The Gender Dimension in the Prevention and Management of Avian Flu and Dengue in Selected Countries in Southeast Asia

Dr. Trinidad Osteria
Outline of Presentation

1. Research Context
   - Framework
   - Methodology
   - Findings

2. Challenges and lessons from the experience

3. Translation of research results into IEC/BCC and policy mainstreaming inputs
In April, 2008, the ASEAN Plus Three Programme embarked on a multiphasic initiative aimed at enhancing policies for the development of gender specific prevention and control strategies dealing with avian flu and dengue in Cambodia, Indonesia and Viet Nam.
The programme was divided into three phases:

<table>
<thead>
<tr>
<th>Phases</th>
<th>Outputs</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Generation of information on gender dimensions of dengue and avian flu occurrence in Cambodia, Indonesia, and Viet Nam;</td>
<td>Research report on the gender issues related to dengue and avian flu</td>
</tr>
<tr>
<td>• Dissemination of research results to ASEAN Plus Three Countries; and</td>
<td>Report on ASEAN+3 conference on Gender Issues in Emerging Infectious Diseases; Fact sheet; Transforming Research Results into IEC and Gender Mainstreaming Inputs</td>
</tr>
<tr>
<td>• Development of a set of recommendations to ASEAN Plus Three Countries on ways of integrating gender issues in dengue and avian flu prevention and control programmes.</td>
<td>Ministry of Health officials’ recommendations on IEC/BCC and Mainstreaming Strategies in Infectious Diseases Management drawn from the ASEAN+3 Regional Workshop</td>
</tr>
</tbody>
</table>
Transforming Research Results into IEC/BCC and Gender Mainstreaming Inputs
FACT SHEET
on
Gender Concerns Related to Avian Flu and Dengue in Cambodia, Indonesia and Viet Nam

Transforming Research into Health Policy Inputs: Mainstreaming Gender in Health Programs in ASEAN

Keynote paper presented during the ASEAN Plus Three Regional Workshop on Gender and Social Issues Related to Emerging Infectious Diseases, Luang Prabang, Lao PDR, 13-14 October 2009
Objectives

The research which represented the first phase of the programme intended to:

1. Understand the sex differentials in risk exposure, knowledge of and attitude toward avian flu and dengue and cultural reaction to the diseases;

2. Determine the differential perceptions of men and women on causation, manifestation and management of the diseases;
3. Elicit the sources of information and management related to avian flu and dengue by sex of the respondents;
4. Delineate the illness experience of family members by sex;
5. Assess the sex differentials in health seeking behaviour;
6. Know the social impact of the illness on male and female family members; and
7. Provide recommendations for gender sensitive dengue and avian flu policies and programmes.
Figure 1. Research Framework

**Differential Vulnerability and Risks**
- Gender Roles (Productive and HH Activities)
- Gender Power Relations
- Children’s Play

**Differentials in Illness Pattern**
- Manifestations
- Causation
- Intensity
- Duration

**Social Impact**
- Caregiving
- Substitution for Patient’s Economic and Household Roles
- Stigmatization
- Indebtedness

**Differentials in Management**
- Home Management
- Interval between Onset and External Consultation
- Sex of Provider
- External Management
- Cost

**Differentials in Knowledge and Utilization of Health Services**
- Services Known and Sought
- Perceived Quality of Services Received
- Attitude toward Provider
- Services to be sought when avian flu/dengue occurs

**Outcome**
- Survival
- Death
**Sampling Selection**

With budgetary and time constraints, a sample size of 60 respondents (30 males and 30 females) was drawn from each study site. After the household listing, systematic sampling was adopted where female and male respondents were chosen using a random start. Sampling was done with substitution to ensure that the minimum size is achieved.
Regional Workshops

Two regional workshops were convened. The objectives of the research were reiterated and the protocol was discussed in the first workshop held on April 21-23, 2008 in Vietnam.
A folder was distributed that contained the following:

