Best Practices for Gender in the Monitoring and Evaluation of HIV Programs

Introduction

Gender is a critical component of efforts to control the HIV epidemic. Gender influences who is vulnerable to HIV and able to seek and access care and treatment, as well as norms around HIV prevention, treatment, and stigma. To reach epidemic control effectively, gender must be considered in HIV programs and policies, and thus in monitoring and evaluation (M&E).

MEASURE Evaluation, which is funded by the United States Agency for International Development and the United States President's Emergency Plan for AIDS Relief (PEPFAR), created this brief to share best practices in gender M&E for HIV programming. We recommend including gender at every step of monitoring and evaluating the clinical cascade; using qualitative and quantitative gender data to inform and adapt HIV programming; paying special attention to priority populations; and keeping gender-based violence and structural considerations in the forefront of planning and interpretation to ensure advancement toward HIV epidemic control.

Look at Gender Across the Cascade

The most fundamental way to understand the effect of gender on HIV program efforts is to **disaggregate key indicators by sex**. These data can identify where, when, and if gender inequalities exist. Sex disaggregation is imperative in achieving the 95-95-95 goals[1] because it can identify gender gaps in testing, treatment, and adherence so that HIV-affected populations can be reached more effectively.

For example, an analysis of data from Demographic and Health Surveys in 16 countries found that, on average, about 54 percent of people living with HIV were aware of their status; in most of these countries, women were more likely than men ever to have been tested (Staveteig, et al., 2013). Young women are twice as likely to acquire HIV as their male counterparts. In addition, gender norms, such as perceived weakness of men seeking healthcare, can have negative impacts on the HIV cascade for men. For example, studies have shown that men often enroll in antiretroviral therapy (ART) later than women, which can reduce life expectancy (Croce-Galis, et al., 2015).

Age can be a compounding factor in behavior, power and decision making, and health outcomes. Data across the care cascade should therefore be **disaggregated and analyzed by sex and age**. If there are differences between men and women or boys and girls, there is a need to identify the sex and age cohorts not being reached with prevention, testing, and treatment services, and the reasons why. Reporting of age bands by PEPFAR programs should follow monitoring, evaluation, and reporting (MER) indicator standards (PEFPAR, 2017).

The following are examples of HIV M&E related to gender and the cascade:

- The Importance of Collecting and Using Valid Data on Reaching Partners Through Index Testing for HIV Results and Recommendations
- Using Social Media Data to Understand Changes in Gender Norms

Collect Quantitative and Qualitative Data

To fully understand, track, and address gender in HIV, use both quantitative and qualitative data when possible. Quantitative data help answer the question of **what** is happening regarding gender in HIV, and qualitative data begin to illuminate **why** it might be happening.

Quantitative data, whether they are routine health information system data or special surveys, should be collected, analyzed, and reported by sex and age. In addition to disaggregating data by sex, **gender-sensitive indicators** can help identify program successes and gender-related

[1] These goals state that by 2030, 95 percent of people with HIV will have been tested, 95 percent of those tested will be on retroviral therapy, and 95 percent of those in treatment will be virally suppressed.

gaps that may hinder HIV prevention or treatment efforts. Gender-sensitive indicators measure changes in the status, roles, expectations, and norms pertaining to people based on their sex (USAID, 2017). These indicators are often complex, sometimes requiring more advanced data collection and analysis, but they offer an in-depth picture of gender equality in a community or region. The following are some examples of gender-sensitive indicators:

- Proportion of people (disaggregated by sex) who experienced physical violence from an intimate partner in the past 12 months
- Proportion of people (disaggregated by sex) who agree that women should have the same rights as men
- Proportion of women who can make decisions about their own healthcare/healthcare for their children

The benefits of using both quantitative and qualitative data can be seen in a recent study to characterize the male sexual partners of adolescent girls and young women (AGYW) in Mozambique. This study used focus group discussions with AGYW to learn about the types and characteristics of male sexual partners, HIV risk behaviors, and gender dynamics. AGYW were also asked the types of public spaces where male sexual partners congregate so men could be reached for a quantitative survey. Quantitative data were collected from adult men about their sexual partners and behaviors, HIV risk behaviors, and HIV service use and preferences. The mix of qualitative and quantitative data allowed researchers to obtain an in-depth picture of AGYW perspectives about and experiences with their sexual partners, power imbalances, and sexual risk-taking—in combination with examining associations between the characteristics of men and types of AGYW partners, sexual risk-taking behaviors, and access to HIV services. Results led to a better understanding of current gaps and more targeted recommendations for HIV programming (Chapman, et al., 2018).

Focus on Priority Populations

Gender often intersects with other identities, such as age, occupation, and sexual orientation, thus compounding the risk of HIV infection and onward transmission. As such, certain groups may be a priority for program targeting.
Compare trends within your population of interest to the general population trends to understand whether there are differences that need to be programmatically addressed. **Size estimates** help to show whether observed differences are to be expected or not. One tool to help you understand the size of your priority population is the MEASURE Evaluation-developed Priorities for Local AIDS Control Efforts (PLACE) method, which you can use to identify and tailor prevention programs based on where key populations are found within communities (n.d.). Size estimates from PLACE or other studies (such as an Integrated Biological and Behavioral Surveillance Survey) can also provide the **denominator** for the "first 95 goal" specific to your priority population.

