

A tool for

strengthening gender-sensitive national HIV
and Sexual and Reproductive Health (SRH)
monitoring and evaluation systems



World Health
Organization



UNAIDS

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Contents

- Acknowledgements.ix**
- Abbreviations and acronyms.x**
- Introduction1**
- Gender inequality and HIV2
- Gender inequality and sexual and reproductive health.3
- Why has this tool been developed?4
- Who can use this tool?4
- How is the tool structured?5
- How can the tool be used?5

- Module 1 Asking the right questions about monitoring and evaluation of gender inequality 10**
- Introduction 10
- What are the key concepts you need to know? 10
- What you can do? Apply the public health questions approach to monitoring and evaluation 12
- Public health question 1: Understanding gender inequality dimensions 15
 - Step 1: Assess gender-based health inequities 15
 - Step 2: Identify the contributing factors 16
- Public health question 2: Understanding potential responses 17
 - Step 3: Identify promising interventions 18
 - Step 4: Determine what is needed to implement interventions effectively 19
- Public health question 3: Monitoring gender-responsive programming 21
 - Step 5: Monitor the quality of gender-responsive programmes 21
 - Step 6: Monitor the outputs of gender-responsive programmes 23
- Public health question 4: Evaluating results of gender-responsive programming 24
 - Step 7: Evaluate the outcomes of gender-responsive programmes 24
 - Step 8: Evaluate the impact of gender-responsive programmes 25

- Module 2 Identifying an appropriate set of gender-sensitive indicators 30**
- Introduction 30
- What are the key concepts you need to know? 30
- What can you do? Construct a set of gender-sensitive indicators 33
 - Step 1: Assess whether existing indicators are gender-sensitive. 33
 - Step 2: Identify gaps in measuring and monitoring gender-based health inequalities and gender inequality in current M&E framework. 35

Step 3: Formulate indicator sets	42
Adding new indicators to an existing indicator set.	43
A note on data sources	45
Module 3 Generating meaningful data through gender analysis	48
Introduction	48
What are the key concepts you need to know?	48
What can you do? Conduct a gender analysis	50
Step 1: Descriptive analysis	51
Step 2: Analysis of trends, across subgroups and compared with other countries.	52
Step 2a. Analysis of trends	53
Step 2b. Analysis across subgroups.	54
Step 2c. Comparison with other similar populations in different settings	55
Step 3: Data triangulation: analysis of gender inequality as a social determinant of health	57
Step 3a. Analyse knowledge and risk behaviours (proximate determinants)	57
Step 3b. Analyse social and cultural, policy and legal context (structural factors)	58
Conclusions.	62
Module 4 Making M&E systems gender-sensitive	68
Introduction	68
What do you need to know?	68
What can you do?	70
Step 1: Assess the gender-sensitivity of your M&E system	70
Step 2: Improve the gender-sensitivity of your M&E system	72
Conclusions.	74
Glossary	76
Annex 1 Sexual and reproductive health: assess gender-based health inequities.	79
Annex 2 Sexual and reproductive health: identify the contributing factors	80
Annex 3 Sexual and reproductive health: identify promising interventions	81
Annex 4 Sexual and reproductive health: monitor the quality of gender-responsive programmes	83
Annex 5 Sexual and reproductive health: monitor the outputs of gender-responsive programmes	85

Annex 6	Sexual and reproductive health: evaluate the outcomes of gender-responsive programmes	86
Annex 7	Sexual and reproductive health: evaluate the impact of gender-responsive programmes	87
Annex 8	Sexual and reproductive health: gap analysis of how well do major SRH indicator sets measure and monitor gender-based health inequities and gender inequality	88
Annex 9	Sexual and reproductive health: gender analysis.	92
Annex 10	A template for conducting a gap analysis of your own HIV or SRH indicator set	106
References	108

Tables

Table 1	Example of a gap analysis: Measuring gender-based health inequalities and gender inequality in the Kenyan national HIV M&E framework	38
Table 3	HIV prevalence by age and sex, South Africa, 2008.	51
Table 4	Disparity in female–male HIV prevalence rates, by age, South Africa	52
Table 5	HIV prevalence among 15–24 year olds, by sex, South Africa, 2002–2008	53
Table 6	Changes in absolute and relative inequality in HIV prevalence, by sex, among youth, ages 15–24, South Africa, 2002–2008	54
Table 7	HIV prevalence, knowledge and risk behaviours among young people, South Africa, 2008	57
Table 8	Actions that can be taken to make the national M&E system gender-sensitive	73

Figures

Fig. 1	Overview of actions you can take with this tool.	7
Fig. 2	The eight steps of the public health questions approach to gender-sensitive monitoring and evaluation	13
Fig. 3	Adult HIV prevalence, by sex	49
Fig. 4	HIV prevalence (%) by sex and age, South Africa, 2008	55
Fig. 6	HIV prevalence (%) by sex and age, Zambia, 2007.	55
Fig. 5	HIV prevalence (%) by sex and age, Kenya, 2008	55
Fig. 7	HIV prevalence (%) among youth, by sex, South Africa, Zambia and Kenya	56
Fig. 8	Organizing framework for a functional national M&E system	69

Boxes

Box 1	Asking the right questions to understand how gender inequality shapes the HIV epidemic.	15
Box 2	Asking the right questions to identify the role of gender inequality as an underlying factor in shaping HIV vulnerability and inequities in HIV outcomes.	17
Box 3	Asking the right questions to identify effective or promising gender equality interventions in the context of HIV	18

Box 4	Asking the right questions about the requirements for implementing effective gender equality interventions for improving HIV outcomes	20
Box 5a	Process monitoring.	21
Box 5b	Asking the right questions to guide process monitoring of gender-responsive HIV programmes	22
Box 6a	Output monitoring	23
Box 6b	Asking the right questions to guide output monitoring of gender-responsive HIV programmes	23
Box 7	Asking the right questions to guide outcome evaluations of gender-responsive HIV programmes.	25
Box 8	Asking the right questions to evaluate the impact of gender-responsive HIV programmes	26
Box 9	Criteria for good indicators	31
Box 10	Gender-sensitive indicators for HIV.	32
Box 11	Intimate partner violence: a risk factor associated with HIV and a proxy for gender inequality	34
Box 12	Resources for gender-sensitive SRH and HIV indicators and gender equality indicators	36
Box 13	Standards for a coherent and balanced indicator set.	42
Box 14	A coherent and balanced indicator set for measuring and monitoring gender-based health inequalities and gender inequality.	43
Box 15	Criteria for adding new indicators	44
Box 16	Absolute versus relative inequality	49
Box 17	Intimate partner violence, relationship power inequity and HIV infection among young women in the Eastern Cape of South Africa	59

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Abbreviations and acronyms

AIDS	acquired immunodeficiency syndrome
ANC	antenatal care
CEDAW	Committee on the Elimination of Discrimination Against Women
DHS	Demographic and Health Survey
HIV	human immunodeficiency virus
ICPD	International Conference on Population and Development
IPV	intimate partner violence
MC	male circumcision
MDG	Millennium Development Goal
MICS	Multiple Indicator Cluster Survey
M&E	monitoring and evaluation
NCPI	National Commitments and Policy Instrument
NGO	nongovernmental organization
SRH	sexual and reproductive health
STI	sexually transmitted infection
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
WHO	World Health Organization

Introduction

Gender inequality adversely affects the health of millions of women and girls throughout the world. It is a key social determinant of health, shaping exposure to health risks and affecting health behaviours, access to services, and health outcomes, including morbidity and mortality.

In all societies unequal gender relations, roles and norms privilege men over women in terms of power, resources, authority and status. This privilege, while benefitting men, can also affect their health by translating into risky and unhealthy behaviours. Interventions and programmes to address gender inequality and women's human rights are critical to efforts to reduce health inequities overall (Sen and Östlin, 2008).

A strong evidence base is important for targeting health programmes and services and reducing health inequities in all countries. Policies and programmes to improve health outcomes and reduce health inequities are more effective when systems are in place to record, report, measure and monitor health data, analyse such evidence and apply it to design effective strategies. The 2008 final report of the World Health Organization (WHO) Commission on the Social Determinants of Health emphasized the need to ensure that routine monitoring systems are in place locally, nationally and internationally (CSDH, 2008). However, it is not sufficient to have only data on aggregate measures of health outcomes. To track and address health inequities, it is also necessary to have data that illustrate whether and how these outcomes differ for various subgroups of populations. It is equally important to have data showing how social and environmental factors influence these health outcomes and health inequities.

Global action to reduce health inequities has not consistently taken into account evidence of how women's and men's health differs. Improved health surveillance and monitoring efforts can generate such evidence by disaggregating data and conducting gender analysis. Health statistics are most effective and beneficial when they include demographic variables that can reflect the influences on health of gender inequality. Obtaining sex-disaggregated data is a critical first step to understanding both, sex-specific health trends and health inequities between women and men (that is, gender-based health inequities). In addition, other stratifiers of health data such as age, socioeconomic status, geography and ethnicity, as well as data on gender inequality as a social determinant, are essential to analysing health inequities between women and men and also among subgroups of women and men. Such knowledge helps us to understand how gender inequality influences the risk and experience of disease or ill health, access to health care and quality of life and hence, to take actions to reduce health inequities.

The importance of statistics on gender inequality, including the importance of sex-disaggregated health as well as other development data (for example, statistics on labour, education, agriculture, poverty, etc.), has been highlighted in a number of internationally agreed health and development instruments (for example, the Beijing Platform for Action on Women (UN, 1995); the International Conference on Population and Development Programme of Action in Cairo (UNFPA, 2014); the Millennium Development Goals

Programmes and policies to address the health of women and girls, particularly their sexual and reproductive health and HIV status, must be informed by evidence and address gender inequality.

(MDGs) (UN Millennium Project, 2006); and the Political Declaration on HIV and AIDS (UNGASS, 2011). These instruments highlight the importance not only of routinely collecting data that are disaggregated by sex, ethnicity and socioeconomic status, but also of conducting gender analysis of these data and using them to inform policies and programmes.

While gender inequality affects many health conditions and outcomes, nowhere is it more pronounced than in matters of sexuality and reproduction. Gender inequality influences the ability of women and girls to exercise control and autonomy when it comes to matters of their own sexuality (for example, choosing sexual partners, deciding when to have sex, refusing sex, engaging in safe sex) and reproduction (for example, deciding to or not to have children, using contraception and protecting themselves from sexually transmitted infections (STIs), including HIV). Hence, programmes and policies to address the health of women and girls, particularly their sexual and reproductive health (SRH) and HIV status, must be informed by evidence and address gender inequality.

Gender inequality and HIV

Now in its fourth decade, the global HIV epidemic continues to exert a disproportionate impact upon women and girls, especially in some regions of the world. Women account for 51% of those living with HIV worldwide, and 58% of HIV-positive people in sub-Saharan Africa, the most heavily affected region of the world (UNAIDS, 2013a). Globally, 13% of all women living with HIV age 15 years and older are young women 15–24 years old. Of these, 79% live in sub-Saharan Africa. In this region women acquire HIV infection at least 5–7 years earlier than men (UNAIDS, 2014a). In low- and middle-income countries, female sex workers are 13.5 times more likely to be living with HIV than women of reproductive age in the general population (Baral et al., 2012).

While there are regional variations, globally, compared with men and boys, women and girls, including those from key populations, are more vulnerable to HIV and its consequences, due to a range of physiological and sociocultural factors. Women are also more likely to shoulder the burden of caring for others who are infected. Women's unequal legal, economic and social status, along with specific barriers to access to health services and gender-based discrimination and violence, contribute to their higher rates of HIV infection in some regions of the world. Yet, progress in addressing these inequalities and improving HIV outcomes for women and girls has been frustratingly slow.

Despite scaling up HIV interventions aimed at preventing new infections, expanding access to treatment, and eliminating HIV-related stigma and discrimination, national HIV strategies and policies have not always been adequately informed by evidence about how gender inequality affects the

National HIV strategies and policies have not always been adequately informed by evidence about how gender inequality affects the epidemic.

epidemic and the impact of programmes on women and girls. A growing emphasis on evidence-based approaches to the national HIV response is captured in the motto “know your epidemic, know your response”. This awareness has highlighted the need for a deeper understanding of how gender inequality drives the epidemic and how to use evidence to design and implement HIV programming tailored to the specific needs of women and girls, including those from key

populations. It has also led to calls for national HIV monitoring and evaluation systems to become more gender-sensitive in their design and orientation, including greater use of gender-sensitive indicators and the generation of statistics that track inequities between women and men in HIV-related outcomes.

Supporting national partners to better “know their epidemic and their response” in order to effectively meet the needs of women and girls is the first of three action areas in the UNAIDS Agenda for Accelerated Action for Women, Girls, Gender Equality and HIV (UNAIDS, 2010d). The Action Framework aimed to intensify efforts to address gender inequality and human rights violations that increase women’s vulnerability to HIV. It suggested ways to generate better evidence and to tailor national AIDS responses to address the specific needs of women and girls while protecting and promoting their rights. Generating improved evidence and tracking reductions in gender-based inequities in HIV outcomes between women and men will make an important contribution towards the achievement of the new commitments and targets adopted for the Sustainable Development Goals (SDGs) in 2015 (United Nations, 2015). The new commitments include a goal (goal 5) on the achievement of gender equality and empowering all women and girls, with targets related to the elimination of discrimination against women and girls, violence against women and girls and harmful practices as well as ensuring universal access to sexual and reproductive health and reproductive rights. They also include a goal (goal 3) on ensuring healthy lives and promoting well-being for all at all ages, with specific targets for ending the epidemic of AIDS as well as ensuring universal access to sexual and reproductive health-care services.

Gender inequality and sexual and reproductive health

Women continue to suffer a high burden of a range of sexual and reproductive health (SRH) problems, including high rates of maternal mortality and morbidity, unintended pregnancies, unsafe abortions, sexually transmitted infections and reproductive cancers. Despite a global decline in maternal mortality by 44% between 1990 and 2015, high rates of maternal mortality continue among countries in sub-Saharan Africa and within countries among the poorest women (WHO, 2015). Inequalities in access to family planning and maternal health services contribute to a high burden of sexual and reproductive health problems. An estimated 225 million women who want to avoid a pregnancy are not using an effective contraceptive method. Of the 125 million women who give birth each year, 54 million make fewer than the minimum recommended four antenatal visits; 43 million do not deliver their babies in health facilities; and 21 million need, but do not receive, care for major obstetric complications. Each year an estimated 204 million women have one of the four major curable STIs (chlamydia, gonorrhoea, syphilis or trichomoniasis), and 170 million of these women (82%) do not receive STI services (Guttmacher Institute, 2014).

In 1994, the Cairo International Conference on Population and Development (ICPD) Programme of Action emphasized a rights-based approach to sexual and reproductive health (SRH) and recognized the importance of promoting gender equality as critical to these efforts (UNFPA, 2014). Twenty years later, the review of the ICPD Programme of Action highlighted the fact that, despite notable progress towards achieving sexual and reproductive health and rights, this progress has been unequal and fragmented. The lowest wealth quintiles have been left behind, along with those marginalized for reasons of age, marital status, residence, ethnicity, race, and disability, among others. The ICPD review finds that, while discrimination against certain populations is

common in many countries, the discrimination that is universal is gender-based discrimination against women and girls. It concludes that the empowerment of women and gender equality remain the unfulfilled objectives of the ICPD Programme of Action (UN, 2014). Therefore, the Secretary General's report on the framework for action for the ICPD beyond 2014 and for the post-2015 agenda underscores the importance of addressing gender along with other inequalities as essential to achieving more inclusive and sustainable development (UN, 2014). Also critical is a focus on reaching the underserved in all aspects of policy design, legal and regulatory reforms, service delivery and programme implementation as well as in monitoring and accountability.

Why has this tool been developed?

This document is a tool to assist countries in strengthening systems for national monitoring and evaluation (M&E) of HIV and sexual and reproductive health with the aim of:

- improving evidence on how gender inequality affects HIV and SRH outcomes and programmatic responses
- measuring and monitoring gender-based inequities in HIV and SRH outcomes.

A number of guidance documents, resources and tools support the integration of gender equality into SRH and HIV programmes, plans and donor proposals. These include tools such as gender assessment of national HIV responses (UNAIDS, 2014b); integrating gender into the new funding model of the Global Fund to Fight AIDS, TB and Malaria (UNDP, 2014); and a roadmap for mainstreaming gender into national HIV strategies and plans (UNDP, 2012). However, to the best of our knowledge, there exists no other tool that provides a framework and concrete steps for building attention to gender inequality into the monitoring and evaluation of sexual and reproductive health and HIV responses, into the information systems that generate evidence, and into data analysis. This tool, therefore, enables the generation of strategic information (that is, data and evidence for decision-making) that supports mainstreaming gender in national plans and programmes. It is complementary to the tools mentioned above, which focus on analysis of national policy responses.

This tool enables the generation of strategic information that supports mainstreaming gender in national plans and programmes.

Who can use this tool?

This tool is intended to be used, first and foremost, by monitoring and evaluation and/or health information management officers involved with national HIV or SRH M&E systems, as well as in SRH or HIV programmes at the sub-national level (for example, at the district level, individual projects, community-based programmes, nongovernmental organization (NGO) programmes and interventions). However, it may also be relevant to other stakeholders who are familiar with the basics of M&E and who use HIV or SRH data for advocacy and for decision-making for policy and programmes (for example, researchers, academics, advocates and policy-makers).

As presented here, the core content of the tool is applied to M&E of the HIV epidemic and response. However, the tool can be easily applied to M&E of SRH as well as other health problems and programmes. Annexes 1 to 9 provide examples and material illustrating how the core concepts of the tool can be applied to SRH data.

How is the tool structured?

The tool is structured into four modules as outlined below. Each module offers practical and concrete aids, such as checklists, examples and tables.

Module 1 adapts the public health questions approach to M&E to provide users with a logical framework for monitoring and evaluating the impact of gender inequality on HIV and SRH outcomes and programme responses.

Module 2 guides users in selecting indicators that help answer questions about gender inequality and HIV or SRH.

Module 3 helps users to conduct gender analysis and interpret data gathered using gender-sensitive indicators.

Module 4 provides practical suggestions to assess and integrate gender sensitivity into the components of a national M&E system. In order to ask the right questions, select appropriate indicators, and analyse and interpret data. M&E systems themselves must be gender-sensitive.

How can the tool be used?

This resource has been designed in a modular format. Each successive module builds on the previous one. Module 1 sets the framework for a public health approach to ask the right questions about gender inequality in relation to HIV or SRH. Module 2 guides users to identify gender-sensitive indicators that respond to or answer the questions posed in Module 1. Module 3 guides users to conduct a gender analysis of data that are collected using gender-sensitive indicators identified in Module 2. Finally, module 4 provides guidance making M&E systems gender-sensitive through planning, surveillance mechanisms and dissemination methods so that health information or monitoring and evaluation officers are supported in conducting actions in the other three modules. It is not assumed that users will need to read or use the tool from start to finish. Depending on users' roles and responsibilities in their M&E system, and the extent to which the system is already able to generate data on gender inequality and HIV or SRH, the modules can be used either sequentially or separately. (See Fig. 1 for an overview of actions facilitated by this tool.)

This tool aims to provide guidance on how to generate evidence on gender inequality and HIV or SRH.