- Framework and Objectives of the Research
- Questions and Answers on Avian Flu
- Questions and Answers on Dengue Fever
- Questionnaire on Gender Dimension of the Transmission, Prevention and Management of Avian Influenza
- How to Fill Out the Household Questionnaire on Gender Dimension of Avian Influenza
- Questionnaire on Gender Dimension of the Transmission, Prevention and Management of Dengue Fever
- How to Fill Out the Household Questionnaire on Gender Dimension of Dengue

Aside from what were contained in the folder, discussions focused on the sampling methodology, time lining and budget. The revised questionnaires were sent to the country teams together with the coding manual and prescribed tabulations based on research objectives.
In the second workshop which was held five months later (September 22-26, 2008) in Manila, the country teams brought their data sets which were reviewed, retabulated, graphically presented and analyzed to arrive at conclusions regarding the gender dimension of the specific diseases.

The presentation was largely tabular and graphical with corresponding analysis of the data.
Avian Flu
Examples of Graphical Presentations

**Gender differentials in exposure to risks related to poultry raising**

![Bar chart showing percentage distribution of household members by sex and economic risks related to avian flu, Cambodia 2008.](chart.png)

### Figure 7. Percentage distribution of household members by sex and economic risks related to avian flu, Cambodia 2008

- **Feeding chicken**: Male 35.2%, Female 64.8%
- **Cleaning the yard**: Male 21.6%, Female 78.4%
- **Handling bird droppings**: Male 35.7%, Female 64.3%
- **Collecting eggs**: Male 39.4%, Female 60.6%
- **Slaughtering poultry**: Male 65%, Female 35%
- **Removing feathers**: Male 57.2%, Female 42.8%
- **Bringing poultry to market**: Male 12.5%, Female 87.5%

**RISKY ECONOMIC ACTIVITIES**

- Male
- Female
Figure 15. Percentage distribution of household members by sex and household risks related to avian flu, Viet Nam 2008
Gender differentials in children’s play

Figure 16. Percentage distribution of children by sex and play, Cambodia 2008

<table>
<thead>
<tr>
<th>Activity</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Playing with birds/poultry</td>
<td>77.8</td>
<td>22.2</td>
</tr>
<tr>
<td>Playing in rice paddies, swamps, and marshes where migratory or wild</td>
<td>62.5</td>
<td>37.5</td>
</tr>
<tr>
<td>birds are found</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Playing in places where poultry is slaughtered</td>
<td>60.0</td>
<td>40.0</td>
</tr>
<tr>
<td>Playing in places where birds usually stay</td>
<td>54.5</td>
<td>45.5</td>
</tr>
</tbody>
</table>

CHILDREN'S PLAY
Gender power relations

Figure 19. Percentage distribution of household members with family decision power by sex, Indonesia 2008

<table>
<thead>
<tr>
<th>Family Decision Power</th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>Keeping money of household</td>
<td>62.8%</td>
<td>37.2%</td>
</tr>
<tr>
<td>Budgeting family income</td>
<td>63.6%</td>
<td>36.4%</td>
</tr>
<tr>
<td>Deciding on purchases for daily needs</td>
<td>78.3%</td>
<td>21.7%</td>
</tr>
<tr>
<td>Deciding on health care of family members</td>
<td>59.0%</td>
<td>41.0%</td>
</tr>
<tr>
<td>Taking care of sick family members</td>
<td>81.7%</td>
<td>18.3%</td>
</tr>
</tbody>
</table>
Figure 22. Percentage distribution of respondents by sex and knowledge of modes of transmission of avian flu, Indonesia 2008.