Adolescent Girls and Young Women

In sub-Saharan Africa, AGYW (ages 15–24 years) account for one in five new HIV infections, despite constituting just 10 percent of the population; also, in the hardest-hit countries, adolescent girls account for more than 80 percent of new HIV infections in their age group (UNAIDS, 2019). Along with their being more vulnerable to infection, laws, policies, and stigma can create obstacles for AGYW in accessing HIV treatment, care, and support services, including coercive HIV testing, age-of-consent requirements, and mandatory parental consent notification (Basu & Menon, 2011). Because of their age and vulnerability, data collection on AGYW must be carried out ethically and thoughtfully to ensure appropriate consent and follow international guidelines. Despite data collection challenges, it is important to measure barriers that AGYW face in accessing care and treatment, which may require special studies and data from multiple data sources, including data on education, health, and social services.

HIV infections among AGYW may occur within the context of sexual relationships with older men, which are often characterized by inequitable gender norms and lack of power by young women to negotiate condom use or refuse sex. As noted above, **special studies** can characterize male sexual partners of AGYW, the dynamics within these relationships that put AGYW at risk, and the factors resulting in less access to and use of care and treatment.

The following are examples of resources available on HIV M&E related to AGYW:

- Characterizing Male Sexual Partners of Adolescent Girls and Young Women in Mozambique: Key Findings
- Who Are the Male Partners of Adolescent Girls and Young Women in Swaziland? Analysis of Survey Data from Community Venues Across 19 DREAMS Districts

Female Sex Workers

Globally, the prevalence of HIV is 12 times greater among female sex workers (FSW) than the general population (UNAIDS, 2014a). Stigma and discrimination, violence, and punitive legal and social environments are key determinants of increased HIV vulnerability. Punitive environments have been shown to limit the availability, access to, and uptake of HIV prevention, treatment, care, and support for FSW and their clients.

Data on these populations often come from **special studies** that ensure confidentiality and adhere to strict ethical processes to protect the identity of FSW. These studies should also include other **gender considerations,** such as measures of relationship power dynamics and gender-based violence, because FSW are particularly vulnerable and these factors are known to increase HIV risk.

The following are examples of resources available on HIV M&E related to FSW:

- Reaching Key Populations Through Key Venues: Insights from the Jamaica HIV Prevention Program
- Haitian Female Sex Workers in the Dominican Republic A Qualitative Study of HIV Vulnerability and Service Use

Men Who Have Sex with Men

When compared with the general population, men who have sex with men (MSM) are 19 times more likely to be HIV-positive but are less likely to have access to safe and competently delivered HIV services (UNAIDS, 2014b). HIV prevention for MSM has long been complicated by a lack of complete data. MSM may or may not self-identify their sexual orientation as homosexual or bisexual. For this reason, projects implementing services for them should capture information on **sexual behavior** as well as **sexual orientation**.[2]

In some contexts, it may be highly stigmatized or even illegal to identify as a man having sex with men, so programs should be particularly sensitive to **confidentiality** and structuring data collection to safely support elicitation of this information.

Newer interventions for prevention among priority populations, including pre-exposure prophylaxis for MSM, provide opportunities for **new indicators** and data sources. However, as new data emerge, it is critical to assess their **quality and accuracy**.

The following are examples of resources available on HIV M&E related to MSM:

- Unlocking Health Services for MSM and Transgender Women in San Salvador
- Validating Estimates of the Size of Key Populations: A Study in Region 4 of Guyana

Transgender People

Globally, transgender women are 49 times more likely to acquire HIV than the general population (Baral, et al., 2013). Projects implementing HIV service provision may face challenges in obtaining accurate information about a client's **gender identity** because of the stigma and violence that transgender populations face. Gender identity—a person's sense of being male, female, or something else—may differ from the sex they were assigned at birth, so it is important that HIV programs document both sex and gender identity. Gender identity terms and forms of **gender expression** vary across cultures, geographic areas, communities, and at the individual level. It is important to understand and use the **appropriate terminology** to accurately capture meaningful HIV M&E data for transgender clients (MEASURE Evaluation, 2018).

Other challenges include matching data needs to the appropriate measures and **structuring data collection** to support elicitation of sensitive and stigmatized information. Obtaining good-quality data regarding sexual orientation and gender identity is important for PEPFAR programs to better understand how to effectively design, implement, monitor, and evaluate HIV services for transgender persons using accurate data.

Like MSM, transgender men and women often face stigma and discrimination in health services. Although important to measure, lack of stigma and discrimination alone is an insufficient benchmark of quality HIV services. Rather, services must be delivered so they meet national and global standards for the minimum package of services in accordance with recognized guidelines and protocols for HIV services and referrals (Andrinopoulos, Do, Wares, & Djapovic Scholl, 2016). **Assessing the quality of services** for

[2] See the Sexual Orientation and Gender Identity mini course in the Resources section for more information.

key populations can shed light on barriers to progress toward the 95-95-95 goals.

