



## Illustrative Gender Indicators for Emerging Infectious Diseases

### Sex-Disaggregated Indicators:

The prevalence of ID (by sex and age)

The incidence of ID (by sex and age)

The number treated for ID (by sex and age)

Mortality/morbidity from ID (by sex and age)

Knowledge, perceptions, and beliefs about ID & its symptoms (by sex)

Access to healthcare (by sex)

Health-seeking behavior and use of healthcare (by sex)

### Gender-Sensitive Indicators:

The incidence of ID among pregnant women

The percentage of currently married women who usually make decisions about their own healthcare, either by themselves or jointly with their husbands

The percentage of women who can make the decision to take a child to a health facility if the child is displaying ID symptoms

The percentage of men and women who hold gender-equitable beliefs (on the Gender Equitable Men [GEM] Scale) (Nanda, 2011)

The existence of a multisectoral ID strategy that includes gender, addressing the needs and vulnerabilities of men, women, girls, and boys

Laws, regulations, or policies that present obstacles to effective ID response for marginalized populations or vulnerable groups

# The Importance of Gender in Emerging Infectious Diseases Data

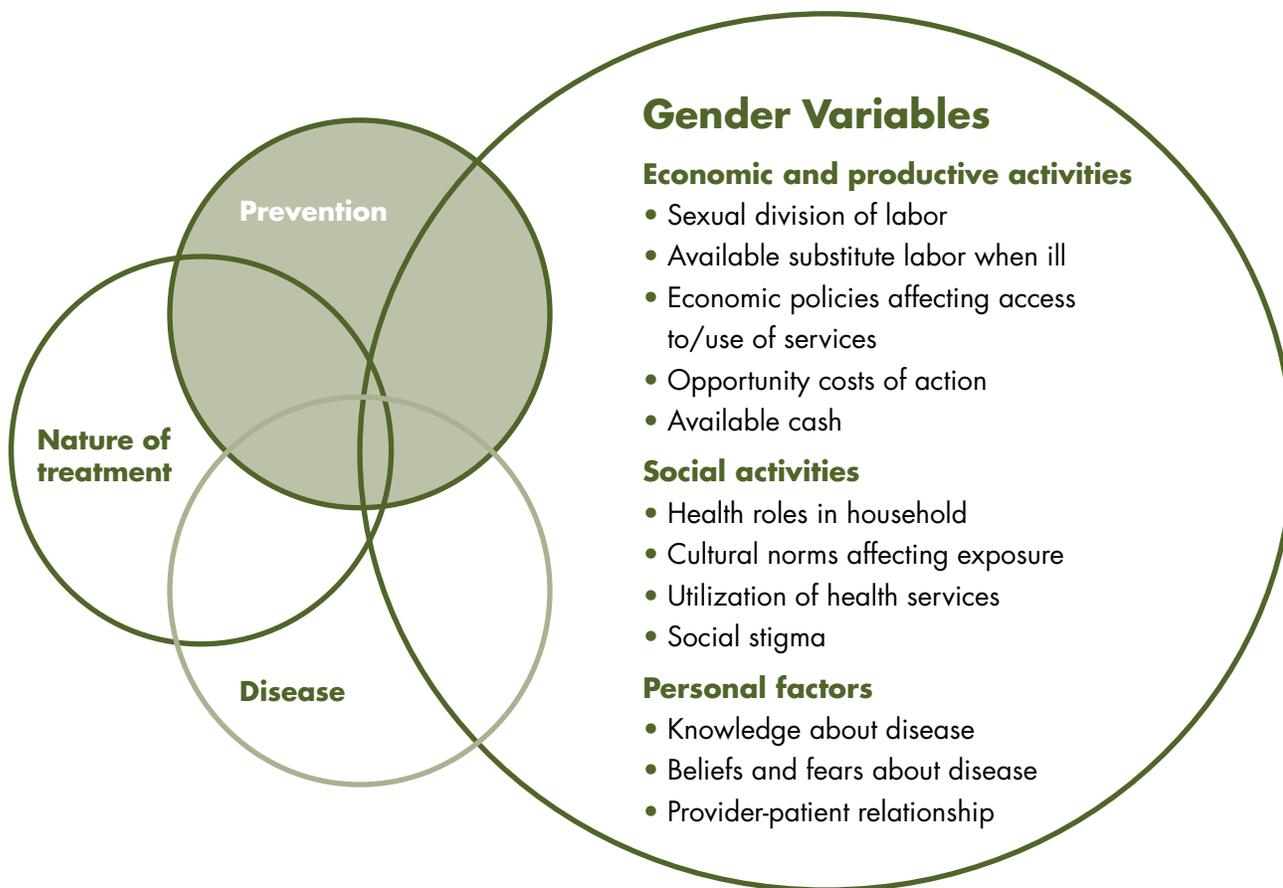
Addressing gender when monitoring and evaluating emerging infectious disease (ID) interventions and programs helps to ensure equity in access and benefits for men and women. This brief explores the importance of gender in monitoring and evaluation (M&E) activities and suggests indicators to reveal and explain gender gaps in emerging ID outcomes.