- **Know at least one mode of transmission**: 60.0% Male, 76.7% Female
- **Contact with feces of infected birds**: 40.0% Male, 23.3% Female
- **Contact with surfaces contaminated by blood, flesh, feces and other secretions of infected birds**: 23.3% Male, 30.0% Female
- **Contact with flesh of infected birds**: 3.3% Male, 16.7% Female
Figure 23. Percentage distribution of respondents by sex and knowledge of modes of transmission of avian flu, Viet Nam 2008

- **Know at least one mode of transmission:**
  - Male: 80.6%
  - Female: 87.1%

- **Contact with feathers of infected birds:**
  - Male: 48.4%
  - Female: 58.1%

- **Inhaling droplets of infected birds:**
  - Male: 45.2%
  - Female: 35.5%

- **Contact with feces of infected birds:**
  - Male: 35.5%
  - Female: 22.6%
Knowledge of signs and symptoms of avian flu

Figure 24. Percentage distribution of respondents by sex and knowledge of signs and symptoms of avian flu, Cambodia 2008

- **Know at least one sign/symptom**
  - Male: 64.5%
  - Female: 51.7%

- **Fever**
  - Male: 64.5%
  - Female: 51.7%

- **Shortness of breath**
  - Male: 32.3%
  - Female: 24.1%
Knowledge of ways to avoid avian flu

Figure 27. Percentage distribution of respondents by sex and knowledge of ways to avoid avian flu, Cambodia 2008
Figure 35. Percentage distribution of respondents by sex and sources of avian flu information, Viet Nam 2008
Figure 40. Percentage distribution of respondents by sex and content of avian flu information from television, Viet Nam 2008.
Sex differentials in utilization of health care facilities

Health care facilities visited

Figure 41. Percentage distribution of respondents by sex and health care facilities visited, Cambodia 2008
Figure 42. Percentage distribution of respondents by sex and health care facilities visited, Indonesia 2008
Figure 46. Percentage distribution of respondents by sex and health care facilities visited, Viet Nam 2008
Table 4. Gender differentials in exposure to risks related to poultry raising

<table>
<thead>
<tr>
<th>EXPOSURE</th>
<th>MORE MALES</th>
<th>MORE FEMALES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exposure to Economic Activities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Slaughtering poultry</td>
<td>C</td>
<td>-</td>
</tr>
<tr>
<td>Removing feathers</td>
<td>C</td>
<td>-</td>
</tr>
<tr>
<td>Bringing poultry to market</td>
<td>-</td>
<td>C, V</td>
</tr>
<tr>
<td>Exposure to Activities related to Keeping Birds</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cleaning bird cages/yard</td>
<td>-</td>
<td>C, V</td>
</tr>
<tr>
<td>Feeding birds</td>
<td>-</td>
<td>C</td>
</tr>
<tr>
<td>Collecting bird droppings</td>
<td>-</td>
<td>C, V</td>
</tr>
</tbody>
</table>

C - Cambodia                                   V - Viet Nam
Table 5. Gender differentials in exposure to household risks related to Avian Flu

<table>
<thead>
<tr>
<th>HOUSEHOLD ACTIVITY</th>
<th>MORE MALES</th>
<th>MORE FEMALES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cooking family meals</td>
<td>-</td>
<td>C, I, V</td>
</tr>
<tr>
<td>Going to wet or live poultry market</td>
<td>-</td>
<td>C, I, V</td>
</tr>
<tr>
<td>Attending cockfights</td>
<td>V</td>
<td>-</td>
</tr>
</tbody>
</table>

C - Cambodia                              I - Indonesia                         V - Viet Nam
Table 6. Gender differentials in exposure to Avian Flu by children’s play

<table>
<thead>
<tr>
<th>CHILDREN’S PLAY</th>
<th>MORE MALES</th>
<th>MORE FEMALES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Playing with birds/poultry</td>
<td>C, V</td>
<td>-</td>
</tr>
<tr>
<td>Playing in the fields or rice paddies, swamps, marshes where migratory or wild birds are usually found</td>
<td>C, V</td>
<td>-</td>
</tr>
<tr>
<td>Playing in places where poultry is slaughtered</td>
<td>C, V</td>
<td>-</td>
</tr>
<tr>
<td>Playing in places where birds usually stay</td>
<td>C, V</td>
<td>-</td>
</tr>
</tbody>
</table>