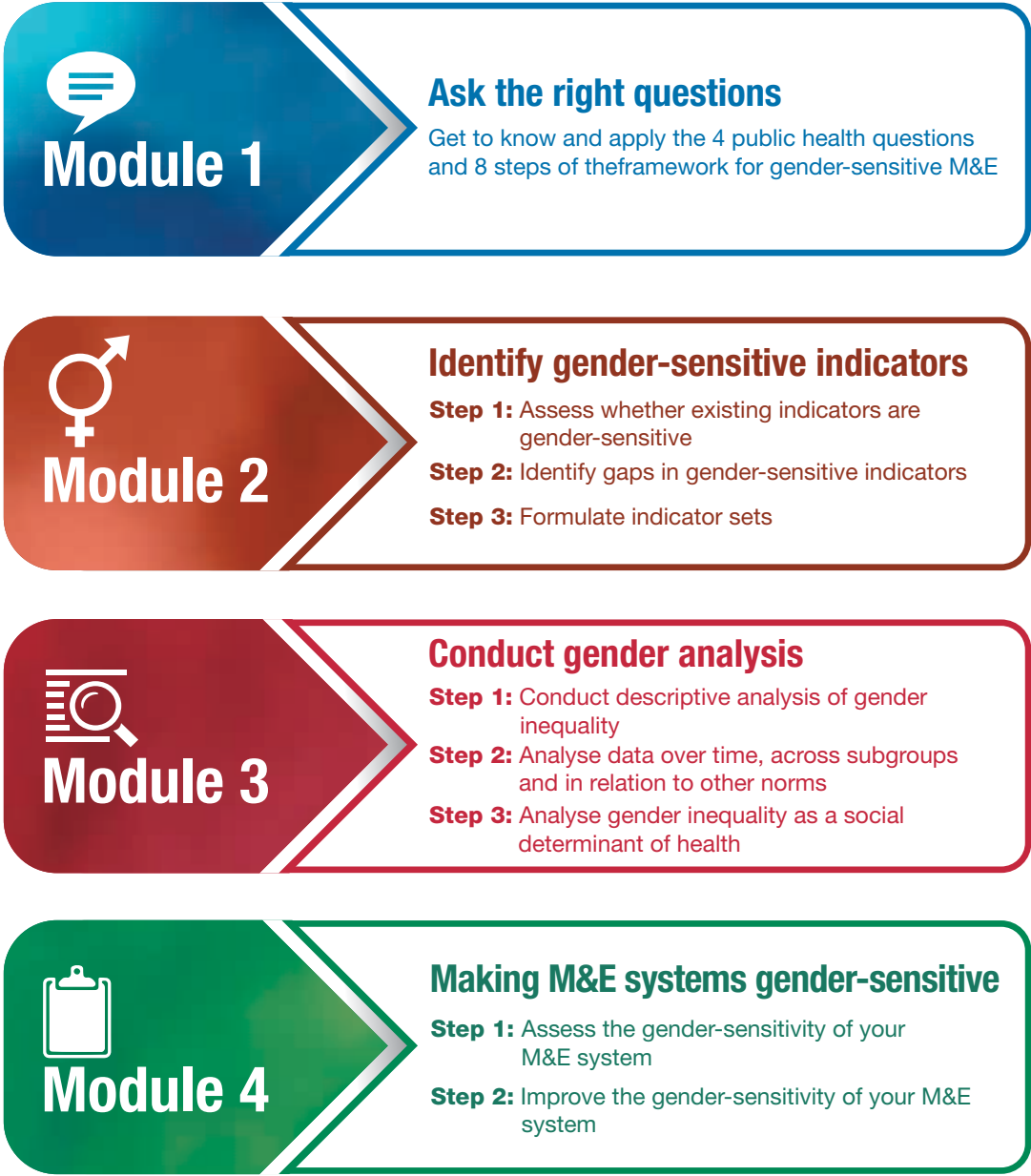
If you already have a national monitoring and evaluation framework for your HIV or SRH programme, you may want to focus on two of the exercises in this tool:

- the gap analysis in Module 2, which helps identify additional indicators needed to see fully the extent and impacts of gender inequality and of programmes intended to address that inequality (pages 37–41);
- the gender analysis in Module 3, which suggests how to analyze the available evidence to understand the reasons behind gender-based inequities in health outcomes – and thus suggest where programmatic efforts could concentrate (pages 51–64).

This tool is not intended to be a comprehensive resource on monitoring and evaluation. For example, it does not include statistical methods for data and equity analysis. Also, it does not cover activities or interventions to integrate attention to gender equality into health programming and policies. These topics are covered by other resources (WHO 2011a, 2013a and c). Rather, it aims to provide guidance on how to generate evidence on gender inequality and HIV or SRH to users who are already familiar with the basics of monitoring and evaluation and statistical methods for data analysis.

The health challenges faced by women and men, and girls and boys, differ across contexts, as do efforts to address them. Therefore, users can apply the suggestions from this tool to their own context, including local indicators, data and M&E systems for HIV or SRH.

Fig. 1. Overview of actions you can take with this tool



Module 1

Ask the right questions



Module 4

Making M&E systems gender-sensitive



Module 2

Identify gender-sensitive indicators



Module 3

Conduct gender analysis



Module 1

Asking the right questions about monitoring and evaluation of gender inequality

Get to know and apply the 4 public health questions and 8 steps of the framework for gender-sensitive M&E

Module 1

Asking the right questions about monitoring and evaluation of gender inequality

Introduction

This section of the tool helps users identify and ask the right questions. These questions will guide users to the kind of M&E information and data that are needed to better understand how gender inequality shapes both health outcomes and programmatic responses. This module is structured around eight steps that form the basis of the public health questions approach to monitoring and evaluation.

The examples in this module concern gender inequality in the context of the HIV epidemic. Annexes 1–9 illustrate the application of this approach to SRH outcomes and programmes.

The “public health questions approach to monitoring and evaluation” provides a structured methodology for asking questions that uncover how and why gender inequality influences health outcomes, what interventions can address gender inequality and how to monitor and evaluate such interventions (Rugg et al., 2004). Understanding how and why gender inequality relates to health outcomes begins with the competence to systematically ask the questions that generate strategic information through both, statistics and other types of data.

The “public health questions approach” constitutes a logical framework for building and guiding evidence-based public health programmes. This module applies this framework for M&E, particularly how gender inequality and interventions to address gender inequality influence HIV and SRH programmes. The questions posed by applying this framework are the basis for the steps presented in Modules 2 and 3 to identify appropriate indicators and conduct analysis of data to monitor and evaluate how gender inequality influences HIV and SRH programmes.

What are the key concepts you need to know?¹

Gender inequality refers to unequal chances or opportunities for groups of women and men to obtain and control social, economic and political resources, including protection under the law (such as health services, education and voting rights). Gender inequality determines differential, unequal and negative health outcomes for women and men and for girls and boys.

¹ The definitions in this section are taken from Gender mainstreaming for health managers: a practical approach (WHO, 2011a) and from the Handbook on health inequality monitoring: with a special focus on low- and middle-income countries (WHO, 2013b).

It shapes people's vulnerability to various health problems, influences their access to health care and affects their experience of living with disease. It is a form of inequality that systemically disadvantages women and girls. In all societies women and girls are, by and large, given less power, privilege and access to resources, and are more discriminated against than men and boys. This document primarily uses the construct "gender inequality" as distinct from the construct "gender" recognizing that it is not just differences, but unequal access to power, resources, and discrimination that has implications for health inequities. The construct "gender" recognizes that the social construction of masculinity can also have negative health consequences for men and boys. This document also recognizes that, in fact, male and female roles are not fixed binary alternatives, as they are often socially constructed. Some individuals identify themselves as transgender and face disadvantage in terms of their health and exercising their rights because of this gender identity. This document also recognizes that gender inequality intersects with inequalities that reflect other determinants, such as class, race, ethnicity and age, as well as gender identity and sexual orientation. This means that sub-groups (for example, women from different ethnic or racial groups, adolescent girls, women and girls living in rural areas, women and girls from poorer socio-economic groups, or transgender women) may face disadvantages related to both, gender and other intersecting inequalities.

Gender-based health inequities refer to unfair, avoidable or preventable differences in health that exist between women and men. Following from the above definition of gender inequality, this document extends the analysis of gender-based health inequities to include unfair, avoidable or preventable differences that exist across sub-groups of women or men, who, as noted, face multiple forms of disadvantage due to both gender inequality and other forms of inequality. Health inequity is a normative concept – meaning that it is based on what is perceived as unfair – and, hence, cannot itself be precisely observed, measured or monitored.

Gender-based health inequality refers to differences in health measures and outcomes between women and men (or subgroups of women or men) that can be observed, measured and monitored. Monitoring gender-based health inequalities serves as an indirect means of tracking gender-based health inequities. Gender inequality is a key social determinant of health, producing health inequities or health inequalities.

Gender equality in health exists when women and men have equal conditions or opportunities to realize their full rights and potential to be healthy and benefit from health interventions. The poor health outcomes and health inequities generated by gender inequality are not fixed. They can be changed – for the better – through carefully targeted health and social policy interventions that promote more egalitarian distribution of power and resources; counter discrimination, exclusion and marginalization of disadvantaged groups; and improve access to services.

Gender-responsive programming is one such measure to promote gender equality in health. The term refers to policies or programmes that explicitly consider and address unequal gender norms and roles, power dynamics, distribution of resources between women and men, counter discrimination faced by women and girls in societies, and improve their access to services.

What you can do? Apply the public health questions approach to monitoring and evaluation

The “public health questions approach” to M&E (Rugg et al., 2004) is a systematic way of gathering and analysing information about a health problem and the response to it by answering the four key questions below at left.

A gender-sensitive M&E system measures the underlying gender inequality that leads to poor health outcomes and to inequities between and within groups of women and men. It also monitors and evaluates the performance of programmes designed to address the underlying gender inequality and, thus, reduce health inequities. As shown below at right, the four key “public health questions” can be adapted to focus on building a gender-sensitive M&E system.

Public health questions

- 1. What is the nature of the problem?
- 2. What interventions are suitable for addressing the problem?
- 3. Are these actions being carried out as intended?
- 4. Are these interventions making a difference?

Questions for gender-sensitive M&E

- 1. What is the nature of the gender inequality underlying the problem?
- 2. What are the right interventions to address the gender inequality underlying the problem?
- 3. Are these interventions being carried out in a way that addresses gender inequality?
- 4. Are the interventions to address gender inequality ultimately making a difference in the desired health outcomes?

As Fig. 2 shows, each of these four questions can be broken down into two steps, each step with two sub-questions. The four main questions, eight steps and 16 sub-questions that make up the public health questions approach guide us through a process (see right column of Fig. 2). That process begins with understanding the problem (gender analysis) and ends with an assessment of whether efforts to address the problem are making a difference (evaluation of gender-responsive programming).

The eight steps build upon one another. The questions can be addressed in sequence, but this is not essential. Making an existing M&E system more gender-sensitive usually means working in an iterative manner, assessing and building on what is already there. The ultimate aim is to develop an M&E system that provides a complete picture of the gender inequality that underlies a health problem and the response to it.

The ultimate aim is to develop an M&E system that provides a complete picture of the gender inequality that underlies a health problem and the response to it.

The remainder of this module addresses each of the four key public health questions in turn.

Fig. 2. The eight steps of the public health questions approach to gender-sensitive monitoring and evaluation

Question	Step	Action
<p>Understanding gender inequality dimensions</p> <p>What is the nature of the gender inequality underlying the problem?</p>	<p>Step 1: Assess gender inequalities</p> <ul style="list-style-type: none"> Do inequalities exist between women and men in specific health outcomes in your country? Are these inequalities between men and women consistent across different population subgroups? Are there subgroups that bear a disproportionate burden of the health problem? <p>Step 2: identify the contributing factors</p> <ul style="list-style-type: none"> What underlying social norms and/or cultural, economic and legal factors explain the health outcomes and inequities? What are the pathways through which these underlying factors shape or influence health outcomes and inequities? 	<p>Conduct a situational analysis of the health problem and the response to date. Analyse surveillance, survey and programme data across sex, age, socio-economic status, and other relevant stratifiers.</p>
<p>Understanding potential responses</p> <p>What are the right interventions to address gender inequality as a determinant of the health problem?</p>	<p>Step 3: Identify promising interventions</p> <ul style="list-style-type: none"> What interventions have been shown to effectively address gender inequality as an underlying contributing factor to the health problem? How should actions or interventions to promote gender equality be integrated into interventions to address the health problem? <p>Step 4: Determine what is needed to implement interventions effectively</p> <ul style="list-style-type: none"> What is needed to implement gender equality interventions? How can we implement ongoing health interventions in a gender-responsive way? 	<p>Review available evidence or conduct operations research, formative research or special studies to identify effective interventions.</p> <p>Conduct needs, resource and response analysis, as well as input monitoring using gender-sensitive indicators.</p>

Question	Step	Action
<p>Monitoring gender-responsive programming</p> <p>Are these interventions being carried out in a way that addresses gender inequality?</p>	<p>Step 5: Monitor the quality of gender-responsive programmes</p> <ul style="list-style-type: none"> • Are programmes taking into account gender-related barriers faced by women and men when accessing the programmes and services? • Are the programmes being delivered in ways that promote equality, rights and choices for beneficiaries? <p>Step 6: Monitor the outputs of gender-responsive programmes</p> <ul style="list-style-type: none"> • Are we implementing programmes as planned? • Are they reaching beneficiaries equitably and are they meeting their specific needs? 	<p>Activities</p> <p>▶</p> <p>Outputs</p> <p>▶</p> <p>Conduct process monitoring and evaluation, as well as quality assessments focusing on whether services are gender-responsive.</p> <p>Conduct outputs monitoring to determine if men and women, and subgroups among them, are receiving services equitably (where applicable) and if the services meeting their needs.</p>
<p>Evaluating results of gender-responsive programming</p> <p>Are the interventions to address gender inequality ultimately making a difference in the desired health outcomes?</p>	<p>Step 7: Evaluate the outcomes of gender-responsive programmes</p> <ul style="list-style-type: none"> • Are the interventions improving gender equality-related outcomes (e.g. power, decision-making, access to and control over resources, support for equitable norms and attitudes)? • Are the interventions improving health outcomes? <p>Step 8: Evaluate the impact of gender-responsive programmes</p> <ul style="list-style-type: none"> • Have gender-responsive programmes fundamentally improved health status, morbidity or mortality among women and men? • If so, are the declines similar among women and men or have the inequities between them reduced? 	<p>Outcome</p> <p>▶</p> <p>Long-term outcomes and impact</p> <p>▶</p> <p>Conduct outcome evaluation studies that measure changes in attitudes, knowledge, practices and behaviour that contribute to improving health outcomes and to reducing gender inequalities.</p> <p>Conduct or review survey, sentinel and surveillance data disaggregated by sex, age, socio-economic status and other relevant stratifiers.</p>

Source: Adapted from Rugg et al., 2004.

Public health question 1: Understanding gender inequality dimensions

General question: What is the nature of the problem?



Specific question: What is the nature of the gender inequality underlying the problem?

The first public health question asks whether we understand the nature of a particular health problem. When a gender-sensitive focus is applied to this question, the question becomes whether we understand the nature of the gender inequality that underlies the health problem.

There are two steps to answering this question. Steps 1 and 2 are about: a) identifying the inequities in health outcomes between women and men; b) recognizing that gender inequality intersects with other types of inequalities, identifying inequities in health outcomes within or across groups of women and men; and c) uncovering how gender inequality contributes to inequities identified in point a and b. These steps are the focus of gender analysis (described in Module 3) and the building blocks for all that follows: Without an understanding of the inequities in health outcomes between and within groups of women and men, and of how gender inequality contributes to a given health problem and to inequities in health outcomes, it is not possible to put in place an appropriate and effective response.



Step 1: Assess gender-based health inequities

Understanding the nature of the problem requires considering the following sub-questions:

- Do inequities exist between women and men in specific health outcomes in your country?
- Are these inequities between men and women different across different population subgroups? Are there subgroups that bear a disproportionate burden of the health problem?

Box 1 provides examples of questions that could be asked to better understand gender-based inequities in HIV outcomes in your country. Annex 1 contains examples of questions that could be asked in relation to sexual and reproductive health.

Box 1

Asking the right questions to understand how gender inequality shapes the HIV epidemic

1. Are there inequities between women and men in the following HIV outcomes in your country?

- HIV incidence and prevalence rates
- Comprehensive and correct knowledge about HIV
- Sexual risk behaviour and protective behaviour
- Access to HIV information and services.

2. Are these inequities between women and men different across different subgroups of the population? Do these inequities exist in the above outcome areas between women and men across:

- Different age groups
- Different socioeconomic groups
- Residents of urban and rural areas and sub-national areas
- People of different ethnic backgrounds
- Key populations?¹

¹ Key populations are defined as groups who, due to specific higher-risk behaviours, are at increased risk of HIV irrespective of the epidemic type or local context. The five major key populations are 1) men who have sex with men, 2) people who inject drugs, 3) people in prisons and other closed settings, 4) sex workers and 5) transgender people (WHO, 2014a).

To answer these questions, you can make use of surveillance, survey and programme data disaggregated by sex, age, socioeconomic status and other relevant stratifiers. You could:

- conduct a situational analysis that enables you to analyze existing epidemiological data and uncover inequities in health outcomes, behaviours, and access to services between women and men, and girls and boys.
- generate a profile of the inequities in health outcomes for different subgroups, for example by sex, age group, ethnic background, place of residence, educational background, and socioeconomic status. (See Module 3 for further guidance on gender analysis of data)

Related resources

Knowing the national HIV epidemic and context. In: UNAIDS gender assessment tool: towards a gender-transformative HIV response (UNAIDS, 2014b).

Gender mainstreaming for health managers: a practical approach (WHO, 2011a).

Handbook on health inequality monitoring: with a special focus on low- and middle-income countries (WHO, 2013b).

 **Step 2: Identify the contributing factors**

The next step helps to identify the underlying factors that may contribute to inequities in health outcomes between women and men or among subgroups of women and men. This step requires us to consider the following questions:

- What underlying social norms and cultural, economic and political factors explain the health outcomes and inequities?
- What are the pathways through which these underlying factors shape or influence health outcomes and inequities?

The task here is to ask questions that can help pinpoint the underlying factors in a country or region that are shaping women and men's different vulnerabilities to health problems and that contribute to inequities in health outcomes.

Box 2 provides examples of questions that could be asked to help understand how gender inequality affects women's and men's vulnerability to HIV and contributes to inequities in HIV

outcomes. Annex 2 contains a list of example questions that can be asked to clarify how gender inequality affects sexual and reproductive health outcomes.

Box 2

Asking the right questions to identify the role of gender inequality as an underlying factor in shaping HIV vulnerability and inequities in HIV outcomes

1. Why are there differences in HIV prevalence rates, risk behaviours and access to services between women and men and among subgroups of women and men?

- What are the underlying social norms and cultural, economic and legal factors that shape women and men's vulnerabilities to HIV and produce inequities in outcomes?

2. What are the pathways through which the underlying factors shape or influence different HIV outcomes for women and men and for different subgroups among them?

- How do harmful gender norms influence HIV outcomes differently for women and men (for example, sexual behaviour, condom use, health-seeking behaviour)?
- How does gender-based violence influence women's vulnerability to HIV?
- How does women's lack of power influence their vulnerability to HIV?
- How do discriminatory laws and policies shape women's and men's vulnerability to HIV?

To answer these questions, you can:

- conduct or use existing qualitative and quantitative research that describes how gender inequality shapes vulnerability to specific health issues;
- use gender inequality indicators and other gender-sensitive indicators to conduct statistical analyses;
- identify risk factors and pathways of gender inequality that are responsible for perpetuating a given health problem in your setting.

Public health question 2: Understanding potential responses

General question: What interventions are suitable for addressing the problem?

➤ *Specific question:* What are the right interventions to address gender inequality as a determinant of the health problem?

Once the specific gender inequality that underlies the problem is identified, the next step is to plan a response. Steps 3 and 4 are about identifying gender-responsive programmes that can address gender inequality and determining what is needed to implement these programmes successfully.



Step 3: Identify promising interventions

Step 3 requires us to identify programmes or interventions that are suitable for addressing gender inequality and/or actions to improve gender equality within existing interventions that address a health problem. The factors to be addressed by the interventions should be identified through the analysis of the health problem, as described in Steps 1 and 2.

There are two main questions to be asked:

- What interventions have been shown to effectively address gender inequality as an underlying contributing factor to the health problem?
- How should actions or interventions to promote gender equality be integrated into interventions to address the health problem?

Box 3 provides examples of questions that should be asked to identify gender equality interventions in the context of HIV. Annex 3 provides similar questions that can be asked in relation to other sexual and reproductive health problems.

Box 3

Asking the right questions to identify effective or promising gender equality interventions in the context of HIV

A wide variety of HIV interventions and programmes are available to national policy-makers and planners as they design the national HIV response. The challenge – given limited resources and the urgent demand for HIV services – is to identify those which have been proven effective in meeting the specific needs of women and men for HIV services and in bringing about greater gender equality.

