

DOMINICAN REPUBLIC GENDER ANALYSIS

A study of the impact of the Zika virus on women, girls, boys and men

Doctors of the World and Oxfam

The current outbreak of Zika virus in the Dominican Republic is having severe consequences on the lives and health of thousands of people. In order to assess the gender, practical and strategic needs of women, girls, boys and men, Oxfam and Doctors of the World conducted a gender analysis in May–October 2016. The analysis seeks to understand the impact of Zika on different population groups, their specific vulnerabilities and needs and their coping mechanisms. The study aims to provide findings and recommendations to support humanitarian agencies to intervene in this health emergency in a gender-responsive way and also to mainstream Zika with a gender perspective into emergency responses caused by natural disasters.



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ACRONYMS AND ABBREVIATIONS

ART	Anti-retroviral treatment
CDC	Centers for Disease Control and Prevention
CENCET	National Center for the Control of Tropical Diseases
CNE	National Emergency Commission
CSO	Civil Society Organization
DIPECHO	Disaster Preparedness ECHO programme
DRM	Disaster risk management
DRR	Disaster risk reduction
ECHO	European Civil Protection and Humanitarian Aid Operations
ERC	Enhanced Response Capacity
FAO	Food and Agriculture Organization of the United Nations
FGD	Focus group discussion
GBS	Guillain-Barré syndrome
GBV	Gender-based violence
GDP	Gross domestic product
GWG	Gender Working Group
IOM	International Organization for Migration
KII	Key informant interview
LAC	Latin America and the Caribbean
LAPOP	Latin American Public Opinion Project (Vanderbilt University)
M&E	Monitoring and evaluation
MOSCTHA	Socio-Cultural Movement for Haitian Workers
MUDHA	Movement of Dominican-Haitian Women
NER	Net enrolment rate
NFI	Non-food item
NGO	Non-governmental organization
OCHA	United Nations Office for the Coordination of Humanitarian Affairs
PAHO	Pan American Health Organization
RedLAC	Latin American and Caribbean Network of Environmental Funds
SDR	Secondary data review
UNAP	Primary healthcare unit
WASH	Water, sanitation and hygiene
WEF	World Economic Forum
WFP	World Food Programme
WHO	World Health Organization

EXECUTIVE SUMMARY

The global outbreak of the Zika virus is a high-profile and complex crisis. In 2015–16, 47 countries worldwide confirmed cases of Zika infection transmitted by vectors (mosquitoes) and five countries reported sexually transmitted cases of Zika.¹ According to the World Health Organization (WHO), Brazil has the highest rate of infection, with 196,976 confirmed cases and 1,949 cases of microcephaly over the two years.² In the Dominican Republic the number of recorded and suspected cases is very high compared with the country's population of 10.4 million, with 5,123 cases of Zika³ and 22 reported cases of microcephaly.⁴

Despite often being relatively mild in its symptoms, this virus is now challenging the lives of women, girls, boys and men, as it could be responsible for a large increase in cases of microcephaly among infants. Gender has an impact on people's experiences and behaviours relating to outbreaks of infectious disease, and this is particularly true of a disease like Zika which can exacerbate existing vulnerabilities, aggravate poverty and reinforce gender gaps. It is thus extremely important to view such a crisis from a gender perspective.

Oxfam and Doctors of the World conducted this gender analysis in May–October 2016 in the Dominican Republic with further research done in January 2017. This included secondary data review of available epidemiological studies with primary field research, including focus group discussions (FGDs) with marginalized women, men, boys and girls in four selected urban locations and as well as interviews with key informants within the government health service.

This targeting was based on purposeful sampling to reach the most vulnerable households in urban settings, according to epidemiological indicators of Zika incidence rates over the past three years, and ensuring a representative sample in terms of gender and age. The urban locations chosen were the *barrio* (neighbourhood) settlements of Barrio Galindo, Aduana and Pinzón (Municipality of Comendador, Elias Piña Province), Barrio de Puerto Rico (San Cristóbal Province), Barrio de Buenos Aires (Municipality of Santo Domingo Oeste, Santo Domingo Province) and Barrio 'Play' (Municipality of Monte Cristi, Monte Cristi Province).

The overall aim of this study is to provide evidence from affected communities and set out recommendations for the design and implementation of gender-sensitive programming, policies and political engagement for addressing Zika directly, and mainstreaming Zika in other humanitarian responses.

SUMMARY FINDINGS

1. Overall needs in the current crisis

- Outbreaks of infectious diseases tend to have a disproportionate impact on poor and vulnerable populations, such as poor women and girls, due to social, economic, environmental and medical determinants of health.
- Zika may have serious consequences for women and girls who are pregnant as they risk giving birth to children affected by microcephaly. 22 cases of microcephaly have been confirmed to date in the Dominican Republic.
- Another possible outcome of the Zika virus is Guillain-Barré syndrome (GBS), a rare but serious disorder of the nervous system in which a person's own immune system damages the nerve cells, causing muscle weakness and sometimes paralysis.
- Data for the Dominican Republic demonstrate the feminized nature of the Zika epidemic. Of the 5,123 cases officially reported, 74 percent have been in females. The feminization of the outbreak is unexplained - it could be due to male-to-female sexual transmission.

- The largest number of cases of Zika in the Dominican Republic were in the age group 20 – 40 (51%).
- Symptoms in children are generally worse than in adults.
- Pregnant women and girls, elderly people and children were considered by respondents across all FGDs in the four locations to be the groups most vulnerable to Zika.

2. Vulnerable populations and gender-related impacts of the emergency

2.1 Food security and livelihoods

- Women, girls, and children, especially in female-headed households, are often deprioritized in terms of food access and consumption both during and after natural disasters and in subsequent outbreaks of disease, posing serious risks for their health and well-being.
- In relation to livelihoods, there was a general consensus among FGD respondents that Zika led to the loss of resources and opportunities. Women and girls, especially in female-headed households, bear the main burden of productive and reproductive work and were considered by respondents to be an especially vulnerable group.
- In the FGD conducted in Santo Domingo, men reflected on the challenges the Zika epidemic combined with other mosquito-borne illnesses posed to their livelihoods, such as losing their jobs.

2.2 Access to shelter and WASH facilities

- Lack of access to clean water can affect women and girls more than men and boys in disasters, because they have to spend more time on service tasks such as water collection, which is a gendered role.
- Management of shelters during natural disasters do not meet international minimum standards and do not adequately take into account the protection needs of women, girls, children, people with disabilities or people of Haitian descent, among others, resulting in increased levels of violence and discrimination.
- Women and girls also face major challenges from poor sanitation conditions, which can lead to the spread of infections.
- In addition, in post-disaster situations women and girls must continue to take responsibility for domestic household chores and caring for their families, which places a further burden on them. Women and girls are more affected by this than men and boys.
- Most of those interviewed live in impoverished neighbourhoods affected by frequent natural disasters, such as hurricanes, floods and heavy rains.
- Living conditions among the surveyed communities are overcrowded, with 87 percent of homes having 1–3 rooms and 63 percent of households having 2–4 adults and more than three children.
- Vector (mosquito) breeding sites were present both within houses, which suffer from inadequate basic sanitation, a lack of clean water and poor waste management arrangements, and outside, with contaminated ditches and rubbish dumps and solid waste abandoned in the street.
- The FGDs revealed the lack of WASH facilities in overcrowded urban settlements. Of the households surveyed, 81 percent receive water from piped water, with 58 percent receiving drinkable water in this way; however, 56 percent have water only weekly or even less frequently.
- Due to inadequate water supply, families store water in containers such as water tanks, bottles and other receptacles and these, according to entomological surveys conducted in different neighbourhoods, provide the main artificial breeding reservoirs for *Aedes aegypti* mosquitoes. This mosquito can spread Zika, Dengue, Chikungunya, and other vector-borne diseases.
- Of the households surveyed, 49 percent reported that they had no access to solid waste collection services, while 51 percent had access to services only weekly or less frequently; 41 percent of households had a rubbish dump less than 100 metres away from their houses. Services for the management of solid waste are also inadequate, and 36 percent of women surveyed dumped waste in

the street, 25 percent in ditches and 10 percent in backyards. This creates further breeding reservoirs for vector mosquitoes.

2.3 Access to education

- The spread of infectious diseases such as Zika can exacerbate school absenteeism and reduce children's capacity to complete school programmes. Data gathered for this analysis show that children who are often sick do not attend school and so miss out on life opportunities offered by education.
- Girls stated in the FGDs that Zika was limiting their ability to access education. When they are sick, they are confined at home and cannot go to classes. Absenteeism can affect their school performance and limit the skills and qualifications they may acquire.
- After a hurricane, for example, the loss of educational inputs (uniforms, school materials, etc.) can be a determinant of the disaster's impact on children's educational development; in the Dominican Republic access to school is not allowed without uniforms and supplies.
- The health and nutrition conditions of children worsen after disasters and, while some schools offer national school breakfast programmes, vitamin distributions, deworming etc., there are no educational activities related to the impacts of disasters on children's health.

2.4 Health, including sexual and reproductive health

- There are still no mechanisms in place to guarantee psychological support for pregnant women and girls and their partners in cases where an unborn baby has been diagnosed with microcephaly.
- Across the region, risks of Zika in pregnancy are leading more women to seek access to abortion, even if they live in a country whose laws restrict it or ban it altogether. Women may risk undergoing abortions in unsafe or clandestine circumstances, with consequent risks to their own lives and health.
- The criminalization of abortion also has implications for the mental health of pregnant women and girls infected with Zika.
- The lack of quality, female-friendly treatment, and violence against women in health facilities, may discourage women from seeking medical care. Some 67 percent of the women surveyed thought that they had had Zika during the weeks of the epidemic, but 73 percent of them did not seek healthcare services either in Primary healthcare units (UNAPs) or hospitals.
- The pattern of social and institutional discrimination in the Dominican Republic against people of Haitian descent increases their vulnerability to disasters, including health emergencies.
- Across the four locations surveyed, only 30 percent of women, girls, boys and men were aware that Zika could be sexually transmitted. 58 percent of adult respondents did not have access to contraceptive methods or to sexual and reproductive health education on the Zika virus.
- Women in FGDs in all four locations reported that their main concern was the effects of Zika on pregnant women and girls and their babies; there is evidence that fear around the nature of the disease is increasing.
- Women in the FGD in Azua stressed the importance of seeing a doctor if at risk of contracting Zika and, in the case of pregnancy, taking a test.
- The perception of the quality of services in hospitals and primary healthcare units was largely positive. However, 7 percent of the women surveyed said that they had been mistreated in hospitals or UNAPs.
- Men in an FGD in Santo Domingo reported that they or family members had been infected with Zika through mosquito bites, and called for free treatment in hospitals and UNAPs.