C – Cambodia  V- Viet Nam
Table 7. Gender differentials in family dynamics related to home and health management

<table>
<thead>
<tr>
<th>FAMILY DYNAMICS</th>
<th>MORE MALES</th>
<th>MORE FEMALES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Keeping money of household</td>
<td>-</td>
<td>C, I, V</td>
</tr>
<tr>
<td>Budgeting family income</td>
<td>-</td>
<td>C, I, V</td>
</tr>
<tr>
<td>Deciding on purchases for daily needs</td>
<td>-</td>
<td>C, I, V</td>
</tr>
<tr>
<td>Deciding on health care of family</td>
<td>-</td>
<td>C, I, V</td>
</tr>
<tr>
<td>Taking care of sick family members</td>
<td>-</td>
<td>C, I, V</td>
</tr>
</tbody>
</table>

C - Cambodia  I - Indonesia  V- Viet Nam
### Table 8. Gender differentials in knowledge on Avian Flu

<table>
<thead>
<tr>
<th>KNOWLEDGE</th>
<th>MORE MALES</th>
<th>MORE FEMALES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Know at least one mode of transmission</td>
<td>-</td>
<td>I, C</td>
</tr>
<tr>
<td>Contact with flesh of infected birds</td>
<td>-</td>
<td>I</td>
</tr>
<tr>
<td>Contact with feathers of infected birds</td>
<td>-</td>
<td>V, I</td>
</tr>
<tr>
<td>Contact with feces of infected birds</td>
<td>I</td>
<td>-</td>
</tr>
<tr>
<td>Contact with surfaces contaminated by blood, flesh, feces and other secretions of infected birds</td>
<td>C</td>
<td>I</td>
</tr>
<tr>
<td>Inhaling droplets from infected birds</td>
<td>V</td>
<td>-</td>
</tr>
<tr>
<td>Know at least one sign/symptom of avian flu</td>
<td>C</td>
<td>V</td>
</tr>
<tr>
<td>Know ways to avoid avian flu</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hand washing</td>
<td>C</td>
<td>-</td>
</tr>
<tr>
<td>Carefully washing raw meat and poultry from the market</td>
<td>V</td>
<td>-</td>
</tr>
<tr>
<td>Cleaning surfaces which have been contaminated by raw poultry meat or blood</td>
<td>V</td>
<td>C</td>
</tr>
<tr>
<td>Avoiding cockfights</td>
<td>C</td>
<td>-</td>
</tr>
</tbody>
</table>

C - Cambodia  I - Indonesia  V- Viet Nam
**Table 12. Illness experience, management and outcome of avian flu, Cambodia, Indonesia and Viet Nam, 2008**

