom [23].

Adolescents may face power imbalances when trying to negotiate contraception or condom use with their partners, particularly if their partner is older. There is some indication of age disparities in sexual partners in Guatemala, where 9.8% of young women aged 15-19 who have had sex in the preceding 12 months had a partner who was 10 or more years older than themselves [23]. Among married Guatemalan women aged 15–19, 63% report needing to ask their husband for permission to practice contraception [34].

Guatemala has one of the highest child marriage rates in Latin America. In 2017, 5% of Guatemalan girls married by 15, and 30% by age 18. To address this, the Guatemalan government increased the legal minimum age of marriage to 18 years in 2015 to align with international standards. Previously, the minimum age for marriage in Guatemala was 14 for girls and 16 for boys. In November 2015, the age for getting married was increased from 14 years for girls and from 16 years for boys to 18 years. Also, the legal loophole for judges to make exceptions prior to 18 was closed in 2017. This will help reduce the number of early marriages and pregnancies in adolescents and girls [35].
2. Indigenous women

Indigenous people make up 43% of Guatemala’s total population. Indigenous populations face discrimination, that manifests in inequitable health, education, and financial access and outcomes. For example, in 2011, the illiteracy rate was 48% and 25% for indigenous women and men respectively, compared to 19% and 11% for non-indigenous women and men [8]. Guatemala’s high maternal and infant mortality and chronic malnutrition rates are concentrated primarily among the poor and indigenous populations in the rural areas of Guatemala’s Western Highlands. Exclusion and racism have produced structural, legal, and institutionalized forms of violence and discrimination towards indigenous people, particularly indigenous women [8].

According to qualitative research studies, indigenous people in Guatemala face discrimination at health care facilities that are staffed by predominantly Ladino personnel; they have greater distrust of modern health care services; and they prefer traditional alternatives to institutional prenatal care and delivery [36]. The ethnic difference in use of modern institutional prenatal care was small, however, delivery at formal healthcare facilities was far less common among indigenous women (36%) than among non-indigenous women (73%), as was met need for modern contraceptives (49% vs. 72%). Not speaking Spanish accounted for the largest portion of these ethnic differentials, affecting healthcare access, understanding, and compliance [36].

Traditional midwifery and modern pregnancy-related care are often seen as complementary in Guatemala. As a result of the government’s efforts to integrate traditional midwives into the formal health care system, many indigenous women who are cared for by traditional midwives also receive institutional prenatal care, often on their midwives’ referral. Approximately 40% of pregnant indigenous women who received institutional prenatal care also received care from a traditional midwife. Furthermore, indigenous women continue to prefer traditional midwives for assistance at delivery [36]. This preference is rooted in multiple reasons: responding to traditional beliefs, trust, care in the home, and reduced costs compared to traveling to a health center. In some cases, their male partners prefer midwives, to avoid the risk for their wives to be touched and observed by male providers [36].

Childbearing can be highly ritualized in indigenous communities, where traditional midwives often assume symbolic roles and provide physical, social, and spiritual care. The mystical meaning attached to women’s reproduction contradicts the idea that fertility can be calculated or controlled [36].

Young, poor, indigenous women living in rural areas are extremely vulnerable to Zika infection. Indigenous girls and women carry the dual burden of discrimination based on their ethnic background and their sex. For example, child marriage is most common among the Maya indigenous communities, with 40% of indigenous girls entering a consensual or formal union before the age of 18 [37]. Once married, girls are expected and often pressured to start a family. Early pregnancy can lead to severe health consequences for young girls. Maternal mortality rates in Guatemala are among the highest in the region and are three times higher among indigenous populations than non-indigenous populations [37].

Indigenous Guatemalan girls largely reside in rural areas and have poor access to basic and reproductive health services, few educational and economic opportunities, and higher rates of poverty than the non-indigenous population. Men occupy most public roles in the Maya tradition and women tend to the home, food preparation, and childrearing, placing them in a position subordinate to Mayan men.

Women and adolescent girls have limited access to contraceptive methods, health information, and decision-making power regarding contraceptive use and many other aspects of their lives. This means that sexual and reproductive health work in rural Guatemalan communities is never just about sexual and reproductive health; it must also confront and address cycles of oppression that have marginalized Maya culture, language, and women for centuries [37].
VI. PRESENTATION AND DISCUSSION OF RAPID GENDER ANALYSIS FINDINGS

The main objective of the gender analysis, which included FGDs and KIIIs, was to identify gender issues affecting the Zika response in Guatemala. The results are presented in eight parts: (A) Knowledge about Zika and its transmission; (B) Gender disparities and gender norms affecting condom use to prevent Zika transmission and CSaZ, especially during pregnancy; (C) Outreach to men; (D) Sexual behavior during pregnancy; (E) Other barriers to Zika Response; (F) Regional differences, (G) Urban-rural differences; and (H) Vulnerable populations.

A. Knowledge about Zika

There is low knowledge about Zika among both men and women. While many participants had heard of Zika, very few knew about the transmission pathways and possible consequences of contracting Zika during pregnancy. Some participants learned about Zika from health facilities, word of mouth, and through the television or the internet. However, most of this knowledge was incomplete and focused on vector transmission through mosquitoes, not sexual transmission.

“They don’t go in depth, but there have been announcements on the TV, in the health center they explain the risks, but not with much detail, not in depth.” (Pregnant woman, Amatitlán)

Women:

Overall, women were more likely to volunteer information they had heard about Zika compared to men. Some women had heard that it caused deformities in unborn babies, specifically referring to the size of the head. However, there was a lot of confusion between microcephaly and hydrocephaly, with many women claiming that they heard that the heads were abnormally large instead of small.

When prompted about Zika transmission pathways and prevention methods, most answers focused on mosquito-borne transmission and vector control strategies (emptying water receptacles around the house, using repellent, cleaning water tanks, using mosquito nets, etc.) Only a few women who had participated in a Zika health presentation at a facility (charla or plática) mentioned sexual transmission and even fewer specifically mentioned condom use as a form of prevention.

More women than men reported learning about Zika from a health facility, either from a health talk from a provider, a community health promoter, or from posters displayed at the facility. This could be because women interface with the health system more often than men.

“It is also sexually transmitted, I learned it in a talk at a health center in the community a few years ago, there were not many people, but some were there.” (Woman, Barberena)

“It was written on a poster in the health center.” (Woman, Barberena)

Some women reported hearing about Zika on the television, radio, or via the internet.

“Two years ago, I heard on the news that sometimes the babies are born with defects, with difficulties.” (Pregnant woman, Barberena)

Pregnant women:

Knowledge about Zika was limited among pregnant women, even at very advanced stages of pregnancy (eighth and ninth month), with levels of knowledge related to which health facility the women visited for ANC. Pregnant women receiving ANC at facilities where ASSIST is present received counseling about Zika, but many of the women participating in the FGDs had either started care late, previously attended by midwives, or transferring from another healthcare site (a health post or a private provider) where information about Zika was inconsistent or nonexistent, and therefore had not received Zika education. This is particularly concerning since Zika infection in the first trimester of pregnancy is associated with a
higher risk of microcephaly, and therefore education about prevention is particularly crucial early in pregnancy. Midwives explained that concerns about costs and lack of transportation contribute to late entrance to ANC, particularly in rural and hard-to-reach communities.

For example, nine out of the eleven pregnant women in Barberena were at least six months pregnant. Even though some of them had previous ANC at a health post or a private provider, it was everyone’s first time receiving ANC at that health center, and only two of them knew about Zika prevention.

According to the testimonies of pregnant women who were attended by private gynecologists, private providers do not always give comprehensive counseling in Zika prevention during pregnancy. As one health provider explained, private providers do not focus on Zika prevention as much as providers that work for the MSPAS, and therefore pregnant women do not consistently receive complete information about Zika prevention.

“Private doctors do not put the same emphasis [on Zika]. At a national level [where ASSIST does not work], not all doctors from the Ministry of Health do either.” (Health Provider, Nueva Santa Rosa)

In addition, due to fear of costs and lack of awareness or transportation, many women enter ANC later in their pregnancy.

“The others are transferred to the health center, especially if it is their first child or if they are young. They are afraid to do exams, they go at the fifth month because they are worried about costs.” (Midwife, Nueva Santa Rosa)

“They start attending ANC at 6 months. This is what happens in the communities in the highlands.” (Midwife, Zacapa)

“In certain communities, there is no transportation nor time to bring them in [for ANC or birth].” (Midwife, Zacapa)

One man in Zacapa linked gendered decision-making norms, particularly in indigenous communities, with late or no entry into ANC, explaining that men ultimately make the decision about whether their partners seek formal care in a facility. As explained in the desk review, there can be multiple reasons for preferring midwives, one is that some men do not want their partners observed or handled by male providers in a health center.

“Maternal mortality is an accident, because many women seek treatment from midwives and go to the doctor only if necessary, if their man does not let them.” (Man, Zacapa)

“They have to walk to the highway, an hour or more. There, the ambulance or the firetruck picks them up. Many times, they are so far away that they give birth in the ambulance or in the fire truck. They show up in the hospital and the baby has already been born.” (Health provider, Zacapa)

Therefore, ANC that does not include Zika education or late access to ANC hampers prevention and detection efforts. This is a lost opportunity that leaves women with little to no information or care for a long period of time.

Men:

Men generally had less knowledge about Zika compared to women. This could be because they interface with the health system less than women, or they consider it a women’s issue. They were more likely to cite hearing about it from the media (television or radio) or through word of mouth.

“One of the deficiencies in the country is the lack of information. I only heard about Zika in the media, through the TV and radio, but it was not possible to understand how it is transmitted, what risks there are.” (Man, Teculután)
Misconceptions about Zika:

There was general confusion regarding asymptomatic Zika virus infection and the perception of feeling sick being an indicator of infection. None of the participants in the FGDs volunteered information about asymptomatic nature of and that they could transmit the virus without knowing they were infected.

Needing to prove the existence of Zika infection to justify condom use was a common concern particularly in the male FGDs. Machismo and masculine gender norms in the region often tie men’s appearance of health with their masculinity and ability to provide for their family. Many men feel pressure not to discuss or reveal pain or health problems and consider doubts about their health to be doubts about their masculinity. This is particularly problematic, because many participants, both men and women, including a midwife, said that it was only necessary to use condoms when someone appeared sick.