Programme effectiveness is determined by assessing the quality of evidence and determining the strength and consistency of programme effects on indirect outcomes (for example, HIV and gender-related knowledge, behaviour and attitudes) and direct outcomes (for example, HIV incidence and prevalence, and levels of gender-based violence), ideally across different programme settings and contexts.

1. What are effective and promising interventions that promote gender equality as a critical enabler to reducing women's and men's vulnerability to HIV?

- What are effective interventions to change harmful gender norms that underpin sexual risk-taking among women and men or to promote gender-equitable norms and attitudes in relation to sexual behaviour?
- What are effective and promising interventions to empower women and girls to reduce their risk of HIV?
- What interventions work to promote and enforce laws and policies that advance gender equality and women's rights? What interventions work to remove laws and policies that discriminate against those affected by and living with HIV?
- What are effective and promising interventions to prevent and reduce gender-based violence as a factor that is associated with HIV?

2. What are effective and promising interventions to take gender equality into account in the implementation of core HIV interventions?

- What are effective approaches to reduce gender-related barriers faced by women to access and use services for the prevention of mother-to-child transmission of HIV?
- What are effective approaches to support women living with HIV to make informed reproductive choices (for example family planning or whether or not to continue with a pregnancy)?
- What are effective approaches to support women and men to safely disclose their HIV status to their partners?

To answer these questions, you can:

- review existing evidence within the country or from countries with similar epidemics to identify effective interventions;
- collaborate with others who are doing research synthesis, operations research and other special studies to identify effective and promising interventions.

Related resources

16 ideas for addressing violence against women in the context of the HIV epidemic: A programming tool (WHO and UNAIDS, 2013a).

What works for women and girls: Evidence for HIV/AIDS interventions. 2nd edition (Futures Group, Health Policy Project, 2012).

Step 4: Determine what is needed to implement interventions effectively

Step 4 requires answering two questions:

- What is needed to implement gender equality interventions?
- How can we implement ongoing health interventions in a gender-responsive way?

Selecting a set of interventions is not only about the “what”, but also about the “how” i.e. what capacities, skills and attitudes will be required to implement gender-responsive programmes. Addressing these issues may require asking questions about how interventions can be tailored to address the specific roles and needs of women and/or men in the household or community. It may require asking about the human, financial and technical support resources that are needed to implement gender equality interventions. It may also require considering if there could be any unanticipated adverse reactions or consequences to the interventions that may differently affect women and men, or subgroups of women and men, and that may perpetuate or worsen gender inequality.

Box 4 provides examples of the kinds of questions that may need to be asked about the requirements for implementing gender equality interventions for HIV. These questions are equally applicable for implementing SRH interventions.

In order to answer these questions, you can:

- conduct a needs assessment;
- conduct a resource and response analysis;
- identify input indicators that need to be monitored.

Box 4

Asking the right questions about the requirements for implementing effective gender equality interventions for improving HIV outcomes

1. What is needed to implement gender equality interventions in the context of the HIV epidemic?

- What financial resources are needed?
- Are costing data or estimates available?
- Has a financial gap analysis been undertaken?
- What technical support resources are needed?
- What equipment, materials and other technical resources (for example, technical assistance) will be needed to implement the interventions? Are these available?
- What human resource capacity is needed?
- Do programme staff and service personnel have the knowledge, awareness and willingness to address gender equality?
- What sensitization and capacity-building measures may be required?
- What community resources are needed?
- How can community leaders be engaged in supporting or enabling women, girls and other beneficiaries to participate in programmes?
- How will the views of women and girls be taken into account? Are women and girls involved in the planning and implementation of programmes?
- What approaches can be used to engage women's groups and civil society organizations working on gender equality, key population advocacy groups and adolescents as stakeholders?

2. How can we implement on-going interventions in a gender-responsive way?

- What physical, financial, psychological, and/or cultural obstacles need to be addressed to ensure that target groups are able to participate in programmes as intended?
- Do ongoing interventions take into account women's caregiving and childcare roles? Do they take into account the gender roles of men?
- Are ongoing interventions tailored to provide information about health issues and related services to women who cannot read or write?
- Is there specific information and material available that is tailored to adolescent girls and boys?
- Are the service hours and locations tailored appropriately to be accessible to women and men, including adolescents?
- Are there specific communication materials available that are tailored to men?
- How can men be engaged as partners, fathers and beneficiaries? If appropriate, what strategies will be used to reach out to and involve men (and/or boys)?

Public health question 3: Monitoring gender-responsive programming

General question: Are these actions being carried out as intended?



Specific question: Are these interventions being carried out in a gender-responsive way?

Gender-responsive programmes should be designed with an explicit understanding of the sociocultural and economic situations of their intended beneficiaries and the factors that might deter women and men from accessing services. Good-quality interventions take steps to minimize potential barriers to programme participation and uptake, whether these are financial, logistical, psychological or cultural.

Once gender-responsive programmes are underway, regular programme monitoring shows whether activities are being implemented as planned and whether they are reaching their intended beneficiaries. Steps 5 and 6 are about monitoring the quality and reach of the gender-responsive services being provided.

Step 5: Monitor the quality of gender-responsive programmes

Step 5 requires us to ask two fundamental questions:

- Are programmes taking into account gender-related barriers faced by women and men when accessing programmes and services?
- Are programmes being delivered in ways that promote equality, rights and choices for beneficiaries?

To answer these questions, you can conduct process monitoring (see Box 5a), which is focused on assessing the quality of programme delivery (UNAIDS 2010e). This monitoring looks at whether programmes are being delivered in ways that promote gender equality and protect the rights of beneficiaries and whether these programmes are having any unintended harmful effects.

Box 5b provides examples of questions that can guide this type of process monitoring in the context of HIV. Similar examples of questions that can guide

Box 5a **Process monitoring**

Process monitoring pays attention to which services are being implemented and how they are being implemented. In the context of gender-responsive programmes, this means understanding whether the people for whom the programmes are designed are able to access services and feel comfortable doing so. Process monitoring can, for example, tell us whether beneficiaries feel that their rights to information and confidentiality have been respected and that programme staff have treated them in a sensitive and non-discriminatory way.

process monitoring in the context of other sexual and reproductive health issues are included in Annex 4.

Box 5b

Asking the right questions to guide process monitoring of gender-responsive HIV programmes

1. Are programmes taking into account gender-related barriers faced by women and men when accessing programmes and services?

- Are the intended beneficiaries aware of services, such as HIV testing and counselling or antenatal care, that are available to them?
- Have steps been taken to make services physically available to those who can benefit from them? Has attention been paid to issues such as the logistics and costs of transportation, convenient opening hours, and minimizing the number of required visits to health centres?
- Are programme and service facilities friendly and welcoming for women, including women with children, and likewise for men? For example, are there private areas for consultations, a waiting area with enough seats and separate functioning toilets for men and women?
- Do programme staff and service providers know how to respond to women who may be at risk of violence from partners or other family members?
- Do programmes and services reach out to men, both, in their capacities as partners and fathers, and also as clients requiring health services in their own right?

2. Are programmes being delivered in ways that promote equality, rights and choices for beneficiaries?

- Are programmes guided by core principles of human rights including non-discrimination, informed choice, informed consent, confidentiality, respect for all, access for all, and meaningful participation and inclusion of people living with HIV and other affected groups such as for example, those representing key populations?
- Do programme staff and service providers have the awareness, capacity and willingness to address gender equality, sexuality and human rights as they relate to HIV?
- Are programme staff aware of power dynamics in their own interpersonal communication with beneficiaries? Do they use communication (language and style) that fosters empowerment and agency among the beneficiaries to make informed choices?
- Do clients, including those living with HIV, feel that the programme staff has treated them in a non-discriminatory manner, without moralistic views or negative or judgemental attitudes?

Source: Adapted from Tool for integrating gender into HIV/AIDS programmes in the health sector (WHO, 2009).



Step 6: Monitor the outputs of gender-responsive programmes

The basic questions to be considered in Step 6 are:

- Are we implementing programmes as planned?
- Are programmes reaching beneficiaries equitably, and are they meeting their specific needs?

To answer these questions, you can conduct output monitoring (see Box 6a) to determine who is being reached and whether access is equitable (see: UNAIDS 2010e).

Box 6b provides examples of questions that should be asked in order to monitor outputs of gender-responsive HIV programmes. Questions that can be asked of other types of sexual and reproductive health programmes are included in Annex 5.

Box 6a

Output monitoring

Output monitoring is undertaken to determine whom programmes are reaching. It answers the questions *who?* and *how many?*. The findings generated by output monitoring can reveal barriers that may be preventing certain individuals from accessing programmes intended to meet their needs. This can, in turn, point to areas requiring detailed investigation in order to understand the nature of these barriers and how they may be overcome.

Box 6b

Asking the right questions to guide output monitoring of gender-responsive HIV programmes

Are women and men, and subgroups among them, accessing the programmes or services as intended?

- What proportion of women and men, and subgroups among them, are reached by HIV programmes and services, including:
 - HIV testing and counselling?
 - ART programmes?
 - condom promotion/distribution programmes?
 - targeted information, education and communication?
 - prevention and treatment of STIs?
 - related services, such as prevention, diagnosis and treatment of tuberculosis?

- Are there inequities in uptake or coverage of any of the above-mentioned services between women and men and/or among subgroups of women and men by age, geographical area, socioeconomic status, educational status or other variable?
- If inequities exist, what factors explain them? Are these differences due to lack of information, lack of transport, stigma, gender norms about health-seeking behaviour and/or unequal access to resources?
- Are women and men satisfied with their access to HIV services and with the quality of services they receive? Are there differences in the levels of satisfaction between women and men? What factors account for these differences?

Public health question 4: Evaluating results of gender-responsive programming

General question: Are these interventions making a difference?



Specific question: Are the gender-responsive interventions making a difference in the desired outcomes?

Steps 7 and 8 are concerned with evaluating the effectiveness of gender-responsive programming. Are these programmes bringing about changes in people's knowledge, attitudes and behaviours as expected (that is, outcomes)? And, are these changes great enough to improve the health of the population on a large scale (that is, impact)?



Step 7: Evaluate the outcomes of gender-responsive programmes

Step 7 is concerned with monitoring the outcomes of health programmes. There are two fundamental questions to consider here:

- Are the interventions improving gender equality-related outcomes (for example, egalitarian power, decision-making, access to and control over resources, and support for equitable norms and attitudes)?
- Are the interventions improving health outcomes?

To respond to these questions you can conduct outcome evaluation studies that measure changes in both, gender equality and health outcomes.

Box 7 provides examples of questions that could be asked concerning gender equality in outcome evaluations in the context of HIV. Example questions about how to measure gender equality outcomes in the context of other sexual and reproductive health issues are included in Annex 6.

Box 7

Asking the right questions to guide outcome evaluations of gender-responsive HIV programmes

1. Are interventions improving gender equality outcomes?

- Have there been improvements in men's and women's attitudes toward more equal gender norms?
- Have there been reductions in women's experience of violence and/or men's perpetration of gender-based violence?
- Have there been improvements in women's power or decision-making abilities with respect to their sexual relationships?
- What factors have contributed to these changes?

2. Are interventions improving HIV-related outcomes?

- Have there been improvements in men's and women's knowledge and behaviours related to risk of HIV transmission (for example, comprehensive and correct knowledge of HIV, condom use, number of sexual partners)?
- Have the inequities in these outcomes between women and men diminished? Are the reductions in inequities between women and men consistent across different subgroups of the population?
- What factors have contributed to these changes?

To answer these questions, you can:

- conduct outcome evaluation studies that measure changes in attitudes, knowledge, practices and behaviours that contribute to gender inequality (UNAIDS 2010e);
- undertake trend analyses of outcome indicators;
- undertake evaluation studies that investigate the extent to which outcomes can be attributed to gender-responsive programmes.



Step 8: Evaluate the impact of gender-responsive programmes

Step 8 is concerned with impact evaluation of long-term results of interventions. It asks two critical questions:

- Have gender-responsive programmes fundamentally improved health status, morbidity or mortality among women and men?
- If so, are the changes similar among women and men, or have the inequities between them diminished?

Impact evaluation is a complex exercise, which ideally draws upon a wide range of data sources: population-based epidemiological and behavioural surveys, sentinel surveillance, specially commissioned studies, and qualitative research of various sorts.

Box 8 provides examples of specific impact evaluation questions for gender-responsive HIV programmes. Questions for other types of sexual and reproductive health programmes are included in Annex 7.

Box 8

Asking the right questions to evaluate the impact of gender-responsive HIV programmes

1. Have gender-responsive programmes improved health status, morbidity or mortality among women and men?

- What changes can be seen in HIV incidence and prevalence rates among women and men, and subgroups among them?
- What changes can be seen in HIV-related mortality rates among women and men, and subgroups among them?

2. Have the changes in incidence and prevalence been equitable?

- Have changes in incidence and prevalence reduced gender-based inequities?
- Have HIV incidence and prevalence declined equitably among different subgroups (for example, young women and men, poorer and wealthier women and men)?

To answer these questions, you can:

- conduct national household health surveys
- use national sentinel surveillance to measure relevant health outcomes and disaggregate them by sex, age and other stratifiers.

Module 1
Ask the right
questions



Module 4
Making M&E
systems gender-
sensitive



Module 2
Identify
gender-sensitive
indicators



Module 3
Conduct gender
analysis

Module 2

Identify gender-sensitive indicators

Step 1: Assess whether existing indicators are gender-sensitive

Step 2: Identify gaps in gender-sensitive indicators

Step 3: Formulate indicator sets

Module 2

Identifying an appropriate set of gender-sensitive indicators

Introduction

This section is concerned with indicators. Indicators are a fundamental component of any M&E system, but it is challenging to use them well. Here we focus particular attention on how to identify, select and develop indicators that help us to assess the results of efforts to promote gender equality for better health. We also provide practical suggestions on how to construct balanced, coherent indicator sets that will both, enhance our understanding of how gender inequality influences a particular health problem and monitor progress towards eliminating gender-based inequities in health.

The material presented in this section will be of use to those working in national M&E systems who are planning to review their indicator sets, who are interested in strengthening the gender sensitivity of their indicator frameworks, or who are thinking about how well their current indicator sets enable them to measure and monitor gender equality aspects of the public health problem for which they are responsible.

What are the key concepts you need to know?

Indicators: An indicator is a quantitative metric that provides information that can be used to monitor performance, to measure results against targets and to assess accountability (UNAIDS, 2010a). Indicators feature at all levels of an M&E system and can provide answers to the key public health questions described in the previous section. The strategic information produced by indicators, used alongside other types of information, helps to track changes in public health problems and the effectiveness of efforts to address health problems.

Related resource

An introduction to indicators
(UNAIDS, 2010a).

Good-quality indicators (see Box 9) allow us to produce reliable, standardized information that can be compared over time, in different contexts (for example across programmes) and in different places (for example provinces, countries, regions).

Gender-sensitive indicators are indicators that help us to understand gender-based health inequities and gender inequality as a social determinant of health. Gender-sensitive indicators are used to measure the current situation of women or men in relation to a specific norm or in comparison with another reference group (for example, the proportion of girls who are enrolled in primary school compared with boys). They are also used to measure and monitor inequalities in

access to health services (for example, the difference in the proportion of women and men with access to antiretroviral therapy) and the success of efforts to reduce gender inequality over time.

Box 9

Criteria for good indicators

Action focused: Indicator data should be useable and lead to action.

Important: The indicator should help to address the problem at hand.

Measurable: A sound and feasible methodology for data collection is required.

Simple: Use good, simple indicators rather than striving for perfect, complex ones.

Source: An introduction to indicators (UNAIDS, 2010a).

In the field of health we need gender-sensitive indicators in order to:

- measure whether there are inequalities¹ in health outcomes between women and men and subgroups among them;
- understand why these health inequalities might exist;
- track whether health inequalities between women and men are growing or shrinking over time;
- assess, understand and measure changes in how gender inequality as a social determinant is influencing health outcomes and health inequalities.

There are three types of **gender-sensitive indicators**:

- **Sex-specific indicators** pertain to only women or only men, or subgroups among them.
- **Sex-disaggregated indicators** measure differences between women and men in relation to a particular metric.
- **Gender-inequality indicators** measure gender inequality directly, or are proxies for gender inequality.

¹ In this module we use the term “health inequalities” instead of “health inequities”, as the former is what can be measured and monitored, whereas the latter is a normative concept.

Box 10 presents examples of gender-sensitive indicators used to measure dimensions of the HIV epidemic.

Box 10

Gender-sensitive indicators for HIV

Gender-sensitive indicators are used in a wide range of sectors, from education to rural development. In recent years, growing attention has been paid to the development of gender-sensitive HIV indicators, which are used to inform our understanding of gender equality aspects of the HIV epidemic. Two types of gender-sensitive indicators are used in relation to HIV: HIV indicators and gender inequality indicators.

HIV indicators measure aspects of the HIV epidemic and of the response that may reveal differences and inequalities between and among women and men (and subgroups among them). They make it possible to track changes in the way the HIV epidemic, and the response to it, are affecting women and men differently. These indicators may be sex-specific – that is, dealing with just one sex, or sex-disaggregated – that is, the same indicator applied to each sex. By disaggregating data, we can see differences in HIV prevalence and incidence, service uptake, or knowledge and behaviours that put women and men at risk of infection. Global AIDS Progress Reporting 2015 provides guidance on which global monitoring indicators are recommended for sex and age disaggregation (UNAIDS, 2014c, Appendix 7).

The following are examples of gender-sensitive HIV indicators:

Sex-specific HIV indicators

- Percentage of pregnant women attending antenatal care services whose male partner was tested for HIV
- Percentage of men reporting condom use at last anal sex with a male partner

Sex-disaggregated HIV indicators

- Percentage of young men and women who have had sex before the age of 15
- Percentage and number of men and women ages 15–49 who received an HIV test in the last 12 months and who know their test results.

Gender inequality indicators make it possible to monitor changes in gender inequality in various aspects of society that may influence the dynamics of the HIV epidemic. These are gender inequality measures for which evidence suggests a plausible link to HIV outcomes – for example, economic marginalization, gender-based violence, and gender-based norms and attitudes that disempower women in their intimate relationships.

The following are examples of gender inequality indicators:

- Prevalence of recent intimate partner violence (IPV)
- Proportion of women and men who say that wife-beating is an acceptable way for husbands to discipline their wives.

What can you do? Construct a set of gender-sensitive indicators

In most countries M&E frameworks in the field of public health are well established and already use defined indicator sets for measuring the performance of the national response to specific health issues. Making M&E systems gender-sensitive does not imply starting from the beginning or otherwise interrupting existing M&E processes. Strengthening the gender sensitivity of an M&E system almost always requires an iterative approach, using the existing framework as a starting point and gradually refining it to make it better able to track gender inequality and gender-based inequalities in health.

The remainder of this module provides practical guidance on how to construct balanced indicator sets containing gender-sensitive indicators. The three steps outlined below may be useful when opportunities arise to review and adjust indicators. These steps can be used, for example, as part of periodic reviews or when a new national strategy is being developed for a particular health issue. The steps call upon you to:

1. assess whether existing indicators are gender-sensitive (use guidance in Module 1 to ask the right questions about gender inequality);
2. identify gaps in current M&E frameworks in measuring and monitoring gender-based health inequalities and gender inequality; and
3. formulate indicator sets.



Step 1: Assess whether existing indicators are gender-sensitive

The first step is to review the indicators currently in the national M&E plan to identify which ones are gender-sensitive. Gender-sensitive indicators meet the following criteria (Beck, 1999):

- **Disaggregation.** Data should be disaggregated by sex and age, at minimum, and ideally by other relevant stratifiers (for example, socioeconomic status, ethnicity or place of residence) to enable a deeper analysis of the dynamics in society that have contributed to the specific situations of women and men.
- **Measure change over time.** Indicators should be reliable enough to use as a time series, allowing the detection of trends over time.
- **Comparison to a norm.** The indicator should make explicit the comparison group: If an indicator measures the status of women, the comparison group could be men, another group of women in the same country (for example, in a different part of the country or of a different socioeconomic status) or women in another country.
- **Participatory development.** Indicators should be developed through as participatory a process as possible, and used in a participatory way.
- **Include gender inequality measures.** Indicators should focus not only on inequalities in health outcomes and behaviours between women and men (and subgroups among them), but also capture – directly or through proxies – measures of gender inequality and of other social factors (for example, class or poverty, racial or ethnic disparities) that intersect with gender inequality to determine health.