<table>
<thead>
<tr>
<th></th>
<th>CAMBODIA</th>
<th>INDONESIA</th>
<th>VIET NAM</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sex</strong></td>
<td>MALE</td>
<td>MALE</td>
<td>MALE</td>
</tr>
<tr>
<td><strong>Age (Years)</strong></td>
<td>28</td>
<td>10</td>
<td>12</td>
</tr>
<tr>
<td><strong>Exposure to economic risks</strong></td>
<td>Slaughtered poultry</td>
<td>Raised turkey</td>
<td>Raised chicken</td>
</tr>
<tr>
<td></td>
<td>Removed feathers</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Exposure to household risks</strong></td>
<td>Cooked family meals</td>
<td>Cooked family meals</td>
<td>Cooked family meals</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Went to wet/live market</td>
<td></td>
</tr>
<tr>
<td><strong>Exposure to risks related to keeping of birds</strong></td>
<td>Cleaned cages/yard, Fed chicken</td>
<td>Cleaned yard, Fed turkey, Collected droppings</td>
<td>Do not know</td>
</tr>
<tr>
<td></td>
<td>CAMBODIA</td>
<td>INDONESIA</td>
<td>VIET NAM</td>
</tr>
<tr>
<td>----------------------</td>
<td>---------------------------</td>
<td>-----------------------------------------------</td>
<td>-----------------------------------------</td>
</tr>
<tr>
<td><strong>Mode of transmission</strong></td>
<td>Do not know</td>
<td>Possibilities: Passed by neighbouring village with infected poultry on way to school Played in the neighbouring village with infected birds Ate grilled chicken (cooked outside) a day before symptoms appeared</td>
<td>Inhaled feather particles</td>
</tr>
<tr>
<td><strong>Signs and symptoms manifested</strong></td>
<td>Fever Shortness of breath</td>
<td>Cough Shortness of breath Bloody sputum</td>
<td>Fever Cough Shortness of breath Chest pain</td>
</tr>
<tr>
<td></td>
<td>CAMBODIA</td>
<td>INDONESIA</td>
<td>VIET NAM</td>
</tr>
<tr>
<td>----------------------</td>
<td>-----------------------------------</td>
<td>----------------------------------</td>
<td>-----------------------------------</td>
</tr>
<tr>
<td><strong>Duration of illness</strong></td>
<td>About a week</td>
<td>2 weeks</td>
<td>About 2 weeks</td>
</tr>
<tr>
<td><strong>Home management</strong></td>
<td>“Coined” skin</td>
<td>Over-the-counter flu medication</td>
<td>Over-the-counter flu medication</td>
</tr>
<tr>
<td><strong>Outside consultation</strong></td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Timing of consultation</strong></td>
<td>A few days after onset of symptoms</td>
<td>Sometime after appearance of signs and symptoms</td>
<td>A few days after onset of symptoms</td>
</tr>
<tr>
<td><strong>Type of health facility consulted</strong></td>
<td>Public Sector Central hospital (National Hospital, Phnom Penh)</td>
<td>Central hospital Private clinic</td>
<td>Public sector Health center Provincial hospital Central hospital</td>
</tr>
<tr>
<td><strong>Management in health facility</strong></td>
<td>Medication</td>
<td>Medication</td>
<td>Medication</td>
</tr>
<tr>
<td><strong>Outcome</strong></td>
<td>Death</td>
<td>Death</td>
<td>Death</td>
</tr>
</tbody>
</table>
Dengue
Exposure to dengue by household risks

Figure 58. Percentage distribution of household members by sex and economic risks related to dengue transmission, Indonesia 2008
Figure 60. Percentage distribution of household members by sex and household risks, Cambodia 2008

- **Washing clothes**: Male 18.7%, Female 81.3%
- **Cleaning house**: Male 19.3%, Female 80.7%
- **Cleaning yard**: Male 22.0%, Female 78.0%
- **Cleaning garage**: Male 27.3%, Female 72.7%
- **Cleaning roof gutter**: Male 68.4%, Female 31.6%
Exposure to dengue by children’s play

Figure 63. Percentage distribution of children by sex and play areas, Cambodia 2008

- Near junkshops/vulcanizing shops: Male 75.0%, Female 25.0%
- Near waterforms: Male 63.0%, Female 37.0%
- Outside the house around 7-8 am and/or 5-6 pm: Male 58.7%, Female 41.3%
Figure 103. Percentage distribution of household members by sex and social impact of dengue on family members, Cambodia 2008

- Accompanied sick member to health facility: Male 22.9%, Female 77.1%
- Assumed roles and responsibilities of sick member: Male 26.7%, Female 73.3%
- Stayed with sick member in the hospital: Male 27.9%, Female 72.1%
- Cared for sick member in the home: Male 40.3%, Female 59.7%
- Volunteered to give blood for transfusion: Male 51.0%, Female 49.0%

ROLES AND RESPONSIBILITIES

- Male
- Female
Figure 104. Percentage distribution of household members by sex and social impact of dengue on family members, Indonesia 2008