"How do you know if he is sick? Well, if you are not sick, if you are well and do not feel anything, you should not use a condom. One must know when they are sick." (Woman, Barberena)

“There are many [men] who do not understand why they have to use condoms if they feel they are healthy and faithful. They do not understand that there are diseases.” (Woman, Zacapa)

Even a midwife, who knew the risks of Zika during pregnancy and that the Zika virus can remain in semen for up to six months, resisted promoting condom use when symptoms were absent:

“Why should I tell the men to use condoms if he is not sick? If he had not Zika in the last six months there is no problem and I don’t tell them to use condoms; I just attend the pregnancy as usual” (Midwife, Nueva Santa Rosa)

Another misconception that was common throughout the FGDs, is that many people, particularly men, did not believe Zika was a real disease. Several participants shared anecdotes about men in their communities who did not believe Zika and microcephaly were real since they had not seen any cases, or that it was a conspiracy from a foreign government. Participants also mentioned that men were not likely to believe anything about Zika unless they heard it directly from a doctor or health provider. In several cases they stressed that men usually do not consider their wives as reliable sources of information on these topics.

“They [men] say it's a lie because a professional did not tell them. It's hard to get them to believe women.” (Woman, Teculután)

Men’s reliance on health providers as the only sources of reliable health information is particularly concerning given their reluctance to attend such facilities to seek care.

It is clear that there are critical gaps in knowledge and misconceptions about Zika that need to be addressed. There is low knowledge about Zika, its transmission pathways, possible consequences, and prevention methods in general. While women of reproductive age are more likely to have access to information thanks to their visits to the health centers, men lack any kind of information and are confused about the messages heard on TV or radio.

Many pregnant women enter ANC at a very advanced stage of pregnancy and, therefore, are not informed and have not adopted preventive measures. Although there are counseling guides and specific personnel for counseling in Zika, according to some accounts, adequate information on Zika prevention during pregnancy is not offered in all services, both in the public and private sector. In addition, misconception about Zika, reduces risk perception in women, men, midwives, and health providers.

These findings highlight the need to reach people, but particularly men, through different strategies, including at the community level. It is critical to design ways to promote prevention of unplanned pregnancy in different settings (public and private health facilities at local and national levels, community centers, schools, mass media methods, homes etc.) and to reach women, girls, men, and boys. Strengthening alliances with key actors like midwives, health promoters, and community leaders to
educate pregnant women and couples from the first months of pregnancy about Zika prevention is also fundamental.

B. Gender issues influencing condom use

Many communities and facilities are making strides to distribute condoms, especially to pregnant women during ANC. Some participants were eager to share success stories within their communities.

“*There (in my community) women ask for as many [condoms] as they want, and they are given them. It is confidential. They give them 15-20.*” (Pregnant Woman, Amatitlán)

However, participants also reported numerous issues limiting access to condoms and their use, particularly during pregnancy.

1. Access to condoms: shame as a barrier

Men and women in every FGD knew that condoms were available for free in health posts/centers and through nurses that conduct home visits. Participants mentioned that condoms were also available for purchase in pharmacies, supermarkets, and local stores (*tiendas* or *despensas*).

Women:

Despite knowing where to obtain condoms, many women said that social discomfort, shame, and embarrassment kept them from asking for or purchasing them. Many reported that it was not generally accepted or common for women to carry condoms on their person.

“*They have not given them [condoms] to me [at the ANC appointment], I knew they were given, but I did not ask for them […] Maybe it’s uncomfortable for a woman who is not used to carrying condoms in her bag.*” (Pregnant woman, Nueva Santa Rosa)

Women commonly reported that they feared purchasing or receiving condoms from people they knew in their community (from pharmacies or from the local health facility). Since condoms are associated with extramarital affairs, women feared that people would assume that they were cheating on their partners and that gossip would spread.

“*People who I know sell them [condoms] … It is already embarrassing enough in the health center, but it’s even more so for a woman to go and buy them.*” (Pregnant woman, Amatitlán)

“*There are people who like to talk and gossip in stores. They think that one asks for them [condoms] to use it with other people [aside from their partner]. They take notice of how many one buys, and it is embarrassing, so one does not buy them.*” (Pregnant Woman, Amatitlán)

“*Here, when one person finds out, the whole country knows about it. People talk too much.*” (Pregnant woman, Zacapa)

Men:

While carrying condoms is more socially acceptable for boys and men, and in some instances considered positive as proof of sexual prowess, men still reported experiencing shame and embarrassment when purchasing or asking for them. While it was to a lesser degree than with women, men expressed concern about receiving condoms from someone they knew in the community and fear of gossip. Some men reported that it was easier to buy condoms in a pharmacy that was remote from their community or in the larger hospital, where they don’t know the personnel.

*Man 1: “It’s a pain to buy [condoms]. One is worried that they [health personnel] will gossip that you are cheating. It’s also embarrassing to ask for it here at the community health post.”*

*Man 2: “In the hospital one deals with different personnel, it’s not a pain.”* (Men, Llano de Animas)
One man claimed that he felt uncomfortable receiving condoms from a woman, and that he felt less embarrassed buying or receiving them from a man. He claimed that men are more discrete and understanding.

"Men are more discrete." (Man, Barberena)

While men claimed condoms were easy to obtain for other men, some shared that not everyone knows how to use them. Some claimed this was the case because of the shame to reveal that they are uninformed and that men in general are reluctant to seek out health care or approach health personal. Rather than seeking advice about condoms and sexual health from health professionals or other reliable sources, young boys prefer to listen to their friends.

"When we are 10-12 years old, instead of asking a health professional we go to friends. The older ones tell the others. We learn from our friends on the street. But we are all equally ignorant." (Man, Zacapa)

Shame is a critical barrier, inhibiting both men and women from seeking condoms and professional advice. Privacy and confidentiality are essential for clients looking for condoms, other family planning methods, and counseling. To address these barriers, it is essential that health facilities and pharmacies guarantee that sensitized and informed personnel, preferably of the clients’ same sex, offer these services, free from biases, with privacy, and confidentiality. Additionally, it would be important to strengthen the campaigns on the need to use condoms to prevent sexually transmitted Zika and Congenital Syndrome associated to Zika.

2. Access to condoms: cost and stock-outs as barriers

Another barrier to condom access and use are stock-outs in public facilities. Long periods of stock-outs during the last years were reported by FGD participants and providers, in Santa Rosa and in Zacapa. Several Key informants informed this was a problem at national level.

Since it was not possible to deliver condoms for free to pregnant women during the stock-outs, providers gave prescriptions to the women to purchase condoms from private pharmacies. Both providers and users described how stock-outs limit condom use. One health provider in Zacapa shared that she believed many people did not use condoms during the stock-out period because they could not afford them.

"Between the end of 2017 and February 2018 there was a shortage of condoms, so we could only give [pregnant women] the prescription to buy them. When there are no condoms in the health post, in the health center or in the hospital, many do not use them because of economic constraints, since they cannot buy them." (Health provider, Zacapa)

The cost of condoms in pharmacies was commonly discussed among both men and women. It was a concern particularly in rural areas, where both men and women said their earnings were too low to maintain the family and buy condoms.

"Outside, when you go to the pharmacy, [condoms] are very expensive, 3 for 10-12 Quetzal. It is an impediment, it is not like having a box at home and saying I will always protect myself. There is no competition in brands, I would like more brands, to make it easier." (Pregnant Woman, Amatitlán)

Cost is a more considerable barrier for women since, according ENSMI (2008 – 2009), 67% of women need to ask their partners permission to use household finances and they are less likely to engage in paid employment outside the home [25].

In Zacapa, during the FGD with men of the urban area, young men said that they usually do not get their condoms from the health center, but instead prefer pharmacies or supermarkets because they are open
at more convenient hours. In contrast, older men preferred health centers because the condoms were free.

One man in Zacapa shared that some people prefer to buy condoms because there are rumors that condoms distributed in health centers are low quality and were not effective. Midwives also discussed limitations in their ability to respond to their clients’ request for condoms.

“The men ask me to bring [condoms] to them if I can. But we midwives only receive trainings, we do not receive condoms.” (Midwife, Nueva Santa Rosa)

To increase condom use during pregnancy to prevent Zika, it is essential to prevent condoms stock-outs in public health facilities. Good quality condoms should be regularly distributed to pregnant women and couples during counseling, upon the clients’ agreement. Condoms should be available for free in all health facilities. Distribution of free condoms during home visits by health promoters and midwives could be another strategy to increase condom use during pregnancy.

“First you have to talk with him [the partner], then later you can buy the condoms.” (Pregnant woman, Amatitlán)

3. Men’s reactions and perceptions about condom use during pregnancy

Men’s initial reaction when advised to use condom during pregnancy were overwhelmingly negative, with reasons ranging from physical discomfort when wearing condoms, stigma associated with unfaithfulness, and fear of pleasure reduction and virility.

Condom use in general:

Many men complained that condoms cause irritation, discomfort, or allergic reactions.

“I am 39 years old and I used condoms only once. I had a partner, I went to a bar and used one, but it hurt me, it irritated me. Since that time, it has always been on my mind. I think it [the condom] gave me irritation because I am diabetic.” (Man, Llano de Animas)

Many men complained that condoms did not feel the same or lessened their sexual satisfaction. There were several common analogies used to illustrate this point.

“My brother-in-law said to my sister: do you like to eat bananas? Do you like to eat it with peel? You don’t? It's the same, it does not feel the same!” (Woman, Zacapa)

“As far as they are concerned, men say that it is not the same, that they do not like it. Women explain to them, but they tell us that if they take it to the husband he does not accept to use it, they say that it is like eating a sweet without taking away the paper.” (Health Provider, Zacapa)

Resistance to condom use because they are thought to reduce men’s pleasure was reflected in responses from participants, who mentioned that traditional masculine norms prioritize male sexual satisfaction over female satisfaction and health.

“The man says ‘no, I do not use it and it's over’ the man thinks only of satisfaction, not of the satisfaction of the woman and not of her health.” (Man, Llano de Animas)

Other common reactions included complaints that men weren’t accustomed to using condoms, that some men do not know how to use condoms, and that they just forget to use them.