Like any indicators, gender-sensitive indicators should be simple, measurable, reliable and focused on outcomes and impacts (rather than on inputs).

Assessing current indicators can help identify where there are gaps in measuring and monitoring gender inequality and gender-based health inequalities. It can also reveal relatively simple ways that existing indicators could be made gender-sensitive, for example, by changing the data disaggregation requirements.

Box 11 Describes a gender-sensitive indicator that has been adopted as a global core indicator to monitor progress in addressing HIV.

Box 11

Intimate partner violence: a risk factor associated with HIV and a proxy for gender inequality

In 2012 the Joint United Nations Programme on HIV/AIDS (UNAIDS) added a new indicator to its set of core indicators that countries are encouraged to use in the Global AIDS Progress Reporting cycle. Indicator 7.1 (under Target 7: Critical Enablers and Synergies with Development Sectors) reads as follows:

The proportion of ever-married or partnered women aged 15–49 who experienced physical or sexual violence from a male intimate partner in the past 12 months.

The indicator measures progress in reducing the prevalence of intimate partner violence (IPV) against women as both an outcome in and of itself and as a proxy for gender inequality. IPV has been shown to put women at higher risk of HIV infection.

How does Indicator 7.1 fare in terms of the criteria for gender-sensitive indicators?

- **Disaggregation.** The indicator is sex-specific, in that it measures the prevalence of IPV among women only. The indicator guidelines suggest that data be disaggregated by **age** (15–19, 20–24 and 25–49) and by **HIV status**, where possible.
- **Measure change over time.** The indicator should be measured **every 3 to 5 years**. The indicator was specifically developed with a focus on recent instances of IPV (rather than “ever experienced” IPV) in order to allow monitoring of progress over time. Sustained reductions in IPV can come about only as a result of fundamental changes in unequal gender norms, gender relations at the household and community levels, women’s legal and customary rights, and in women’s unequal access to health care, education, and economic and social resources. Changes in the IPV indicator can, therefore, reflect broader changes in the status and treatment of women in all the different societal domains, which in turn contribute directly and indirectly to reduced risk of HIV.
- **Comparison to a norm.** Using data generated by this indicator, the prevalence of IPV among women in a given country can be compared with that of women in other countries or in the region as a whole. Prevalence can also be compared among subgroups of women, for example, women of different ages or living in different subnational areas or of different socio-economic groups.

- **Participatory development.** The inclusion of Indicator 7.1 in the UNAIDS set of core indicators was the result of a participatory process involving civil society organizations, networks of women living with HIV, researchers, United Nations agencies, and bilateral and multilateral donors.
- **Includes gender inequality measures.** Indicator 7.1 is a proxy measure of gender inequality. In countries with high levels of IPV, other gender inequality measures – such as girls’ school enrollment rates and the gender development index (GDI) – are low.

Source: UNAIDS, 2013b and UNAIDS, 2014c.



Step 2: Identify gaps in measuring and monitoring gender-based health inequalities and gender inequality in current M&E framework

The next step is to identify important aspects of gender-based health inequalities and gender inequality that the current indicator set or framework does not address. One way to identify these gaps is to determine whether the current indicator set provides the information and data necessary to answer the eight public health questions described in Module 1. The eight steps in Module 1 offer a systematic way of gathering and analysing information about gender-based health inequalities, underlying gender inequality as well as monitoring and evaluating the success of programmes designed to reduce these inequalities.

This step leads you to ask what information you have available, through the current indicator framework, to answer these key public health questions. If the current indicator set does not respond to these questions, it may be necessary to modify or add to the indicator set to fill the gaps.

Gender-sensitive indicators for sexual and reproductive health or HIV and gender equality indicators are available from a range of sources (Box 12). You may also want to consider available national indicators from various sectors (for example, gender equality or women’s ministries, labour, police, justice, social welfare) and from entities that are monitoring and evaluating programmes related to gender equality, such as programmes on violence against women or gender-based violence, women’s access to employment or their access to education. If your country has conducted Demographic and Health Surveys (DHS), these can also provide several indicators on gender equality including indicators related to women’s empowerment, autonomy, gender-based violence and gender norms.

Box 12

Resources for gender-sensitive SRH and HIV indicators and gender equality indicators

1. *Compendium of gender equality and HIV indicators.* MEASURE Evaluation, 2014.
<http://www.cpc.unc.edu/measure/publications/ms-13-82>
2. *Global AIDS response progress reporting 2014: Construction of core indicators for monitoring the 2011 UN Political Declaration on HIV/AIDS.* UNAIDS, 2014.
http://www.unaids.org/sites/default/files/media_asset/GARPR_2014_guidelines_en_0.pdf
3. *Consolidated strategic information guidelines for HIV in the health sector.* WHO, 2015
<http://www.who.int/hiv/pub/guidelines/strategic-information-guidelines/en/>
4. *Indicators for monitoring of the achievement of universal access to reproductive health.* WHO, UNFPA, 2008
http://whqlibdoc.who.int/publications/2008/9789241596831_eng.pdf
5. *Measuring sexual health: conceptual and practical considerations and related indicators.* WHO, UNFPA, 2010.
http://whqlibdoc.who.int/hq/2010/who_rhr_10.12_eng.pdf
6. *Indicators on reproductive, maternal and child health.* Commission on Information & Accountability for Women & Children's Health, 2011.
http://www.who.int/woman_child_accountability/progress_information/recommendation2/en/
7. *Indicator registry for tracking the HIV epidemic.*
<http://www.indicatorregistry.org>
8. *Indicators of gender inequality, women's empowerment and gender-based violence from the Demographic and Health Survey (DHS).*
<http://www.dhsprogram.com/topics/Womens-Status-and-Empowerment.cfm>
9. *The OECD Social Institutions and Gender Index (SIGI).*
<http://www.oecd.org/dev/development-gender/theoecdsocialinstitutionsandgenderindex.htm>
10. *The World Bank's Genderstats database of gender statistics.*
<http://genderstats.worldbank.org>
11. *Minimum set of gender indicators.*
<http://genderstats.un.org/>
12. *ECLAC gender statistics in Latin America and the Caribbean (English and Spanish).*
http://estadisticas.cepal.org/cepalstat/WEB_CEPALSTAT/estadisticasIndicadores.asp?idioma=i
13. *United Nations Economic and Social Commission for Western Asia.*
<http://www.escwa.un.org/divisions/teams.asp?teams=Social%20Statistics&division=SD>
14. *United Nations Economic Commission for Europe (UNECE) gender statistics website.*
<http://www.unece.org/statistics/areas-of-work/statsoc/gender-statistics.html>

Table 1 (page 38) illustrates how a gap analysis can be conducted. It uses material from Kenya's national M&E framework for HIV/AIDS¹, which includes several gender-sensitive indicators in its core indicator set. Annex 8 presents a similar gap analysis table for sexual and reproductive health indicator sets of several international organizations.

¹ National AIDS Control Council, 2009.

In Table 1, for each of the eight steps (column 1), the relevant questions that should be asked about gender inequality and HIV are indicated (column 2). Examples of gender-sensitive indicators in Kenya's national M&E framework that could help to answer the questions are provided (column 3). The current indicator set does not respond to all eight questions; where gaps exist (column 4), ideas are suggested for areas that might be measured.



Conduct your own gap analysis using the table template

Annex 10 presents Table 1 again, but columns 3 and 4 are blank. You can use this template to document your own indicators gap analysis. For each row in the table, consider the question in column 2 and then:

1. Take stock: What indicators do you have in the national HIV indicator set? In column 3 of the Annex 10 table template, list the available indicators and disaggregation that would help you answer the question.

2. Assess and fill gaps: Are there any gaps in your indicator list? What additional indicators will you need to answer the question? List these in column 4.

To identify additional indicators that address the gaps, you can refer to the resources listed in Box 12 and determine if these indicators are available in your country. They may be available through population-based surveys, through specific research studies or from routine statistics – not just statistics on sexual and reproductive health or HIV programmes, but also statistics from other sectors such as women's empowerment or gender equality ministries, labour, police, justice, social welfare and education.

Table 1. Example of a gap analysis: Measuring gender-based health inequalities and gender inequality in the Kenyan national HIV M&E framework

1. Step	2. Relevant questions	3. Examples of gender-sensitive indicators	4. Gaps (available gender-sensitive or gender equality indicators to address gaps).
<p>1 Assess gender inequalities</p>	<p>Do inequalities exist between women and men in specific health outcomes in your country?</p> <p>Are these inequalities between women and men consistent across different population subgroups?</p> <p>Are there specific subgroups that bear a disproportionate burden of the health problem because of gender inequality?</p>	<ul style="list-style-type: none"> • Annual number of new HIV infections among adults and children (disaggregated by age, sex, regions, and key populations (sex workers, people who inject drugs, and men who have sex with men)) • Percentage of adults 15–64 years infected with HIV (disaggregated by sex and age subpopulations) • Number of annual deaths attributable to HIV and AIDS (disaggregated by sex and age) 	
<p>2 Identify the contributing factors</p>	<p>What are the underlying social norms and cultural, economic, and legal factors that perpetuate gender inequality?</p> <p>What are the pathways through which these underlying factors shape or influence health outcomes and inequalities?</p>	<ul style="list-style-type: none"> • Percentage of young women and men who have had sexual intercourse before the age of 15 	<ul style="list-style-type: none"> • Gender-based violence; gender norms, women's autonomy • Economic empowerment indicators (for example, women's ownership of property) • Legal, regulatory and policy environment affecting HIV prevention, treatment, care and support • Women's literacy rates, girls' school enrolment rates • Cross-generational sex between young women and older men

1. Step	2. Relevant questions	3. Examples of gender-sensitive indicators	4. Gaps (available gender-sensitive or gender equality indicators to address gaps).
3 Identify promising interventions	<p>What interventions have been shown to effectively address gender inequality as an underlying contributing factor to the health problem?</p> <p>How should actions or interventions to improve gender equality be integrated into interventions to address the health problem?</p>	None applicable	<ul style="list-style-type: none"> • Reviews of effective interventions from Kenya or from similar settings that promote gender-equitable norms; reduce gender-based violence; expand reproductive health/family planning services for women living with HIV; offer HIV and reproductive health services for couples/partners.
4 Determine what is needed to implement interventions effectively	<p>What is needed to implement gender equality interventions?</p> <p>How can we implement ongoing health interventions in a gender-responsive way?</p>	None applicable	<ul style="list-style-type: none"> • Training of programme staff to address unequal gender norms • Expenditure on gender-responsive interventions • Availability of programmes/materials targeted to specific subgroups (for example, youth, women, men, illiterate adults)
5 Monitor the quality of gender-responsive programmes	<p>Are programmes taking into account gender-related barriers faced by women and men when accessing programmes and services?</p> <p>Are programmes being delivered in ways that promote equality, rights and choices for beneficiaries?</p>	None applicable	<ul style="list-style-type: none"> • Awareness among the population of availability of gender-responsive programmes • Client satisfaction with gender-responsive programmes • Participation of men and boys in gender-responsive programmes • HIV service providers trained to identify, refer and care for women subjected to gender-based violence

1. Step

2. Relevant questions

- 6 Monitor the outputs of gender-responsive programmes
- Are we implementing programmes as planned?
Are they reaching beneficiaries equitably and are they meeting their specific needs?

3. Examples of gender-sensitive indicators

- Number of individuals who received testing and counselling services for HIV and received their test results (disaggregated by sex, age)
- Number of male and female condoms distributed
- Number and proportion of males from low circumcision prevalence provinces that have been circumcised as part of the minimum package of male circumcision for HIV prevention services
- Number of people provided with post-exposure prophylaxis (disaggregated by sex and age)
- Percentage of people living with HIV (adults and children) receiving nutritional support (disaggregated by age, sex)

4. Gaps (available gender-sensitive or gender equality indicators to address gaps).

- Percentage of pregnant women attending antenatal care services whose male partner was tested for HIV
- Proportion of women who were asked about physical and sexual violence during a visit to a health unit

1. Step	2. Relevant questions	3. Examples of gender-sensitive indicators	4. Gaps (available gender-sensitive or gender equality indicators to address gaps).
7 Evaluate the outcomes of gender-responsive programmes	<p>Are interventions improving gender equality-related outcomes (for example, power, decision-making, access to and control over resources, support for equitable norms and attitudes)?</p> <p>Are the interventions improving health outcomes?</p>	<ul style="list-style-type: none"> Percentage of female and male sex workers reporting the use of a condom with their most recent client Percentage of men and women with comprehensive correct knowledge of HIV prevention (disaggregated by sex and age group (15–19, 15–49, 15–64)) Percentage of women and men ages 15–9 who received an HIV test in the past 12 months and who know the results Percentage of women who have experienced violence during the 12 months preceding the survey 	<ul style="list-style-type: none"> Percentage of currently married women ages 15–49 who usually make a decision about their own health care either by themselves or jointly with their husbands Proportion of respondents 15–49 years old who believe that, if her husband has an STI, a wife can propose condom use Proportion of women and men who say that wife-beating is an acceptable way for husbands to discipline their wives
8 Evaluate the impact of gender-responsive programmes	<p>Have gender-responsive programmes fundamentally improved health status, morbidity or mortality among women and men?</p> <p>If so, are the declines similar among women and men or have the inequities between them reduced?</p>	<ul style="list-style-type: none"> Annual number of new HIV infections among adults and children (disaggregated by age, sex, regions and key populations) Percentage of adults 15–64 years of age infected with HIV (disaggregated by sex and age subpopulations) 	

Source: Column 3: National AIDS Control Council (2009).

Source: Column 4: MEASURE Evaluation (2014), UNAIDS (2014c) and other indicator lists and registries listed in Box 12.

Step 3: Formulate indicator sets

A single indicator has limited usefulness. Reducing the complexity of a public health problem to one or even a few routine indicators obscures the significant differences that often exist between different population groups in terms of their vulnerability to disease, the way they are being reached by interventions, and the extent to which they are affected by poor health. For this reason, indicators are usually incorporated into sets that are able to generate a comprehensive and multifaceted view of an issue.

At the same time, the national M&E framework must, by definition, be selective in the indicators that it utilizes. Including too many indicators results in an unmanageable data collection burden and may undermine the overall quality of the evidence produced. It is also important that the indicator set be balanced and engages with the most fundamental aspects of the health problem, including underlying gender inequality.

Box 13 outlines basic standards for crafting a balanced and coherent indicator set.

Box 14 describes criteria for assessing whether an indicator set is adequate for measuring and monitoring gender-based health inequalities and gender inequality.

Box 13

Standards for a coherent and balanced indicator set

- The indicator set gives an overall picture of the adequacy or inadequacy of the response being measured.
- It has an appropriate balance of indicators across elements of the response.
- It is relevant to the national context.
- It contains an appropriate mix of indicators measuring inputs, outputs, outcomes and impact.
- It contains an appropriate mix of indicators measuring quantitative and qualitative elements (for example, measuring both the quantity and quality of services provided).
- The number of indicators is reasonable.

Box 14

A coherent and balanced indicator set for measuring and monitoring gender-based health inequalities and gender inequality

The indicator set should cover the following four domains:

- **Health status:** measurements of individual health status and the quality of life of people who are suffering ill health.
- **Determinants of health:** biological, behavioural and social determinants of health, including socioeconomic and sociocultural status and individual characteristics that affect risk for a disease or ill health.
- **Health system performance:** the coverage, accessibility and quality of programmes and interventions to respond to the different needs of men and women (for example, quality of care, stewardship, availability, accessibility, and affordability); integration of services to improve comprehensive care for men and women.
- **Community and structural factors:** resources, organizational and macro-level characteristics (for example, laws, policies, enforcement, governance, inclusiveness, and composite measures of gender inequality).

Source: Adapted from Haworth-Brockman and Isfeld, 2011.

Adding new indicators to an existing indicator set

Revising indicator sets necessitates a difficult balancing act. While there is likely to be a desire to measure more and more dimensions of a health problem – including, but not limited to gender inequality – there are also limits to resources, feasibility and usefulness of ever-expanding indicator sets. Practical experience has shown that challenges emerge when trying to manage a profusion of data and indicators. In making difficult and strategic choices to include additional gender-sensitive indicators in official indicator sets, it is particularly important to reach consensus on what data gaps related to gender inequality demand immediate attention in the national M&E framework and what indicators are suitable candidates to fill those gaps (see Box 15). One solution is to select indicators that can be integrated relatively easily into existing data collection systems, or those for which there are existing data sources rather than adding new layers of data collection requirements. When considering changes to an indicator set – such as adding new indicators or adjusting existing ones – use the questions in Box 15 as a guide.

Box 15

Criteria for adding new indicators

Does the new indicator fill a gap in monitoring gender inequality aspects of the health problem?

Any new indicators introduced into the set should provide data that fill the most important gaps identified in the assessment of the adequacy of the current indicator set for monitoring inequality in aspects of the health problem. Some specific questions to ask include:

- Which stakeholders need and would use the information collected by this indicator?
- How would the information from this indicator be used?
- What effect would this information have on planning and decision-making?
- Is this information available elsewhere, either from other indicators or from other sources?

Is the proposed indicator of good quality?

Any new indicator incorporated into an indicator set should meet the standards for good quality indicators. This includes:

- The indicator has technical merit.
- The indicator is fully defined.
- It is feasible to measure the indicator.
- The indicator has been field-tested or used operationally.

It is generally recommended, whenever possible, to choose an existing indicator with a successful track record rather than to develop a new indicator from scratch. Indicator registries and databases exist (Box 12) that contain information about hundreds of proven indicators, including their precise definitions, methods of measurement and calculation, methods for data collection, and discussion of their strengths and weaknesses.

Does the indicator work coherently with the other indicators in the set?

Indicator sets should be assembled carefully and systematically. Good quality indicators are a necessary, but not sufficient, condition for a good overall indicator set (UNAIDS, 2010c). An indicator set can be comprised of indicators, each of which individually meets the standards for good quality, but which do not work well together. The following are questions to consider:

- Does the indicator fill a gap in terms of the types or levels of indicators in the set?
- Does the indicator contribute to a balance between quantitative and qualitative indicators?
- Does the indicator overlap with any existing indicators?

A note on data sources

This module has addressed how to identify good quality gender-sensitive indicators and how to combine these into a balanced and coherent indicator set. In this final section we consider the issue of data sources: how and where to find information that can form the basis for a rigorous gender analysis of a health problem and of the national response to it (see Module 3).

Depending on the setting and the sophistication of existing health information and surveillance systems, it may be possible to obtain sex-disaggregated data for a range of indicators, including women's and men's health outcomes, health-seeking behaviours and service coverage at a national or subnational level. The main sources for such data could include:

- surveillance data (antenatal care data, reportable disease registries)
- census and vital statistics (births, deaths)
- health information systems (service-level administrative data)
- exit surveys of health service users (quality, client satisfaction)
- population-based surveys (for example, Demographic and Health Survey, behavioural surveys, national prevalence surveys, household surveys on nutrition, resource allocation)
- service coverage data by region (distribution of services, service uptake rates)
- administrative and survey data from other sectors (for example, education, welfare, social grants databases).

Although gender analysis uses sex and gender as its organizing principle, it is also concerned with exploring how other factors interact with sex and gender to magnify inequities in health outcomes. For this reason, the most valuable data are those that are disaggregated not only by sex, but also by other relevant stratifiers –such as age, ethnicity, sexual orientation, socioeconomic status, disability status, educational background or place of residence. This allows for more complex and nuanced analyses across and within subgroups of the population. Such analyses can reveal how combinations of factors intersect in different contexts and settings and how the burdens of inequality are distributed within households, in different types of communities and across different groups of people.

A good gender analysis will draw upon a variety of data, both quantitative and qualitative. This should include data from within and outside of the health sector, given that the root causes of gender-based health inequities extend beyond the health sector itself. It is worthwhile to consider work by academic researchers and institutes and nongovernmental organizations with expertise in gender and women's health that includes studies on gender relations, gender norms and the impact of violence against women. Qualitative data can be particularly useful for understanding the pathways through which gender inequality acts to shape differing health outcomes between women and men and subgroups among them.