2.5 Access to information

- In terms of health information, 71 percent of the women surveyed reported that they had received a visit from a public health team at home, and 61.5 percent believed that they had essential information about preventing Zika and dengue fever and about protection measures and health promotion.
- Only 9 percent of women/girls were pregnant at the time of being interviewed, but 85 percent of women of reproductive age said that sexual and reproductive health services and maternity services in both hospitals and local health facilities failed to give them sufficient information about the risks of Zika during pregnancy.
- Men and boys were aware of the possibility of pregnant women and girls giving birth to children with problems of mental disability, but the general level of information reaching men is still very low.
- Communication relating to health emergencies is failing to take into account both the strategic and practical needs of women and girls. Pregnant women and girls who have been exposed to Zika need access to comprehensive and unbiased information about the virus and about microcephaly.

2.6 Protection issues, including gender-based violence

- In terms of protection, men and boys perceived the current security situation to be ‘unbearable’, highlighting the risk that women and girls face of being assaulted when seeking medical care at night-time.
- Female respondents pointed to increased levels of insecurity since the outbreak and felt threatened by the challenges that Zika posed to their health. They also felt abandoned and isolated when sick and feared being infected.
- Girls said that they were afraid of being assaulted when seeking medical services at night and stressed as a limiting factor the high cost of transportation (i.e. taxis) to reach health facilities. They also reported the risk of being assaulted on public transport (such as in shared cars).
- Boys’ perceptions of security revealed a perception of great danger of being killed when seeking medical help late at night.
- Interviews with women and girls showed that they are frequently mistreated when seeking medical care in public hospitals and medical centres. Testimonies included women being victims of abuse and psychological violence perpetuated by health professionals.

2.7 Decision-making and leadership

- Half of women in the households surveyed are providers and manage economic resources, making decisions for the survival of the family. In 31 percent of cases these responsibilities are shared, while men are providers and decision makers over economic resources in only 19 percent of households.
- Although women have a high level of decision-making space within the household, the same is not true when it comes to exercising their rights to health, especially sexual and reproductive health.
- Regarding public decision-making and leadership, the women and girls surveyed were most of the time confined at home. FGDs with women and girls and mixed groups provided evidence of a gender gap in decision-making outside the household, with women and girls having very limited power or voice to make decisions affecting their own lives and the well-being of their families and communities.

3. Changing gender dynamics and coping strategies

3.1 Care work in the home

- Traditionally, women in the Dominican Republic face double and triple workloads, with unpaid family care and household tasks on top of employment in the formal or informal sectors. In an emergency situation this burden is multiplied, as household members are exposed to higher levels of risk and vulnerability, and women and girls have to ensure that the household’s basic needs are met.

- In terms of gender roles in the household, men see domestic work such as cooking and cleaning as being mostly the domain of women and girls. Men were concerned about their inability to perform domestic tasks and manage the household when their partners were infected by Zika.
- 80 percent of women and girls took care of children and elderly family members on their own, and only 19 percent shared such tasks with men. Only 1 percent of respondents said that men bore the burden of care. Similarly, women were solely responsible for caring for sick family members in 79 percent of cases. Eighty-four percent of women and girls perform domestic tasks (cooking, cleaning, etc.) without any help from men, while 74 percent of women and girls are exclusively responsible for the management of waste, cleaning the yard and house and for basic sanitation.
- Women and girls make huge efforts and sacrifices to overcome difficulties created by disasters and epidemics, but their roles as primary care-givers, guardians of health, food producers and providers and economic actors are not recognized.
- A Zika epidemic occurring as a consequence of a major natural disaster could seriously affect the physical and mental health of elderly people, in particular women, as well as increasing the burden of unremunerated work at the household level.

3.2 Care work in the community

- In times of crisis, responsibility for care work in the community falls largely on women and girls. However, care work done by women and girls in response to disasters or epidemics is usually considered voluntary and an extension of domestic care work; it is not considered worthy of remuneration and continues to be invisible and underrecognized.
- Women and girls play an important role in the recovery process after a natural disaster or epidemic. Analysis of the qualitative data collected shows that many women in affected communities are especially proactive. They understand the consequences of disasters and epidemics for their neighbourhoods and their potential long-term impacts, and they really want to make a difference for the sake of their children and the future of their communities.

3.3 Participation in health promotion programmes

- Interviews with key informants indicated that health programmes in the Dominican Republic have been successful in conveying appropriate information on mosquito-borne diseases, as shown by the levels of knowledge amongst the urban populations in the locations surveyed. However, information about the sexual transmission of Zika is still poor.
- A lack of consultation or involvement of the local population means that gender perspectives are not taken into account at any level. As reported by a UNAP health specialist, gender is not considered in data collection, in assessing the population's needs or in health promotion activities.
- This is despite the fact that outbreaks of diseases such as Zika have different impacts according to gender and age groups that need to be identified and properly addressed. It is not only women and girls who suffer from the differentiated impacts of Zika: it is reported that children with microcephaly are at risk of being abandoned by their parents, especially after the first or second year of life, which suggests that the number of abandoned children is likely to increase considerably over the next few years.

3.4 Coping strategies

- In the qualitative data gathered, women, girls, men and boys all cited the lack of WASH infrastructure as a major problem in their neighbourhoods.
- In order to reduce risk of exposure to the Zika virus, some respondents, mostly women and girls confined to the home, reported that as a coping strategy they had increased levels of household hygiene, stating that poor hygiene conditions were not related to poverty but were rather a matter of individual choice.
- Women and girls in the FGDs in Santo Domingo (San Cristóbal) underlined the importance of preventing the spread of disease, starting with proper waste management in their homes and the treatment of standing water (e.g. by covering open water tanks and containers).
- Knowledge about the connection between Zika and microcephaly is still low, but women and girls were aware of the importance of a pregnancy test if they suspected Zika.

- For male respondents, the main strategy to prevent the spread of Zika was to ensure better hygiene conditions and to be aware of any source of contamination in order to avoid unnecessary exposure.
- Generally speaking, respondents affected by Zika, or who suspected they might be, would go to the nearest hospital by taxi or by public transport; they avoid calling ambulances because they cost too much and take a long time to come.

SUMMARY RECOMMENDATIONS

Targeted gender recommendations for responding to Zika (humanitarian agencies – NGOs, government and volunteers)

- Guarantee care and support focusing primarily on the needs of women and girls of childbearing age and children born with complications due to infection with the Zika virus and families and communities affected by or at risk from the Zika outbreak.
- Urgently provide health education/promotion and hygiene kits, especially to female-headed households, to prevent the spread of disease, as well as detailed information about the Zika virus and how it is spread. The kits should also address the prevention of other vector-borne diseases such as dengue fever and chikungunya.
- Ensure universal access to a full range of high-quality, voluntary and user-friendly contraceptive methods, including barrier methods such as female and male condoms and emergency contraception, as well as comprehensive information and services on sexual and reproductive health, including antenatal services to enable early detection of microcephaly, quality obstetric care, safe abortion services (where legal), and post-abortion care.
- Target women, girls, men and boys in public health awareness campaigns, especially in light of recent evidence that Zika can be sexually transmitted, recognizing that the responsibility for safer sex methods falls on both men and women and cannot be shouldered by women and girls alone.
- Address the psychological and economic impact of complications caused by the Zika virus by providing adequate psychosocial and mental health support and by dealing with the long-term implications for children affected by microcephaly and other complications through rehabilitative services, early stimulation, social assistance and protection, psychosocial support and specialized healthcare and education.
- Extend the categorization of vulnerable populations to include breastfeeding mothers affected by Zika or at risk of being infected, with the provision of a food package that follows normal infant feeding guidelines as set out by WHO.⁵

Targeted gender recommendations for mainstreaming Zika in humanitarian response (humanitarian agencies – NGOs, government and volunteers)

- Provide additional safe and appropriate shelters for populations affected by natural disasters, taking account of UNDP and IOM minimum standards and ensuring safe water and functioning latrines and the provision of the most urgently needed NFIs (e.g. mosquito nets, repellents and hygiene kits).
- Create income-generating opportunities for women and men to overcome the loss of their traditional livelihoods due to natural disasters and epidemics such as Zika.
- Enhance school enrolment rates for girls by providing 'cash for education' to them or their families in order to pay school fees and cover meal costs, as a strategy to avoid early marriage and unwanted pregnancies.
- Install WASH hardwares, based on participatory and inclusive consultation with all community members on the most appropriate designs and locations for lockable latrines, safe and well-lit bathing spaces and

solid waste management systems, to improve the availability and usage of clean water and to reduce the prevalence of open defecation.

- Ensure special attention to the protection of high-risk groups such as pregnant and breastfeeding mothers, babies, infants, older people, those with restricted mobility and those who are sick.
- Enhance the participation of women and girls in empowerment and leadership roles in response and recovery programmes and provide resources and tools to women's groups and networks to increase their decision-making power.