One younger woman in Amatitlán shared that in the past there was stigma associated with condom use because they were associated with use by gay men. This is probably because they were heavily promoted to prevent HIV among high risk populations such men who have sex with men.
"It used to be said that if a man used the condom he was gay." (Woman, Amatitlán)

Condom use in formal relationships:
Since condoms are associated with extramarital relationships, many men mentioned that condoms were not necessary or acceptable with their committed partners.

“If I am married, I do not have a problem with my wife, there are other methods of not getting pregnant. But if there is promiscuity, if you go out in the street, you have to use a condom to prevent HIV and other STIs. For me it would not be normal with my wife, but outside the house yes.” (Man, Zacapa)

Men also emphasized that not wearing condoms is a sign of trust between partners.

“If you have trust in your spouse, then you don’t need to use a condom.” (Man, Zacapa)

If a person proposes condom use it often construed as an accusation that their partner is unfaithful or an admission that they themselves have been unfaithful. While women most commonly voiced concerns about their partners’ reaction, men also expressed concern about their partner’s reaction if they proposed condoms use.

“They should give a health talk about condoms in the community or health center, that way she will understand. Otherwise [if you propose condom use] she will think that you have a partner other than her and that you bought them to use outside. You have to explain to her that it’s for her protection.” (Man, Barberena)

Condom use with pregnant partners:
Men initially did not understand the purpose of condom use because their partners were already pregnant and claimed they were not sick/infected or having sex with other partners.

“Men say no because the mentality is that she is already pregnant. They do not think about the risks of other infections. Many protect themselves only from pregnancy.” (Woman, Amatitlán)

In reaction to women learning how to use condoms and bringing them home from ANC counseling, men were concerned. One man admitted that if his partner knew more about condoms than he did, it would make him feel uncomfortable and emasculated.

“We’re the ones who use it, but the woman explains how to put it on. It’s a gender clash.” (Man, Zacapa)

Some men would not listen to their partners after their ANC appointment. One husband of a pregnant woman in Teculután shared that when his partner returned with information on condoms and Zika from her ANC appointment, he refused to listen to her and he affirmed that they had been not using condoms during the past 6 months of pregnancy. He interpreted her suggestion to use condoms as an accusation that he was unfaithful and ended the conversation. This reflects that often the woman attends the appointment, but the man does not participate and does not get proper information from a source of authority; it also illustrates the lack of agency and decision-making power some women have in their relationships.

“They told my wife to explain to me, I told her no, because I didn’t do anything wrong. She said it was for sexually transmitted infections, I told her no because I’m not doing anything wrong with anyone else. [...] she did not explain the consequences, I did not want to talk about this and we closed the subject. No, I did not give her the chance to talk anymore.” (Man, Teculután)

Positive reactions:
However, after a thorough explanation of Zika and prevention methods, most of the men in the FGDs said that they were open to condom use. Many of the men reiterated that if other men were well informed
about the risks to their future child that they would use a condom.

"The man's first reaction to using it is negative, but if he understands the risks, he accepts it." (Nurse Assistant, Barberena)

"There is no information [about Zika]. When we are informed, we understand it easily. We must make a chain so that everyone knows. If a person is informed, he uses it by necessity." (Man, Barberena)

It is also important to note, that while it’s not as common as violence against women, there are some instances where women can get violent.

"There are many violent men, but there are also many women who do not react well. They say to him: Did you get sick from being with another woman? For example, I explained to a friend that he had to use a condom with his pregnant wife because of Zika, when he proposed it to her (he is not violent) she got angry. She thought he had AIDS." (Pregnant Woman, Amatitlán)

4. Women’s reactions and perceptions about condom use during pregnancy

Most women reported that their initial reaction to the recommendation of condom use during pregnancy was generally negative and that it was uncomfortable for both men and women.

"It's not nice, it's uncomfortable for both of us." (Woman, Barbarena)

When counseled about condoms use during pregnancy, women did not initially understand why they needed to use them. There was confusion because condoms are used primarily as a form of birth control within established relationships, and in this case, the woman is already pregnant. Once it is explained that it is to protect the child, they more easily accept the recommendation to use condoms during pregnancy.

"A woman told me: if I'm already pregnant, why should I use condoms? I'm not going to get pregnant again. I told her it's to protect the baby from Zika and that she must explain it to her partner, so the father too can understand." (Pregnant woman, Amatitlán)

Misconceptions about condom use during pregnancy:

There were several myths, misconceptions or fears commonly discussed among women in FGDs that inhibit condom use. The most frequently cited fear is that condoms could cause irritation, or even vaginal or urinary tract infections. These misconceptions were based on personal experiences, but also on what they heard from other women and healthcare providers, who sometimes perpetrate these myths.

"When a woman is pregnant, she is prone to vaginal and urinary tract infections, the condom heats up and gives infection." (Woman, Nueva Santa Rosa)

"The doctor from another private center where I attend told me that the condoms transmit infections, so it is not good to use condoms during pregnancy. He says not to use the condom during pregnancy because the baby has his own bag - the placenta - that already protects him." (Pregnant woman, Barberena)

Another woman described how her grandmother told her that the latex in condoms was bad for the baby. This illustrates the influence that older generations have on many younger people seeking advice and knowledge from them.

"My grandmother says that one shouldn't use latex during pregnancy. That a loose condom affects the baby." (Pregnant woman, Zacapa)

Some women raised doubts that condoms were not always effective in preventing pregnancies and STIs.

"I heard they do not always work." (Woman, Barberena)

Fear of violent reactions and limited decision-making power over sexual and reproductive health:
One of the most prominent themes when discussing condom use was women’s fear of violence and maltreatment from their partners. Both, pregnant women and providers in Amatitlán and Nueva Santa Rosa highlighted that one of the main issues limiting women’s acceptance of condoms when offered during ANC is the fear of their partner’s reaction. This is related with lack of information on the part of men. One health provider in Zacapa estimated that two or three out of every ten women refuse to accept condoms and prefer to seek permission from their partners first before taking them home.

“First you have to talk with him [the partner], then later you can buy the condoms.” (Pregnant woman, Amatitlán)

Many women mentioned both physical violence and several forms of psychological violence, including insults and threats to leave them for other women if they insisted on using condoms.

“Most men are machista. They ask, ‘where did you find these [condoms]?’ Some hit women.” (Woman, Zacapa)

“Where I live, a woman came from the clinic and said ‘They gave us condoms’ he told her’ these are lies. Why am I going to use this? ‘They fought. This is a big problem.” (Woman, Nueva Santa Rosa)

“Maybe it might not go so far as physical violence, but yes there is psychological violence, they threaten the woman. For example, they [men] say that if the woman does not want to have sex, they will leave them for other women. This is the woman’s biggest concern.” (Pregnant Woman, Amatitlán)

“There is a lot of infidelity, men look for another person if their wife wants to use a condom.” (Health provider, Amatitlán)

In patriarchal societies, where men are perceived as the primary decision-makers, often their female partners are not valued as intelligent or trustworthy enough to be believed.

“Today, most men are ‘machista’; a husband only understands when the doctor speaks to him, but some men do not even want the woman to have a Pap smear. At first, he [her partner] said, ‘This is a joke! Why are you going to use condoms with me?’ I then explained that it was for the baby, so that the disease is not transmitted, but he said, ‘This is nonsense.’ We went to the doctor together and she explained and then he understood. He did not believe me.” (Pregnant woman, Zacapa)

This also illustrates the service gap. Even if a woman is given comprehensive information about Zika during ANC care, she fully understands the risks, and is given condoms for free, it may not be enough to ensure condom use. In some cases, if pregnant women fear their partners will not believe them, refuse, threaten, or beat them, then they may decide to not inform their partners about the recommendation to use condoms and throw them out.

“Sometimes it’s better to keep quiet so a man does not fight you, does not insult you. He does not contain himself.” (Pregnant Woman, Amatitlán)

“It depends on the attitude of the man. A woman might prefer to remain silent if he threatens to leave her for another woman or if he can become violent.” (Pregnant woman, Teculután)

“The women say, ‘I understand’, they take the condoms, but they never tell their partners for fear of how they will react. They prefer to be silent. The husband does not even know. It would be important to call the husband, but it is not possible in this facility, because of space, among antenatal consultation, pediatrics, etc. spaces are always all filled. There is no space, it is full and there would be the risk that pregnant women get accidentally hit.” (Health Provider, Zacapa.)
It is often not enough to just give women male condoms during ANC consultations. The threat of violence remains salient in a woman’s decision to propose condom use to her partner and should therefore be addressed in ANC counseling or through other interventions to reach men. Additionally, this highlights the need for universal screening for gender-based violence for all ANC patients to identify women in violent relationships and to offer support and appropriate referrals to help support the improvement of their overall health and wellbeing, including their ability to prevent Zika infection. As recounted in the desk review, intimate-partner violence is often associated with STIs, and therefore sexual transmission of Zika, because men who are violent are more likely to have multiple partners, which heightens risk of STIs. IPV often prevents women from seeking healthcare, whether that is STI screening or ANC, due to shame, fear of IPV related stigma, and fear of further reprisal from the violent partner [27,28].

The limited decision-making power women have about condom use and their sexual and reproductive health in general was emphasized repeatedly throughout the focus groups and interviews. Several nurses mentioned the importance of confidentiality, since many of their female patients decide to use contraception secretly, disregarding their partners’ or their mother-in-law wishes.

Mother-in-laws have been identified by FGD participants as another actor that often threaten and restrict women’s decision-making related to sexual and reproductive health. Mother-in-laws are often invested in having grandchildren, or may be very religious, and so may prevent her daughter-in-law from using contraception.

“The husbands and mothers-in-law do not like that women use family planning in any form.” (Health provider, Nueva Santa Rosa)

The gender analysis highlighted that fear of discomfort and irritation affect condom use among men and women, however there are specific gender issues limiting the willingness to use condoms for women and for men. While women are most concerned about fear of violence, men are more concerned about not diminishing their pleasure, reaffirming their gender role as primary decision-maker, and avoiding doubts about infidelity. It is important to address concerns from both groups to improve correct and consistent condom use, and it is fundamental to properly address the gendered nature of condom use and negotiation.

