



## Illustrative Gender Indicators for HIV

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

### Sex-Disaggregated Indicators:

[The proportion of young people \(ages 15–24; men and women\) who have had sexual intercourse before the age of 15](#)

[The percentage of adults \(men and women\) who report the use of a condom during their last intercourse](#)

[The percentage of people \(men and women\) who received an HIV test in the past 12 months and know their results](#)

[The percentage of people living with HIV \(PLHIV\) \(men and women\)](#)

[The percentage of eligible people \(men and women\) currently receiving antiretroviral therapy](#)

[The percentage of people \(men and women\) on antiretroviral therapy who are virally suppressed](#)

[The percentage of key populations who are living with HIV](#)

### Gender-Sensitive Indicators:

[The prevalence of intimate partner violence](#)

[The proportion of respondents who believe that if a woman's husband has an STI, she can propose condom use](#)

[The percentage of currently married women who usually make a decision about their healthcare, either by themselves or jointly with their husbands](#)

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

[Existence of a multisectoral strategy to respond to HIV that has a specific budget for HIV-positive women](#)

[Laws, regulations, or policies that present obstacles to effective HIV prevention, treatment, care, and support for key populations and vulnerable groups](#)

# The Importance of Gender in HIV and AIDS Data

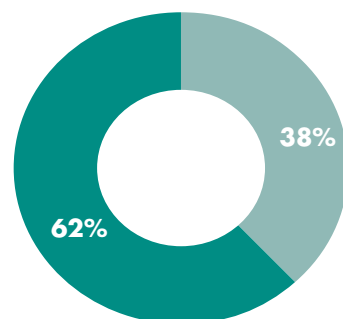
Addressing gender when monitoring and evaluating HIV projects ensures equity in access and benefits for men and women. This brief establishes the importance of addressing gender in monitoring and evaluation activities and suggests indicators to reveal and explain gender gaps in HIV and AIDS outcomes.

## Background

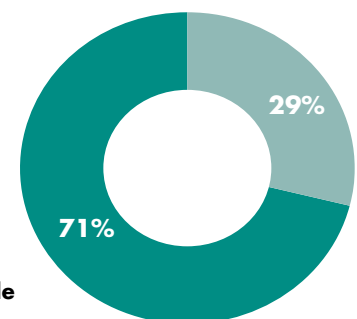
Gender constructs change across location and time and have a significant impact on a person's health outcomes. Gender expectations shape behaviors and beliefs related to HIV risk and vulnerability. They also affect health-seeking behavior for HIV testing, treatment, and adherence. Gender also shapes the way in which HIV services are structured and provided. These social expectations lead to important differences in HIV risk and service use for men, women, and key populations, and the associated outcomes. Here are some telling facts:

- HIV is the leading cause of death for women of reproductive age, worldwide (World Health Organization, 2013).
- Globally, only three out of every 10 adolescent girls and young women (ages 15–24) have comprehensive and accurate knowledge about HIV (Joint United Nations Programme on HIV/AIDS, 2016).
- Globally, men who have sex with men are 19 times more likely to be HIV-positive than the general population (El-Bassel, Shaw, Dasgupta, & Strathdee, 2014).
- Transgender women are 48 times more likely to have HIV than others of reproductive age (Gilbert, et al., 2015).

**Proportion of new HIV infections among adolescents that are among adolescent girls in sub-Saharan Africa**



**Proportion of new HIV infections among adolescents that are among adolescent girls globally**



Source: UNAIDS, 2016

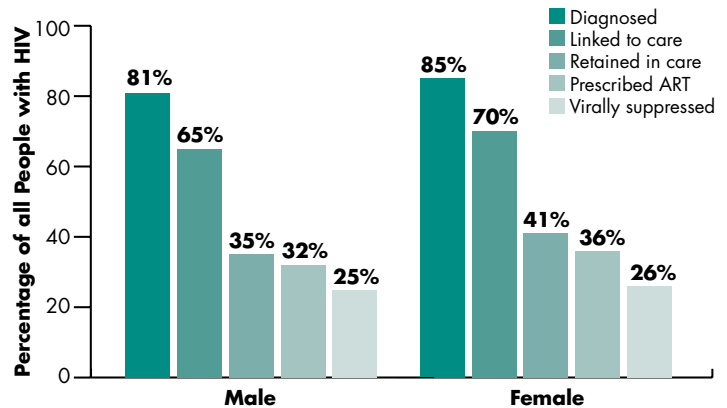
Increasingly, there is also evidence that gender norms play a role in creating these disparities. For example:

- Harmful notions of masculinity can increase men’s risk-taking behavior, making them vulnerable to acquiring HIV (Sikweyiya, Jewkes, & Dunkle, 2014). The same notions make men less likely to seek help and may give men a harder time adjusting to living with HIV, post-diagnosis (Dworkin, 2015).
- Among people who inject drugs, women are often at greater risk for contracting HIV. Common shared-needle practices involve women using needles last, after their male partners (El-Bassel, et al., 2014).
- Women also face different challenges than men when seeking HIV treatment, including fear of status disclosure and subsequent GBV [gender-based violence] and IPV [intimate partner violence] (Gilbert, et al., 2015; Wechsberg, et al., 2015).