Targeted recommendations for responding to the Zika crisis (government health system)

- Consider 'health cause' when microcephaly is confirmed as a reason for access to legal, safe, comprehensive, free and high-quality procedures for termination of pregnancy, free of any requirement for marital or parental consent. Simply encouraging women not to get pregnant when access to safe abortion is limited or abortion is totally criminalized risks driving up rates of unsafe abortion, with increased levels of maternal morbidity and mortality.
- Support pregnant women and girls who decide to continue their pregnancy to carry it safely to term, including providing access to comprehensive pregnancy, safe delivery, pre- and post-partum care and neonatal care services, as well as the provision of special needs therapy and health and educational services as needed for children with microcephaly.
- Improve paediatric care services, including early screening and support for women/girls and their children affected by foetal or newborn complications. All children born to women infected with Zika should be monitored closely for complications for at least three years after birth.
- Promote gender equality and human rights approaches in health systems and ensure that health communication and promotion campaigns have a gender perspective, to guarantee female and children-friendly medical spaces and treatments and to ensure gender justice in the distribution of benefits, power, resources and responsibilities to avoid creating new gender inequalities or reinforcing existing ones.
- Conduct country trainings against GBV for public health personnel to prevent cases of GBV against women and girl patients, and support surveillance and accountability mechanisms against GBV perpetuated by health professionals.
- Encourage the active participation of affected women, girls, boys and men in the design, implementation, monitoring and evaluation of public health communication campaigns and in health service provision by taking into consideration social determinants of differential access to health (such as gender, age, socio-economic status, household characteristics, education levels, disabilities, ethnicity and language barriers) in the design of interventions.
- Ensure that the health sector implements WHO/FAO guidelines for pesticide management and updates vector control practices according to WHO/FAO indications. In addition, disaster/epidemic-affected populations must be informed about the potential risks of substances used in chemical vector control and the schedule for application, and must be provided with protection during and after the application of poisons or pesticides, according to internationally agreed procedures.
- Improve systems for the collection of sex- and gender-disaggregated data and ensure that a gender-based approach is integrated into health services, especially at the local level.
- Ensure that Haitian migrants, refugees, asylum seekers and internally displaced persons, as well as hidden, poor, marginalized or hard-to-reach populations, are included in national health and protection response plans, and that relevant activities are carried out in coordination with local authorities and partners.

Targeted gender recommendations for addressing Zika in Disaster Risk Management (government and humanitarian agencies)

- Increase coordination among humanitarian actors to guarantee cooperation between the Dominican state and civil society actors (including women's rights groups, academia and the private sector) through existing platforms, such as the WASH Working Group, at both national and provincial levels, working in conjunction with the Provincial and Municipal DRR Committees.
- Encourage leadership by women and girls, and women's rights groups and networks, in disaster risk management to coordinate and implement actions and programmes to meet the special needs of women, youth and children affected by disasters and epidemics.
- Take concrete steps to prevent the spread of vector-borne diseases as part of the state's DRM policies via the National Emergency Commission (CNE) and organized civil society platforms such as the Disaster Risk Management Forum and the Feminist Forum.

1 INTRODUCTION

1.1 DOMINICAN REPUBLIC: COUNTRY PROFILE AND GENDER INEQUALITY

The Dominican Republic is a Caribbean country with a population of than 10.4 million; it shares the island of Hispaniola with Haiti. Its economy is the largest in the Caribbean region, and in 2012 its gross domestic product (GDP) was estimated at \$98.74bn.⁶ Like other countries in Latin America, it has high levels of urbanization, with 63 percent of people living in urban areas.⁷ According to the World Bank, although the country has one of the highest levels of growth in Latin America and the Caribbean (LAC) region, one in every three Dominicans is still living in poverty. In 2015, 14 percent of the country's working-age population of 4.5 million were unemployed.⁸ The World Economic Forum (WEF) has ranked it as the worst country in the world for wasteful government spending (144th out of 144 countries) and one of the worst for favouritism in decisions made by government officials (141st) and the diversion of public funds (140th).⁹

Despite recent progress in the status of women as regards health, educational attainment and economic empowerment,¹⁰ the Dominican Republic has high levels of gender inequality. The Gender Gap Index 2015, published by the WEF, ranks the Dominican Republic 86th out of 145 countries,¹¹ and it has dropped down the rankings since 2006 (when it was in 59th position). Women and girls are now achieving higher levels of education compared with men and boys, but this advantage is not reflected in equal access to jobs.

Women participate in a segmented labour market where they are concentrated in lower-paid and more precarious areas, with poor working conditions. In a patriarchal social structure, it is considered normal that women should perform most of the unpaid domestic work that allows the productive sector to function.¹² Around 48 percent of women workers are either domestic workers or are engaged in informal trade, in the services sector or in community work.¹³ Thirty-six percent of women do not have their own income, compared with 14 percent of men and a Latin America average for women of 32 percent.¹⁴ The unemployment rate stands at 23 percent for women compared with 9.7 percent for men.¹⁵ Gender inequality has a significant impact on female-headed households, and 40 percent of households are female-headed (a marked increase from 28 percent in 2002 and 35 percent in 2007).¹⁶

Dominican Republic has always had high levels of gender-based violence (GBV). Moreover the reported incidence of GBV increased between 2007 and 2013,¹⁷ and violence against women and girls, especially domestic violence, appears to be becoming more common and widespread. More than a quarter of women (26 percent) report having experienced physical violence at some point in their lives since the age of 15.¹⁸ Women and girls most affected by any form of violence appear to be those who are separated, widowed or divorced, those with five or more children, those who have completed only primary education and those in the bottom quintile of wealth.¹⁹

Prevailing gender roles and norms, and a lack of access to sexual and reproductive health rights, are among the structural causes of poverty for women and girls.²⁰ The risk of becoming pregnant is six times higher for a teenage girl who has only primary education than for one with a higher level of education,²¹ and being a teenage mother increases the probability of being poor from 16 percent to 28 percent.²²

Maternal mortality is a sensitive indicator of social exclusion and reflects women's lack of access to health centres, as well as cultural and gender factors that contribute to this. According to the World Health Organization (WHO), the maternal mortality ratio in the Dominican Republic in 2015 was 150 per 100,000 births, higher than the average of 130 per 100,000 in the LAC region, though lower than the global average of 400 per 100,000 births.²³

Due to these intersectional factors and other issues, gender is a key determinant of vulnerability in times of crisis caused by natural disaster (see section 1.2 below).

1.2 VULNERABILITY TO HUMANITARIAN CRISIS

The island of Hispaniola is vulnerable to natural climatic events that have the potential to cause disasters.²⁴ The geographical location of the Dominican Republic in the sub-tropical zone makes it susceptible to tropical storms and hurricanes that originate primarily off the coast of Africa and move in from the North Atlantic, and it is frequently hit by environmental disasters such as storms and floods. It is also affected by storms that develop in the warm waters of the Gulf of Mexico, especially in the annual 'hurricane season' between June and November. In 2015 the country was affected by its worst drought for 20 years which, according to Latin American and Caribbean Network of Environmental Funds, affected more than 1.6 million people.²⁵ Data collected on the ground by Oxfam show that in 2016 more than 500,000 people were affected by the La Niña phenomenon (which included the impact of Hurricane Matthew in September/October 2016).²⁶

Extreme weather events and frequent natural disasters produce severe changes in epidemiological behaviours. Weather conditions greatly influence the reproduction rates of insects and there is a clear relationship between rainfall and infectious diseases that are spread by insect vectors, such as mosquitoes,²⁷ which require standing water to lay their eggs. In 2014–16 one of the strongest El Niño events on record affected weather patterns worldwide, bringing with it major flooding and severe drought that affected the health of millions of people. El Niño has ended for now, but scientists are currently monitoring La Niña, which may create conditions conducive to the spread of mosquito-borne diseases such as the Zika virus.²⁸ According to the Department of Infectious Diseases, University of Georgia, 'this is a public health concern because certain climatic factors like temperature, relative humidity, and rainfall are strong environmental drivers of vector-borne disease transmission'.²⁹ This means that the prevalence of pathogens such as Zika virus and their survival may ebb and flow with changes in weather conditions caused by La Niña.³⁰

The spread of mosquito-borne diseases is also affected by climate change. WHO predicts that global warming of 2–3°C would put up to 7 percent more people – several hundred million globally – at risk of malaria, another disease carried by mosquitoes.³¹ Like other viruses spread by mosquitoes and ticks, Zika could soon have a greater reach. Last year, a team of researchers mapped the global distribution of *Aedes* mosquitoes to better understand the global human health risk, noting that the mosquitoes are more widely distributed than ever before.³²

In 2005, Paul Epstein of Harvard Medical School published an influential paper on climate change and human health, which noted the sensitivity of mosquitoes to changes in temperature.³³ It stated: 'Warming of their environment – within their viable range – boosts their rates of reproduction and the number of blood meals they take, prolongs their breeding season, and shortens the maturation period for the microbes they disperse.' In other words, when it is warmer, they bite more, breed more and spread more disease.

According to the Global Climate Risk Index published by NGO Germanwatch, in 2013 the Dominican Republic was one of the 10 countries most affected by climate change between 1992 and 2011 (fourth in the LAC region).³⁴ This vulnerability will only worsen as climate change continues to generate more extreme storms, landslides, floods and droughts, along with slower changes such as rising sea levels and a gradual reduction in the quality and quantity of fresh water available. With a high incidence of floods and heavy rains, the country is vulnerable to a combination of natural disasters, worsened by the effects of climate change, followed by a health crisis caused by an epidemic of mosquito-borne diseases such as Zika.

The gendered impact of disasters in the Dominican Republic

Since 2002 the Dominican Republic has developed an effective system of disaster risk management (DRM) and response, with shelters ready to provide refuge in the event of extreme weather or a natural disaster such as a hurricane or flood.

However, globally, unequal gender and power relations in the physical, economic, social, cultural and environmental spheres directly increase the vulnerability of women and girls to disasters and influence their capacities for recovery. Likewise, the likelihood of a woman or girl becoming target of domestic or sexual violence increases after a disaster, so many women avoid shelters or refugee camps for fear of being raped or infected with sexually transmitted diseases or of unwanted pregnancies.³⁵ The intersection of gender inequalities with racial, religious and other factors creates social conditions that increase exposure to risk for different groups of women and girls when disasters occur.³⁶

In economic terms, the consequences of disasters include a loss of livelihoods for women and a reduction in their share of productive activities in both the formal and informal sectors. Women and girls are disadvantaged in multiple ways: not only do they directly lose productive assets and sources of income from work, but they also lose opportunities for income with the increased burden of unpaid household and community care work.³⁷ They may suffer further financial damage due to debts that cannot be repaid after a disaster.³⁸ Social exclusion and discrimination are often embodied in formal policies, customary laws and the legal framework (e.g. land ownership), as well as by institutions (e.g. poor representation of women or minority groups in management positions).³⁹

The most relevant differential impacts of disasters in the Dominican Republic have been recorded in the areas of sexual and reproductive health. A 2008 study by UN-INSTRAW and the UN Population Fund examined impacts on women and girls of reproductive age both during and after natural disasters, with a focus on Hurricane Noel in 2007.⁴⁰ Interviews with affected women highlighted the limitations they faced in accessing pre-natal and post-natal care, as well as the increased risks of vaginal infections, complications of pregnancy including spontaneous abortion, unplanned pregnancy and post-traumatic stress. An increase in violence against women was also recorded. Problems faced by children and adolescents included cases of violence, health problems and damage to education infrastructure. Elderly people suffered material losses and the reduction of income-generating activities, along with deteriorating health and post-traumatic stress, and faced obstacles in receiving assistance to evacuate their homes and move into shelters. Lastly, people living with HIV/AIDS faced difficulties in accessing anti-retroviral treatment (ART).⁴¹

1.3 BACKGROUND TO THIS REPORT

In order to respond to the Zika outbreak in the Dominican Republic, coordinated action with a gender perspective is required between the government agencies, international aid agencies and NGOs, volunteer forces and other civil society groups. A response to Zika requires both targeted policies and initiatives, and also mainstreaming Zika into the humanitarian responses to frequent natural disasters such as floods, droughts and hurricanes.