5. Condom negotiation

Distributing condoms to pregnant women does not guarantee that couples will use them correctly and consistently. When health providers in Teculután followed-up with women they encountered push back. According to the key informants, many pregnant women who say they are not using condoms, justify this by saying that they are single, that their husband works in another part of the country, or that they are not sexually active.

“When we ask if they use it, 40% say that they use it. The others say, ‘I didn’t have relations, my husband works away, we are separated.’” (Health provider, Teculután)

While providers in Teculután confirmed that many men in agroindustry move to other cities for work, this is not the case for all the women. Having limited decision-making power remains a pressing issue.

One of the key debates that emerged during the focus groups was about who makes the final decision to use a condom within a couple. A few women insisted that women are who make the final decision and that if their partners refuse to use condom, they can take a firm stance saying, “no condom, no sex.” However, most of the participants of both sexes agreed that the man makes the ultimate decision on whether a couple uses condoms.

All groups agreed that due to pervasive machismo norms of male dominance in decision-making, women often must comply with their partner’s wishes even if it conflicts with their desire to wear a condom. As previously expressed, other agents like mothers-in-law intervene in this decision-making process.
Participants confirmed what is evident in the data, that most women need their partner’s permission to use contraception.

“Men have more resistance. Women adapt, they want to collaborate, but the man does not, so we have to obey them.” (Woman, Barberena)

“Because of machismo, the man says ‘I am the boss here. If the doctor told you this, he is not here, so we’re not going to use it’. There is not good communication.” (Man, Llano de Animas)

Since women are given male condoms, they don’t have the power to obligate men to wear them if they don’t agree.

“We decide, because we are the ones that have to put it on.” (Man, Teculután)

While female condoms are not common in Guatemala, some women expressed the desire to access to this method. They considered that female condoms could empower them to make decisions about their sexual and reproductive health, balancing power dynamics with their partners.

“We don’t give out female condoms, but we do give out male condoms, and these are not worn by women. We [the midwives] can tell you, but if the man says, ‘I do not wear it’ it’s ‘I do not wear it’. The most you can do is talk the husband, he is the man who decides.” (Midwife, Nueva Santa Rosa)

“At the health center they offer condoms to men, he decides. It would be better to have condoms for women. If my husband does not want to use it, I’ll wear it. But I do not know much about this method, nor do I know how much it costs. We women are more open to protection, men tend to decide for us.” (Pregnant woman, Amatitlán)

Most participants agreed that women who would prefer to use condoms to protect themselves and their unborn children from STIs but find themselves in the situation of having unprotected sex. It is important to recall that the law against femicides and other forms of violence against women (Decreto 22-2008) considers the denial of the women right to adopt protection measures against STIs and unplanned pregnancy as forms of sexual violence.

Women also presented a wide variety of experiences and strategies they used when talking to their partners about condom use. Some women said they did or would not find it difficult to talk to their partners about condom use, putting emphasis on protecting the unborn child.

“They told me at the ANC consultation. They gave me twelve condoms and the lubricant. When I got home, I said ‘We’re going to be better.’ We use it, even though it’s uncomfortable, but it’s to protect the baby.” (Pregnant woman, Barberena)

“Love him and explain the risk to baby. He will understand for the sake of the baby.” (Woman, Barberena)

Another strategy that some younger women mentioned was leveraging allies when talking to their partners about condom use. For example, one 17-year-old pregnant adolescent, who was pressured by her partner to have unprotected sex against her will, recounted how she had her mother intervene.

“They offered [condoms] to me if I wanted to take them, but I did not want to talk to him [her partner]. I thought it was better not to have sex. My mom talked to him. She told him that it was my first child and that he should understand that it was not easy with my stomach like this, and that the child could be born sick. It helped him to listen to my mom, he was ashamed. Now, we either use a condom or we do not have sex.” (Pregnant adolescent, Amatitlán)

Some women mentioned choosing an ideal moment to talk to their partners about condom use, choosing a time when they are content or happy instead of waiting to talk right before sex.

“When he’s happy, grab him at the best moment, you know him.” (Woman, Barberena)
Men and women in every FGD discussed the importance of clear communication between partners, with emphasis on the protection of the child as the key to convince men to use condoms.

"The explanation is important, if it is not explained well there are reactions based on machismo. If it is explained point by point, it should be understood that it is for the child. Communication, before anything." (Man, Llano de Animas)

While this man was emphasizing the importance of assertive communication, he also normalized aggressive reactions to an incomplete explanation given by the woman. This illustrates how GBV is socially accepted and justified.

This gender analysis highlights many of the deeply-rooted machismo norms present in Guatemala. Women must navigate unbalanced power relations, which limit their decision-making power, particularly regarding their sexual and reproductive health. Empowering girls and women, with health provider’s help, to give comprehensive explanation of the reasons for using condom is good first step, but it is clear this is not enough. Boys and men must be addressed and taught to manage equitable conversations and relationships with women, based on mutual respect for them, their rights and opinions.

C. Male outreach

Most participants agreed that to increase condom use during pregnancy, it is important to involve men in Zika response. If men were given comprehensive information about Zika and its consequences by a health professional through health presentations or at ANC visits, participants agreed they would be more receptive to condom use and could reduce violent reactions.

Several studies have demonstrated that partner involvement in ANC visits increased likelihood of contraception usage, uptake of HIV testing, adoption of preventive interventions for vertical and sexual transmissions of HIV, improvement in couple communication, and an increase in joint decision-making [38,39]. Since Zika is sexually transmitted, these findings permit us to infer that ANC visits are a key window of opportunity to counsel pregnant couples and promote condom usage for Zika prevention [40].

Despite studies highlighting the benefits of male involvement, it is important to have a nuanced view. Men’s involvement in ANC needs to align with the individual woman’s wishes. She may value her independence in certain matters, and in cases where inter-partner violence (IPV) is present, involving the partner in care could be dangerous. It could also be detrimental if women with partners were prioritized in care, since this would further marginalize single mothers. This highlights the need to discuss men’s involvement in care with women first and to ensure that any engagement with the partner is done with the woman’s consent.

To understand the local view on male involvement in ANC, all FGD participants and key informants were asked about the acceptability and feasibility of involving men in ANC. Every FGD participant agreed that it was important to involve men in ANC, and that it would be the best way to inform them about the risks of Zika and about the importance of wearing condoms. They mentioned that it is more powerful for men to hear the recommendation directly from a health provider rather than secondhand from their partner.

"In the health center of Teculután, the doctor asks that the husband accompany his wife [during ANC consultations]. My husband goes. He asks for permission in the morning and then goes to work in the afternoon, but there are those who do not have this ability."(Pregnant woman, Zacapa)
However, all groups identified several limitations to this strategy. The most common limitation reported was difficulties in obtaining permission to leave work. Both men and women talked about the fear of losing their job and about the inability of men to lose a day of wages to attend an ANC appointment. This illustrates the additional challenges in promoting male involvement amongst lower income families.

“Most men work, people with formal work do not ask for permission. They cannot disregard the money and are afraid of being fired.” (Woman, Amatitlán)

“Two of every 100 cases men accompany their partners to ANC. The man cannot ask permission. If he does not go to work, he is not paid for that day “(Health provider, Barberena)

Cost can also be an issue as it is more expensive to pay for two people’s transportation to the health facility and food for the day.

“It is costly here in Guatemala to get permission to accompany the woman. If I can get the money, sometimes it’s enough for my partner to go, for her exams and her food. We do not earn enough to pay for the tickets for both of us and for the food." (Man, Llano de Animas)

Participants emphasized that men generally avoid health facilities when possible. Many men claimed that they are bored while waiting for health services, and they consider it a waste of time. Some cited gender stereotypes claiming that men do not have the same patience as women and that health facilities are places for women and children. They also mentioned that men only go if they are gravely injured and they are ashamed of going if it is not something serious. This reinforces gender stereotypes that men are to be seen as strong and infallible, that they do not need to seek care in a facility, while the women are the caretakers of the family and visiting health facilities (for themselves or their children) is part of their domestic responsibilities.

For example, one women explained that men do not like engaging in the health system.

“In the Guatemalan culture the health center is used practically only by women and children, the men prefer to pay for a private consultation, and only for the health check he needs for work, but not for personal consultation.” (Man, Teculután)

Even if the importance of male participation in sexual and reproductive health is continuing to gain traction and emphasized in the Programme of Action of the International Conference on Population and Development, most sexual, reproductive, and maternal health programs and care are often targeted exclusively at women. Participants mentioned that the health system is organized in a way that creates barriers for men’s participation in ANC. In some instances, men said that they were not allowed to accompany their partners during their consultations at some hospitals, like those of the social security system.

“They let only the wife in [into the consultation], the man stays outside. They give the number only for the woman, she goes by herself, the wife enters, the husband waits outside. In the IGSS it’s worse: one has to wait on the street.” (Man, Llano de Animas)

During outreach outside of health facilities and in the community, many community workers and midwives find it difficult to engage men in issues of health or their health of their partners or children.

“It is important that the nurses go from house to house, perhaps by appointment, when the husband is there so they can talk to the husband, because they mostly do not want to use condoms. But sometimes men run away.” (Pregnant Woman, Amatitlán)

“I attend several pregnant women. When I arrive at their homes, the men escape. They arrive at night and go straight to what they come for (sex).” (Midwife, Nueva Santa Rosa).

Despite these challenges, many health facilities are implementing initiatives to involve men. For example, the Health Center of Teculután started a program to invite male partners to ANC.
“It’s been three months after the start of the project, that we started to invite men to ANC consultations. […] It is easier with the youngest, 20-30 years old, who are entering a new stage and are excited, they become more aware; the older adults on the other hand use any excuse: ‘I do not have permission at work’, ‘I do not have time'; ‘This is her problem, not mine.” (Health provider, Teculután)

Health providers mention that the younger men are more participatory, but that older men continue to resist due to cultural norms that pregnancy and protecting the unborn child is the woman’s responsibility.

“In a month, out of 20-30 pregnant women, four are accompanied by the husband; the others work. We would like them to come, even once at the beginning or at the end, but it is difficult.” (Health provider, Teculután)

While these initiatives are setting the precedent among health providers to make efforts to engage men, there are still many cultural barriers to address.