## Background

Emerging ID programs must account for gender norms, roles, and dynamics when assessing the specific risks and vulnerabilities of men, women, boys, and girls. For example, a commonly cited risk factor for leptospirosis—a bacterial disease spread by animal urine—is being male (Skufca & Arima, 2012). This is because of occupational and recreational exposures involving contact with carrier animals and contaminated water and soil (in rice fields, for example) that in some cultures are associated with traditional male roles. Similarly, school-age girls and adult women show higher disease burden during cholera outbreaks, likely owing to exposure associated with traditional gender roles, such as fetching water and preparing food (UNICEF, 2010). The World Health Organization has developed a framework for conceptualizing the different impacts of ID on men and women. (See the figure on the next page.)

The recent outbreaks of the Ebola and Zika viruses have disproportionately affected women. Women are often responsible for providing healthcare in formal and informal roles. The social expectation that women will care for the sick limited women's options and the ability to control their risk of infection during the Ebola outbreaks in West Africa (Diggins & Mills, 2015). Lawmakers responded to the Zika outbreak by discouraging women from becoming pregnant (Dyer, 2015) without taking into account inequitable gender norms that inhibit women's ability to negotiate contraceptive use or engage in family planning. Though Zika affects women more harshly than men biologically, the institutional response increased women's vulnerability, by failing to focus on the couple unit and underlying gender relations.

**Figure 1. Framework on gender variables developed by the World Health Organization Special Programme for Research and Training in Tropical Diseases**



The gendered effects of these epidemics are not limited to risks associated with the specific disease. For example, efforts to contain and respond to emerging epidemics often divert resources away from routine health services, and this particularly affects women, because they access health services more regularly than men do—for contraceptives, maternal health, and postnatal care (Barden-O’Fallon, Barry, Brodish, & Hazerjian, 2015). Future international responses to IDs call for more research examining the effects of gender in public health emergencies, to avoid exacerbating existing inequities.

### **Integrating Gender in ID Data**

Sex is an essential demographic variable for ID surveillance, and the majority of health surveillance systems disaggregate outcome data by sex. Even so, the full significance of sex and gender factors is often not recognized in monitoring and evaluating ID programs. When disaggregated data are used to assess sex or gender differentials in disease risk or outcome without context, the complete picture behind the observed data may be missed or misinterpreted. Looking at other existing health indicators can help to identify whether inequities occur, other than those seen in outcome data. For example, outcome data may show higher mortality

rates among males than females from a treatable ID, and interviews with health clinic staff might reveal that men are presenting with more advanced infection at health centers, resulting in poorer outcomes.

Underlying gender norms and expectations that drive inequalities can be monitored and evaluated using gender-sensitive indicators. However, these are not often collected as part of routine data and require special studies or larger surveys, such as Demographic and Health Surveys (DHS). Gender-sensitive indicators can be explored through qualitative data methods, but these can be expensive and time-consuming. In the above example, deeper gender analysis may reveal “traditional masculine behavior” as an explanation for delays in seeking help among men who experience illness. Together, these data should be used to inform emerging ID programs. If programs to address emerging IDs are specifically aimed at women, this may worsen, or otherwise affect, already existing gender differences in healthcare-seeking behavior or access.

Gender data from evaluation activities can help determine the extent to which emerging ID programs contribute to or are affected by gender inequities.