This analysis has been developed by the Gender Working Group (GWG) which was established in 2016 in Dominican Republic by Oxfam. It comprises eight organizations, including government bodies and international and local NGOs: Oxfam, the Ministry of Women, the Office of the Attorney General, the National Council of Elderly People, the National Council of People Living with HIV, the Movement of Dominican-Haitian Women (MUDHA), the Socio-Cultural Movement for Haitian Workers (MOSCTHA) and the Civil Defence. The group is supported by the ECHO-funded project 'Institutionalizing Gender in Emergencies – Bridging Policy and Practice'. This 18-month-long project aims to catalyse change within the humanitarian sector by institutionalizing gender mainstreaming in emergencies. The scope of the working group is to bring together different humanitarian actors to create sustainable change in the aid system, enabling response capacity for adapted assistance to meet gender needs.

1.4 SAMPLING AND METHODOLOGY

The gender analysis was undertaken during the period May–October 2016 and used a combined methodology which included a secondary data review (SDR), focus group discussions (FGDs) and key informant interviews (KIIs) at household and community levels. The methodology was designed to triangulate these qualitative and quantitative datasets.

FGDs were conducted with 101 individuals, of whom 69 percent were female and 31 percent male; 13 percent were girls/young women aged 12–25 and 13 percent were boys/young men of the same age. The selection criteria for respondents were based on purposeful and targeted sampling in order to reach households most vulnerable to the spread of Zika virus and ensuring the representation of women, girls, boys and men. The urban study locations were chosen based on epidemiological and sociodemographic indicators from secondary sources (population density, prevalence rate over the past three years of larval arbovirus and vector indices) and the presence of public health services.

The study covered the urban *barrio* (neighbourhood) settlements of Barrio Galindo, Aduana and Pinzón (Municipality of Comendador, Elias Piña Province), Barrio de Puerto Rico (San Cristóbal Province), Barrio de Buenos Aires (Municipality of Santo Domingo Oeste, Santo Domingo Province) and Barrio ‘Play’ (Municipality of Monte Cristi, Monte Cristi Province). These neighbourhoods are fairly representative of the Dominican population as a whole: 63 percent live in urban areas and 40 percent in households that are headed by women.⁴² The selected settlements are characterized by poor access to basic services, high levels of unemployment (especially for women and young people), low levels of education and a lack of sanitation and hygiene facilities.

Ten FGDs were conducted in the four surveyed sites with groups of women, girls, boys and men, separately and in mixed groups.

In addition, 18 KIIs were conducted with public health representatives in the selected sites, using a semi-structured questionnaire. Ten enumerators (eight women and two men) shared their direct observations during the fieldwork, and feedback was collected from participants to ensure validation of the research findings.

1.5 OVERALL NEEDS IN THE CURRENT CRISIS

Impact of the Zika outbreak in Latin America and the Caribbean

The Zika virus was first identified in 1947 in the Zika forest in Uganda (Africa). It is an arbovirus transmitted by bites from the *Aedes aegypti* mosquito.⁴³ In 2015–16, 47 countries worldwide confirmed cases of Zika transmitted by vectors and five countries reported cases of sexually transmitted Zika⁴⁴ (Table 1). In most people the illness tends to be mild, with clinical manifestations similar to dengue and chikungunya infections; the most common symptoms are fever, headaches, rash, myalgia and conjunctivitis. To date Zika virus has been found in Africa, Asia, the Americas and Europe.⁴⁵

Table 1: Zika in Latin America and the Caribbean – most affected countries, 2015–16

Country	Suspected cases	Deaths
Brazil	196,976	6
Colombia	95,412	
Venezuela	57,717	
Martinique	36,270	
Honduras	31,530	
Guadeloupe	29,850	
Puerto Rico	24,127	
El Salvador	11,215	3
French Guyana	9,740	
Jamaica	5,747	
Dominican Republic	5,135	

Source: PAHO/WHO status report as of 6 October 2016.⁴⁶

Although symptoms are often relatively mild, in pregnant women and girls the virus appears to be responsible for a large increase in cases of microcephaly among infants. Microcephaly means that the infant's head and brain do not develop normally, leading to a range of serious health and developmental problems for that child. The dramatic rise in the incidence of microcephaly in Brazil points to the involvement of the Zika virus,⁴⁷ though further studies are necessary to prove this conclusively. This connection prompted Brazil to declare Zika a public health emergency in November 2016. By 13 November 2016, 22 cases of microcephaly have been confirmed in the Dominican Republic.⁴⁸

However, until more is known, precautions are being recommended for everyone in areas at risk to prevent mosquito bites and sexual transmission of the virus, and special prevention measures are recommended for pregnant women and girls to avoid infection and detect Zika at an early stage of pregnancy.⁴⁹ The most effective way to prevent Zika infection is to avoid being bitten by mosquitoes; the virus cannot be transmitted directly from one person to another through casual contact.⁵⁰

Aedes aegypti is endemic in Latin America and is well adapted for indoor and daytime biting in urban areas. Mosquitoes breed in still water such as puddles, open water containers and pots and waterlogged plants. Women can be infected with Zika at any stage of a pregnancy, but the incidence of infection in pregnant women is not known and data are limited.⁵¹ Also, no data exist to suggest that pregnant women are more susceptible to infection from the Zika virus than anyone else, or that they experience the disease more severely during pregnancy.⁵²

However, another possible outcome of the virus is Guillain-Barré syndrome (GBS), a rare but serious disorder of the nervous system that causes a person's own immune system to damage the nerve cells, leading to muscle weakness and sometimes paralysis. A number of countries that have recently experienced outbreaks of Zika have also reported increases in the number of people affected by GBS. Research by the Centers for Disease Control and Prevention (CDC) in the USA suggests that GBS is strongly associated with Zika; however, only a small proportion of people infected with Zika will develop GBS.⁵³

There is no vaccine or specific antiviral treatment for Zika; treatment is mainly supportive and includes rest, the consumption of fluids and use of analgesics (to reduce pain) and antipyretics (to reduce fever). The virus does not pose a risk to future pregnancies, as it tends to remain in the bloodstream of an infected person for only up to one week.

Children and adolescents are likely to manifest more severe symptoms than the general population.

Table 2: Confirmed cases of microcephaly, 2015–16

Country	Confirmed cases
Brazil	1,949
Colombia	42
Guatemala	17
Martinique	12
Dominican Republic	22
Cabo Verde	9
French Polynesia	5
Panama	5
El Salvador	4
Marshall Islands	1
Puerto Rico	1

Source: Based on PAHO/WHO status report, 6 October 2016; and PAHO/WHO data for the Americas.⁵⁴

Impact of Zika epidemic by gender and age

The Zika epidemic has a feminized nature in the Dominican Republic. According to sex-disaggregated data analysis done by Oxfam and Doctors of the World, of 5,123 cases officially reported, 74 percent were in females (3,790) (see Table 3).

By age group, adults aged 20 – 40 appear to be most affected, accounting for 51% of total cases. For all age groups except young children under 10, the trend is for many more cases in females than in males (Table 3).

Table 3: Zika cases analysed by age group and sex in the Dominican Republic

Age group	Suspected Zika cases – female	Suspected Zika cases – male	Total
<1	40	43	83 (2%)
1–4	96	99	195 (4%)
5–9	85	93	178 (3%)
10–19	404	176	580 (11%)
20	1,176	278	1,454 (28%)
30–39	924	239	1,163 (23%)
40–49	539	183	722 (14%)
50–59	360	135	495 (10%)
>60	166	87	253 (5%)
Total:	3,790	1,333	5,123

Source: Doctors of the World / Oxfam RD analysis August 2016. Note that the figures vary slightly from Table 1 due to differences in the reporting of epidemiological weeks and availability of data.

Feminization of the disease impact seems to be a general trend across different countries. Data collected by Centers for Disease Control and Prevention (CDC) in Puerto Rico, evaluating more than 29,000 laboratory-confirmed cases of Zika, showed that 62% were women.⁵⁵ Similar patterns have been observed in Brazil and El Salvador.

One obvious explanation might be that pregnant women are more likely than men to seek treatment for Zika because of the potential risk of birth defects. To attempt to control for this factor, the researchers in Puerto Rico excluded all pregnant women who tested positive for the virus. Of the remaining 28,219 men and non-pregnant women (aged 20 and above) testing positive for Zika, 61 percent of cases occurred in women, indicating that increased reporting may not account for the difference. Moreover, the findings for Zika in

Puerto Rico differ from those for prior outbreaks of arboviruses transmitted by the same mosquitoes. For example, in a 2010 outbreak of dengue and an outbreak of chikungunya in 2014, the number of infections was distributed equally between women and men.

Another possible explanation for this phenomenon of feminization is put forward by the CDC, as quoted by Reuters in relation to a study in Puerto Rico in 2015: 'It is possible that male-to-female sexual transmission is a contributing factor to this skewing of the burden of disease toward women.' It added, however, that the contribution of sexual transmission to overall Zika rates was just beginning to be explored.⁵⁶

The trend towards the feminization of the virus has also been observed in girls and adolescents aged 0–19 years.

As with other infectious diseases, and as described in the sections below, it could be that the risk of exposure to the Zika virus mirrors the gender, racial, class and geographical inequalities that run through all aspects of people's lives. Outbreaks of infectious diseases tend to disproportionately affect poor and vulnerable populations, such as poor women and girls, due to social, economic, environmental and medical determinants of health.