“Accompanying pregnant women in ANC is not part of the culture.” (Health provider, Teculután)

1. Participants’ recommendations to involve men in Zika response

Participants in all FGDs were asked how to inform men about Zika and involve them in prevention activities. After a brainstorming session, participants were asked to prioritize the activities they cited by those they felt would be most effective. The following chart is a list of activities organized by those voted most to least effective (unweighted) and the strengths and weaknesses that participants identified with each activity.

Table 3. Male outreach activities matrix

<table>
<thead>
<tr>
<th>Rank</th>
<th>Activity</th>
<th>Strengths</th>
<th>Challenges</th>
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</table>
| 1.   | Involving partners in ANC visits.  
   a. Make appointments for couples together.  
   b. Doctor sends invitation for the pregnant woman to take home to her partner (with her consent).  
   c. ANC appointments on the weekends or outside of working hours so partners do not need to take time off work.  
   “If they had ANC consultations on Saturday and Sunday, it would be easier for the man to accompany their wife, so both of them can receive information.” (Man, Llano de Animas) | • Men are more likely to accept and trust information about Zika prevention and condom use directly from a doctor.  
• Men become more invested in the health of their partner and child when they participate in ANC. | • Men find it difficult to obtain permission to leave work or cannot afford to forgo wages for the day or risk to lose their jobs.  
• Transportation and other expenses may be costly for two people to make a trip to the health facility.  
• Male gender norms dictate that they do not engage with the health system, that it is a women’s place. |
| 2.   | Health presentations: charlas or platicas – about Zika (the risks, consequences, and prevention methods including the importance of, and how to use, condoms).  
   a. For men.  
   b. For couples.  
   c. Conducted in the communities (aldeas): in | • Feasible for health promoters, nurses, and doctors to implement.  
• Can reach men at their workplaces, where they are together, which can contribute to steps to | • Charlas are usually organized around the schedules of health promoters and are likely to take place during men’s working hours, when they are not at home as at work. |
### Gender Issues Influencing Zika Response in Guatemala

<table>
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<tr>
<th>Rank</th>
<th>Activity</th>
<th>Strengths</th>
<th>Challenges</th>
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<tbody>
<tr>
<td></td>
<td>b. Conducted in businesses or places where men work.</td>
<td>- Can reach a large audience.</td>
<td>By creating alliance with the Community Development Councils -COCODE, they can guarantee the presence of most of the community population.</td>
</tr>
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<td></td>
<td>c. Conducted on the weekends so men can participate.</td>
<td>- Can reach a large audience.</td>
<td>- Many people are illiterate, so materials should focus on illustrations and photos.</td>
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<td></td>
<td>d. Accompanied with material to take home (see #3).</td>
<td>- By creating alliance with the Community Development Councils -COCODE, they can guarantee the presence of most of the community population.</td>
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<td></td>
<td>e. Conducted in the waiting room of the health post/center/hospital.</td>
<td>- Can reach a large audience.</td>
<td>- People often do not pay attention to these materials and throw them away without reading.</td>
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<td></td>
<td>f. Conducted in businesses or places where men work.</td>
<td>- By creating alliance with the Community Development Councils -COCODE, they can guarantee the presence of most of the community population.</td>
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<td></td>
<td>g. Accompanied with material to take home (see #3).</td>
<td>- Many people are illiterate, so materials should focus on illustrations and photos.</td>
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<tr>
<td></td>
<td>“… because men cannot go to the center or to presentations, there are institutions that will give them information. For example, in the farm where I work, an engineer came to give a presentation about STIs, family planning ... only a few men came, but they understood. &quot;(Woman, Barberena)</td>
<td>- By creating alliance with the Community Development Councils -COCODE, they can guarantee the presence of most of the community population.</td>
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<td></td>
<td>“Because of the work, the men do not have time to accompany the woman to ANC consultation, so it is necessary that they give us didactic material to take home.&quot; (Pregnant Woman, Amatitlán)</td>
<td>- Many people are illiterate, so materials should focus on illustrations and photos.</td>
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<td></td>
<td>“If the man at least saw photos he would have more conscience. If there is a video, I do not know of it. There are no pamphlets to send [home with the pregnant women] nor to teach with in the consultation, there is no flipchart on Zika. It would be important to have pamphlets for pregnant women to take to their partners.” (Health Provider, Barberena)</td>
<td>- Many people are illiterate, so materials should focus on illustrations and photos.</td>
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<td></td>
<td>“If they don’t see it, they don’t believe it”. (Health Provider, Barberena)</td>
<td>- Many people are illiterate, so materials should focus on illustrations and photos.</td>
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<td>3.</td>
<td>Visual informative material for pregnant women at the ANC appointments to take home to their partners.</td>
<td>- Feasible for health promoters, nurses, and doctors to implement.</td>
<td>- Many people are illiterate, so materials should focus on illustrations and photos.</td>
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<td></td>
<td>a. Pamphlets explaining Zika and how/why to use condoms (which are already being delivered in many centers).</td>
<td>- Can be a trustworthy source of information that men are more likely to trust.</td>
<td>- People often do not pay attention to these materials and throw them away without reading.</td>
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<td></td>
<td>b. Use illustrations and pictures of children with CSaZ.</td>
<td>- Illustrations, photos, and examples can be powerful and more likely to convey the risk of Zika. “If they don’t see it, they don’t believe it”.</td>
<td>- Many people are illiterate, so materials should focus on illustrations and photos.</td>
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<td>4.</td>
<td>Posters (in health facilities, schools, and community spaces).</td>
<td>- Feasible for health promoters, nurses, and doctors to implement.</td>
<td>- Many people are illiterate, so materials should focus on illustrations and photos.</td>
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<tr>
<td></td>
<td>a. Explaining Zika and how/why to use condoms</td>
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<td>- Many people are illiterate, so materials should focus on illustrations and photos.</td>
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<td>Rank</td>
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<td></td>
<td>b. Use illustrations and pictures of children with CSaZ.</td>
<td>• Illustrations, photos, and examples can be powerful and more likely to convey the risk of Zika.</td>
<td>• People may not see it or pay attention to it.</td>
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<td></td>
<td></td>
<td>• People may not see it or pay attention to it.</td>
<td>• Men tend to avoid health facilities.</td>
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<td>5.</td>
<td>Leveraging the internet.</td>
<td>• Widely used among youth.</td>
<td>• Not everyone has a phone and the people who might need the information most is least likely to have a phone.</td>
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<tr>
<td></td>
<td>a. Links to credible websites with more information about Zika.</td>
<td>• Novel and exciting for people to use.</td>
<td>• Some people don’t view the internet as a credible source of information, they might not take it seriously.</td>
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<td></td>
<td>b. Links to videos explaining Zika</td>
<td>• Convenient way to reach a large audience.</td>
<td>• Many people share phones so there is little privacy and it could be difficult to receive messages about things like condom use.</td>
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<td></td>
<td>c. Using Whatsapp to create men’s and/or women’s groups, or to send out reminders about Zika prevention.</td>
<td>• Illustrations, photos, and videos can be powerful and more likely to convey the risk of Zika.</td>
<td>• Some people don’t view the internet as a credible source of information, they might not take it seriously.</td>
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<td></td>
<td>d. Other social media sites.</td>
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<td>• Many people share phones so there is little privacy and it could be difficult to receive messages about things like condom use.</td>
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<td></td>
<td>• Illustrations, photos, and videos can be powerful and more likely to convey the risk of Zika.</td>
<td>• Some people don’t view the internet as a credible source of information, they might not take it seriously.</td>
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<tr>
<td>6.</td>
<td>Home visits by a community health promoter.</td>
<td>• Way to directly reach men.</td>
<td>• Health promoters usually visit during the day when the men are still at work.</td>
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<td></td>
<td>• Convenient for patients.</td>
<td>• Labor intensive for health promoters.</td>
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<td>7.</td>
<td>Television (TV) and/or radio announcements about Zika prevention and condom use.</td>
<td>• Can reach a large audience.</td>
<td>• May be difficult or costly to coordinate with television and radio networks.</td>
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<td>“It is necessary to increase the promotion in the media. There are no announcements on the radio nor on local and national TV.” (Health provider, Barberena)</td>
<td>• Can be a trustworthy source of information that men are more likely to believe.</td>
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<td>• In the case of TV announcements, Illustrations, photos, and videos can be powerful and more likely to convey the risk of Zika.</td>
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<td>8.</td>
<td>Leveraging community leaders (both men, women, and the Community Development Councils -COCODE).</td>
<td>• When COCODE organize a meeting, they can gather most of the community.</td>
<td>• May be difficult to coordinate with COCODE.</td>
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<td>• Community leaders know their communities best and can help in spreading information about</td>
<td>• Community leaders may have biases that influence their decision to promote certain Zika prevention strategies or other health</td>
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Male involvement in Zika prevention during pregnancy, especially in ANC counseling, are considered fundamental to improve health outcomes. However, not all men are able to participate in ANC counseling, so participants offered alternative initiatives could still involve men in Zika prevention efforts if alliances with key actors, such as community leaders and midwives, were leveraged.

Engaging men during pregnancy, particularly through ANC visits, is a critical entry-point for Zika prevention, to improve MNCH, and to address couples’ decision-making dynamics. Men’s greater involvement can also open opportunities to improve men’s own sexual and reproductive health, disrupt intergenerational cycles of violence, and promote men’s roles as advocates for MNCH [41]. ANC visits increase men’s knowledge about the importance of maternal, postnatal, and child health services which could make them more invested in the health of their partners and children [42,43]. This knowledge can translate into the provision of resources for accessing maternal services such as transportation to the hospital for delivery and payment of user fees, but also as long-term investments such as early father involvement in the infant’s life which is beneficial for child development [44]. Several studies in low and middle-income countries report other positive benefits of male involvement in maternal health and ANC visits, which include: increased maternal access to antenatal and postnatal services, use of a skilled birth attendant, discouragement of unhealthy maternal practices such as smoking and alcohol consumption, improved maternal mental health, improved maternal nutritional status, reduction of stress, pain, and anxiety during delivery, and higher rates of breastfeeding [38, 39, 41, 43, 45].