<table>
<thead>
<tr>
<th>ROLES AND RESPONSIBILITIES</th>
<th>PERCENTAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assumed roles and responsibilities of sick member</td>
<td>100.0</td>
</tr>
<tr>
<td>Volunteered to give blood for transfusion</td>
<td>100.0</td>
</tr>
<tr>
<td>Cared for sick member in home</td>
<td>36.4</td>
</tr>
<tr>
<td>Stayed with sick member in the hospital</td>
<td>40.0</td>
</tr>
<tr>
<td>Assumed roles and responsibilities of caregiver</td>
<td>40.0</td>
</tr>
<tr>
<td>Accompanied sick member to health facility</td>
<td>44.4</td>
</tr>
</tbody>
</table>

ROLE S AND RESPONSIBILITIES

male: blue  female: pink
Figure 105. Percentage distribution of household members by sex and social impact of dengue on family members, Viet Nam 2008

- Assumed roles and responsibilities of sick member: Male 67.6%, Female 32.4%
- Accompanied sick member to health facility: Male 52.5%, Female 47.5%
- Volunteered to give blood for transfusion: Male 46.9%, Female 53.1%
- Stayed with sick member in the hospital: Male 43.9%, Female 56.1%
- Cared for sick member at home: Male 35.6%, Female 64.4%
II. Multi-country Coordination Experience

Issues

1. Arriving at an appropriate research configuration
   - Need for a multi-country perspective encompassing both quantitative and qualitative analyses for meaningful cross-country comparison
   - Development of a regional research protocol that incorporates the various dimensions of the gender concerns in infectious diseases to ensure uniformity in data collection
Research Framework

Differential Vulnerability and Risks
- Gender Roles (Productive and HH Activities)
- Gender Power Relations
- Children’s Play

Differentials in Illness Pattern
- Manifestations
- Causation
- Intensity
- Duration

Social Impact
- Caregiving
- Substitution for Patient’s Economic and Household Roles
- Stigmatization
- Indebtedness

Differentials in Management
- Home Management
- Interval between Onset and External Consultation
- Sex of Provider
- External Management
- Cost

Differentials in Knowledge and Utilization of Health Services
- Services Known and Sought
- Perceived Quality of Services Received
- Attitude toward Provider
- Services to be sought when avian flu/dengue occurs

Outcome
- Survival
- Death
Preparation of pertinent materials for discussion in the organizational meeting. In this purview, the materials were:

a. Questions and answers regarding the two diseases (avian flu and dengue);
b. Objectives and framework of the research;
c. Draft questionnaires; and
d. Interviewer’s guide.

The following were sent to the project teams during the data collection phase:
e. Coding manual; and
f. Prescribed tables (according to the objectives set).
• Ensuring synchronization in project implementation through constant communication among the country teams, ASEAN Secretariat and gender consultant and the convening of two regional workshops. The first workshop dealt with the research design and implementation and the second with the presentation and analysis of information. These meetings imbued in the participating teams a sense of ownership of the project and provided the means for intercountry dialogues and comparison of results.

• Securing stakeholders’ involvement through the attendance by the division chiefs of the participating ministries in the presentation of results and their formal acceptance of the data for policy making and programming.

• Validation of data at the coordination level to ensure that tabulations are amenable to analysis.
Lessons from the Inter-country Study

1. The compilation, aggregation and review of literature on gender issues in infectious diseases provide the base for the formulation of a meaningful research framework.

2. A common understanding of the issues and concerns related to the infectious diseases is a prerequisite for conducting intercountry studies. Therefore, a document on the objectives, framework and methodology of research can guide the discussions and institute appropriate corrections, if needed.
3. The biggest challenge of the research is the development of a framework that encompasses the multifaceted gender concerns.