Perception of impact

Participants in the FGDs in all four locations considered pregnant women and girls, children and elderly people to be the groups most vulnerable to Zika. A girl taking part in an FGD in Santo Domingo said: 'I have met elderly people who died after Zika. Children affected by Zika virus are also vulnerable because they have reduced defences to fight against the disease.'

Women in an FGD in Santo Domingo pointed out the vulnerabilities of pregnant women and girls, who 'can give birth to children with small heads [microcephaly]'. They also stressed the importance of meeting the health needs of elderly people because of their reduced resistance.

Another important observation made by women participants was the need for government support to target people living in locations vulnerable to Zika and those living in the poorest shelters. Men in an FGD in Santo Domingo said that children and youth were the most vulnerable groups and should be targeted.

2 VULNERABLE POPULATIONS AND GENDER-RELATED IMPACTS OF THE CRISIS

2.1 FOOD SECURITY AND LIVELIHOODS

Overall food consumption has increased in the Dominican Republic in recent decades, reaching 2,619 calories per person per day in 2014–16.⁵⁷ Between 2004 and 2013 the country reduced the prevalence of food poverty from 54.4 percent to 40.7 percent, while extreme poverty declined by 8.8 percentage points over the same period, to affect 20.2 percent of the population.⁵⁸ In 2016 the country ranked 64th out of 113 countries on the Global Food Security Index, which analyses the affordability, availability, quality and safety of food.⁵⁹

During and after natural disasters

Frequent natural disasters impacts food security and livelihoods among vulnerable groups. Globally, women, girls and children, especially in female-headed households, are often deprioritized in terms of food access and consumption during and after natural disasters and subsequent outbreaks of disease, which poses serious risks to their health and well-being. Access to food is particularly difficult in a disaster context and while living in shelters.⁶⁰ Groups with specific dietary requirements can easily be left without food or proper nutrition – in particular pregnant women/girls, children, elderly people and people with chronic diseases. This is shown to also be the case in the Dominican Republic.⁶¹

Zika epidemic

There was a general consensus among FGD respondents that the Zika virus had led to a loss of resources and opportunities. Women and girls, especially those in female-headed households, who face a heavy burden of productive and reproductive work, were considered by respondents to be a particularly vulnerable group. A girl in an FGD in Buenos Aires, Santo Domingo, said: ‘People can’t go to work, and if their absence is prolonged they will be fired. My mother was sick with Zika and she lost her job because of it. Here we have plenty of female-headed households and women have to be both mother and father.’

The poorest people face additional challenges in affording treatment for diseases, and when they are sick they cannot work, which further reduces their ability to buy medicines. With no public medical health system to protect them, they must remain healthy if they are to earn a living. Falling sick and having to pay for medical services may lead to further impoverishment, indebtedness and even homelessness, as reported by a woman respondent in an FGD in Santo Domingo: ‘Zika affects our livelihoods because we have to spend money on treatments. In order to get medical attention we waste money that should be used to buy food. Sometimes we have to ask for credit.’

Men in an FGD in Santo Domingo reflected on the challenges posed to their livelihoods by the Zika epidemic and the risk of losing their jobs: ‘We face challenges in continuing to work when affected by Zika and other diseases caused by mosquito bites. A friend of mine lost his job after [Zika infection].’

2.2 ACCESS TO SHELTERS AND WASH FACILITIES

In 2015, 15% of the Dominican population do not have access to improved water sources, and about 5% do not have access to improved sanitation (see Table 5). According to FAO, the Dominican Republic is one of the few countries in the LAC region not to have made significant progress on access to water supply and sanitation facilities.⁶²

Table 5: Improved access to water and sanitation in the Dominican Republic (2015)

	Urban (60%)	Rural (40%)	Total
Access to improved water sources	87%	82%	85%
Access to improved sanitation	97%	90%	95%

Source: WHO/UNICEF Joint Monitoring Programme for Water Supply and Sanitation (2015).⁶³

People living in environments that lack WASH services are more exposed to the risk of Zika. Insufficient water supply, water contamination (which can also occur in a large-scale disaster), the proximity of rubbish dumps or other potential breeding reservoirs and overcrowded housing disproportionately expose poor people and vulnerable groups to the risk of contracting the Zika virus.

During and after natural disasters

During hurricanes and other natural disasters in Dominican Republic, short periods of displacement occur with large numbers of people seeking refuge in shelters; these movements are usually temporary, although in some cases people may lose their homes and have to be housed in shelters permanently.⁶⁴ Nationally, there are many difficulties involved in training response actors in shelter management that meets the international minimum standards established by UNDP and IOM. In the vast majority of cases, emergency shelters remain school or other municipal buildings.⁶⁵ During emergencies the management of shelters by volunteers and government agencies do not sufficiently take into account the protection needs of women, girls, children, people with disabilities or people of Haitian descent, among others, resulting in increased levels of violence and discrimination.⁶⁶

Globally, lack of access to clean water can affect women and girls more than men and boys, because they have to spend more time on tasks such as fetching water in order to keep the family and household functioning; this burden becomes heavier in times of disaster.⁶⁷ Women and girls also face major challenges from poor sanitation conditions, which can lead to the spread of infections. Women interviewed after Hurricane Sandy in 2012 reported that the biggest problems they faced in shelters were the lack of privacy and lack of hygiene. The lack of toilets in shelters meant that women and children had to go outside, often in pairs in order to avoid exposure to risk of aggression, while the lack of running water for personal hygiene and lack of access to clean underwear caused an increase in infections and other hygiene and health problems.

Zika epidemic

The majority of the people in the study sample live in impoverished neighbourhoods that are vulnerable to frequent natural disasters, such as heavy rains, hurricanes and floods. Houses are overcrowded: 87 percent of homes have 1–3 rooms but 63 percent of households contain 2–4 adults and more than three children. These overcrowded and unsanitary neighbourhoods clearly contain vector breeding sites both inside houses,

which have inadequate basic sanitation and lack clean water and waste management facilities, and outside, where there are contaminated ditches, rubbish dumps and solid waste abandoned in the streets.

One woman in an FGD in Monte Cristi pointed out: 'We lack hygiene and sanitation facilities and there is rubbish in the street. We have to avoid the contamination centres and have to take more care about hygiene in our shelters if we want to avoid Zika and dengue.'

Of the households surveyed, 81 percent get some water from piped water and 58 percent get drinking water in this way; however, 56 percent have access to clean drinking water only weekly or even less frequently. For this reason, families store water in water tanks, bottles and other containers which, according to entomological surveys conducted in communities in different provinces, provide the main artificial breeding reservoirs for the *Aedes aegypti* mosquito.⁶⁸

As regards solid waste collection, 49 percent of households said that they did not have waste collection services, while 51 percent had services weekly or less frequently. Forty-one percent of households had a rubbish dump less than 100 metres away. Due to the lack of services, household management of solid waste is also inadequate: 36 percent of the women surveyed left solid waste in the street, 25 percent threw it in ditches and 10 percent dumped it in the backyard; grounds for mosquitoes.

It is important to note that neither water collection nor waste management would be so time-consuming or risky for women if potable water and waste collection were public services provided reliably by the state. The failure of public services has a strong gender impact which, however, remains invisible due to the lack of gender mainstreaming in public policies.

2.3 ACCESS TO EDUCATION

While Dominican Republic has improved primary enrolment rates, and more than 78 percent of children completing primary school the number of secondary age students in school as a percentage of the total population of students in that age group (the net enrolment rate (NER)) is still poor at less than 70%. The NER also reveals a significant gender difference as 57.7% of secondary aged boys attend school whereas 66.5% secondary age girls attend school.⁶⁹

During and after natural disasters

Educational facilities in the Dominican Republic are frequently exposed to natural disasters – a hurricane, for example, can damage or destroy school classrooms. If the buildings used for education and training are physically vulnerable, they endanger the lives of the children and adults who use them. The loss of educational inputs (uniforms, materials, etc.) in disasters can also affect the educational development of children, as entering to school without uniforms and supplies is likely to prevent access to poorer students.⁷⁰

The use of schools as shelters in times of disaster is another factor that undermines access and the right to education for children and adolescents.⁷¹ The destabilization of households in the recovery process is also a factor, as it is common for girls to stay off school in order to work at home, while boys contribute to the recovery of livelihoods; both boys and girls help with agricultural work or with finding water.⁷²

In addition, health and nutrition conditions worsen for children after disasters. Some schools offer support such as national school breakfast programmes, the distribution of vitamins or deworming, but there are no health activities relating to the impacts of a disaster on children's well-being and health, such as relating to epidemic diseases that particularly affect children, including viral conjunctivitis or dermatitis, or attention to the sexual and reproductive health of adolescents.

In Dominican Republic schools have a critical role to play in sharing information from public health authorities, addressing concerns and questions raised by students, families and staff members about the Zika virus, and implementing the recommendations of public health authorities in a timely fashion. School administrators should understand the roles and responsibilities of accessing healthcare and consult with

them on issues relating to Zika virus infection; they should also implement measures to avoid students contracting Zika during school hours.

Zika epidemic

The spread of infectious diseases such as Zika can exacerbate absenteeism from school and reduce children's capacity to complete school programmes. The data gathered in the analysis show that children who are often sick do not attend school. A girl participating in an FGD in San Cristobal said: 'If we [girls] get sick with Zika virus, our social life is limited. We have to stay alone in our homes without speaking to anybody, just with our family. We will miss classes and the possibility to go to school. In this way we may face a reduction in our skills and qualifications and absenteeism will affect our school performance.'

2.4 HEALTH, INCLUDING SEXUAL AND REPRODUCTIVE HEALTH

The Zika virus has been a slow-onset threat that has posed challenges to multiple dimensions of health, including sexual and reproductive health. The Dominican government's strategy to combat the disease has to date been focused on vector control, and little attention has been paid to strategies on sexual and reproductive rights or changes to access in health care. Although Dominican Republic does provide public health care, the reality however, is that most still end up paying out-of-pocket expenditures for medical supplies and various services. The poorest people face more challenges in terms of purchasing power in obtaining treatment for diseases. When they are sick, they are less able to work and to buy the medicines they need.