Module 1
Ask the right
questions



Module 2
Identify
gender-sensitive
indicators



Module 4
Making M&E
systems gender-
sensitive



Module 3
Conduct gender
analysis



Module 3

Conduct gender analysis

Step 1: Conduct descriptive analysis of gender inequality

Step 2: Analyse data over time, across subgroups and in relation to other norms

Step 3: Analyse gender inequality as a social determinant of health

Module 3

Generating meaningful data through gender analysis

Introduction

Collecting data with gender-sensitive indicators is ultimately only as useful as the analysis of these data and its use to shape the response to a public health problem. This section focuses on gender analysis as a tool for generating meaningful information about the different experiences of women and men in relation to a particular health issue. It describes a simplified, three-stage process for undertaking: a) a descriptive analysis of disaggregated data; b) analysing these data over time and in relation to norms; and c) interpreting data with reference to the broader sociocultural, economic and political context.

The ability to conduct gender analysis is an important skill, not only for those working within national M&E systems, but also for health researchers, statisticians, gender advocates and others who are interested in the relationship between gender inequality and health. This section introduces the basics of gender analysis and presents a step-by-step example concerning HIV in South Africa. The approach described can also be applied to other health issues. Annex 9 presents an example from Senegal in the field of sexual and reproductive health.

What are the key concepts you need to know?

Gender analysis is an approach to working with information that brings into focus the similarities, differences and inequalities that exist between women's and men's experiences. In the field of health, gender analysis is a tool for identifying how men's and women's different circumstances – economic, personal, social, cultural, legal – differently and often unequally influence their health status, their vulnerability to disease, their access to care, and their experience of living with poor health.

Related resource

Guidelines for gender-based analysis of health data for decision-making (PAHO, 2008).

Gender analysis is an essential component of monitoring and evaluation. It helps to identify, assess and inform actions to address gender-based health inequalities and gender inequality. It reveals who is and is not being well served by existing policies and programmes and where changes may be required. Its ultimate aim is to contribute to better, more equitable and more effective programmes, policies and interventions to address gender inequality and to improve the health of both women and men.

Measures of inequality: A basic gender analysis starts by measuring the magnitude of the health inequalities between men and women, or between subgroups of men and women, in relation to a

specific health outcome. Many different statistics can be used to measure health inequalities and to monitor whether change occurs over time. The choice of measures will depend on the aspects of inequality that are most important to capture and understand (WHO, 2013).

Measurements of inequality can be expressed in either absolute or relative terms. **Absolute inequality** refers to the difference in rates between two groups – for example, the absolute difference in lung cancer mortality rates among women and men in a given population – and is expressed in the natural units of the health outcome in question (in this case, deaths per 100 000 population per year). **Relative inequality** is expressed as a ratio of these rates. Both approaches are valid ways to measure inequality. It is generally recommended to present inequality measurements in both absolute and relative terms. In some situations the two measures can lead to different conclusions about the magnitude and direction of changes in inequality over time (see Box 16).

Box 16

Absolute versus relative inequality

Gender-based inequalities in health can be measured on both absolute and relative scales. It is helpful to present both measures, because levels of absolute and relative inequality do not always mirror one another. For example, decreases in levels of absolute inequality can sometimes mask increases in relative inequality. The following example shows how this can be the case.

Fig. 3 presents HIV prevalence rates for adult men and women from a fictitious country for the years 2002 and 2010. We can see clear inequality in prevalence rates, with females having higher HIV prevalence than men in both 2002 and 2010. We can also see that HIV prevalence rates among both men and women declined over the period 2002 to 2010. But what happened to inequality during this time?

Fig. 3. Adult HIV prevalence, by sex



The **absolute disparity in inequality** is expressed as the difference in prevalence rates between the two groups (that is, female prevalence minus male prevalence). In 2002 the female–male difference was 3.4; in 2010 it was 2.7. Over the period 2002–2010, absolute inequality in HIV prevalence between females and males *decreased* by 0.7, or 21%.

The **relative disparity in inequality** is expressed as a ratio of the two groups' prevalence rates (that is, female prevalence/male prevalence). In 2002 the female–male ratio was 1.8; in 2010 it was 2.1. Thus, over the period 2002–2010 – when absolute inequality declined by 21% – relative inequality between men and women in terms of HIV prevalence *increased* by 15%.

How can we explain these seemingly contradictory results?

Both measures are correct; they are simply measuring different aspects of inequality. When we measure absolute inequality, we are concerned with how each group has moved on an absolute scale – in this case, inequality decreased because the gap between female and male prevalence rates tightened over the time period in question. When we measure relative inequality, we are concerned with the proportionate decline within each group. In this example, the HIV prevalence rate among males declined *more* in percentage terms than the rate among females, leading to an increase in relative inequality between the two groups.

Source: Adapted from Handbook on health inequality monitoring: with a special focus on low- and middle-income countries (WHO, 2013b).

Data triangulation: Statistics are extremely valuable, but a statistic can tell only one part of the story. Data triangulation is the process of drawing upon multiple data sources to validate statistical findings, to fill gaps or shore up weaknesses and to strengthen conclusions drawn from the data. A full gender analysis will use triangulation techniques to place the findings of a statistical analysis of inequality into a broader social, cultural, economic and legal context.

Related resource

An introduction to triangulation (UNAIDS, 2010b).

What can you do? Conduct a gender analysis

This section offers a worked example of a gender analysis of the HIV epidemic, using data from South Africa. Annex 9 presents a similar worked example of gender analysis of adolescent fertility, using data from Senegal. Step-by-step instructions for conducting your own gender analysis are on pages 62-64.

The section outlines three basic steps to a comprehensive gender analysis:

1. a descriptive analysis of sex-disaggregated data;
2. an analysis of these data over time, in comparison with other groups and in relation to other norms; and
3. data triangulation that examines the broader social, cultural, economic, legal and health systems factors (that is, gender inequality as a social determinant of health).

South Africa is a country with an information-rich national M&E system. This system includes a functioning health information system; availability of routine service-level data; regular population-based surveys on knowledge, behaviours and HIV prevalence; and a rich assortment of qualitative

and quantitative research studies on gender inequality and HIV. The breadth and depth of available information makes it possible to conduct a comprehensive gender analysis.

In many countries sex-disaggregated data and gender-related qualitative and quantitative research studies may be sparser than in the example below. However, it is still possible and worthwhile to undertake gender analysis following the three-step process described here.

Step 1: Descriptive analysis

The starting point for a gender analysis of the HIV epidemic is to compare basic descriptive statistics for women and men for key indicators such as HIV prevalence or incidence. This makes it possible to quantify the differences, if any, that exist between women and men for the key HIV indicators. To ensure comparability of data, it is important not only to see that the indicator is appropriate, but also that the data source is appropriate to answer the question of interest (e.g. prevalence data for two different time periods should be drawn from similar data collection sources such as a survey).

Table 2 presents HIV prevalence data from a 2008 population-based survey in South Africa. National HIV prevalence among South Africans over two years of age is 10.9%. Women have a higher HIV prevalence than men. In absolute terms, female HIV prevalence is 5.7 percentage points higher than male prevalence; in relative terms, female prevalence is 1.7 times higher than male prevalence.

Table 2. HIV prevalence by sex, South Africa, 2008

Population group	Prevalence
Both sexes (age >2 years)	10.9%
Female	13.6%
Male	7.9%

Source: South African National Prevalence, Incidence, Behaviour and Communication Survey, 2008

Table 3 shows the 2008 HIV prevalence rate broken down into five-year age bands. Female HIV prevalence is higher than male prevalence in all, except four age groups (2–14, 40–44, 50–54, 60+). Prevalence peaks among women at ages 25–29 years (32.7%) followed by women ages 30–34 years (29.1%) and men ages 30–34 (25.8%).

Table 3. HIV prevalence by age and sex, South Africa, 2008

Age group	Female	Male
2–14	2.0%	3.0%
15–19	6.7%	2.5%
20–24	21.1%	5.1%
25–29	32.7%	15.7%
30–34	29.1%	25.8%
35–39	24.8%	18.5%
40–44	16.3%	19.2%
45–49	14.1%	8.4%

Age group	Female	Male
50–54	10.2%	10.4%
55–59	7.7%	6.2%
60+	1.8%	3.5%

Source: South African National Prevalence, Incidence, Behaviour and Communication Survey, 2008

Table 4 shows the absolute and relative inequalities in female–male HIV prevalence by age group. Absolute inequality is highest among those ages 25–29 years, and HIV prevalence among females is 17 percentage points higher than among males. Relative inequality is highest among young people ages 20–24, where HIV prevalence among females is 4.1 times higher than among males.

Table 4. Disparity in female–male HIV prevalence rates, by age, South Africa

Age group	Absolute disparity (percentage points)	Relative disparity
2–14	–1.0	0.7
15–19	4.2	2.7
20–24	16.0	4.1
25–29	17.0	2.1
30–34	3.3	1.1
35–39	6.3	1.3
40–44	–2.9	0.8
45–49	5.7	1.7
50–54	–0.2	1.0
55–59	1.5	1.2
60+	–1.7	0.5

Source: South African National Prevalence, Incidence, Behaviour and Communication Survey, 2008

► How to interpret these data?

It is already apparent that there are marked gender-based disparities in HIV prevalence in South Africa and that these disparities are established at a young age. Women are more likely to be infected with HIV at younger ages than men.

However, these descriptive statistics do not yet help us understand the reasons for young women’s disproportionate risk of HIV. In the next step we conduct further analysis, focusing on the 15–24 age group, where the inequalities between women and men are particularly pronounced.

Step 2: Analysis of trends, across subgroups and compared with other countries

The gender analysis began by quantifying the differences in HIV prevalence between women and men. In this step we obtain a more detailed picture by analysing the data over time and in

comparison with other subgroups and similar populations in other countries. Three questions guide this step:

2a. Analysis of trends: How have the measured differences in HIV prevalence between women and men changed over time?

2b. Analysis across subgroups: How are the measured differences between women and men reflected across various subgroups of the population?

2c. Comparison with other similar populations in different settings: How do these differences compare with those among other similar populations in different settings?

Asking and answering these three questions enables us to paint a fuller picture of patterns and trends and takes us closer to identifying explanations for the gender-based inequalities in HIV prevalence.

Step 2a. Analysis of trends

If data are available, consider how HIV prevalence rates for women and men have changed over time. In South Africa population-based surveys that included HIV testing and serostatus were conducted in 2002, 2005 and 2008. Table 5 presents HIV prevalence figures for women and men (ages 15–24 years) from these three surveys.

Table 5. HIV prevalence among 15–24 year olds, by sex, South Africa, 2002–2008

Age	2002	2005	2008
All 15–24	9.3%	10.3%	8.7%
Males 15–24	6.1%	4.4%	3.6%
Females 15–24	12.0%	16.9%	13.9%

Source: South African National HIV Prevalence, Behavioural Risks and Mass Media Household Survey, 2002; South African National HIV Prevalence, HIV Incidence, Behaviour and Communication Survey, 2005; and South African National Prevalence, Incidence, Behaviour and Communication Survey, 2008.

HIV prevalence among 15–24 year old men declined steadily between 2002 and 2008. In contrast, HIV prevalence among females ages 15–24 rose sharply between 2002 and 2005 but then declined between 2005 and 2008. Over the period as a whole, HIV prevalence among females rose slightly.

Table 6 shows trends in absolute and relative inequality in HIV prevalence between young women and men. Gender-based inequality grew significantly in both absolute and relative terms between 2002 and 2008. The growth in inequality was particularly noticeable between 2002 and 2005, tapering off between 2005 and 2008.

Table 6. Changes in absolute and relative inequality in HIV prevalence, by sex, among youth, ages 1524, South Africa, 2002–2008

	2002	2005	2008	Change (2002–2008)
Female prevalence (%)	12.0	16.9	13.9	+1.9%
Male prevalence (%)	6.1	4.4	3.6	–2.5%
Female–male difference (absolute inequality) (in percentage points)	5.9	12.5 (+112%)	10.3 (–18%)	+75%
Female–male ratio (relative inequality)	2.0	3.8 (+90%)	3.9 (+3%)	+95%

Note: Figures in parentheses represent percentage change from previous survey period.

Source: South African National HIV Prevalence, Behavioural Risks and Mass Media Household Survey, 2002; South African National HIV Prevalence, HIV Incidence, Behaviour and Communication Survey, 2005; and South African National Prevalence, Incidence, Behaviour and Communication Survey, 2008.

➤ How to interpret these data?

Analysis of HIV prevalence data over time shows divergent patterns between young women and men in South Africa. HIV prevalence among men declined steadily over the period 2002 to 2008, while female prevalence rose over the period as a whole, including a sharp increase between 2002 and 2005. These opposing trends explain the marked increase in inequality (in both absolute and relative terms) between female and male HIV prevalence over the period.

Step 2b. Analysis across subgroups

How are inequalities in HIV prevalence reflected across various subgroups of the population? Applying additional stratifiers – beyond sex and age – to HIV prevalence data can shed light on factors that may be contributing to the inequalities in prevalence between women and men.

The ability to conduct a further analysis across subgroups depends on the availability of prevalence data broken down by additional demographic stratifiers such as income, place of residence, race or marital status. These data are not always collected in routine surveillance or special studies, or information may be collected, but full data sets may not be made available for further analysis. The latter is the case in South Africa – that is, HIV prevalence data are disaggregated by a range of stratifiers for the population as a whole, but data showing how age, sex and other variables interact with one another are not available. If such data were available, it would be of interest to look for differences in HIV prevalence for young women and men in relation to such variables as place of residence (province), type of settlement (urban, rural, formal, informal), race, income quintile, and education level.

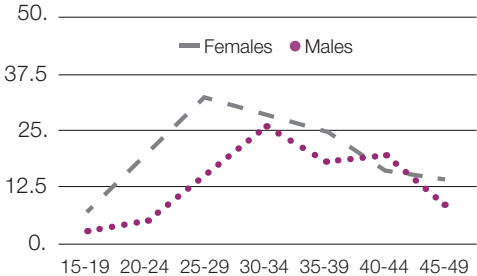
It would also be important to examine HIV prevalence among key populations, such as sex workers, people who inject drugs, and men who have sex with men, and to compare these with data for young women and men in the general population. Looking in detail at prevalence

data across a number of subgroups should make it possible to paint a more detailed picture of infections among young people.

Step 2c. Comparison with other similar populations in different settings

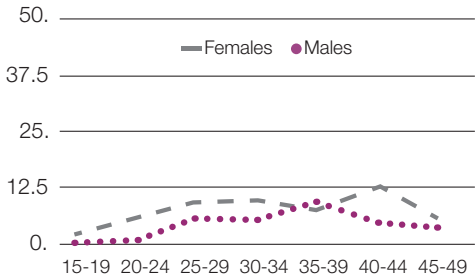
After comparing time trends across various subgroups, the next step is to compare these data with data from similar populations in different contexts – such as data from neighbouring countries, regional and global trends or data from a different sociocultural context altogether.

Fig. 4. HIV prevalence (%) by sex and age, South Africa, 2008



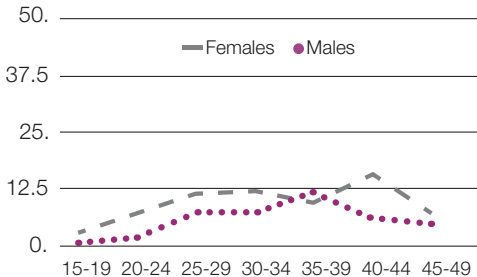
Source: South African National Prevalence, Incidence, Behaviour and Communication Survey, 2008.

Fig. 5. HIV prevalence (%) by sex and age, Kenya, 2008



Source: Kenya Demographic and Health Survey 2008–09.

Fig. 6. HIV prevalence (%) by sex and age, Zambia, 2007



Source: Zambia Demographic and Health Survey 2007.

These comparison can help to highlight any country- or setting-specific aspects of gender-based inequalities in HIV.

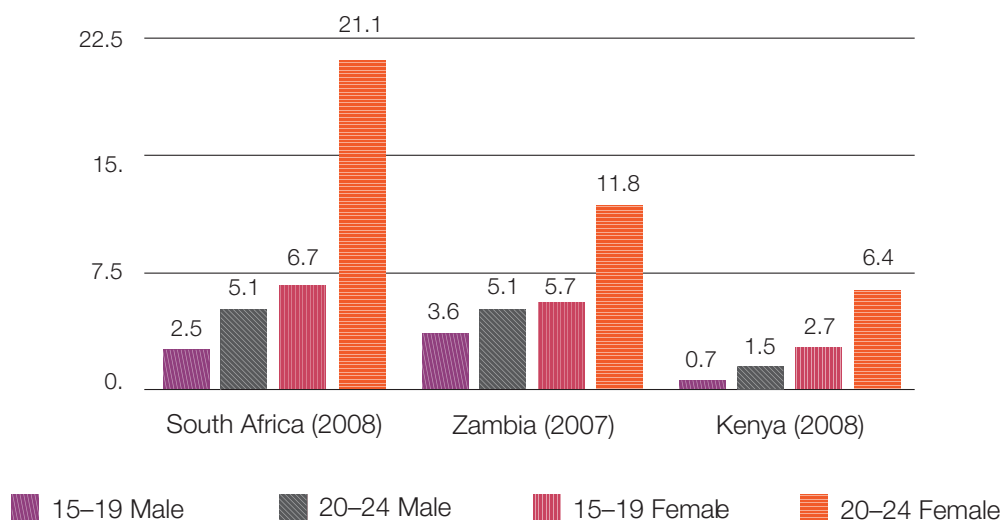
Fig. 4 to 6 present HIV prevalence data, disaggregated by sex, in five-year age bands for adults ages 15–49 in South Africa (2008), Kenya (2008) and Zambia (2007).

Similar patterns of gender-based inequalities in HIV prevalence are visible in all three countries. From the time they enter adolescence, women in all three countries are more likely than men to be infected with HIV. Prevalence increases with age group through the 25–29 age cohort in all three

countries. After this point, infection patterns diverge somewhat, but, generally, HIV prevalence in women eventually begins to decline while prevalence in men continues to climb.

Using the same data, Fig. 7 focuses on HIV prevalence among the youth population, ages 15–24, in the three countries. The patterns of youth HIV prevalence are broadly consistent. Women in both age groups are more likely to be infected than their male counterparts, and infections among youth are particularly concentrated among women ages 20–24 years.

Fig. 7. HIV prevalence (%) among youth, by sex, South Africa, Zambia and Kenya



Source: South African National Prevalence, Incidence, Behaviour and Communication Survey 2008; Zambia Demographic and Health Survey 2007; Kenya Demographic and Health Survey 2008–09.

The absolute inequality in HIV prevalence between women and men is greater in South Africa than in Kenya and Zambia, reflecting the particularly high female prevalence in South Africa. But the greatest relative inequality is in Kenya, where women ages 15–19 years are 3.9 times and women ages 20–24 years are 4.3 times more likely to be infected than young men of comparable age. Relative inequality is less in South Africa (2.7 and 4.1) and Zambia (1.6 and 2.3).

► How to interpret these data?

HIV prevalence among youth in South Africa is similar to that in Zambia and Kenya, two other large African countries. This suggests that a common factor or factors in the region may explain why young women’s prevalence is higher than men’s. It points towards examining broader social determinants of health that may be similar across the three countries.

Despite the similar prevalence patterns across these countries, the data from South Africa stand out because of the particularly high prevalence among women ages 20–24. The third step of the gender analysis considers whether there may be country-specific sociocultural, economic, policy and health systems factors that make this age group especially vulnerable to HIV infection.

Step 3: Data triangulation: analysis of gender inequality as a social determinant of health

In Steps 1 and 2 we conducted descriptive analysis, examined trends over time and compared the data across different age groups and to similar groups in different settings. The final step involves data triangulation to explore gender inequality as a social determinant of health – that is, the broader social, cultural, policy and health systems factors that may contribute to the observed health inequalities. This step in the analysis often benefits from triangulation with both quantitative and qualitative research studies and with information and datasets that are more broadly focused on gender inequality.

Step 3a. Analyse knowledge and risk behaviours (proximate determinants)

Returning to the South African example, we move beyond HIV prevalence data and look at information about proximal determinants of HIV infection among young people. This includes factors such as HIV-related knowledge and risk behaviours, condom use at last sex, early sexual debut, having multiple sexual partners and engaging in intergenerational sex (Table 7).