Precursor of the Framework: The WHO Perspective

**Figure. Framework on gender variables developed by the World Health Organization Special Programme for Research and Training in Tropical Diseases in Periago, Fescina and Pardo, Emerging Infectious Diseases, November, 2004.**

- Gender variables
  - Economic and productive activities
    - Sexual division of labor
    - Available substitute labor when ill
    - Economic policies affecting access to/use of services
    - Opportunity costs of action
    - Available cash
  - Social activities
    - Health roles in household
    - Cultural norms affecting exposure
    - Utilization of health services
    - Social stigma
  - Personal factors
    - Knowledge about disease
    - Beliefs and fears about disease
    - Provider-patient relationship
The ASEAN+3 Research Framework

Differential Vulnerability and Risks
- Gender Roles (Productive and HH Activities)
- Gender Power Relations
- Children's Play

Differentials in Illness Pattern
- Manifestations
- Causation
- Intensity
- Duration

Social Impact
- Caregiving
- Substitution for Patient's Economic and Household Roles
- Stigmatization
- Indebtedness

Differentials in Management
- Home Management
- Interval between Onset and External Consultation
- Sex of Provider
- External Management
- Cost

Differentials in Knowledge and Utilization of Health Services
- Services Known and Sought
- Perceived Quality of Services Received
- Attitude toward Provider
- Services to be sought when avian flu/dengue occurs

Outcome
- Survival
- Death
3. Capacity building in data collection and analysis is a major feature of this intercountry study with emphasis on collecting, processing, tabulating, presenting and analyzing data since the technical knowledge of the three project teams is uneven.

4. The active involvement of the Ministry of Health officials in the constituent countries from the first stage of data collection to research utilization focuses attention on critical issues and choices – a way of bridging research and policy.
5. The individual country reports provided the baseline information for country and gender specific programming and policymaking for EIDs.

6. Consolidation of research results of the three countries facilitated the assessment of commonalities and differences in gender associated exposure variables that are linked to illness occurrence and provided a small scale regional picture of the situation.
Group Discussions of the Ministry of Health Officials and International Agencies (in the Laos Conference, October 13-14, 2009)

Emerging Concerns related to Appropriate Advocacy IEC/ BCC and Mainstreaming Approaches

A. Advocacy
1. Paucity of sex disaggregated data in morbidity and mortality reports on emerging infectious diseases
2. Perception of gender as an externally imposed feminist issue which is understood as women’s concern alone
3. Inability to see emerging infectious diseases as having sex differentiated exposure, management and care giving burden. Initiatives are viewed as “one size fits all”
4. Current approach is largely biomedical focusing on the vector, the organism and medical management
5. Resource allocation for gender based initiatives is largely limited

B. IEC/BCC

1. Gender blindness in information dissemination - messages, materials, and modality of dissemination
2. Lack of technical capacity to develop gender and culture specific IEC/BCC approaches. The tendency is to draw from international manuals with no attempt toward application of guidelines to specific situations
3. Financial limitations in the conduct of IEC/BCC initiatives

4. Geographical constraints in reaching vulnerable groups

5. Lack of appropriate monitoring and evaluation mechanisms to assess success or failure of information dissemination and BCC
C. Gender Mainstreaming

1. Lack of data for identification of gender gaps in vulnerability, exposure, severity, management and caregiving in EIDs that can serve as basis for programming
2. Policies are not gender sensitive since focus has been largely biomedical
3. Lack of technical skills to incorporate gender concerns in policies and programs
4. Heavy work load of health staff to provide quality services to male and female clients – information, management, choices, technical competence, interpersonal relations, referrals and follow up

5. Monitoring and evaluation of gender sensitive programs in terms of selection of appropriate indicators, their retrieval and analysis.
Issues in BCC Design for Gender Sensitive EID Programming

Stages in behaviour change continuum

1. Unaware of Risks, Prevention and Management
   - Aware
   - Concerned
   - Knowledgeable
   - Motivated to change
   - Changed behaviour through risk preventive behaviour and use of appropriate services
   - Sustained behaviour change

Enabling factors

- Effective gender sensitive IEC/BCC strategies and appropriate contents
- Supportive environment through gender sensitive policies, programmes, and positive community values
- User-friendly and accessible services to men and women

Channels

- Mass media (TV, Radio)
- Community networks and traditional media
- Interpersonal/group communications etc.