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<tr>
<th>Rank</th>
<th>Activity</th>
<th>Strengths</th>
<th>Challenges</th>
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<td>Zika prevention by word of mouth and other networks.</td>
<td>information that is not in line with traditional gender norms.</td>
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<td></td>
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<td>● Community leaders are trusted sources of information who men and women are likely to believe.</td>
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<td>9.</td>
<td>Organizing Zika prevention awareness campaigns that coincide with recreational activities (i.e., a soccer match, festivals, community center activities, school activities etc.) or other existing community group activities (i.e., nutrition/cooking groups run through health centers).</td>
<td>● Can directly reach men where they spend time.</td>
<td>● May be difficult to coordinate.</td>
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<td></td>
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<td>● Can be a fun and engaging way to teach men about Zika.</td>
<td>● Many of these activities take place outside of traditional working hours for health providers.</td>
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<td></td>
<td>● Takes advantage of existing networks.</td>
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<td>10.</td>
<td>Leveraging and training midwives.</td>
<td>● Midwives visit women in their homes and have an opportunity to interact with their partner.</td>
<td>● Midwives may have biases that influence their decision to promote certain Zika prevention strategies – particularly because many are older and have more traditional views.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>● Midwives are a trusted source of information in the community.</td>
<td>● Midwives work directly with women and usually do not interact with men.</td>
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D. Sexual behavior during pregnancy

While there have been several studies investigating attitudes, perceptions, and beliefs about sexual activity during pregnancy, little information is known about beliefs in this region and in the context of Zika. Since promotion of condom use during pregnancy is a key Zika prevention strategy, it is crucial to understand beliefs around sexual activity during pregnancy to identify strategies to promote condom use during pregnancy.

In previous studies in other countries, positive beliefs about sex during pregnancy included that it makes labor easier, prevents infidelity, and improves fetal wellbeing. Negative beliefs were more frequent: that sex could harm the unborn child (cause injuries, miscarriage, or infection) and endanger the pregnancy or maternal health [46]. Other studies have found that sexual activity decreased during pregnancy in all age groups, but it decreased significantly with increasing age. The main reasons for reduced sexual activity included: decreased libido, the doctor's suggestion, fears concerning child's health, reduced satisfaction with sexual life during pregnancy in comparison with the previous period and some women reported feeling less attractive while pregnant [46].

Many responses from participants in the FGDs echoed these sentiments. When participants were prompted about sexual activity during pregnancy, most said the frequency of intercourse reduces over the course of the pregnancy. As the woman's pregnancy progresses she gets less comfortable, more tired, and her belly grows, etc.

“At the beginning it is normal, but as time goes on it lessens.” (Man, Barberena)

A few women claimed that the opposite, that they wanted more sexual relations because of their hormones or they liked the intimacy.

“Sometimes it increases because the hormones in pregnant women are very high.” (Woman, Nueva Santa Rosa)

Many women expressed concern that having sex would hurt the baby. Most of these women were younger or were pregnant with their first child and so opted for abstinence.

“With my first child, my wife pushed me away.” (Man, Barberena)

“One has less desire and is also worried for the child.” (Pregnant Woman, Barberena)

Many men were concerned that it might hurt the baby as well.

“My spouse is afraid of hurting the baby.” (Pregnant Woman, Barberena)

“Abstinence for prevention. It’s natural to be worried.” (Man, Zacapa)

“When a woman is pregnant she may want to be with the husband more, the husband is afraid of hurting the baby and tells her no.” (Woman, Zacapa)

A few male participants brought up themes of being sexually rejected by their partners during the pregnancy. Others mentioned that if this is the case, some men will look for sex with other partners.

“Women reject their partner during pregnancy, they may not have sexual desire. They have their moments when you should not bother them.” (Man, Zacapa)

Man 1: “They look for other partners.”

Man 2: “They should have more respect because it she found out she would feel bad.” (Men, Zacapa)

Ultimately, no universal trend about the norms of sexual activity during pregnancy emerged. Many participants said it varied or depended on each person and/or the couple.
E. Other barriers to Zika prevention and care

Several other overarching barriers to Zika prevention and care repeatedly emerged throughout the focus groups and interviews, including machismo and religious beliefs.

1. Machismo

One of the most pervasive themes throughout all FGDs and KIIIs, among both men and women, in every region, and in every type of facility was machismo. Many participants used this concept as an all-encompassing explanation for male behavior, without analysis of other underlying causes.

“Here there is a lot of machismo, there are many people in the community without education, women have to do what their husbands tell them to do.” (Health provider, Zacapa)

“Because of machismo, one cares more about the purity of women, their virginity. For example, I don’t want my 18-year-old sister to post photos on social media and have others talk about her.” (Man, Zacapa)

2. Religion

In Guatemala, an estimated 60% of the total population is Catholic and 30% evangelical Christian [47]. Based on information gathered during FGD and KIIIs, strong religious beliefs on the part of patients and providers, along with the presence of the church as a powerful local institution, are barriers in accessing family planning to prevent or delay pregnancy during a Zika epidemic and use of condoms during pregnancy.

Religious beliefs of health providers, particularly informal providers such as midwives, may cause problems in care. Religious fatalism, or the belief that an individual's health outcome is predetermined or purposed by a higher power and not within the individual's control, is widespread and may inhibit use or promotion of certain healthcare services like family planning [48]. For example, when prompted about distributing family planning to her clients, one midwife claimed:

“God sends babies.” (Midwife, Nueva Santa Rosa)

The Catholic Church was cited as a barrier in the promotion of condom use and family planning in general.

“Sometimes grandmothers go to church and they say it is forbidden to use family planning methods.” (Health provider, Zacapa)

Religious beliefs and closely tied to cultural taboos, like parents not discussing sex, condoms, or contraception with their children.

“Parents do not talk to their children because of religion, it is not accepted ... religion is a limitation. The evangelists, for example, do not allow women to use condoms, pills, or any kind of family planning.” (Man, Barberena)

While Guatemala has several laws and policies in place to ensure adequate sexual and reproductive health services¹,⁴ some participants shared their perspective that religious beliefs held sway at the institutional level, resulting in the lack of sexual education in schools.

¹ Law on Universal and Equitable Access to Family Planning Services and its integration in the National Reproductive Health Program (Decree 87-2005); the law of Healthy Motherhood, the law against femicide, etc.
“This is legislation’s fault. Due to religious issues, the sexual health and reproductive health law has not yet been approved. There is also little information in schools and institutions.” (Man, Zacapa)

Despite the policies in place, the broad, conservative influence of religion significantly impacts women’s ability and willingness to access contraception, including condoms, to prevent unwanted pregnancy and reduce the risk of STI transmission, including Zika.

F. Regional and urban-rural differences

Focus groups and interviews were conducted in six facilities in three different regions of Guatemala. There were stark differences in knowledge and attitudes between urban and rural areas across all regions, and particularly in the department of Zacapa because it is a mostly rural, lower-income, agroindustry area. Health providers emphasized that condom promotion was particularly difficult in rural areas.

“The communities far from the urban centers, in the mountains, they are resistant. Condoms are taboo.” (Community Health Promoter, Nueva Santa Rosa)

“Since we’ve known that Zika is an STI, condom use and visits with men have increased, but while people accept in the urban area, in the rural areas they do not.” (Health provider, Zacapa)

Health providers mentioned that machismo norms are more pervasive in rural areas. Men work, women stay at home, are more restricted, and have less power to act independently and make decisions autonomously.

“The woman is timid, it is hard for her to talk to her husband. There is a lot of ignorance, the people who are educated understand the importance and can talk with their husbands. In the countryside they don’t use them [condoms] because their husbands don’t want to. They are more submissive, humble, and illiterate.” (Health Provider, Barberena)

It is therefore critical to take these key differences into account when creating programming to address gender gaps in urban and rural areas using an intersectional approach\(^2\) that considers other characteristics of the population that make them more or less vulnerable, as well as the context, conditions and acceptability at the local level.

G. Vulnerable populations

There are several vulnerable and marginalized populations in Guatemala that need special consideration and programming to effectively address Zika response including youth and indigenous populations.

1. Youth

Adolescent pregnancy is common in Guatemala and adolescents face unique challenges in the context of Zika prevention. One health provider estimated that a little under one-third of births per day are to adolescents, and most of them are in the rural areas, they attend ANC in health posts and are referred to health centers or the hospital towards the end of their pregnancies. Some never go to ANC and enter a facility for the first time to give birth.

“There are around 5 to 8 pregnant teenagers per day. It is a problem with the family, they are accompanied by a husband or a mother. There is a special clinic for pregnant teenagers where we follow a strict protocol to find out that it is not abuse.” (Health provider, Zacapa)

\(^2\) An intersectional approach addresses multiple forms of discrimination and helps to understand how a set of different identities influences each person’s access to, and enjoyment of, rights and opportunities.
Several health providers claimed that there is often an age gap, with young girls who are pregnant and older men. As previously mentioned in the desk review, adolescents may face even more pronounced power imbalances when trying to negotiate contraception or condom use with their partners, particularly if their partner is older.

“Pregnant teenagers are usually accompanied. Their partners are up to 6-8 years older than them; here it is said ‘old cat with tender mouse.’” (Health provider, Teculután)

“For example, of pregnant adolescents that are 16 and 17 years old, the father of the child in most cases is 27, 28 years old and they are married to other women.” (Health provider, Teculután)

One explanation is that young girls rely on relationships with older men for economic reasons. Health providers in certain communities revealed that this is a common and formal relationship for young girls to engage in.

"Most teenagers do not have relationships with other teenagers, but with adults, because of the economic situation. If he has money she does what he says. They give benefits to whoever gives them money.” (Health Provider, Teculután)

“To survive, girls go with older men, they are called pre-paid girls.' They leave their houses in uniforms like to go to school.” (Health Provider, Teculután)

Some health facilities are trying to address this issue by creating programming targeted at youth, such as youth spaces in schools and health facilities. It is essential for youth to receive comprehensive sexual and reproductive health education, access to contraception, and information about Zika prevention.

“In schools for young people, there are friendly spaces for teenagers managed by health inspectors. We are asking psychologists to serve more because of the influx and now it is not enough.” (Health provider, Teculután)

Younger participants in the focus group discussion also talked about leveraging the popularity of social media and the internet to reach other young people about Zika prevention and services, through Whatsapp, internet, videos.