Table 7. HIV prevalence, knowledge and risk behaviours among young people, South Africa, 2008

	HIV prevalence	Correct knowledge of prevention of sexual transmission of HIV	Condom use at last sex	Sexual debut before age 15	More than one sexual partner in last 12 months	Partner is 5+ years older (15–19 year age group)	Reach of HIV/AIDS communication (youth15–24)
Female 15–24	13.9%	43.5%	73.1%	5.9%	6.0%	27.6%	90.2%
Male 15–24	3.6%	40.6%	87.4%	11.3%	30.8%	0.7%	

Source: South African National Prevalence, Incidence, Behaviour and Communication Survey 2008.

While HIV prevalence is higher in young women, young women are more likely to know of HIV prevention methods. Still, they report lower levels of condom use at last sex than men of comparable ages. Whereas there are fewer young women whose sexual debut occurred before the age of 15 and only one-fifth as many women as men report more than one sexual partner in the previous year, there is a dramatic difference between girls and boys ages 15–19 years in terms of age mixing in sexual relationships. More than one-quarter of sexually active 15–19 year old girls have partners at least five years their senior.

► How to interpret these data?

The data in Table 7 suggest that knowledge of HIV prevention methods does not translate into preventive behaviours among young women. The overwhelming majority of young people in South Africa are exposed to HIV-related communication. But knowledge and exposure to communication, while necessary, are not sufficient to change the proximal determinants of HIV infection.

The data suggest that a) intergenerational relationships of young women with older men and b) young women's lack of power to negotiate safe sex are putting them at disproportionate risk of HIV infection compared with their male counterparts.

Hence, these two factors need to be prioritized in HIV programming, in particular, by developing strategies to reduce age-mixing of young women with older men and to empower young women to negotiate safe sex.

Step 3b. Analyse social and cultural, policy and legal context (structural factors)

So far, we have analysed gender-based inequalities in HIV prevalence data and proximal determinants of HIV infection such as knowledge, sexual behaviour and condom use. Next, we analyse broader structural factors in South African society – that is, social, cultural, economic and legal determinants.

Social and cultural context

Studies from both high- and low-prevalence settings have shown an association between gender-based violence or male control of relationships and HIV infection in women. Multiple pathways – both direct (for example, rape) and indirect (for example, chronically abusive relationships) – connect intimate partner violence with HIV infection.

Gender-based violence is common in South Africa. In a 2010 study Jewkes et al. (2010) found that intimate partner violence and low levels of equity in relationship power increase the risk of new HIV infections among young women (see Box 17).

Qualitative research has found that the links between intimate partner violence, gender inequality and HIV infection lie in the patriarchal nature of South African society (Jewkes and Morrell, 2010). The ideal of masculinity among black Africans celebrates male strength, toughness and demonstration of sexual prowess. Men are expected to be in control of women, and violence can be used to this end. This translates into a range of risky and predatory sexual practices among men.

The ideal of femininity, in contrast, stresses compliance and tolerance of male behaviours, including infidelity. While some women resist male controlling behaviours, the norm is to acquiesce. Female partners of men embodying ideals of masculinity are at particular risk of HIV infection because violence and controlling behaviours limit their ability to influence the circumstances under which sexual encounters occur, including their ability to negotiate condom use (Jewkes and Morrell,

2010). This is particularly true for women who are economically or psychologically vulnerable and are, therefore, least able to risk the loss of material rewards and social status that they secure through sexual relationships.

Box 17

Intimate partner violence, relationship power inequity and HIV infection among young women in the Eastern Cape of South Africa

A 2010 analysis of a longitudinal study in the Eastern Cape province of South Africa between 2002 and 2006 found that intimate partner violence and inequity in relationship power increase the risk of new HIV infections in young South African women ages 15–26 years (Jewkes et al., 2010).

The study found that the incidence of HIV among women with low relationship power equity (measured on a scale, using answers to a questionnaire) was 1.51 times higher than among women with medium or high relationship equity. Also, young women who reported more than one episode of intimate partner violence had an HIV incidence 1.65 times higher than women who reported no or just one episode of violence.

The authors concluded that 13.9% of new HIV infections among young women could be avoided if no women were in relationships with low relationship equity, and 11.9% of new infections could be avoided if women did not experience more than one episode of intimate partner violence.

Although the association between intimate partner violence, relationship power inequality and HIV has long been observed, this study was one of the first to provide evidence of a likely causal link. The study findings have drawn attention to the need to address these risk factors in policies and HIV prevention interventions in South Africa and beyond.

In addition to these entrenched gender norms, high levels of violence of all types in South African society have contributed to a normalization of violence as a means of settling disputes (Jewkes, 2002). For example, a youth panel study in Cape Town found high levels of acceptance of intimate partner violence across a range of scenarios. Exposure to violence as either a victim or perpetrator was correlated with acceptance of intimate partner violence. This suggests that men have internalized norms of violence as a result of their exposure to violence as either victims or perpetrators of assaults; acceptance among women likely derives from exposure to violence in their own families (Thaler, 2012). Exposure to violence from a young age may desensitize many children and adolescents and make them more likely to commit violent acts themselves, including against intimate partners, at a later age (Thaler, 2012).

➤ How to interpret these data?

By drawing upon research on the social and cultural norms that shape intimate relationships in South Africa, the gender analysis has found that young women's vulnerability to HIV infection is linked to the country's high levels of intimate partner violence. In particular, intimate partner violence is widely accepted as a legitimate response to conflicts, particularly when a man suspects or discovers that a woman has been unfaithful. Dominant norms of masculinity and femininity also contribute to a situation in which women tend to have little power in relationships and are often unable to influence the circumstances of sexual encounters.

Policy and legal context

We now turn our attention to the policy and legal environment. To what extent are policies in place that promote gender equality? How do laws and policies address intimate partner violence? And to what extent are women's rights protected, including through effective enforcement of existing legislation?

South Africa's response to the National Commitments and Policy Instrument (NCPI) (2010) provides the following insights into the policy and legal framework as it pertains to women:

- There are laws and policies in place that promote women's rights, address women's vulnerabilities (including violence) and guarantee women and men equal access to HIV-related services, but the implementation and enforcement of these measures weak. The NCPI notes that "the real measure" of the national response to HIV can be found in data about HIV prevalence, HIV incidence and levels of access to care and treatment.
- The Domestic Violence Act of 1998 guarantees the right of either party in a domestic partnership to apply for a protection order in instances of domestic violence (broadly defined) and requires the police to assist complainants in domestic violence cases. In practice, however, the law has not been effectively implemented, and the active involvement of civil society organizations has been required to hold duty-bearers accountable. The NCPI further notes that the HIV implications faced by women who are victims of violence need to be better addressed. For example, victims of sexual assault often struggle to obtain post-rape care due to the failure of the police to implement the policy effectively.
- Official recognition of polygamy (via the Recognition of Customary Marriages Act of 1998) may be undermining women's sexual and reproductive health and increasing their risk for HIV by restricting their ability to negotiate condom use and partner fidelity.
- According to civil society organizations, HIV services and interventions are not reaching sex workers adequately. The criminalization of sex work creates barriers for sex workers and their clients to prevention and treatment services, thereby impeding the country's overall prevention and treatment efforts.
- Migrant women are particularly vulnerable because HIV-related services often turn them away. Although official policy states that refugee and migrant populations should be granted access to clinics and to antiretroviral treatment, many migrant women are turned away due either to discrimination or to health workers' lack of awareness of migrants' right to services.

► How to interpret these data?

Laws and policies have been adopted to promote gender equality and to address some of the factors that heighten young women's vulnerability to HIV. The resources, priority and commitment to implement these laws and policies and some of the regulations themselves, however, are insufficient. The result is a large gap between the vision of the laws and policies on paper and their actual effect in young women's daily lives. Therefore, data suggest that there is a need for policies to empower young women to protect themselves in relation to their relationships with older men. There is also a need to work with men and women to address norms related to masculinity and femininity and to strengthen prevention and response to gender-based violence against women.

Other questions to consider

Step 3 of the gender analysis has shown how social and cultural norms and the policy and legal context (that is, gender inequality) underpin the high HIV prevalence among young women (that is, as social determinant of health).

There is no natural endpoint to a gender analysis; there are always more questions that can be asked. Next steps could include:

- looking further at differences across indicators and across different age groups, as well as within key populations, to determine if similar patterns exist in associations between HIV prevalence and other outcomes;
- looking at health systems indicators such as coverage of HIV-related health services, disaggregated and cross-tabulated by sex and other stratifiers, to see if gender-based health inequalities exist and how they relate to risk factors for HIV;
- considering data on young women's access to key sexual and reproductive health and HIV services, such as antenatal care, HIV testing and counselling, prevention of mother-to-child transmission and antiretroviral treatment, to see what inequalities exist among different subgroups of women and how these relate to HIV prevalence;
- examining how indicators of women's autonomy or decision-making power, ability to refuse unwanted sex, access to formal employment, the social acceptability of violence against women, and mobility may be linked to risk factors for HIV; such data are often available in DHS, as are data on HIV-related risk factors;
- considering the results of qualitative studies on intergenerational sexual relationships, the motivations for entering on such relationships and their link to HIV risk factors;
- reviewing research findings on relationship equity and intimate partner violence among older women as well as in other countries (if available);
- consulting broader indicators, such as the Gender Development Index and Gender Empowerment Measure (included in the Human Development Report of the United Nations Development Programme), which can highlight strengths and weaknesses in policy and practice and thus, help to improve implementation of HIV response to reach men and women equitably.

Conclusions

The gender analysis example in this module comes from a country with high HIV prevalence that has robust information systems and a well-developed body of qualitative studies exploring various aspects of the epidemic. Yet even in this case, not all desired information was available – for example, it was not possible to cross-tabulate data by age, sex and other demographic variables.

In countries where fewer data are available, comprehensive gender analysis along these lines may prove more challenging. This is not a reason to neglect such an analysis, however. It is critically important to ask the right questions about gender-based health inequalities and gender inequality. Data may not always be available to answer such questions fully, but it is only by repeatedly asking such questions that the necessity of better and more comprehensive data collection and analysis will become apparent to a wider circle of stakeholders.



Conduct your own gender analysis

The steps described below are a summary of how to conduct a gender analysis of your HIV epidemic:

Step 1: Descriptive analysis

1. **Choose an indicator** for the burden of HIV – for example, HIV prevalence or number of people living with HIV.
2. **Choose the most recent data for your country** (Hint: such data are also available in AIDSInfo – <http://www.aidsinfoonline.org/devinfo/libraries/aspx/home.aspx> or DHS Statcompiler – <http://www.statcompiler.com>).
3. **Choose a disaggregation.** Hint: Start with sex and then explore sex and age combined. Also consider disaggregating indicators for key populations (that is, sex workers, people who inject drugs, and men who have sex with men) by sex and age.
4. **Generate either a table or a bar or pie chart** to present the data disaggregated by sex or both sex and age groups.
5. **Describe your findings** – for example, the magnitude of the difference between women and men or across subgroups and which groups are disproportionately affected.

Step 2. Analysis of trends, across subgroups and compared with other countries

Step 2a: Analyse trends

Choose an indicator of HIV burden that can show trends – preferably the same indicator used in Step 1.

1. **Disaggregate the data by sex and age** to the extent that data are available. Also consider similar trend analysis for indicators related to key populations.
2. **Generate tables and charts** to present the trends in disaggregated data.
3. **Interpret your findings.** For example, has the burden of HIV been changing more rapidly for some sex or age groups than for others? When did the greatest changes take place?

Step 2b. Analyse data by subgroups

1. **Choose an indicator of HIV burden** for which breakdowns by socio-economic characteristics, such as urban–rural residence, educational attainment and household wealth, are available – preferably the same indicator used in Step 1.
2. **Generate tables and charts** that highlight differences among these subgroups.
3. **Interpret your findings.** For example, which subgroups are disproportionately affected? Which socioeconomic characteristics make the most difference to HIV burden?

Step 2c: Compare with other countries

1. **Compare at least 1 or 2 other countries** in your region with data (Hint: such data may be available in AIDSInfo or DHS Statcompiler) on the same indicator as the one that you analysed in Step 2a.
2. For these countries, **generate charts** like those that you made in Step 2a, part 3. Compare the charts for your country with those for the other countries.
3. **Describe your findings.** How are the countries similar? How are they different?

Step 3: Data triangulation: analysis of gender inequality as a social determinant of health

Step 3a. Analyse knowledge and risk behaviours (proximate determinants)

- 1. Choose indicators that measure risk factors** for HIV outcomes among women and men, or in key populations – for example, comprehensive knowledge of HIV prevention, condom use at last high risk sex or sex with multiple partners in last 12 months.
- 2. Choose the most recent data for your country available** and disaggregate by sex and age, depending on data availability.
- 3. Generate tables and charts.**
- 4. Look for other information to help you understand the pattern of risk factors.** Behavioural and social science research studies can be informative.
- 5. Interpret your findings.** For example, what underlying risk factors are most common and how much do these factors differ among groups? Which groups are disproportionately affected?

Step 3b. Analyse social and cultural, policy and legal context (structural factors)

- 1. Choose indicators – both quantitative and qualitative** – that explore sociocultural or economic or legal and political factors associated with HIV outcomes among women and men, or in specific key populations. For example, you might analyse survey data or other research on “woman’s say in her own health-care decisions” or “attitudes towards wife-beating” or “ability to refuse sex” or “prevalence of physical and/or sexual violence”, or “stigma” or “laws related to criminalization”. Hint: such information is available from AIDSInfo, DHS Statcompiler, special research studies and on human rights of women from the World Bank (<http://datatopics.worldbank.org/gender/>).
2. Where relevant, always **present disaggregated data**, although household or policy indicators may not be always amenable to disaggregation.
- 3. Generate any tables and charts** to help to visualize the information.
- 4. Interpret your findings.** What do the data tell you about underlying sociocultural, legal, economic factors that shape HIV outcomes for women and men?
- 5. Discuss the policy and programme implications** of your findings, taking into account all the findings from steps 1, 2 and 3.

Module 1
Ask the right
questions



Module 2
Identify
gender-sensitive
indicators



Module 3
Conduct gender
analysis



Module 4
Making M&E
systems gender-
sensitive



Module 4

Making M&E systems gender-sensitive

**Step 1: Assess the gender-sensitivity of
your M&E system**

**Step 2: Improve the gender-sensitivity of
your M&E system**

Module 4

Making M&E systems gender-sensitive

Introduction

Modules 1, 2 and 3 described practical ways in which monitoring and evaluation can be strengthened by asking the right questions, identifying and using gender-sensitive indicators, and conducting gender analyses of data. This module will focus on actions that can be taken to make the M&E systems gender-sensitive.

UNAIDS has proposed an organizing framework for a functional national M&E system. Although developed with HIV in mind, this framework can be applied to the monitoring and evaluation of other health programmes, such as sexual and reproductive health. The framework is structured around 12 interrelated components (Fig. 8). Actions to make the M&E system gender-sensitive are needed in each of these twelve components.

What do you need to know?

National health M&E systems are complex undertakings that extend far beyond indicators and datasets. They comprise a set of interrelated structures and processes, joined together in a common framework, that involve planning for, collecting, preparing, analysing and using information to steer the response to a public health problem.

The way an M&E system is structured – and how well its component parts work together – has implications for the reliability, validity, timeliness and usefulness of the data that are ultimately produced. For the overall goal to be achieved, each element has a role to play. For example, excellent data collection systems cannot compensate for weaknesses in data analysis. Also, well-designed M&E operational plans will add value only if adequate resources are allocated for implementation.

A national M&E system is more likely to generate evidence on gender-based health inequalities if the system's components and processes are themselves gender-sensitive in their design. A closer look at each of the three rings of the UNAIDS organizing framework (Fig. 8) for a functional national M&E system reveals why this is the case.

Components 1 to 6 of this organizing framework are about **people, partnerships and planning** in the national M&E system. These components incorporate the basic elements that are required to make an M&E system work, including human resources, organizational structures and planning instruments. It is here that decisions are made about the types of data to collect and about resource allocations for M&E. This is also where the “M&E culture” is defined and where human resource capacity for M&E is built and shaped. In order to generate data on gender-based health inequalities, it is necessary that these data requirements are explicitly articulated in national

plans, that budgets are allocated for the collection of these data and that partnerships with gender equality experts and relevant civil society organizations are established for the purpose of exchanging expertise and disseminating evidence. Similarly, without people who know how to ask the right questions and who can undertake gender analysis of data, an M&E system will struggle to generate the relevant evidence.

Fig. 8. Organizing framework for a functional national M&E system



Source: UNAIDS, 2008

Components 7 to 11 of the organizing framework reflect the core tasks of an M&E system – **collecting, verifying and analysing data**. It is here that routine data collection, epidemiological surveillance data, the results of population surveys and research and evaluation findings (including qualitative research) come together and are turned into strategic information that can be used for decision-making. When these components of an M&E system are designed and undertaken from the perspective of gender inequality, valuable information and analysis can be generated on the different experiences of women and men, and subgroups among them, in relation to health problems. This requires, for example, an explicit commitment to collecting appropriately disaggregated data, constructing databases that allow for the generation of reports

on gender-based health inequalities and gender inequality as a social determinant of health, and conducting evaluations and research that asks how gender inequality shapes health outcomes or health inequalities.

Component 12 of the organizing framework is the most critical one: **using data for decision-making**. In order for policies and programmes to be effective in countering gender-based health inequities, they must be informed by evidence. This requires that key messages and information about gender-based inequalities be distilled and disseminated both widely and strategically to stakeholder groups, including advocates for gender equality, women's rights and health and, most importantly, to decision-makers.

While a gender-sensitive organizing framework for an M&E system is the ideal, reality often falls short. Many people who play important roles in data collection and analysis do not yet recognize the important link between gender inequality and health, including in relation to sexual and reproductive health and HIV. Some underemphasize monitoring gender-based health inequalities or gender inequality as a determinant of health in their M&E work because they prioritize the monitoring of health outcomes and do not perceive gender equality as a valuable goal in and of itself. Others do not have the necessary skills to conduct gender analysis of data. In addition, there are persistent difficulties in ensuring the collection and upward reporting of sex-disaggregated data. And, there are limits to both, the financial and human resources for translating raw data into strategic information, leaving large amounts of potentially important information at a purely descriptive level.

What can you do?



Step 1: Assess the gender-sensitivity of your M&E system

The starting point for improving the gender-sensitivity of a national M&E system is to conduct a rapid assessment of each of its 12 component parts from a gender perspective. You can conduct a rapid assessment by asking managers of M&E systems the following questions for each of the 12 components of the UNAIDS organizing framework of a functional M&E system (see Fig. 8).

Component 1: Organizational structures within M&E

- Is there a focal point or someone who can advise the M&E unit on gender equality?
- Is there an M&E policy that explicitly articulates the goal of identifying gender-based health inequalities?

Component 2: Human capacity for M&E

- Does the M&E staff have the capacity to generate, compile, analyse, interpret and disseminate data that capture gender-based inequalities in SRH or HIV?
- Are there training and capacity-building opportunities available on a regular basis to strengthen the capacity of M&E staff to collect and compile and analyse data from gender-sensitive indicators?

Component 3: M&E partnerships

- Are there partnerships in place with stakeholder organizations that are working on, have expertise in and/or can advocate for gender equality, including researchers, nongovernmental women's rights organizations, other civil society organizations (for example, women living with HIV, youth groups), or gender focal points in different ministries and international agencies?
- Are such stakeholder groups consulted by or included in advisory bodies of M&E units?

Component 4: M&E plan

- Is the national M&E plan for the particular health topic (for example, SRH or HIV) aligned with national gender equality priorities and with global commitments such as the Sustainable Development Goals (SDGs) or the Convention on Elimination of Discrimination Against Women (CEDAW)?
- Does the M&E plan include targets for both women and men/girls and boys and subgroups among them?

Component 5: Costed M&E plan

- Are there resources allocated in the M&E plan for gathering and analysing data: a) on the different situations of women and men, including health inequalities and gender inequality as social determinant of health; b) for monitoring how programmes are meeting the specific needs of women and men and promoting gender equality?