There are still no mechanisms in place to guarantee psychological support for expectant mothers and their partners in cases where an unborn infant has been diagnosed with microcephaly. The Minister of Health recently responded to concerns about sexual and reproductive health by urging Dominican women to 'try not to get pregnant' and 'postpone pregnancy to next year'.⁷³

Limited access to affordable contraception, particularly emergency contraception, and strict abortion laws leave many women with few options. Unfortunately, this leads to an increase in clandestine abortions that pose major health risks. Already, with restrictive laws in place, about 95 percent of abortions performed in Latin America are unsafe, which increases mortality and morbidity risks for women.⁷⁴ Across the region, the risks associated with continuing a pregnancy after infection by the Zika virus are leading more women and girls to seek abortions in countries whose laws restrict it or forbid it altogether.⁷⁵ The criminalization of abortion also has impacts on the mental health of pregnant women and girls infected with Zika, as they face additional fears and anxieties when making decisions in a situation where an abortion might involve the risk of imprisonment or even death.

In a 2016 article for the Huffington Post, academic Kathryn Moeller wrote: 'Government is putting the burden on women and girls themselves to be responsible for having or not having babies with microcephaly. This unfairly places the onus of responsibility for the condition and its life-long consequences onto women and girls and moves it away from the state, whose insufficient actions since the Zika outbreak, inadequate control of mosquitoes during prior mosquito-borne outbreaks, and historical neglect of women's sexual and reproductive health are exacerbating the situation.'⁷⁶

The country's significant population of Haitian descent – both recent immigrants and those of the second or third generations – live on the margins of society, and socially and physically are often the target of violence. The pattern of social and institutional discrimination that they must contend with heightens their vulnerability to disasters, including health emergencies. Haitian people live in the worst housing on dangerous, unwanted or abandoned land, with a lack of infrastructure and access to basic services, all of which exposes them to risks.⁷⁷ Poor infrastructure and housing increase exposure to Zika, especially for women. Haitian migrants and their descendants face additional challenges in reducing the risk of epidemics due to language barriers and discrimination at both the practice and the policy levels. Institutional discrimination may result in reduced

access to health services for people in need, due to a fear of deportation or other legal consequences. A lack of bi-national strategies to tackle Zika among the Haitian population was apparent throughout the study period.

Of other identified vulnerable groups, CDC has not found any evidence that people with HIV infection face any greater risk than the general population of being infected by Zika or any similar viruses.⁷⁸ However, given that people living with HIV often face stigma and discrimination in the Dominican Republic,⁷⁹ including in health services,⁸⁰ those also affected by Zika may face social consequences in accessing services and treatment.

In addition, if children are born with potentially disabling impairments, they are often further isolated by the limited availability of support or social protection from the government and thus become reliant for support on the non-governmental sector if it exists.⁸¹

During and after natural disasters

The picture is made even more complex by natural disasters, which can completely disrupt the provision of services at local and community levels if health and primary care structures are not prepared and if prevention, mitigation and response measures are not taken. This was evident in the aftermath of Hurricane Noel in 2007, according to key informants in the health sector in Bahoruco.

Zika epidemic – awareness and prevention

In the four study locations, only 30 percent of FGD respondents were aware that the Zika virus could be sexually transmitted. However, once they were made aware of this possibility, women and girls stressed the importance of ensuring that sensitization activities encouraged men and boys to use condoms, since it is very difficult for women themselves to negotiate the use of protection measures with their partners. One girl in an FGD in Monte Cristi stated: 'If a man is infected by Zika, then he will be passing it on to his sexual partners, with the risk of further spread of Zika in the neighbourhood.' Data gathered in the analysis show that 58 percent of respondents (both women and men) had no access to contraceptive methods or to sexual and reproductive health education related to Zika.

Women participating in FGDs across the four locations reported that their main concern was the effects of the virus on pregnant women and girls and their children; these concerns are increasing levels of fear and the perception of insecurity around the disease. A woman in an FGD in Santo Domingo said: 'I heard that Zika is transmitted by mosquitoes and that it is worse than dengue because since we can give birth to children with brain problems.' To help prevent the spread of the disease, women in Monte Cristi cited the need to improve hygiene and waste management control, because 'as for every disease, what we have to implement is prevention starting by our actions'.

Women in an FGD in Azua said that the most urgent need was for women who suspected they might have contracted Zika to go to the doctor if pregnant (or suspecting they might be), to take the diagnostic Zika test. This showed an awareness that Zika could potentially cause microcephaly in infants of mothers infected by Zika.

Zika epidemic – access to services

Overall, respondents' perceptions of the quality of services in hospitals and primary healthcare units (UNAPs) were largely positive: 69 percent positive and 31 percent negative for hospitals, and 64 percent positive and 36 percent negative for UNAPs. However, 7 percent of the women surveyed claimed that they had been mistreated in hospitals or UNAPs. Participants in an FGD in Comendador remarked: 'They mistreat patients, and as we do not have much money they do nothing until you pay for it.' 'The quality is bad, they make mistakes in diagnosing, they do not tell you anything, just send you to another service.' 'There is no education about diseases, they don't give talks ever.' 'They have poor hygiene in the doctor's office and in the hospital or UNAPs.'

Respondents also noted difficulties in paying for treatment or diagnostic tests for Zika given the high levels of poverty in communities. Without the protection of a public medical health system, they must remain healthy in order to maintain productive livelihoods. Falling sick and having to pay for medical services may lead to further impoverishment, indebtedness and even homelessness, as reported by women respondents in an FGD in Santo Domingo.

Men in the FGD in Santo Domingo reported that they or family members had been infected by Zika after being bitten by mosquitoes, and called for free treatment in hospitals and UNAPs: 'In our community we don't have free healthcare facilities; we have to go Engombe Hospital [a municipal facility]. If someone has no money to pay for transport in a health emergency, they can die. It takes an hour to get to the hospital via public transport and it costs around 25–50 pesos [\$0.50–1.00]. At night you have to take a taxi and this is very expensive, around 250–300 pesos [\$5.25–6.30].' 'We can't buy medicines, people are not getting the necessary treatments or if they get them, they are not of good quality. If you don't have money, you can't be seen by a doctor.'

The lack of quality female-friendly treatment, and even violence against women and girls in health services, may discourage them from seeking the needed medical care. Some 67 percent of the women surveyed thought that they had had Zika during the epidemic weeks, but 73 percent of them did not seek healthcare services in UNAPs or hospitals. Given the connection between Zika and microcephaly in unborn children, this is alarming; it implies that the lack of quality and gender-sensitive care in health services may mean that many cases of Zika involving microcephaly in the unborn are going undetected.

While there is some recognition of the social determinants of disease, the public health sector does not have the tools or capabilities needed at the local level to apply a gender perspective. Key actors in the health sector interviewed for this study expressed the following opinions: 'There are no gender differences in promotion – no differences were found despite variations in exposure to mosquitoes caused by differences in the roles of men and women.' 'Women have more cases because they stay in the house and the mosquito is urban.' 'More women had dengue.'

2.5 ACCESS TO INFORMATION

Information from government about public issues is usually concentrated in certain population groups and is disseminated via media to which many groups do not have access. Information can also be partial, limiting the access of groups with less power to appropriate information to make decisions that will protect them from the effects of disasters.⁸²

A UNDP study on improving the visibility of gender in response to climate change in the Dominican Republic found that women and girls generally had less access to information relating to important issues such as early notification.⁸³

Notably, in the Zika crisis, due to the traditional gender roles they perform (household management, care of children and the elderly, responsibility for household sanitation and family and community health), women are the main recipients of key health messages, even though they are not considered by the authorities to be a particularly vulnerable group.⁸⁴ Of the women surveyed, 71 percent reported that they had received a visit from a public health team at home, and 61.5 percent believed that they had key information about the prevention of Zika and dengue and about protection measures and health promotion. However, this still means that three out of every 10 women surveyed did not have sufficient information about Zika.

Only 9 percent of women and girls surveyed were pregnant at the time of the interview, but 85 percent of women of reproductive age said that sexual and reproductive health services and maternity services, in both hospitals and local UNAP facilities, did not provide sufficient or timely information about the risks of the Zika virus during pregnancy.

Men and boys showed awareness of the possibility of pregnant women and girls giving birth to children with problems of mental disability, but they perceived that the level of information provided was still very low.

Communication around health emergencies is failing to take into account either the strategic or practical needs of women. Addressing health campaigns exclusively to women (as with the Minister of Health's advice to not get pregnant can result in increased domestic workloads and even increased exposure to the risk of contracting the Zika virus (for instance, by placing the responsibility for basic household and community sanitation exclusively on women), with negative impacts for their practical gender needs.

The Dominican health system appears, at different levels, to be oriented towards influencing the individual behaviour of people exposed to health emergencies rather than tackling social determinants at source.⁸⁵ Most activities undertaken in the neighbourhoods surveyed consisted of nothing more than delivering pamphlets.

Boys in a focus group in Santo Domingo said it was important that very single individual took all possible protection measures before the epidemic reached the 'point of no return', although to date the population had received little information on how to avoid the spread of Zika.

A girl in Santo Domingo (San Cristóbal) stated: 'What are health actors doing if 50 percent of people in our neighbourhood are already affected by Zika? We need the public health sector to alert us before the spread of infectious diseases, before we reach the epidemic level. We need campaigns and sensitization, before the virus affects the entire population.'

2.6 PROTECTION ISSUES, INCLUDING GBV

According to the Latin American Public Opinion Project (LAPOP), based at Vanderbilt University, in 2012 the Dominican Republic was the seventh worst out of 26 countries in the region for perceptions of insecurity.⁸⁶ The country has struggled to control levels of violence over the past decade and its homicide rate doubled between 2001 and 2011, from 12.5 murders per 100,000 people to 25 per 100,000.⁸⁷ Femicide (the killing of women or girls on account of their gender) has reached endemic proportions. In the first six months of 2016, 46 femicides were registered – an average of around eight each month.⁸⁸ In the decade 2005–15, a total of 1,033 femicides were registered by the Office of the Attorney General.⁸⁹

In this complex and insecure context, the spread of Zika is creating further security challenges. The main protection issues reported by respondents relate to movements to reach hospitals at night-time. Men and boys in an FGD in Santo Domingo (San Cristóbal) described the current security situation as 'unbearable', stating that 'if a woman goes to the medical centre early in the morning the risk of being assaulted is very high'. Women respondents in the same location pointed to increased levels of insecurity since the outbreak, indicating that communities may be frightened and confused by the messaging: 'Now there is less security, we feel threatened because we could die after the virus infection and we feel isolated and alone. Few people come to visit women who are affected by Zika, because of the fear of being infected.'