Source: Revised from ILO/FHI; HIV/AIDS Behaviour Change Communication, 2006
Effective behaviour change communication can:

For the policymakers and programmers (Advocacy)

● increase knowledge of differential gender exposure and vulnerabilities in infectious diseases transmission, prevention and management;

● stimulate dialogues on gender concerns in infectious disease transmission, prevention and management. Why are there risk prone behaviours among males and females?; What account for the differential knowledge on EIDs and health services utilization among males and females?
• initiate effective response to outbreaks with consideration of male-female differentials in exposure, vulnerability and responsibility;

• promote essential change toward gender equitable development of information and services; and

• change attitude of health personnel by ensuring quality services equally to both male and female clients.
For the male and female population

- improve skills and sense of efficacy for changed behaviour toward risk prevention and management;
- reduce stigma and discrimination against people with EIDs independent of sex; and
- create a demand for gender sensitive information and services for EIDs.
Recommendations

1. Disaggregate reports on EID cases by sex.

The collection of routine statistics on morbidity and mortality by sex remains a challenge. Without this content in the number and incidence of infection, the information collected and the findings generated are inadequate for the development of responsive policies and programmes.

It is, therefore, important to develop the sex disaggregated health information system to inform policy and programme decision-making.
2. Generate political will for incorporating gender concerns in EID policies and programmes. Examples are:

Political will can be generated in different ways.

- Demonstrate the cost and effectiveness of gender equity in provision of services by linking the cost of gender focused information and services to the overall reduction of mortality and morbidity from EIDs.
- Publicize successful initiatives related to gender equity in access to information and services in EIDs. Success stories need a clear delineation of outcomes (in terms of number of cases and incidence).
3. Institute a gender-sensitive EID policy assessment.

- This will require a preliminary analysis of the context of current policies and a clear understanding of the gender issues involved in EID transmission and management.
- The conduct of a survey with accompanying qualitative analysis is a useful precondition to the assessment. The following questions are raised:
  - Do gender differences in daily activities expose women and men to risks related to EIDs? How are vulnerabilities differentiated according to economic and household activities?
● Are there gender differences in knowledge, perceptions of and attitudes toward the illnesses?

● How are existing gender differences in preventive actions and the use of services explained?

● To what extent is the illness experience in the family affecting the male and female household members?
How are health resources allocated? Do they take into account the different vulnerabilities and risks of women and men?

Can gender sensitive EID policies and programs have a differential impact on women, men and the population in general in terms of illness occurrence?
4. Incorporate gender issues in the EID focused planning process.

This requires an analysis of current EID policies and programmes in terms of their gender sensitivity.

- Are the sectoral objectives cognizant and explicit in terms of the differential risks and exposure of men and women?
- Are the initiatives considerate of these and the gender differentials in knowledge of and access to information and services?
Within the existing programmes and policies, how can these differential vulnerabilities be addressed?

How can the gender sensitive policy statements be clearly phrased and duly operationalized?

How can the programme implementation be monitored and evaluated? What indicators are needed and how can they be retrieved on a regular basis?
Steps in Mainstreaming Gender in EID Policies and Programmes

1. Problem analysis or needs assessment related to EIDs – Where are the gender gaps? (based on researches and existing statistics)

2. Assessment of gender sensitivity of EID policies and programmes (blindness, biases)

3. Advocating for mainstreaming gender into BCC/IEC, prevention and management programmes (through fact sheets, policy briefs, meetings, etc.)
4. Incorporation of gender concerns into EID policies – Where are the entry points? How could EID policy and programme goals be stated such that they can be adequately operationalized?

5. Training for gender sensitive EID policy and programme formulation and services delivery (for policymakers, programme planners and health service providers).

6. Operationalization of gender sensitive programmes – Through the preparation and implementation of operational guidelines, checklists, toolkits and training manuals.

8. Evaluation of impact of the programme on sex differentials in incidence and prevalence of EIDs.