Component 6: M&E advocacy, communications and culture

- Does the communication and advocacy in relation to the M&E data include explicit reference to developing messages and undertaking advocacy for gender equality based on data?

Component 7: Routine programmes monitoring

- Are there efforts to sensitize service providers and programmes staff to the importance of sex-disaggregated data for monitoring gender-based health inequalities?
- Are there mechanisms or processes in place to ensure that data remain disaggregated as they are compiled and reported from the local level to the national level?

Component 8: Surveys and surveillance

- Are data disaggregated by other variables (such as age, socioeconomic status, and ethnicity) generated, as appropriate, in epidemiological surveillance and population-based surveys?
- Are sources of data that provide direct information about gender equality as a determinant of health included in the surveillance system?

Component 9: M&E databases

- Are subnational and national databases designed to accommodate disaggregated data?
- Is there ability to triangulate data across different databases (for example, health, national social statistics about gender inequality) and different types of data sources, both quantitative and qualitative?

Component 10: Supervision and auditing

- Are data quality audits undertaken to check for disaggregated data at various levels and to ensure data quality and timeliness?
- Do supervision and accountability measures support the inclusion of gender in the M&E systems?

Component 11: Evaluation and research

- Does the national research agenda include topics related to gender inequality in the context of SRH or HIV?
- Are questions about the impact of gender inequality included in evaluation plans for SRH and HIV programmes?

Component 12: Data dissemination and use

- Is there an explicit plan to conduct gender analysis and to develop products that disseminate findings about gender inequality?
- Do information products of the M&E system convey a picture of how men and women are differently affected and/or how the national response to the particular health issue is addressing gender inequality?
- Are the key findings or messages about gender-based inequalities presented in a direct, compelling and easy to understand manner?
- Are data regularly, widely and in a timely manner disseminated to stakeholders (for example, through data review and dissemination workshops), especially to those implementing programmes, making policy decisions, conducting research, and advocating for gender equality, including women's NGOs?
- Are data on gender-based inequalities being used in policy decision-making, resource mobilization, advocacy, communication campaigns and/or research publications?



Step 2: Improve the gender-sensitivity of your M&E system

The 12 components that make up the organizing framework of a functional M&E system can be thought of as the building blocks of a gender-sensitive M&E system. These building blocks can be strengthened simultaneously. They need to be approached as steps to be taken in a particular sequence.

This section takes a second look at the organizing framework for a functional national HIV M&E system and uses it to illustrate the kinds of actions that you can take to improve the gender-sensitivity of your own M&E system.

Table 8 presents a list of actions that can be taken for each of the 12 components.

Table 8. Actions that can be taken to make the national M&E system gender-sensitive

Component	Recommended actions
1. Organizational structures with M&E	<input type="checkbox"/> Identify gender focal points within the M&E unit who will assume responsibilities for compiling, analysing, presenting and disseminating relevant data. <input type="checkbox"/> Make explicit in M&E policies that evidence on gender-based health inequalities will be collected.
2. Human capacity for M&E	<input type="checkbox"/> Provide training and supervision for collection, compilation and gender analysis of sex-disaggregated and other gender equality data. <input type="checkbox"/> Allocate resources for capacity strengthening to make M&E systems gender-sensitive.
3. M&E partnerships	<input type="checkbox"/> Build partnerships with stakeholders working on gender equality who can disseminate, advise and advocate using data on gender-based health inequalities. <input type="checkbox"/> Involve and consult women's organizations, networks of women living with HIV, representatives of key populations and groups working on gender equality in the design and implementation of M&E activities.
4. M&E plan	<input type="checkbox"/> Include actions to collect, compile, report, analyse and disseminate data on gender-based health inequalities in annual M&E work plans. <input type="checkbox"/> Include programme target-setting for men and women, boys and girls, as well as subgroups among them, including marginalized groups. <input type="checkbox"/> Ensure that the M&E plan is aligned with national and global priorities for monitoring gender inequality.
5. Costed M&E work plan	<input type="checkbox"/> Identify what it will cost to build capacity, get expertise, strengthen surveillance systems, analyse data and produce information products on gender equality, and include these costs in the M&E budget. <input type="checkbox"/> Monitor spending on efforts to strengthen gender-sensitive M&E of national health programmes.
6. M&E advocacy, communications and culture	<input type="checkbox"/> Develop a dissemination and advocacy plan that includes information products and messages presenting the evidence about gender-based health inequalities and gender inequality as a determinant of health.
7. Routine programme monitoring	<input type="checkbox"/> Design data collection and reporting forms so that relevant information about key variables, such as sex, age and socioeconomic status, can be collected and reported. <input type="checkbox"/> Sensitize those collecting routine data and those compiling and reporting such data to the importance of disaggregated data.
8. Surveys and surveillance	<input type="checkbox"/> Where feasible, and while ensuring confidentiality, collect data to allow for multiple layers of disaggregation. <input type="checkbox"/> Include relevant globally agreed indicators on gender equality and HIV and/or SRH in national M&E indicator sets, taking care to use harmonized definitions. <input type="checkbox"/> Embed a gender analysis plan in the overall data analysis plan.
9. M&E databases	<input type="checkbox"/> Structure M&E databases to allow reporting of disaggregated data from the local to the national level. <input type="checkbox"/> Draw on other sources of data, both qualitative and quantitative, that provide direct information about gender equality (for example, gender norms, gender-based violence, gender-based inequalities in access to economic resources, education).
10. Supervision and auditing	<input type="checkbox"/> Provide regular supervision and conduct data audits to facilitate timely and quality reporting of disaggregated data.
11. Evaluation and research	<input type="checkbox"/> Develop an evaluation plan for interventions and programmes that explicitly looks at their impact on gender inequality as well as on the relevant HIV or SRH outcome. <input type="checkbox"/> Formulate research and evaluation questions that investigate not only proximal determinants but also structural factors such as the social, cultural, economic, legal and policy contexts that underpin gender-based inequalities in health. <input type="checkbox"/> Draw on research on gender inequality and HIV/SRH from other sources, including academic research and research conducted by NGOs, to provide additional information.
12. Data dissemination and use	<input type="checkbox"/> Identify policy-makers, advocates, NGOs, and programme managers who can act as advocates for gender equality and disseminate data to them as well as to key decision-makers. <input type="checkbox"/> Be strategic when timing the dissemination of such information – for example, when a new policy, plan or programme is being developed and can benefit from M&E data.

Conclusions

To generate high-quality, relevant, gender-sensitive data to inform policy and practice, the architecture of the M&E system itself must be gender-sensitive. It is necessary to have:

- people trained to collect and analyse gender-sensitive data;
- plans and budgets to support data collection and analysis;
- data collection and reporting systems that are designed to generate disaggregated health data and information about gender inequality as a determinant of health;
- information products to disseminate messages about gender-based health inequalities; and
- partnerships with people who can use data or evidence about gender inequality and SRH or HIV to advocate, make policy decisions, and design and implement gender-responsive programmes.

Glossary

Absolute inequality: A measure used to express the magnitude of health inequalities between two social groups. Absolute inequality is calculated as the difference in rates between two groups, expressed in the natural units of the health outcome in question (for example, deaths per 100 000 persons per year).

Data triangulation: An approach to analysis that draws upon multiple data sources to validate statistical findings, to fill gaps or shore up weaknesses and to strengthen conclusions about the data.

Gender: Refers to the socially constructed characteristics of women and men – such as norms, roles, and relationships of and between groups of women and men. The concept varies from society to society and can be changed. The concept of gender includes five important elements: relational, hierarchical, historical, contextual and institutional. While most people are born either male or female, they are taught appropriate norms and behaviours – including how they should interact with others of the same and the opposite sex within households, communities and work places. When individuals or groups do not “fit” established gender norms, they often face stigma, discriminatory practices or social exclusion – all of which adversely affect health.

Gender analysis: Identifies, assesses and informs actions to address inequality that arises from: 1) different gender norms, roles and relations; 2) unequal power relations between and among groups of men and women; and 3) the interaction of contextual factors with gender, such as sexual orientation, ethnicity, education or employment status.

Gender analysis in health: Examines how biological and sociocultural factors interact to influence health outcomes and services. It also uncovers how gender inequality affects health and well-being.

Gender-based health inequality: Refers to observable differences in health measures and outcomes between women and men (or subgroups of women or men) that can be measured and monitored. It serves as an indirect means of tracking *gender-based health inequities*. Gender inequality is a key social determinant of health that produces health inequities or health inequalities.

Gender-based health inequities: Refers to unfair, avoidable or preventable differences in health that exist between groups of women and men. Inequity is a normative concept and, hence, cannot be precisely measured or monitored. Health equity is achieved when avoidable, systematic differences in health care are removed, so that all women and men have access to health-sustaining resources and the services they need.

Gender inequality: Refers to unequal chances or opportunities for groups of women and men to access and control social, economic and political resources, including protection under the law (such as health services, education and voting rights). Gender inequality determines differential, unequal, and negative health outcomes for men and women and girls and boys. It shapes individuals’ vulnerability to various health problems, influences their access to health care and affects their experience of living with disease. It is a form of inequality that systemically

disadvantages women and girls. In all societies women and girls are, by and large, given less power, privilege, and access to resources and are more discriminated against than men and boys. This document primarily uses the construct “gender inequality”, as distinct from the construct “gender”, which recognizes that the social construction of masculinity can also have negative health consequences for men and boys. The concept also recognizes that, in fact, male and female roles are not fixed binary alternatives, as they are often socially constructed; some people identify themselves as transgender and face disadvantage in terms of their health because of their gender identity. Gender inequality intersects with inequalities that produced by other determinants, such as class, race, ethnicity, age, gender identity and sexual orientation. As a result, sub-groups of women and men (for example, women of colour or adolescent girls, those living in rural areas or from poorer socio-economic groups or transgender women) may face multiple disadvantages related to both gender and other, intersecting inequalities.

Gender equality: Refers to equal chances or opportunities for groups of women and men to access and control social, economic and political resources, including protection under the law (such as health services, education and voting rights). This concept is also known as equality of opportunity, or formal equality. Gender equality is often used interchangeably with gender equity, but the two refer to different, complementary concepts that are needed to understand gender-based health inequities.

Gender equality in health: Exists when women and men have equal conditions to realize their full rights and potential to be healthy, to contribute to health development and to benefit from its results. The poor health outcomes and health inequities generated by gender inequality are not fixed. They can be changed – for the better – through well-targeted health and social policy interventions to promote more egalitarian distribution of power and resources; to counter discrimination, exclusion and marginalization of groups that are disadvantaged; and to improve their access to services. (See definition below of gender-responsive programming).

Gender equality indicator: A type of gender-sensitive indicator that measures gender equality directly or is a proxy for gender equality.

Gender-responsive programming: One measure to promote gender equality in health. It refers to policies or programmes that explicitly consider and address unequal gender norms, roles, power dynamics and distribution of resources between women and men, counter discrimination faced by women and girls in societies, and improve their access to services.

Gender-sensitive indicator: An indicator that helps to measure and assess gender inequality in a society and how it changes over time.

Indicator: A quantitative metric that provides information for monitoring performance, measuring results against targets and assessing accountability.

Key populations at higher risk of HIV: Refers to those most likely to be exposed to HIV or to transmit it. Their engagement is critical to a successful HIV response – that is, they are key to the epidemic and key to the response. In all countries key populations include people living with HIV. In most settings men who have sex with men, transgender persons, people who inject drugs, sex workers and their clients, and seronegative partners in serodiscordant couples are at higher risk of HIV exposure than other people. Also, there is a strong link between various kinds of mobility

and heightened risk of HIV exposure, depending on the reason for mobility and the extent to which people are outside their social context and norms. Each country should define the specific populations that are key to their epidemic and response based on the epidemiological and social context.

Relative inequality: A measure that expresses the magnitude of health inequalities between two social groups. Relative inequality is expressed as the ratio of rates between two groups.

Sex: The different biological and physiological characteristics of males and females, such as reproductive organs, chromosomes, hormones, etc.

Sex-disaggregated indicator: A type of gender-sensitive indicator that measures differences between women and men in relation to a particular metric.

Sex-specific indicator: A type of gender-sensitive indicator that pertains to only women or only men.

Transgender: An umbrella term for all people whose internal sense of their gender identity is different from their biological sex at birth. A transgender woman is someone who was assigned male at birth but identifies as female. Someone who was assigned as female at birth but identifies as male is a transgender man. Some do not identify either male or female but rather as a third sex.

Annex 1

Sexual and reproductive health: assess gender-based health inequities

Asking the right questions to understand whether gender inequality shapes sexual and reproductive health behaviours/practices and outcomes

Are there inequities among different groups of women (or among different groups of men as applicable) in the following sexual and reproductive health outcomes or behaviours/practices in your country? Consider the following indicators¹ (see footnotes for sources)², disaggregated by age, place of residence, socioeconomic status (for example, income quintile, educational status), demographic characteristics (for example, marital status) and ethnicity, as appropriate.³

- Total fertility rate (health outcome)
 - Contraceptive prevalence rate (health behaviours)
 - Prevalence of anaemia among women of reproductive age (health outcome)
 - HIV prevalence among pregnant women (health outcome)
 - Prevalence of syphilis among pregnant women (health outcome)
 - Perinatal mortality rate (health outcome)
 - Percentage of live births with low birth weights (health outcome)
 - Exclusive breastfeeding for six months (health behaviour)
 - Prevalence of anaemia among women of reproductive age (health outcome)
 - Reported Incidence of urethritis in men (health outcome)
 - Reported prevalence of women with genital mutilation (health behaviour/health outcome).
6. Are there subgroups that are disproportionately affected by poor sexual and reproductive health outcomes or behaviours? Which ones?

1 These are selected examples, not an exhaustive list, of indicators for global and national monitoring of sexual and reproductive health, including maternal and newborn health indicators recommended by WHO.

2 Commission on Information and Accountability for Women's and Children's Health (http://www.who.int/topics/millennium_development_goals/accountability_commission/Working_Group_on_Results_Final_Paper.pdf?ua=1); United National Statistics Division, 2008 (<http://mdgs.un.org/unsd/mdg/Resources/Attach/Indicators/OfficialList2008.pdf>); WHO (<http://www.who.int/reproductivehealth/publications/monitoring/9789241596831/en/>).

3 Recommended stratifiers are listed in the guidelines/guidance for construction of these indicators – see sources in footnote 2.

Annex 2

Sexual and reproductive health: identify the contributing factors

Asking the right questions to identify the role of gender inequality as an underlying factor in shaping vulnerability to adverse sexual and reproductive health outcomes and inequities in these outcomes across different groups

To identify inequities in sexual and reproductive health outcomes or behaviours and in use, access to and coverage of services among different groups of women (or men) in your country, you need to ask the following questions:

1. Why are there differences in the sexual and reproductive health behaviours and outcomes and in use, access to and coverage of services across the different groups of women that are identified by asking the questions in Annex 1?
2. Which differences or inequities across subgroups of women can be explained by underlying social, cultural, economic and legal factors, including those that perpetuate women's lower status in societies relative to men? For example:
 - How do prevailing norms of masculinity and femininity, including cultural expectations about family size/composition and taboos about communication related to sexuality and reproduction, shape sexual and reproductive health behaviours and outcomes?
 - How do unequal power relations between men and women within families and relationships shape sexual and reproductive health behaviours and outcomes?
 - How does gender-based violence shape sexual and reproductive health behaviours and outcomes?
 - How does women's unequal access to and control over resources affect sexual and reproductive health behaviours and outcomes?
 - How do discriminatory laws and policies, including those perpetuating gender inequality in relation to sexual and reproductive health (for example, requiring women to have spousal permission, or an adolescent to have parental consent, for SRH procedures and services) shape sexual and reproductive health behaviours and outcomes?
 - How does the political priority (including funding allocations) assigned to sexual and reproductive health services shape sexual and reproductive health behaviours and outcomes?
 - How does women's and girls' access to education, including sexual and reproductive health education, shape sexual and reproductive health behaviours and outcomes?
 - How do the attitudes, biases and discriminatory practices of health-care providers regarding gender shape sexual and reproductive health behaviours and outcomes?
 - How do harmful traditional practices (for example, child, early and forced marriage, female genital mutilation) shape sexual and reproductive health behaviours and outcomes?

Annex 3

Sexual and reproductive health: identify promising interventions

Asking the right questions to identify effective or promising gender equality interventions in the context of sexual and reproductive health programmes

Once you have clarified the role that gender inequality plays in shaping inequitable sexual and reproductive health outcomes, identify appropriate responses to the problem. The following questions can be used to identify effective or promising gender equality interventions in the context of sexual and reproductive health programmes.

1. What are effective and promising interventions that promote gender equality as a critical enabler for improved sexual and reproductive health?
 - What are effective or promising interventions to promote egalitarian gender norms in families, communities and societies, including those that promote women's autonomy in sexual and reproductive decision-making?
 - What are effective or promising interventions to help couples adopt gender-equitable roles and patterns of communication and decision-making, particularly in relation to sexual and reproductive health decisions?
 - What are effective or promising interventions to empower women and girls in their sexual relationships in order to reduce their risk of unplanned pregnancies, sexually transmitted infections (including HIV) and adverse pregnancy outcomes?
 - What are effective and promising interventions to prevent or reduce gender-based violence and other violence against women?
 - What are effective and promising interventions to end traditional practices that are harmful for women's health?
 - What are effective and promising interventions to promote women's economic empowerment in order to reduce their vulnerabilities to sexual and reproductive health problems?
 - What interventions work to promote and enforce laws and policies that address gender equality and that protect and respect human rights, including in relation to sexual and reproductive health?
2. What are effective and promising actions to take gender inequality into account in the implementation of core sexual and reproductive health interventions?¹
 - What are effective or promising approaches to reduce gender-related barriers faced by women and girls in access to and uptake of sexual and reproductive health services?
 - What are effective or promising approaches to enable women to make informed reproductive choices with respect to contraceptive use and other sexual and reproductive health decisions?
 - What are effective or promising approaches to encourage partners, family members and communities to be supportive of women's autonomy in sexual and reproductive decision-making?

¹ These questions draw in part upon PAHO, 2013.

- What are effective actions for reaching young women and men with information about sexual and reproductive health and encouraging them to use services?
- What are effective or promising approaches to improve health-care providers' competencies in understanding and responding to the different health needs and social contexts of their clients, including by providing gender-responsive care?
- What are effective or promising approaches to promote meaningful participation of women and girls in the design and implementation of sexual and reproductive health programmes, services and policies?
- How can access to sexual and reproductive health services and programmes be improved, taking into account financial vulnerabilities, especially of some groups of women, especially those who face multiple forms of discrimination (e.g. migrant women, those living in rural areas, sex workers etc)?
- What are effective or promising approaches to address disrespect, abuse, stigma and discrimination in health-care settings towards women who seek sexual and reproductive health services?
- How can sexual and reproductive health policies and related laws be developed and implemented so that they promote gender equality and human rights, including reproductive rights of women?

Annex 4

Sexual and reproductive health: monitor the quality of gender-responsive programmes

Asking the right questions to guide process monitoring of gender-responsive interventions for improving sexual and reproductive health outcomes

Once gender-responsive sexual and reproductive health programmes are underway, regular programme monitoring can show whether activities are taking into account gender-related barriers faced in access to programmes and delivering gender-responsive services. The questions below can be used as a guide when monitoring the process of delivering quality gender-responsive programmes.

1. Are sexual and reproductive health programmes and services being implemented in ways that promote equality, rights and choices for the beneficiaries?¹
 - Does the programme address the physical (for example, limited mobility), financial (for example, lack of access to resources) and sociocultural (for example, responsibility for childcare) barriers that communities, particularly women, might face in accessing and using sexual and reproductive health services?
 - Is information about available sexual and reproductive health services made accessible to different groups in ways that are culturally sensitive, suitable for individuals with different levels of literacy and is it non-stigmatizing?
 - Are facilities providing sexual and reproductive health services friendly for women and accompanying children, as well as welcoming for accompanying partners (for example, separate toilets for men and women, privacy for consultations, availability of culturally tailored information)?
 - Are health-care providers trained in competencies for providing gender-responsive care that respects and promotes the rights of women, including their right to make informed choices and decisions?
 - Are sexual and reproductive health programmes providing youth-friendly services, including providing information specifically tailored to adolescent girls and boys?
 - Are all clients, irrespective of their age, background or sociodemographic status, receiving the benefit of integrated sexual and reproductive health services?
 - Are sexual and reproductive health programmes explicitly guided in their policies by the human rights principles of non-discrimination, informed choice, informed consent, confidentiality, respect for all and access for all?
 - Do clients, including those from marginalized groups, feel that they have been treated by programme staff and service personnel with respect for their human rights (for example, that they have received services without discrimination, have been supported in making informed choices, their confidentiality has been maintained, and they have been treated with respect and in a non-judgemental manner)?