2. Indigenous populations

As mentioned in the desk review, indigenous populations in Guatemala have significant social, economic, and health disparities compared with the general population. They are more likely to live in rural areas, to be poor, and have stronger cultural norms around gender and sex which makes them much less likely to have comprehensive information about Zika and utilizing Zika prevention measures. For example, one man explained that indigenous communities are more resistant to condom use:

“There are communities of chortís [indigenous] descent, there they refuse to talk about sex education, about condoms. In the villages of the mountain you cannot. The woman does not take condoms, or they just throw them away. We are far from addressing this taboo.” (Man, Zacapa)

The departments where the FDGs took place are in the Eastern side of the country, where indigenous population is low, therefore few indigenous women participated in FGDs during the gender analysis. They were much more reserved and hesitant to contribute to the conversation compared to other participants. This was probably due to cultural timidity and the language barrier, since they spoke an indigenous language and minimal Spanish. This highlights the need to organize counseling and other informative sessions about Zika in their native language.
**H. Changes implemented by ASSIST to address gender issues limiting condom use during pregnancy**

In health facilities where ASSIST has activities, pregnant women are routinely offered condoms as a routine part of ANC. To help improve condom acceptance and use among pregnant women, many of these facilities have already started implementing strategies meant to address gender issues that limit health outcomes in Zika prevention.

1. Most facilities oriented pregnant women during ANC, beginning with a clear, comprehensive explanation of the consequences of Zika infection during pregnancy, transmission pathways, and prevention methods (highlighting condom use), using images and pictures (rotafolios) before they distribute condoms.

2. Some facilities distributed condoms to pregnant women in discrete envelopes to prevent stigma and reduce shame. Many providers followed up to ask if the condoms were accepted by their partners and offered support in explaining it to their partners. Some providers also followed-up to check they needed more condoms at each subsequent visit.

   “Before there was a clinic after the consultation to deliver it, but not now. It embarrassed some women to be given condoms in front of others so now we deliver condoms in an envelope (five condoms with five packets of lube). It’s all according to their demand, if they ask for more, they are given more.” (Health provider, Zacapa)

3. Some facilities distributed lubricant along with condoms, to reduce the risk of breakage and physical discomfort with condom use.

   “At first, they complained of irritation, then an agreement was made with the clinic and now we also provide lubricant to resolve this complaint.” (Health provider, Teculután)

4. Many providers discussed having “checks for learning” to make sure the women fully understood all important information by having women explain the important points back to them.

   “After the doctor has talked with them [the pregnant woman], I ask them what he said to check if they understood.” (Health provider, Zacapa)

5. Some facilities taught women about correct condom use by demonstrating on a model and then having them practice on it.

6. After noticing that women were not waiting after their ANC visit to pick up condoms from the pharmacy since it was already closed, one hospital rearranged the timing and order of the appointments. They ensured women had adequate time to be sensitized about Zika and then had the nurse accompany them to the pharmacy after their appointment finished.

7. Some providers offered condoms to all women, including those who were unmarried or were not in a monogamous relationship.

   "We always recommend condoms, even when she is a single mother. The doctor always prescribes a dozen condoms, or less if she already has them. We want them to always have condoms." (Health provider, Teculután)

8. In one facility, health providers reported that they encourage women to bring their partners into the next appointment if they were opposed to condom use and needed support explaining to them why. This is now being scaled up across health facilities where ASSIST works.

One health provider shared an anecdote about a man who initially was jealous and thought his partner was cheating on him when she proposed condom use. However, after he accompanied
her to the health facility and heard about Zika and condom use from the nurses and saw videos of the consequences of Zika and microcephaly, he understood their importance.

“One man said to his woman out of jealousy, ‘Are you with another? Come on!’ So, he accompanied her to our health presentation and saw the videos that we put in the waiting room. He then agreed, and said he was going to try to use condoms.” (Health Provider, Zacapa).

However, providers reported that in general men were not responsive and only half of the women brought their partners in.

Even if several gender gaps persist, these are good practices that need to be recognized, monitored and, if successful, expanded.

VII. CONCLUSION

The interviews and FGDs conducted during this assessment showed that few people have complete information about Zika, modes of transmission, and how to prevent infection. It is critical to address this education gap, because knowledge and awareness are prerequisites to generate changes in attitudes and behaviors. Most people had heard of Zika from the radio or the television but did not have comprehensive information. Women were more likely to know more about Zika from a “charla” or a poster at a health center. One of the primary misconceptions is about the asymptomatic nature of Zika, where people believed that if they did not feel sick, then they were not infected.

Due to machismo, women may have a limited decision-making power about condom use; nevertheless, both men and women expressed barriers in access. The two primary barriers in accessing condoms cited by both men and women were shame and cost when there were stock-out at health facilities. While men feel some shame purchasing condoms or asking for condoms from female providers, women feel the shame more acutely. Cost remains an issue when there are stock-outs at the health facilities. For the special case of pregnant women, many facilities are distributing condoms to women during ANC appointments in innovative ways. Best practices include giving condoms and lubricant in discrete packaging, using visuals to explain Zika and condoms use including a condom demonstration, check for learning with the women after her consultation, and rearranging schedules so it’s easier for pregnant women to take condoms. While there is incredible progress being made, some challenges remain including women entering ANC for the first time late in their pregnancy or receiving care from other providers (private, midwives, etc.) that do not give comprehensive information on Zika, lack of follow-up for condom use, and overburdening of facility staff.

The primary issues that men have with condoms is that they are uncomfortable and cause irritation and loss of sexual satisfaction. While women also are concerned with discomfort and irritation, they also have misperception that they cause infection (particularly for babies if the woman is pregnant). Women also grapple with imbalanced power relations with partners, limited decision-making power over their sexual and reproductive health, and the fear of an aggressive or violent reaction from a partner, which continue to be a barrier for condom use. Women not only fear physical violence, but also psychological violence such as threats of abandonment. Both men and women emphasized that condoms are not usually used in committed relationships, and therefore not used during pregnancy, because it is a sign of trust not to use them.

Women use several strategies to approach condom use with their partners including finding the “ideal time” to talk with him, to taking a hard-lined approach (“no condom, no sex”). Other women talked about leveraging allies, such their mother, to help talk with their partner about using condoms, and others talked about inviting their partners into the clinic to talk directly with the doctor. Several women also expressed interest in female condoms as another option.
Ultimately, health facilities with ASSIST activities are making incredible strides to improve Zika prevention practices by implementing innovative and creative changes to educate pregnant women about Zika and promote condom use among couples. However, there are still opportunities for gender-sensitive programming to be implemented to improve health outcomes related to Zika, particularly in promoting condom use during pregnancy, mitigating GBV in the context of condom negotiation, and involving men in Zika response activities.

**VIII. RECOMMENDATIONS AND WAY FORWARD**

To reduce rates of Zika infection and the cases of children born with CSaZ, it is essential to address key barriers identified throughout this assessment at the health facility and community levels.

**Ensure access to contraceptives (especially condoms), quality of care, privacy, and confidentiality.**

- Guarantee availability of and access to a full range of high-quality, modern, voluntary, and user-friendly contraceptive methods, including emergency contraception, for women, girls, men, boys, and adolescents of both sexes to prevent unplanned pregnancy.
- Ensure female condoms are available for women, particularly pregnant women, to give them more choice and power over preventing unplanned pregnancy and STIs, including Zika.
- Strengthen health providers’ knowledge working in sexual and reproductive health about the relevant laws in Guatemala, norms, and protocols that guarantee the right to access to preconception counseling and modern contraception methods, including to adolescents.
- Sensitize health providers working in sexual and reproductive health on how to provide gender sensitive, stigma-free, confidential, and human right-based health services.

**Strengthen communication about Zika and ensure there are materials that target pregnant women, men, and target populations like youth and indigenous people.**

- Utilize images, photos, and videos when communicating about Zika to make them easier to understand, especially for illiterate populations, and to create a lasting impression.
- Utilize images and photos featuring men, women, youth and indigenous people engaging in Zika prevention activities.
- Approach indigenous populations in their own language.
- Ensure that Zika communications materials emphasize sexual transmission, not just vector-borne transmission, and the asymptomatic nature of Zika – not feeling sick does not mean they cannot infect others.
- Distribute promotional materials (posters, flyers, brochures etc.) not only at health facilities, but in places where populations such as men and youth may frequent (places of work, schools, recreational facilities, community spaces etc.)
- Consider online communication through social media (Facebook, Whatsapp, videos, etc.) to reach younger populations.
- Continue to utilize radio and television as media to disseminate information about Zika.
- Consider outreach to schools, for materials and health presentations, to reach youth.
- Translate key messages in different languages used by the population of Guatemala.
- Strengthen the campaigns for condom use to prevent sexually transmitted Zika and Congenital Syndrome associated with Zika.

**Leverage ANC appointments to promote condom use during pregnancy.**

- Health providers should focus on strategies to encourage early enrollment in ANC.
- Health providers should provide both condoms and lubricants in a discrete manner, such as an unmarked envelope.
• Use visuals and/or demonstrations when explaining Zika transmission and prevention methods including condom use.
• Employ "checks for learning" or tests to confirm that the woman understands important information of Zika transmission and prevention.
• If the woman consents, invite her partner to attend ANC appointments with her or offer to explain the importance of condom use to him.
• Give the pregnant women information to take home so she can review or share it with her partner.
• Promote an ANC schedule adapted to the needs of men so that they can attend with their partners.

Conduct comprehensive sexual and gender-based violence prevention and response activities.

• Ensure that women are screened for IPV during ANC and offered support and/or referred to appropriate social, psychological, and legal services.
• Talk about IPV in ANC counseling to raise awareness.
• When distributing condoms during ANC, be mindful about how their partner may react. Give tips for condom negotiation strategies or offer to explain the importance of condom use during pregnancy to their partner.
• Give health presentations in the community about GBV to raise awareness, particularly with men.
• Create promotional materials (posters, flyers, brochures etc.) to address GBV in the context of Zika and condom negotiation.
• Sensitize and train all health staff, not only those involved in sexual and reproductive health, on Zika and GBV prevention.