Unequal power relationships increase women’s vulnerability, by limiting their ability to negotiate sexual relationships and condom use, restricting women’s access to and use of health services, and exposing women and girls to violence. Harmful gender norms and practices associated with a culture’s understanding of masculinity can increase the likelihood that men and boys will engage in sexual risk-taking and substance-use behavior that exposes them to HIV. Gender norms for men and boys may reduce or delay help-seeking behavior and testing and treatment adherence after they acquire the virus. Socially marginalized populations, such as men who have sex with men, female sex workers, and transgender people, are more likely to be exposed to HIV and less likely to seek testing and treatment for fear of social stigma (Foundation for AIDS Research, 2010; Baral, Poteat, Strömdahl, Wirtz, Guadamuz, et al., 2013; U.S. President’s Emergency Plan for AIDS Relief, 2013)

## Integrating Gender in HIV Data

The most fundamental way to understand the effect of gender on program efforts is to disaggregate key indicators by sex. This data can identify where, when, and if gender inequalities exist. Sex disaggregation will be imperative in achieving the 90-90-90 goals of the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR),<sup>1</sup> because it can identify gender gaps in testing, treatment, and adherence so that programs can be targeted more effectively. For example, where women are more vulnerable, data will likely show that they have a higher prevalence of HIV. Women will also likely have a greater presence throughout the care cascade. Data visualization by sex can quickly show if percentages of females diagnosed, linked to care, retained in care, and prescribed antiretroviral therapy are slightly higher than for males, as shown in the figure.



Source: U.S. Centers for Disease Control and Prevention, 2012

Disaggregating data by sex can be challenging and time-consuming, especially without a computer-based system. If resources are scarce, results from a gender analysis (such as those conducted in all PEPFAR countries) (President’s Emergency Plan for AIDS Relief, 2013) could help determine which data should be prioritized for sex-disaggregation. More expedient means to obtain the data needed to uncover gender-related disparities are a record review in a few facilities, to explore potential testing and treatment differences by sex; focus groups with providers; or small-scale surveys. PEPFAR data and other HIV program data are disaggregated by sex. However, it is also important to disaggregate other health data that intersect with HIV, such as those tracking tuberculosis, nutrition, or malaria. Although gender-sensitive indicators offer a deeper picture of progress toward gender equity, they are not often collected as part of routine health information, so they must be collected elsewhere. This could be from a special study, which is expensive and time-consuming, or from general national surveys, such as Demographic and Health Surveys (DHS). DHS collect information on household decision making, attitudes towards gender-based violence, spousal age difference, and related topics that can be used to expose gender dynamics in a population that may influence health outcomes.

Gender-sensitive indicators can illuminate the reasons gender inequities exist in HIV data. For example, studies have demonstrated that gender-based violence is both a risk factor for HIV acquisition and a consequence of acquiring the virus. Gender-based violence increases the risk of acquiring HIV (Jewkes, et al., 2006; Jewkes, 2010; Dunkle, et al., 2004), and those living with HIV often experience violence owing to their HIV status (World Health Organization and Joint United Nations Programme on HIV/AIDS, 2010). It is important to analyze data with a gender lens. Low adherence to treatment among women and high prevalence of GBV may indicate that women are not seeking treatment owing to fear of their partner’s reaction.

<sup>1</sup> These state that by 2020, 90 percent of people with HIV will have been tested, 90 percent of those tested will be on retroviral therapy, and 90 percent of those in treatment will be virally suppressed. Source: PEPFAR 3.0. Controlling the epidemic: Delivering on the promise of an AIDS-free generation. Retrieved from <https://www.pepfar.gov/documents/organization/234744.pdf>

## Questions to Assess How Gender Affects HIV Outcomes

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

- Are there differences in exposure and risk between men and women and boys and girls?
- Are there cultural constraints or power dynamics around discussing sexual health issues and condom use with a spouse or partner?
- Are there gender differences in access to information or knowledge about HIV and AIDS?
- Are there gender differences in who is accessing antiretroviral therapy?
- Are there gender constraints around who has the authority to access health services?
- Do women need permission to seek services for themselves or their children?
- Do ideas of what it means to be a man or woman affect service utilization or treatment access?
- Are there gender norms that affect who is responsible for caring for the sick and dead?
- Is there an unequal burden of care based on gender roles?
- Is there provider bias toward clients based on sex, age, sexual identity, or gender identity?
- Is there gender-related bias in how HIV services are provided to women involved in sex work?
- Is there unequal access to good-quality HIV care for men who have sex with men, transgender women, and sex workers owing to gender-related social and sexual stigma?
- Are there differences in access to good-quality substance use treatment and HIV care between men and women who use injection drugs?

## Resources

- MEASURE Evaluation. (2014). [Compendium of Gender Equality and HIV Indicators](#)
- MEASURE Evaluation. (2016). [Guidelines for Integrating Gender into an M&E Framework and System Assessment](#)
- MEASURE Evaluation. (2012). [Gender and Health Data and Statistics: An Annotated Resource Guide](#)
- MEASURE Evaluation. (2008). [Violence Against Women and Girls: A Compendium of Monitoring and Evaluation Indicators](#)
- WHO. (2016). [A Tool for Strengthening Gender-Sensitive National HIV and Sexual and Reproductive Health \(SRH\) Monitoring and Evaluation Systems](#)

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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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