## Questions to Assess How Gender Affects HIV Outcomes

One can ask a number of questions to assess if and how gender influences ID data and outcomes. Here are some:

- Are there differences in exposure or risk between men and women and boys and girls?
- Are differences in exposure or risk a result of traditional gender norms, expectations, behaviors, or occupations?
- Are there gender differences in access to information or knowledge about an ID?
- Are there gender differences in who accesses treatment for an ID and when they seek services?
- Are there gender constraints related to who has the authority to access health services?
- Do women need permission to seek services for themselves or their children?
- Are there social or cultural perceptions about obtaining medical treatment?
- Are there gender norms that affect who is responsible for the sick or the dead?
- Do gender roles impose an unequal burden of care between men and women?
- Has the redirection of routine health services for emergency response affected men and women differently?

## Resources

- Periago, M. R., Fescina, R., & Ramón-Pardo, P. (2004). Steps for Preventing Infectious Diseases in Women
- WHO. (2011). Taking Sex and Gender into Account in Emerging Infectious Disease Programmes: An Analytical Framework
- WHO. (2007). Addressing Sex and Gender in Epidemic-Prone Infectious Diseases

## References

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## Definitions

**Gender** is the culturally defined set of expectations about the roles, rights, and responsibilities associated with being female and male, as well as the power relations between and among people based on those expectations. Gender varies over time and within and between cultures. Transgender persons, whether they identify as women or men, are also subject to these gender expectations. (Interagency Gender Working Group [IGWG])

**Sex** refers to the classification of people as male or female. At birth, infants are assigned a sex based on a combination of bodily characteristics including chromosomes, hormones, internal reproductive organs, and genitalia. (USAID, March 2012 Gender Equality and Female Empowerment Policy)

**Gender identity** refers to a person's deeply felt internal and individual experience of gender, which may or may not correspond with the sex assigned at birth. It includes both the personal sense of the body, which may involve, if freely chosen, modification of bodily appearance or function by medical, surgical, or other means, and other expressions of gender, including dress, speech, and mannerisms. (American Psychological Association [APA], 2015)

**Sexual orientation** refers to whom a person is physically, spiritually, and emotionally attracted. Categories of sexual orientation typically have included attraction to members of one's own sex (homosexual), attraction to members of the other sex (heterosexual), and attraction to members of both sexes (bisexual). While these categories continue to be widely used, sexual orientation does not always appear in such definable categories and instead occurs on a continuum and is fluid for some people. (APA, 2012) Public health professionals often use the abbreviations MSM (men who have sex with men) and WSW (women who have sex with women) as neutral terms to describe sexual activity of individuals, which may not necessarily correlate with a person's sexual orientation.

**Gender equality** is the concept that all human beings, both men and women, are free to develop their personal abilities and make choices without the limitations set by stereotypes, rigid gender roles, or prejudices. Gender equality means that the different behaviors, aspirations, and needs of women and men are considered, valued, and favored equally. It does not mean that women and men have to become the same, but

that their rights, responsibilities, and opportunities will not depend on whether they are born male or female. (Global Fund Gender Equality Strategy, 2009)

**Gender integration** entails identifying gender differences and resulting inequalities pertaining to specific programs and projects. Gender integration is the process of addressing these differences and inequalities in the design, implementation, monitoring, and evaluation of programs. (USAID, March 2012 Gender Equality and Female Empowerment Policy)

**Gender analysis** is a systematic way of looking at the different impacts of development, policies, programs, and legislation on women and men that entails, first and foremost, collecting sex-disaggregated data and gender-sensitive information about the population concerned. Gender analysis can also include the examination of the multiple ways in which women and men, as social actors, engage in strategies to transform existing roles, relationships, and processes in their own interest and in the interest of others. (Global Fund Gender Equality Strategy, 2009)

**Sex- and age-disaggregated indicators** are regular health indicators that are presented both for men and women or boys and girls. We emphasize disaggregating by sex, because most data are collected according to male and female sex. However, some surveys are beginning to include other identities, such as transgender, in which case the data would be disaggregated by gender identity. Striving to include all gender identities in future M&E efforts will enhance health- and gender-focused programs, by allowing them to understand and respond to all gender differences. (Population Reference Bureau's Framework to Identify Gender Indicators for Reproductive Health and Nutrition Programming, 2002)

**Gender-sensitive indicators** are those that address gender directly and go beyond sex disaggregation alone—for example, gender-based violence, as well as other more complex indicators such as gender attitudes and norms, power differences, female autonomy, and access to educational and economic opportunities. Gender-sensitive indicators should be disaggregated by sex, when possible. Gender-sensitive indicators make it easier to assess how effectively gender dynamics that negatively influence health service access and outcomes have been addressed. (USAID, ADS Chapter 205)

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