Girls in another FGD in Santo Domingo stated: 'We are afraid of being assaulted at night if we seek medical care, and taking a taxi to the hospital is very expensive, which limits our ability to access health services.' They also reported the risk of being assaulted on public transportation (such as in shared cars). Boys in an FGD in Santo Domingo said: 'It is possible to be killed if you go out late at night when you are sick and you have to get to the hospital.'

The testimonies of women and girls in all the selected locations show that they are frequently mistreated when seeking medical care in public hospitals. Some women claimed that they had been victims of abuse, psychological violence and obstetric violence.

Women interviewed for the study also pointed to pre-existing vulnerabilities for women and girls and differential impacts in the context of Zika, especially in relation to GBV, socio-economic discrimination, and discrimination in health services. Women in an FGD in Santo Domingo Oeste made the following observations: 'Unemployment and lack of education are things that always happen for women; we suffer here.' 'There is a lot of domestic violence and violence on the street, a lack of guidance and support on what to do, psychological abuse, and a lack of social conscience.' 'Many single mothers and teenagers are alone and helpless.' 'There is discrimination for being a woman.'

2.7 DECISION MAKING AND LEADERSHIP

Half of the women in the households surveyed are the main providers and managers of economic resources, making decisions for the survival of their families; these responsibilities are shared in only 31 percent of cases. Men are the main providers, administrators and economic decision makers in only 19 percent of households.

However, although women have conquered the decision-making space within the household (while accepting the burden of responsibility that comes with it), the same cannot be said when it comes to exercising their rights to health, especially sexual and reproductive health. In this area, sexist and patriarchal dynamics,⁹⁰ domestic and gender-based violence and the country's gender-blind legislative framework⁹¹ impede women's power to make decisions affecting their own bodies and lives.

The women and girls surveyed are segregated most of the time in their homes and so have little input into decision-making and leadership at the public level. FGDs with women and girls and with mixed groups provided evidence of a gender gap in terms of decision-making outside the household, with women and girls having little voice and very limited power to make decisions concerning their own lives and the well-being of their families and communities, both in normal times and in the event of a natural disaster or health epidemic.

3 GENDER DYNAMICS AND COPING STRATEGIES

Epidemics expose pre-existing inequalities in a society, and this applies as much to gender issues as to any other type of power relation (e.g. socio-economic and political, or intimate relations). Gender roles contribute to a marked division of labour, which assigns women tasks specifically related to reproduction, such as being mothers, wives and care-givers to children, the sick, the elderly and the disabled. This affects women's opportunities to improve their educational prospects, their decision-making power at community and political levels and their ability to develop non-traditional professional skills. Traditional gender roles relegate women to the home or the private sphere and so they often have less access to the kind of public information needed for risk management and to respond effectively in times of emergency.⁹²

The analysis did not find a significant shift in gender roles and dynamics due to the current Zika outbreak. Women and girls across the four locations perform the role of household managers, taking care of their families' needs. As a participant in an FGD in Santo Domingo Oeste observed: 'We are the most important: mothers, partners, friends, fighters. Working in the community, we have many responsibilities, we set the rules [and keep] order, and we take care of the children's education.' Women in an FGD in Monte Cristi had the following to say: 'Women at home play an important role and we are the ones who spend more time at home and with the children.' 'Sometimes men do not take into account when women are tired [from their long haul within the household].' 'The work of women is never-ending, they are the ones who work hardest and have more commitment to family and community.'

3.1 CARE WORK IN THE HOME

Traditionally, women have had to shoulder the burden of double and triple workloads, with unpaid family care and household chores added to employment in the formal or informal sectors. In an emergency situation this burden is multiplied, as household members are exposed to higher levels of risk and vulnerability and women and girls have to ensure that basic household needs are met.

Men and boys, for their part, feel a burden of providing for their households (although in reality this role is often left unmet, with women largely carrying the burden of providing for families – see section 2.7 above). A man in a mixed adult FGD in Santo Domingo (San Cristóbal) said: 'We take care of our families in providing resources. If we are sick because of Zika, we are unable to give economic support to our children and spouses. If this happens there will be a reduction in income, posing problems for our survival.' A man in an all-male FGD in Monte Cristi said of gender roles and responsibilities during the Zika crisis: 'Women are the ones who prepare food. If they are sick, it will affect the economy of the entire household and nutrition because men are not able to cook for their families. We do not know how to prepare food, and we have to learn.'

Of the respondents, 80 percent of women and girls said that they took care of children and elderly relatives on their own, and only 19 percent shared such tasks with men. Only 1 percent of respondents said that men bore the burden of care. Similarly, the burden of caring for sick family members rested solely on the shoulders of women in 79 percent of cases. Of the women and girls interviewed, 84 percent perform household tasks and chores (cooking, cleaning, etc.) without help from men. Similarly, 74 percent of women and girls are exclusively responsible for the management of waste, along with cleaning the yard and basic household sanitation.

Disasters exacerbate pre-existing inequalities and barriers facing women and girls, exposing them to even greater risks in their multiple roles at household level. In the aftermath of a disaster, they have to struggle through recovery efforts; female respondents in all the focus groups said that women and girls often have to

work harder to secure resources, such as water, food and fuel. This reinforces the cycle of poverty and vulnerability faced by women, since in such situations their life choices are increasingly restricted in terms of earning an income, seeking an education or participating in decision-making processes.⁹³ Women make huge efforts and sacrifices to overcome the difficulties created by a disaster or epidemic, but their roles as primary care-givers, food producers and providers, health guardians and economic actors are still not properly recognized. There is an urgent need to pay serious attention to the needs and voices of women and girls in emergency strategies for prevention, mitigation and response in order to broaden and strengthen opportunities for their inclusion, and to make full use of women's leadership capabilities in disaster risk reduction (DRR) planning and activities.

As already mentioned, the Zika epidemic is having an indirect negative impact on girls, who are likely to drop out of school in order to help with household tasks and to care for members of the family who are sick. Many elderly people are physically, socially and emotionally dependent on their families and on community support networks and grassroot associations. Failure to strengthen community-based networks can significantly weaken the support provided to the most vulnerable groups.⁹⁴

After Hurricane Noel, in addition to the loss of their homes and productive resources (e.g. agriculture, cattle), elderly women faced a severe worsening of chronic health conditions. Their levels of autonomy were also affected, as many had to move into the homes of their sons or daughters. Many suffered from post-traumatic stress as the losses they had suffered, combined with health problems, robbed them of hope for the future.⁹⁵ A Zika epidemic occurring as a consequence of a major natural disaster could worsen the physical and mental health of elderly people, particularly women, as well as increasing the burden of unremunerated work at the household level.

3.2 CARE WORK IN THE COMMUNITY

Women and girls play an important role in the recovery process after a natural disaster or an epidemic. Analysis of the qualitative data collected for this study shows that many women in affected communities are especially proactive. They understand the consequences and potential long-term impacts of disasters and epidemics on their villages or neighbourhoods, and they really want to make a difference for the futures of their children and of their communities. A woman in an FGD in San Cristóbal remarked: 'Mostly women dedicate their time and efforts to community work, while men are working outside.'

The FGDs showed that women and girls tended to internalize the role of care-givers at household and community levels, often holding themselves responsible for the success or failure of health campaigns. Women in an FGD in Monte Cristi remarked: 'A woman has to work from when she wakes up until she falls asleep.' 'Women's work is endless; they are the ones who work the most and have to compromise the most within the community.'

Women in an FGD in Puerto Rico made the following observations: 'The public health authorities do not take account of women. They joined a disinfection operation just because the community organized and coordinated it; otherwise they wouldn't have done anything.' 'I think we have a lot of information on mosquito-borne diseases. We have to raise concerns and awareness that it is not a matter of responsibility for public health, but for each one of us.'

It is therefore essential to include measures that actively promote the participation and leadership of women and girls in DRR planning and preparedness. This will build on the work already being done by women and girls and ensure that they are visible in decisions that affect their lives and the well-being of their communities. Disasters should be seen as opportunities to galvanize momentum towards more comprehensive participation and representation of women in all aspects of risk reduction.⁹⁶

3.3 PARTICIPATION IN PUBLIC HEALTH PROGRAMMES

Public health programmes for the prevention of Zika and education about the virus are mostly based on a top-down strategy that does not involve the targeted populations in their design or in monitoring and evaluation (M&E). This is evident from the way that health sector stakeholders describe the programmes. One government public health promoter said: 'We go from home to home disinfecting with Abate and giving instructions on how to keep the chemical. We apply the norms set out by the Ministry of Public Health and we undertake prevention programmes through talks, direct action in coordination with civil society organizations [CSOs] and promoting health education.'⁹⁷

These programmes seem to be successful in communicating appropriate information on mosquito-borne diseases, as demonstrated by the level of knowledge shown by local people in the urban locations surveyed. However, information about the potential sexual transmission of Zika is still poor. A participant in an FGD in Monte Cristi stated: 'Contaminated water is the main source of infection and outbreaks of dengue and Zika in the community.' Another in Comendador described the problems facing communities thus: 'Very low levels of defence, unhygienic, dirty water, no fire hydrants, ditches with water, a polluted environment, a lot of garbage, a lack of fumigation, lack of prevention to avoid mosquitoes breeding, lack of financial insurance. Garbage is a constant, we also have no water and we have to collect it in water tanks.'

Moreover, the lack of consultation with local populations and their scarce involvement mean that the gender perspective is not taken into account at any level. A UNAP health specialist said: 'We don't take into account the gender dimension; we just collect data with no differences. There is no gender difference in promotion yet, despite the difference in exposure to mosquitoes due to the differing roles of women and men.'

Epidemics have diverse impacts on different gender and age groups, and these need to be identified and properly addressed. It is not only women and girls who suffer from the differentiated impacts of Zika: children with microcephaly reportedly risk being abandoned by their parents, especially after the first or second year of life, which suggests that the rate of abandonment will increase considerably in years to come. To minimize this risk, the state should provide adequate training and support for families with infants with microcephaly to enable them to care for the child in their own homes. It should also provide sufficient resources and support for public and private institutions in order to ensure appropriate care for children who may necessitate special assistance.

