



Illustrative Gender Indicators for Family Planning and Reproductive Health

Click the text of each of the following indicators to link to its source in the global literature.

Sex-Disaggregated Indicators:

[The number or percentage of clients \(community and facility based\) who receive FP counseling \(by sex\)](#)

[The percentage of clients with sexually transmitted infections who are diagnosed and treated appropriately \(by sex\)](#)

[The percentage of women of reproductive age and men \(ages 15–49\) using modern contraception/Contraceptive Prevalence Rate](#)

[The percentage of women and men who have heard of at least one long-acting or permanent method \(LAPM\)](#)

[The percentage of women and men who intend to use an LAPM in the future](#)

[The number or percentage of married women and men under the age of 18 exposed to healthy timing and spacing of pregnancy \(HTSP\) counseling or education who subsequently adopted an FP method to delay first pregnancy](#)

[The percentage of sexually active, unmarried adolescents who consistently use condoms \(by sex\)](#)

The Importance of Gender in Family Planning and Reproductive Health Data

Addressing gender when monitoring and evaluating family planning and reproductive health (FP/RH) projects and interventions helps to ensure equity in access and benefits for men and women. This brief explores the importance of gender in monitoring and evaluation (M&E) activities and suggests indicators to reveal and explain gender gaps in FP/RH outcomes.

Background

Gender discrimination and inequities limit women's and men's access to good-quality FP/RH services. They also hinder women's ability to negotiate FP and use contraception effectively. Though traditional gender roles generally place greater constraints on women's access to FP/RH programming, men, too, face gender-related barriers. Men may not feel comfortable accessing FP/RH services that are offered in primarily women-only spaces or may view FP/RH as a woman's issue.

The 1994 Cairo International Conference on Population and Development (ICPD) made a global commitment to women's empowerment, with support from and in partnership with men, as the centerpiece of FP/RH programming (United Nations Population Fund, 1994). Prior to ICPD, FP programs had been tailored almost exclusively to women, focusing on contraceptive prevalence and women's access to services. Over the past 20 years, FP/RH strategies and interventions have actively engaged men not only for the benefit of women but also to address men's FP/RH needs, and gender equity, as a whole. Men have been involved in the development of specific international goals toward gender equality, women's empowerment, and sexual and reproductive rights (Sachs & McArthur, 2005; Magar, 2015; Fredman, Kuosmanen, & Campbell, 2016). These paradigm shifts underscore the importance of including men in data collection for programs, through sex-disaggregation and collection of data on male-specific contraception. Program designers and implementers should also include men's perspectives when measuring gender norms and inequalities, because these are factors that influence demand for and use of FP services (Greene, Mehta, Pulerwitz, Wulf, Bankole, & Singh, 2006).

Access to FP/RH services can promote gender equality, by increasing women's power over reproductive choices and expanding their social and economic opportunities (Health Policy Project, 2014). Behavior

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Gender-Sensitive Indicators:

[The percentage of men and women who share decision making of reproductive health issues with their spouse or sexual partner](#)

[The percentage of men \(husbands\) who are supportive of their partner's reproductive health practices](#)

[The percentage of men who support the use of modern contraception for themselves or their partners](#)

[The availability of accessible, relevant, and accurate information about sexual and reproductive health tailored to young men](#)

[The percentage of users of contraceptive methods whose method requires male cooperation](#)

[The percentage of men who accompany their partner to an antenatal care visit](#)

[The percentage of men present at the health facility during the birth of the last child](#)

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

The existence of an FP/RH strategy that includes gender, addressing the needs and vulnerabilities of men, women, girls, and boys

change communication efforts address underlying attitudes towards gender equality that influence demand for and use of FP services. Because gender norms both affect and are affected by FP/RH programs, effective program implementation requires attention to this interaction. The U.S. Agency for International Development (USAID) seeks to understand gender differences through M&E activities, both to improve the overall impact of its programs and to ensure that women and men have equitable access to the services they need.

Integrating Gender in FP/RH Data

Despite a programmatic shift to include men, many FP service data are not disaggregated by sex. Often these data don't include men at all. Data collection tools available at health centers, such as patient registers and files, do not facilitate tracking male involvement in FP. Community-based FP data-collection tools also neglect measures for capturing male engagement. Because of a lack of routine FP data for men, information on men's FP/RH behavior, attitudes, and use must be gathered from program-specific M&E or semi-periodic demographic health surveys (DHS). Collection, analysis, and reporting of gender- and age-disaggregated data are critical to fully understand the specific needs of men, women, boys, and girls across the life cycle.

To address gaps in FP/RH outcomes, indicators that specifically address gender are essential. These gender-sensitive indicators make it easier to assess how effectively gender dynamics that negatively influence FP/RH have been addressed. Data from indicators on method availability, uptake, and choice can reveal gender imbalances regarding responsibility for FP. The ability to identify these imbalances has important implications at both a programmatic and country level. On the one hand, vasectomy, though safer and less costly, is much less widely available and less widely used globally than is female sterilization. Nearly one-third of all contraceptive users rely on female sterilization, but only seven percent rely on vasectomy, suggesting a heavy bias toward female responsibility for contraception. On the other hand, the male condom, fertility awareness methods, and withdrawal all require male participation or responsibility. Data collected on these methods, and disaggregated by sex, can thus illuminate changes and trends in male and female involvement in and responsibility for FP.

Questions to Assess How Gender Affects FP/RH Outcomes

One can ask a number of questions to assess if and how gender influences FP/RH data and outcomes. We list some of them here:

- Are there gender constraints around who has the authority to access FP/RH services?
- Who in the couple makes FP decisions?
- Do women need permission to seek a contraceptive method for themselves?
- Are there gender norms that affect men's or women's perception of using FP?
- Are there gender norms that affect men's or women's use of FP/RH services?
- Are there unequal decision making abilities between men and women about whether and when to seek FP/RH services?
- Are there gender differences in who is accessing FP/RH services?
- Are there broader, systematic barriers to how men and women access FP/RH services?
- Is there accessible, relevant, and accurate information about FP/RH tailored to young men?
- Are FP/RH service providers friendly to men?
- Do FP/RH facility and/or community-based providers facilitate male involvement?

Resources

- MEASURE Evaluation. [M&E of Family Planning](#).
- MEASURE Evaluation. [Family Planning and Reproductive Health Indicators Database](#).
- WHO. (2016). [A Tool for Strengthening Gender-Sensitive National HIV and Sexual and Reproductive Health \(SRH\) Monitoring and Evaluation Systems](#).
- IGWG. (2002). [A Framework to Identify Gender Indicators for Reproductive Health and Nutrition Programming](#).
- IPPF. (2000). [Manual for Evaluating Quality of Care from a Gender Perspective](#).

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Definitions

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

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

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

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

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

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

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

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

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

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

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