The following are examples of resources available on HIV M&E related to transgender people:

- Measuring Venue-Based Risk_A Programmatic Mapping Study of Key Populations in Khomas Region, Namibia
- Binge Drinking Among Men Who Have Sex with Men and Transgender Women in San Salvador_Correlates and Sexual Health Implications
- Evidence of the Negative Effect of Sexual Minority Stigma on HIV Testing Among MSM and Transgender Women in San Salvador, El Salvador

Gender-Based Violence

Given the high prevalence of gender-based violence (GBV) and its clear association with increased HIV risk, GBV is one of the most critical barriers to reaching epidemic control. Nearly one-third of women experience intimate partner violence in their lifetime, and women who experience intimate partner violence are 1.5 times more likely to acquire HIV (WHO, 2017). Further, experience of GBV is associated with lower use of ART, poorer ART adherence, and worsened viral suppression (Hatcher, et al., 2015).

M&E efforts should incorporate GBV considerations to contribute to **high-quality data collection and reporting** and **incorporate innovative and promising practices** to prevent and respond to GBV and HIV. When conducting any M&E efforts that involve GBV, it is of paramount importance to **do no harm and** maintain utmost **confidentiality**[3]—protocols must be developed and followed to ensure the safety of all (respondents and data collectors/researchers). Secondary data analysis is another good way to examine the potential effects of GBV on HIV outcomes in a safe manner.

The following is an example of resources available on HIV M&E related to GBV:

- Botswana's Gender-Based Violence Referral System Project_Operations Research End Line Report

Structural Influences

Structural factors—such as the social, political, and economic environment—also play a central role in access to and uptake of HIV services, particularly when combined with gender. When designing M&E, it is important to take a moment to identify and unpack the structural factors that might have an impact on someone's exposure to HIV, access to care, ability to stay on treatment, or other aspects of the intervention. For example, women's **property rights** can directly or indirectly influence HIV vulnerability and transmission (Tumlinson, Thomas, & Reynolds, 2014). Other factors, such as **economic empowerment** or the ability to seek **reproductive health services** without consent of a man, can affect a woman's HIV risk.

Gender M&E and HIV Resources

The Importance of Gender in HIV and AIDS Data

Compendium of Gender Equality and HIV Indicators

Gender Matters (Video)

Toolkit for Integrating Gender in the Monitoring and Evaluation of Health Programs

Sexual Orientation and Gender Identity Mini Course

Measurements to Capture the Quality of HIV Services for Men Who Have Sex with Men and for Transgender People

Operational Guidelines for M&E of HIV Programmes for Sex Workers, Men Who Have Sex with Men, and Transgender People – Volumes 1 and 2

Review and Revise: A Tool for Reviewing and Revising Key Population Size Estimates

Evaluating Structural Interventions – Guidance for HIV Prevention Programs

Improving the Quality of Data on GBV to Enhance PEPFAR Program Performance: GEND_GBV Rapid Data Quality Review Tool

Decision Tree for Estimating or Calculating 90-90-90 Among Key Populations

[3] WHO guidelines for researching violence against women can be retrieved from the following: https://www.who.int/reproductivehealth/publications/violence/9241546476/en/; https://www.who.int/reproductivehealth/publications/violence/intervention-research-vaw/en/.

Guidelines on Best Practices for Adolescent- and Youth-Friendly HIV Services – An Examination of 13 Projects in PEPFAR-Supported Countries

Factors Affecting Sex- and Age-Disaggregated Data in Health Information Systems – Lessons from the Field

A Tool for Strengthening Gender-Sensitive National HIV and SRH Monitoring and Evaluation Systems

Violence and HIV Infographic

Compendium of Gender Scales

Gender Considerations Along the HIV Treatment Cascade_An Evidence Review with Priority Actions

Definitions

Gender: A culturally defined set of economic, social, and political roles, responsibilities, rights, entitlements, obligations, and power relations associated with being female and male, and the relationships between and among women and men. Gender varies over time and within and between cultures. Lesbian, gay, bisexual, and transgender people, whether they identify as men or women, can be subject to the same set of expectations and sanctions (Interagency Gender Working Group [IGWG]).

Gender-based violence: GBV comprises physical, sexual, psychological, and other types of violence directed at people based on their biological sex, gender identity, sexual orientation, or perceived nonadherence to culturally defined expectations of what it means to be a woman and man, girl and boy (IGWG).

Gender identity: The personal experience of oneself as a boy or man, girl or woman, as a mix of the two, as neither, or as a gender beyond woman or man (MEASURE Evaluation, 2019)

Gender-sensitive indicators: Indicators that measure gender directly and go beyond sex disaggregation alone; for example, GBV and 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 (USAID, 2017).

Sex: 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, 2012).

Sex- and age-disaggregated indicators: Health indicators 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 (Yinger, et al., 2002).

Sexual orientation: A way to describe who a person is attracted to romantically and sexually, and whether that person is of the same or a different gender (MEASURE Evaluation, 2019).

Transgender: A term used to describe a diverse group of people whose gender identities differ, to various degrees, from that of the sex to which they were assigned at birth (MEASURE Evaluation, 2019).

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