Elderly people also require programmes that address their specific needs. Many people in this group display an attitude of passivity and resignation in response to disasters, due to the mobility difficulties they face and their lack of involvement in community prevention and disaster management activities. This highlights the need to adapt prevention strategies, communication and access to information for elderly people, to avoid reinforcing patterns of exclusion.⁹⁸

3.4 COPING STRATEGIES

Women, girls, men and boys all cited the lack of WASH facilities at both household and community levels as one of the major problems in their neighbourhoods, and a major driving factor of increased risk of infection by Zika and other mosquito-borne diseases. Respondents also said that poor waste management and the prevalence of stagnant water in their communities were creating centres for infection by mosquito-borne diseases. All these are breeding grounds for mosquitoes and increase the risk of dengue fever, chikungunya and Zika virus.

In order to minimize these risks, respondents, mostly women and girls often confined at home, reported that as a coping strategy they had increased levels of household hygiene; some said that poor hygiene conditions were not related to poverty but rather were a matter of individual choice. Women and girls in the FGDs in Santo Domingo (San Cristóbal) stated that to prevent the spread of diseases it was important to start with proper waste management in their homes and with the treatment of standing water (for example,

by covering open water tanks and containers). However, even if they improve sanitation conditions in their own homes, poor conditions at the community level undermine their efforts. One woman said: 'If I clean my house and surroundings but my neighbour is not doing the same, it is impossible to stop the creation of fertile ground for mosquito-borne diseases. We have to work together at community level.'

Levels of knowledge about the connection between Zika virus and microcephaly are still low. However, pregnancy tests are another coping mechanism used by sensitized women and girls to reduce the risk of passing the infection to their children.⁹⁹ Male respondents said that to prevent Zika it was important to ensure better hygiene conditions and to be aware of any contamination centres in order to avoid unnecessary exposure.

4 PRIORITIES AND OPPORTUNITIES FOR GENDER-RESPONSIVE PROGRAMMING

4.1 PRIORITY NEEDS

There is a significant gender disparity in terms of priority needs. Women and girls are deprioritized in access to health services, information, WASH facilities, prevention of GBV and livelihood support, as well as in the provision of food and shelters. A lack of economic resources to purchase medicines to treat Zika and to pay for health insurance were two priorities identified by respondents. Private clinics in the Dominican Republic are costly and medical insurance is needed to ensure access to healthcare. Public hospitals and UNAPs often lack doctors, medicines or they are costly. Furthermore, as repeatedly reported by respondents and by women and girls specifically, doctors sometimes neglect patients or even mistreat them.

The lack of hospitals and medical centres is evident across all the selected neighbourhoods, where it can take from 30 minutes up to an hour to reach the nearest health facility. The cost of getting to a clinic or hospital was seen as high by all respondents. Female respondents frequently expressed concerns about security while travelling to hospital, citing the risk of assault, robbery and GBV, especially at night.

Another priority identified was the provision of chemical treatments for water and larvicides (such as Abate) of sufficient quality and quantity and at relevant times to reduce the prevalence of mosquito breeding grounds, as well as effective waste management solutions and public sanitation facilities. Across different segments of the population, the non-food items (NFIs) most commonly prioritized by the 101 respondents were mosquito nets and repellents.

4.2 STRATEGIES TO ADDRESS UNMET NEEDS

Long-term needs identified by respondents included investment in infrastructure such as hospital and clinics, with special regard to maternity and paediatric facilities; in the surveyed neighbourhoods medical facilities are either scarce or completely absent. Most respondents, both male and female, cited the need for access to free medical treatment and care and the need for doctors and other medical personnel to be trained and aware of gender-based and obstetric violence.

Water supply structures, water treatment against mosquito-borne diseases and segregated latrines for women, girls and children (properly lit and lockable) were also mentioned as priorities. In addition, respondents cited the need for secure transportation to enable them to access health facilities and the importance of improving public ambulance services. Specific requests from women focused on support for hygiene and sanitation at household and community levels, as well as cash for health programmes to ensure access to medical care for them and their families. Female respondents also cited the need for better sexual and reproductive care and for the provision of information on the risk of Zika being sexually transmitted to all sections of the population, along with education and awareness-raising programmes to sensitize people on ways to prevent, mitigate and respond to the Zika outbreak.

5 RECOMMENDATIONS

Based on the analysis above, this report puts forward key recommendations for gender-responsive programming interventions along the humanitarian/development continuum. While focused on the Dominican Republic, these findings may also be important reference points for the humanitarian community in responding to the crisis in neighbouring countries, including Haiti where a large-scale response is under way following Hurricane Matthew in September/October 2016.

Targeted gender recommendations for responding to Zika (humanitarian agencies – NGOs, government and volunteer agencies)

Guarantee care and support focusing primarily on the needs of women and girls of childbearing age and children born with complications due to infection with the Zika virus and families and communities affected by or at risk from the Zika outbreak. To minimize the risk of infants with microcephaly being abandoned, the state should provide adequate training and support for families to enable them to care for the child in their own homes, as well as sufficient resources and support for public and private institutions to ensure appropriate care for children who require special assistance.

Urgently provide health education/promotion and hygiene kits, especially to female-headed households, to prevent the spread of disease, as well as detailed information about the Zika virus and how it is spread. The kits should also address the prevention of other diseases such as dengue fever and chikungunya.

Ensure universal access to a full range of high-quality, voluntary and user-friendly contraceptive methods, including barrier methods such as female and male condoms and emergency contraception, as well as comprehensive information and services on sexual and reproductive health, including antenatal services to enable early detection of microcephaly, quality obstetric care, safe abortion services (where legal), and post-abortion care.

Target women, girls, men and boys in public health awareness campaigns, especially in light of recent evidence that Zika can be sexually transmitted, recognizing that the responsibility for safer sex methods falls on both men and women and cannot be shouldered by women alone.

Address the psychological and economic impact of complications caused by the Zika virus by providing adequate psychosocial and mental health support and by dealing with the long-term implications for children affected by microcephaly and other complications through rehabilitative services, early stimulation, social assistance and protection, psychosocial support and specialized healthcare and education.

Extend the categorization of vulnerable populations to include breastfeeding mothers affected by Zika or at risk of being infected, with the provision of a food package that follows normal infant feeding guidelines as set out by WHO.¹⁰⁰

Targeted gender recommendations for mainstreaming Zika in humanitarian response

Provide additional safe and appropriate shelters for populations affected by natural disasters, taking account of UNDP and IOM minimum standards and ensuring safe water and functioning latrines and the provision of the most urgently needed NFIs (e.g. mosquito nets, repellents and hygiene kits).

Create income-generating opportunities for women and men to overcome the loss of their traditional livelihoods due to natural disasters and epidemics such as Zika.

Enhance school enrolment rates for girls by providing 'cash for education' to them or their families in order to pay school fees and cover meal costs, as a strategy to avoid early marriage and unwanted pregnancies.

Install WASH hardware, based on participatory and inclusive consultation with all community members on the most appropriate designs and locations for lockable latrines, safe and well-lit bathing spaces and solid waste management systems to improve the availability and usage of clean water and to reduce the prevalence of open defecation.

Ensure special attention to the protection of high-risk groups such as pregnant and breastfeeding mothers, babies, infants, older people, those with restricted mobility and those who are sick.

Enhance the participation of women and girls in empowerment and leadership roles in response and recovery programmes and provide resources and tools to women's groups and networks to increase their decision-making power.

Targeted recommendations for responding to the Zika crisis (government health systems)

Consider 'health cause' when microcephaly is confirmed as a reason for access to legal, safe, comprehensive, free and high-quality procedures for termination of pregnancy, free of any requirement for marital or parental consent. Simply encouraging women not to get pregnant when access to safe abortion is limited or abortion is totally criminalised risks driving up rates of unsafe abortion, with increased levels of maternal morbidity and mortality.

Support pregnant women and girls who decide to continue their pregnancy to carry it safely to term, including providing access to comprehensive pregnancy, safe delivery, pre- and post-partum care and neonatal care services, as well as the provision of special needs therapy and health and educational services as needed for children with microcephaly.

Improve paediatric care services, including early screening and support for women/girls and their children affected by foetal or newborn complications. All children born to women infected with Zika should be monitored closely for complications for at least three years after birth.

Promote gender equality and human rights approaches in health systems and ensure that health communication and promotion campaigns have a gender perspective, to guarantee female-friendly medical spaces and treatments (and adequate care for children) and to ensure gender justice in the distribution of benefits, power, resources and responsibilities to avoid creating new gender inequalities or reinforcing existing ones.

Conduct country trainings against GBV for public health personnel to prevent cases of GBV against women and girl patients, and support surveillance and accountability mechanisms against GBV perpetuated by health professionals.

Encourage the active participation of affected women, girls, boys and men in the design, implementation monitoring and evaluation of public health communication campaigns and in health service provision by taking into consideration social determinants of differential access to health (such as gender, age, socio-economic status, household characteristics, education levels, disabilities, ethnicity and language barriers) in the design of interventions.

Ensure that the health sector implements WHO/FAO guidelines for pesticide management and updates vector control practices according to WHO/FAO indications.¹⁰¹ In addition, disaster-affected populations must be informed about the potential risks of substances used in chemical vector control and the

schedule for application, and must be provided with protection during and after the application of poisons or pesticides, according to internationally agreed procedures.

Improve systems for the collection of sex- and gender-disaggregated data and ensure that a gender-based approach is integrated into health services, especially at the local level.

Ensure that Haitian migrants, refugees, asylum seekers and internally displaced persons, as well as hidden, poor, marginalized or hard-to-reach populations, are included in national health and protection response plans, and that relevant activities are carried out in coordination with local authorities and partners.

Targeted gender recommendations for addressing Zika in Disaster Risk Management (government and humanitarian agencies)

Increase coordination among humanitarian actors to guarantee cooperation between the Dominican state and civil society actors (including women's rights groups, academia and the private sector) through existing platforms, such as the WASH Working Group, at both national and provincial levels, working in conjunction with the Provincial and Municipal DRM Committees.¹⁰²

Encourage leadership by women and girls, and women's rights groups and networks, in disaster risk management to coordinate and implement actions and programmes to meet the special needs of women and youth affected by disasters and epidemics.

Take concrete steps to prevent the spread of vector-borne diseases as part of the state's DRM policies via the National Emergency Commission and organized civil society platforms such as the Disaster Risk Management Forum and the Feminist Forum.¹⁰³

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