Engage men in Zika response activities (taken from participant’s recommendation via the prioritization activity, although many health facilities where ASSIST works are already carrying out these activities).

• Focus on reaching men with comprehensive information about Zika prevention strategies (including condoms), but also with strategies for respectful and non-violent communication with their partners.
• If the pregnant woman consents, invite men to participate in ANC counseling and promote active participation during the appointment.
• Work with health personnel to sensitize them on the importance of men’s participation and learning about the disease.
• Distribute materials about Zika and condom use for pregnant women to take home to their partners.
• Engage men that are already in the waiting room (to accompany their partner or otherwise) to provide counseling or presentations about Zika prevention, family planning, masculinity etc.
• Distribute condoms to men, together with comprehensive information about the importance of its use to prevent Zika and other STI and the proper, correct and consistent use.
• When possible, ensure promoters and/or providers of both sexes are available for education and counseling.
• Engage and sensitize community leaders such as COCODES about Zika, condom use, and the importance of male engagement.
• Engage and sensitize midwives to also speak with male partners.
• Reach men through presentations or promotional materials at their place of work, in recreational spaces, in schools, etc.
REFERENCES


50. Interview with OSAR Juvenil, June 20, 2018. Interview with Santa Cruz de Quiche Health Directorate, June 22, 2018
APPENDICES

Appendix I: Focus Group Discussion Guide

GUÍA DE PREGUNTAS PARA EL GRUPO FOCAL
IDENTIFICACIÓN DE ASUNTOS DE GÉNERO QUE AFECTAN EL USO DEL CONDÓN ENTRE PAREJAS Y ESPECIALMENTE DURANTE EL EMBARAZO PARA EVITAR LA TRANSMISIÓN DEL ZIKA

Propuesta preparada por WI-HER, LLC

PREGUNTAS INTRODUCTORIAS RELACIONADAS CON ZIKV

1. ¿Alguien de ustedes podría hablarnos sobre las posibles consecuencias de tener Zika durante el embarazo?
2. ¿Cómo creen ustedes que se puede prevenir la transmisión sexual del Zika?

IDENTIFICACIÓN DE ASUNTOS DE GÉNERO QUE AFECTAN EL USO DEL CONDÓN ENTRE PAREJAS Y ESPECIALMENTE DURANTE EL EMBARAZO

3. ¿Ustedes creen que es fácil conseguir condones? ¿Dónde?
4. Desde su punto de vista: ¿qué dificultades puede encontrar una persona casada o en una relación estable que vaya a un servicio de salud a pedir condones?
   - Indagar sobre: críticas por parte de la familia y comunidad; falta privacidad en los servicios; actitud de proveedores/as.
   - Averiguar si hay respuestas diferentes sobre las dificultades que enfrentan hombres, mujeres, adolescentes de ambos sexos, mujeres embarazadas con o sin pareja)
5. En su opinión: ¿en qué ocasiones se usan los condones? (escuchar si citan embarazo y Zika)
6. Desde su punto de vista: ¿Las parejas usan condones durante el embarazo? Explique porque no o porque sí.
7. En base a sus experiencias o las experiencias de personas a ustedes cercanas ¿En los servicios de salud se recomienda usar condones a las mujeres embarazadas?
8. En su opinión: ¿Cuáles pueden ser las reacciones de una mujer embarazada cuando el personal de salud le recomienda usar condón? (lo acepta, lo entiende)
9. ¿Ustedes creen que para una mujer sería fácil poner en práctica esta recomendación? ¿O ustedes creen que podrían encontrarse con algunas dificultades? ¿Cuáles?

Si pertinente:

10. En su opinión: ¿Porque las personas se resisten a usar condones durante el embarazo? Quienes tienen más resistencias, las mujeres embarazadas, sus parejas, ¿o igual?
11. En su opinión ¿Cuáles podrían ser las principales preocupaciones de una mujer embarazada a la hora de proponer el uso del condón a su pareja? ¿Y cuáles podrían ser las preocupaciones de un hombre a la hora de proponer usar el condón a la pareja embarazada?
12. En su opinión: ¿Cuáles podrían ser las reacciones de un hombre cuando su pareja embarazada le pide usar el condón? / ¿Cómo podría reaccionar la mujer embarazada cuando su pareja le piden usar condón? (escuchar a que respuestas y/o reacciones violentas se refieren)
13. En su opinión, ¿Cómo una mujer podría convencer a su pareja a usar condones durante el embarazo, si al principio ella no está de acuerdo? ¿Cómo un hombre podría convencer su pareja a usar condones durante el embarazo, si al principio ella no está de acuerdo? (escuchar si se refieren a la forma de decirlo, al momento, a la explicación, o a involucrar personas influyentes)
14. Desde su perspectiva: ¿quién es que toma la decisión final sobre el uso o no uso del condón durante el embarazo?
15. ¿Considera que la asistencia de los hombres en las consultas de atención prenatal podría ser útil?
16. Desde su perspectiva ¿Cómo pueden sentirse los hombres que asisten en la consulta prenatal? ¿Hay algo que les podría hacer sentir más o menos incomodos? (ej. actitud proveedores, sala de espera, ambiente)

17. Desde su perspectiva: ¿Quiénes podrían convencer una de las dos parejas que esté en contra el uso del condón sobre la importancia de usarlo y con qué argumentos?

- Aparte del médico, ¿hay alguien de la familia, de la comunidad o de otro entorno de socialización que podría influir en estos tipos de decisiones?
- ESCRIBIR LAS PERSONAS CON MAYOR INFLUENCIA EN UN PAPELÓGRAFO, PARA LUEGO VOTAR POR SUBIDA DE MANO LAS PERSONAS CON MÁS INFLUENCIA

18. En base a su experiencia o en general, ¿una pareja durante un embarazo tiene relaciones sexuales con la misma frecuencia de cuando no hay el embarazo? ¿Más o menos?
- ¿Generalmente, hay cambios en el deseo sexual del hombre? ¿Incremento o disminución?
- ¿Generalmente, hay cambios en el deseo sexual de la mujer? ¿Incremento o disminución? ¿Es diferente según el trimestre de embarazo?
- ¿Las mujeres tienen alguna preocupación en tener relaciones sexuales durante el embarazo?
- ¿Los hombres tienen alguna preocupación en tener relaciones sexuales durante el embarazo?

_Hay alguna pregunta que ustedes quieran hacer?

¡Gracias por tomarse el tiempo de hablar con nosotras!
Appendix II: Key Informant Interview Guide
GUÍA PARA ENTREVISTAS A PROVEEDORES DE SERVICIOS
Propuesta preparada por WI-HER, LLC

Ubicación: ______________________  Fecha: _______________________
Institución: _______________________________________________________
Nombre persona entrevistada: ________________________________  Sexo: ___________
Puesto que ocupa: _________________________________________________

Introducción:
Presentación de los objetivos de la entrevista y tiempo estimado, agradecimiento por su disponibilidad.

Preguntas:

1. ¿En qué circunstancias se propone el uso de condones a mujeres embarazadas? ¿Se les propone el uso de condón, aunque no tengan pareja?

2. ¿Cómo reaccionan generalmente las mujeres embarazadas cuando se les propone usar los condones?
   - ¿Lo aceptan o no?,
   - ¿Cuáles son sus preocupaciones principales?
   - ¿Expresan tener inquietudes acerca de las reacciones de su pareja u otras consecuencias?
   - ¿Demuestra temer los comentarios de otras personas de la familia o de la comunidad?
   - ¿Hay dificultades en entender porque lo deben usar si están embarazadas?
   - ¿Se los llevan o no?

3. En su opinión ¿hay más resistencia a usar el condón durante el embarazo por parte de la mujer embarazada, del hombre o de ambas partes?

4. Según su experiencia, ¿las mujeres embarazadas que reciben los condones, los usan? Explique.

5. En base a su experiencia y a los relatos de las usuarias ¿Cuáles son los principales problemas que enfrenta una mujer embarazada al proponer el uso del condón a su pareja?
   Por ejemplo:
   - Incapacidad o temor en explicar a la pareja porque deberían usarlo
   - Incomprensión por parte del hombre de la razón porque deben usarlo
   - Rechazo incondicional al uso
   - Reacciones violentas de la pareja
   - Amenaza de romper la relación
   - Amenaza de infidelidad
   - Miedo a fomentar la infidelidad
   - Miedo a ser acusada de infidelidad
   - Temor a las opiniones ajenas

6. ¿Cuáles estrategias que usted adopta para promover el uso de condones en parejas durante un embarazo les resultan efectivas?

7. En su opinión, ¿qué más se podría hacer para aumentar el uso de condón por parte de mujeres en edad reproductiva y específicamente durante el embarazo?
8. En el caso que las parejas acudan: ¿Cómo es la reacción del hombre cuando se recomienda el uso del condón? Desde su perspectiva: ¿proponer el uso del condón a la pareja a la presencia de las dos partes aumenta la aceptación a su uso?

9. ¿Usted invita a las parejas de mujeres embarazadas a asistir a la consejería y a los servicios de Atención Prenatal? ¿Cuáles son sus estrategias para motivar los hombres a participar? ¿Qué porcentaje de hombres usted estima que acompañen a las parejas embarazadas?

10. ¿Cuáles son los principales obstáculos que enfrentan los hombres a acompañar sus parejas en consultas de Atención Prenatal? (Notas para entrevistadora - por ejemplo: falta de disponibilidad de tiempo, normas de género, ambiente poco amigable, sesgos por parte de proveedores, etc.)

11. En base a su experiencia y a los relatos de las usuarias, durante el embarazo varía la frecuencia de relaciones sexuales entre la pareja? ¿Hay algún trimestre en el cual aumenta y otro en el cual disminuye? ¿Cuál es su opinión al respecto? (Notas para entrevistadora - por ejemplo: miedos de hacer daño al bebé; variación deseo de mujeres o hombres, etc.)

12. ¿En este servicio se atienden con consejería y asesoría en anticoncepción a personas adolescentes? ¿Cuál es la reacción de los proveedores y las proveedoras cuando adolescentes solicitan condones? ¿Hay reacciones diferentes de los proveedores y de las proveedoras según el sexo de la persona adolescente?

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