¹ Adapted in part from WHO, 2011a..

- Are programme staff members aware of power dynamics in their own interpersonal communication with beneficiaries? Do they use empathic communication (language and style) that fosters empowerment and agency among the beneficiaries to make informed choices?
- Do programme staff show the awareness, capacity and willingness to address gender equality, sexuality and human rights as they relate to sexual and reproductive health?

Annex 5

Sexual and reproductive health: monitor the outputs of gender-responsive programmes

Asking the right questions to guide output monitoring of gender-responsive interventions for improving sexual and reproductive health outcomes

Once gender-responsive sexual and reproductive health programmes are being implemented, regular programme monitoring can also show whether the activities are reaching intended beneficiaries and whether access to the services is equitable. The questions below can be used as a guide when monitoring the outputs of gender-responsive sexual and reproductive health programmes and services.

- Are women and men, and subgroups among them, accessing sexual and reproductive programmes or services in the numbers expected?
- What proportion of women and girls of reproductive age are being reached by sexual and reproductive health programmes and services as assessed by:
 - antenatal care cover age;
 - skilled attendant at birth;
 - postnatal care for mothers and babies within two days of birth;
 - antiretroviral (ARV) prophylaxis among HIV-positive pregnant women to prevent vertical HIV transmission and antiretroviral therapy for (pregnant) women who are eligible;
 - contraceptive prevalence rates, modern methods?
- Are there inequities in uptake or coverage of any of the above-mentioned services among subgroups of women by age, geographical area, socioeconomic status, educational status or other variable? Are there disparities by sociodemographic status (for example, married versus unmarried women)?
- If inequities exist, what underlying factors explain them (for example, lack of information, lack of physical or financial access, discrimination against unmarried women, stigma, gender norms, limited mobility and lack of autonomy in health decision-making)?
- Are women who access services satisfied with the quality of the services they receive (for example, is demand for modern contraception satisfied, or are contraceptive users satisfied with services)? Are there differences in the levels of satisfaction between different groups of women? What factors account for these differences?
- Of those women who want their male partners involved, are these men attending sexual and reproductive health services along with their partners?

Annex 6

Sexual and reproductive health: evaluate the outcomes of gender-responsive programmes

Asking the right questions to guide outcome evaluations of gender-responsive interventions for improving sexual and reproductive health outcomes

The following questions can help to guide efforts to assess both gender equality outcomes and sexual and reproductive health outcomes of gender-responsive interventions.

1. Are interventions improving gender equality outcomes?¹ For example:
 - Have power relations become more equitable, including power relations in sexual and reproductive decision-making?
 - Have men's and women's attitudes toward gender or social norms become more equitable or egalitarian?
 - Have there been positive changes in women's agency and empowerment (for example, economically, self-esteem, self-efficacy, autonomy)?
 - Have there been improvements in the extent to which women, including young women, are able to negotiate and practice safer sex?
 - Have there been positive changes in communication within couples in relation to sexual and reproductive health issues?
 - Have there been reductions in women's experience of violence and/or men's perpetration of gender-based violence?
 - Has the acceptability of harmful traditional practices (for example, female genital mutilation, son preference, early and forced marriages) decreased at the individual and community levels?
 - Has the quality of sexual and reproductive health services improved, including in ways that promote informed choices and decisions among women about their reproductive health?
 - Have there been positive changes towards the development or enforcement of policies related to sexual and reproductive health that promote gender equality and/or human rights (for example, removal of requirements for or the practice of obtaining spousal consent for SRH procedures for women or removal of third-party authorization requirements for women seeking abortion)?
2. Are interventions improving sexual and reproductive health-related behaviours and outcomes? And are these improvements similar across different subgroups? For example:
 - Has knowledge about sexual and reproductive health increased (for example, contraceptive methods, ways to prevent STIs or HIV, signs for seeking care during pregnancy and after delivery)?
 - Has age at sexual debut increased?
 - Has condom use among adolescents increased?
 - Has the adolescent birth rate declined?
 - Has unmet need for family planning been reduced?

¹ Questions draw in part upon Caro, 2009.

Annex 7

Sexual and reproductive health: evaluate the impact of gender-responsive programmes

Asking the right questions to evaluate the impact of gender-responsive interventions on sexual and reproductive health outcomes

The following questions can help to guide efforts to measure the impact of gender-responsive interventions on sexual and reproductive health outcomes

1. Have gender-responsive SRH programmes contributed to improvements in gender equality? For example, have there been declines in:
 - prevalence of intimate partner violence against women?
 - child marriage rates?
 - prevalence of female genital mutilation?
2. Have gender-responsive interventions contributed to improving sexual and reproductive health outcomes including reduced morbidity and mortality? For example, have there been positive changes in:
 - fertility rates?
 - adolescent birth rates?
 - prevalence of anaemia?
 - maternal mortality ratio?
 - HIV prevalence rates among pregnant women?
 - prevalence of syphilis among pregnant women?
3. Have these changes been equitable across different subgroups?
4. What factors help to explain inequities in the extent of change across different subgroups?

Annex 8

Sexual and reproductive health: gap analysis of how well do major SRH indicator sets measure and monitor gender-based health inequities and gender inequality

A gap analysis of existing indicator sets is one way to identify whether current M&E systems are missing important aspects of gender inequality. To conduct such a gap analysis, the table below applies the eight public health questions described in Module 1 to: a) WHO reproductive health indicators;¹ b) indicators of maternal, newborn and child health of the Commission on Information and Accountability for Women and Children's Health;² and c) Family Planning 2020 core indicators.³ Gender-sensitive indicators or gender equality indicators can be drawn from MDG indicators and the UN minimum set of gender indicators.^{4,5}

Table A1. Gap analysis of WHO's reproductive health indicators, Commission on Information and Accountability for Women's and Children's Health indicators of maternal, newborn and child health, and Family Planning 2020 core indicators⁶

Gap analysis: How well do major SRH indicator sets measure and monitor gender inequality?

1 WHO, 2006 (http://whqlibdoc.who.int/publications/2006/924156315X_eng.pdf)

2 Commission on Information and Accountability for Women and Children's Health (http://www.who.int/woman_child_accountability/progress_information/recommendation2/en/)

3 FP2020 (<http://www.track20.org/download/data/FP2020%20Core%20Indicators%20Table%20February%202015.pdf>)

4 Available at: <http://genderstats.un.org/>

5 UNSD, 2008 (<http://mdgs.un.org/unsd/mdg/Resources/Attach/Indicators/HandbookEnglish.pdf>)

6 Many of these indicators already have recommendations for disaggregation specified in the guidance documents. All other indicators also need to be disaggregated by the appropriate stratifiers as suggested in the guidance.

1. Step	2. Relevant questions	3. Examples of gender-sensitive indicators	4. Gaps (available gender-sensitive or gender equality indicators to address gaps).
1	Assess gender inequalities	<ul style="list-style-type: none"> • Do inequalities exist between women and men in specific health outcomes in your country? • Are these inequalities between women and men consistent across different population subgroups? • Are there specific subgroups that bear a disproportionate burden of the health problem because of gender inequality? 	<ul style="list-style-type: none"> • Total fertility rate • Adolescent birth rate • Maternal mortality ratio • Perinatal mortality rate • Prevalence of low birth weight • Prevalence of positive syphilis serology in pregnant women • Reported incidence of urethritis in men • Prevalence of HIV infection in pregnant women
2	Identify the contributing factors	<ul style="list-style-type: none"> • What are the underlying social norms, and cultural, economic and legal factors that perpetuate gender inequality? • What are the pathways through which these underlying factors shape or influence health outcomes and inequalities? 	<ul style="list-style-type: none"> • Reasons for non-use of contraception • Age of sexual debut or proportion of young women and men who have had sex before age 15 • Median age at first contraceptive use • Prevalence of recent intimate partner violence • Prevalence of tolerance or acceptability of wife-beating (proxy for unequal gender attitudes) • Prevalence of child marriage • Median age at marriage • Prevalence of female genital mutilation • School enrolment rates for adolescent girls and boys • Literacy rates for women • Presence of laws that prohibit/ban violence against women,¹ female genital mutilation, child marriage • Women's access to wage employment (MDG 3 indicator)²

1 UN Women (<http://www.un.org/womenwatch/daw/vaw/v-database.htm>)

2 UNSD, 2008 (<http://mdgs.un.org/unsd/mdg/Resources/Attach/Indicators/HandbookEnglish.pdf>)

1. Step	2. Relevant questions	3. Examples of gender-sensitive indicators	4. Gaps (available gender-sensitive or gender equality indicators to address gaps).
3 Identify promising interventions	<ul style="list-style-type: none"> What interventions have been shown to effectively address gender inequality as an underlying contributing factor to the health problem? How should actions or interventions to improve gender equality be integrated into interventions that address the health problem? 	None applicable	<ul style="list-style-type: none"> Reviews of effective and promising interventions that promote gender-equitable norms related to sexuality and reproductive decision-making, prevent and respond to gender-based violence, offer services in a manner that promotes informed choice and decision-making, prevent child marriage and prevent and respond to FGM, provide adolescent-friendly SRH services, empower women and girls³
4 Determine what is needed to implement interventions effectively	<ul style="list-style-type: none"> What is needed to implement gender equality interventions? How can we implement ongoing health interventions in a gender-responsive way? 	<ul style="list-style-type: none"> Annual expenditure on family planning from government domestic budget Availability of basic essential obstetric care Availability of comprehensive essential obstetric care Women provided with information on family planning in the last 12 months 	<ul style="list-style-type: none"> Service delivery points delivering family planning services relative to population of catchment area (measure of physical access) Recent exposure to family planning messages Service delivery points offering appropriate medical and psychological post-rape care
5 Monitor the quality of gender-responsive programmes (process monitoring)	<ul style="list-style-type: none"> Are programmes taking into account gender-related barriers faced by women and men when accessing programmes and services? Are programmes being delivered in ways that promote equality, rights and choices for beneficiaries? 	<ul style="list-style-type: none"> Method Information Index (that is, extent to which women were made aware of alternative contraceptive methods and provided adequate information about their side-effects – a measure of promoting informed choice/decisions) Clients informed of the permanence of sterilization (a measure of promoting informed choice) 	<ul style="list-style-type: none"> Women who had to pay for family planning or other reproductive health services Health facilities that have a formal mechanism for quality assurance or a system for client feedback in place. Health facilities that offer family planning counselling and services to adolescents Contraceptive users reporting privacy during consultation Contraceptive method mix available (in order for women to have choices)

3 WHO, 2013a, 2013c, 2014d (http://www.who.int/reproductivehealth/publications/violence/vaw_hiv_epidemic/en/; <http://www.who.int/reproductivehealth/publications/violence/vaw-clinical-handbook/en/>; <http://www.who.int/reproductivehealth/publications/violence/vaw-adolescent-friendly-srh/en/>)

1. Step	2. Relevant questions	3. Examples of gender-sensitive indicators	4. Gaps (available gender-sensitive or gender equality indicators to address gaps).
6 Monitor the outputs of gender-responsive programmes	<ul style="list-style-type: none"> Are we implementing programmes as planned? Are programmes reaching beneficiaries equitably, and are they meeting their specific needs? 	<ul style="list-style-type: none"> Contraceptive prevalence, modern method use Antenatal care coverage (one and four visits) Births attended by skilled birth attendants Coverage of postnatal care for mothers and babies within two days of birth Antiretroviral prophylaxis among HIV-positive pregnant women to prevent transmission, antiretroviral therapy for (pregnant) women who are eligible for treatment Proportion of women whose demand for family planning is satisfied with a modern method of contraception 	<ul style="list-style-type: none"> Percentage of pregnant women attending antenatal care services whose male partner was tested for HIV⁴
7 Evaluate the outcomes of gender-responsive programmes	<ul style="list-style-type: none"> Are the interventions improving gender equality-related outcomes (for example, power, decision-making, access to and control over resources, and support for equitable norms and attitudes)? Are the interventions improving health outcomes? 	<ul style="list-style-type: none"> Reductions in unmet need for family planning Improvements in contraceptive prevalence rates Increases in condom use at last high-risk sex More young people (15–24 years) with comprehensive correct knowledge of HIV/AIDS Increase in proportion of women who made family planning decisions alone or jointly with their husbands 	<ul style="list-style-type: none"> Reductions in tolerance or acceptability of wife-beating (proxy for unequal gender attitudes or norms) Increase in age of sexual debut Increase in median age at marriage Changes in legal or policy frameworks that enable women and adolescents to access SRH services without discrimination (for example, without required spousal or parental consent for SRH services or third-party authorization for abortion)
8 Evaluate the impact of gender-responsive programmes	<ul style="list-style-type: none"> Have gender-responsive programmes improved health status, morbidity or mortality among women and men? If so, are the declines similar among women and men or have the inequities between them decreased? 	<ul style="list-style-type: none"> Reductions in total fertility rate Reductions in adolescent birth rate Reductions in maternal mortality ratio Reductions in prevalence of positive syphilis serology in pregnant women Reductions in reported incidence of urethritis in men Reductions in prevalence of HIV infection in pregnant women 	<ul style="list-style-type: none"> Reductions in prevalence of intimate partner violence against women Reductions in child marriage rate Reductions in prevalence of female genital mutilation

4 WHO and UNICEF, 2012 (http://apps.who.int/iris/bitstream/10665/75341/1/9789241504270_eng.pdf)

Annex 9

Sexual and reproductive health: gender analysis

A gender analysis of adolescent fertility in Senegal

Every year 16 million girls ages 15–19 and some 1 million girls under 15 give birth with a range of adverse health, social and economic consequences, including higher rates of maternal and child morbidity and mortality. Understanding and addressing the social determinants of teenage pregnancy, including the role of gender inequality as a determinant, is a top global health priority.

Gender analysis can help us understand the causes of teenage pregnancy. As an example, this annex presents a gender analysis of adolescent fertility in Senegal. The analysis follows the three basic steps described in Module 3:

1. descriptive analysis of disaggregated data from key indicators
2. analysis of these data over time, in comparison with other groups, and in relation to other norms
3. data triangulation that involves the interpretation of the data and examination of the broader social, cultural and policy context.



Step 1: Descriptive analysis

The first step considers key indicators for the health issue in question. While for many health issues it makes sense to begin by comparing outcomes between men and women, this is not relevant in the case of fertility and childbearing; the data concern women only. Therefore, the first step is to consider key indicators for women of different ages.

Teenage pregnancy and childbearing

As Table A2 shows, one-fifth (19%) of teenage girls in Senegal have already begun their reproductive lives. More than one of every 10 17-year-olds and one-quarter of 18-year olds are already mothers.

Table A2. Percentage of adolescent girls who have begun their reproductive lives, Senegal, 2010–2011

Age group	% ages 15–19 already had a live birth	% ages 15–19 currently pregnant	% ages 15–19 who have begun their reproductive lives
All (15–19)	15.5	3.1	18.7
15	2.4	1.3	3.7
16	7.3	3.8	11.2
17	11.6	4.2	15.8
18	26.2	2.9	29.1
19	28.3	3.7	32.1

Source: Senegal DHS 2010–11; MEASURE DHS STATcompiler

A woman's overall fertility is influenced by the age at which she begins childbearing. As Table A3 shows, marriage takes place shortly after first intercourse, and pregnancy follows marriage by about a year, on average.

Table A3. Median age of women (25–49 years) at sexual debut, first marriage and first childbirth, Senegal, 2010–2011

	Median age
Sexual debut	18.8
First marriage	19.3
First childbirth	21.0

Source: Senegal DHS 2010–11; MEASURE DHS STATcompiler.

Family planning and contraceptive use

Only 12% of married women ages 15–49 currently use a modern method of contraception including only 5% of married adolescents (Table A4). Unmarried sexually active women are significantly more likely to use modern contraception than are their married counterparts.

Table A4. Women's current use of modern contraceptive methods, by age group, Senegal, 2010–11

Age group	All	Currently married	Unmarried sexually active ¹
All women (15–49)	8.9	12.1	25.0
15–19	1.9	5.0	
20–24	6.0	8.4	
25–29	11.0	12.8	
30–34	7.7	15.1	
35–39	8.2	14.2	
40–44	5.7	15.8	
45–49	3.7	9.9	

Source: Senegal DHS 2010–11; MEASURE DHS STATcompiler

Unmet need for family planning refers to women at risk of pregnancy who are not currently using contraception and who either do not wish to have any more children or wish to delay having more children for at least another two years. As Table A5 shows, nearly 30% of married Senegalese women have an unmet need for family planning. This level does not vary greatly by age. Considering the percentage of overall family planning demand that is satisfied among different age groups, however, reveals that younger women – particular adolescents – are not well-served by family planning services. Among married adolescents, only 13.5 % of the demand for modern methods is currently being met, compared with 28% among 25–29 year olds, and 36% among 40–44 year olds.

1 Numbers were too small for unmarried sexually active women to disaggregate by five-year age intervals

Table A5. Unmet need for family planning among currently married women, by age group, Senegal, 2010–2011

Age group	% of women with unmet need for family planning	% of family planning demand (unmet need plus met need) for modern methods that is being satisfied
All (15–49)	29.4	28.3
15–19	31.1	13.5
20–24	29.6	21.6
25–29	31.2	28.4
30–34	30.7	31.8
35–39	30.9	30.4
40–44	27.1	35.7
45–49	20.4	31.5

Source: Senegal DHS 2010–11; MEASURE DHS STATcompiler

► How to interpret these data?

- This initial look at statistics related to fertility, age at the start of childbearing and contraceptive use reveals that Senegal has a high overall fertility rate and high levels of early fertility, with 19% of adolescent women having already begun childbearing. Nearly one-third of married adolescent girls are not currently using contraception but would like to. The proportion of the overall family planning demand that is satisfied by modern contraceptive methods is lower among married adolescents than among any other age group.
- These descriptive figures point to issues that may require further consideration, such as marriage patterns and access to family planning services, particularly among adolescents. However, these data are derived from aggregate data and so may mask important specific patterns and associations. In the next step we consider changes in adolescent fertility in Senegal over time and compare these data across subgroups of women and against other norms.

Step 2: Analysis of trends, across subgroups and compared with other countries

Step 2a. Analysis of trends

At the national level, fertility has been steadily declining in Senegal, from an average of 6.4 children per woman in 1986 to 5.7 in 1997 and 5.3 currently (Senegal DHS, 2012–13). The adolescent fertility rate has also declined, from 154 births per thousand teenagers in 1986 to 80 births per thousand today – a 48% decline over the past quarter century.

Fig. A1. Declines in fertility by mother's age (1986–2013), Senegal

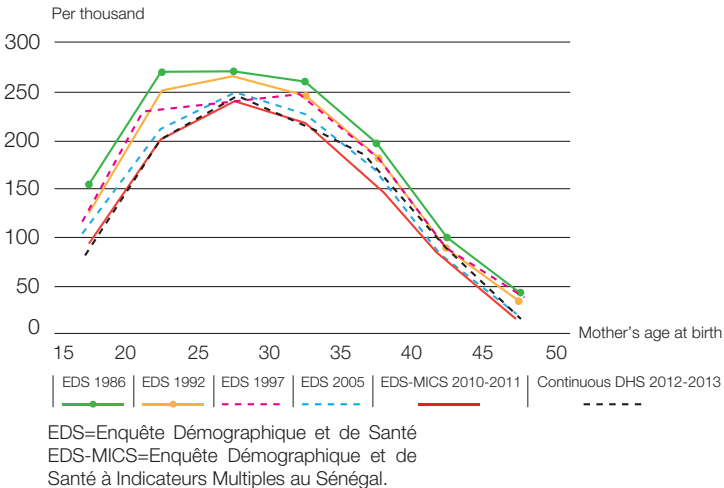
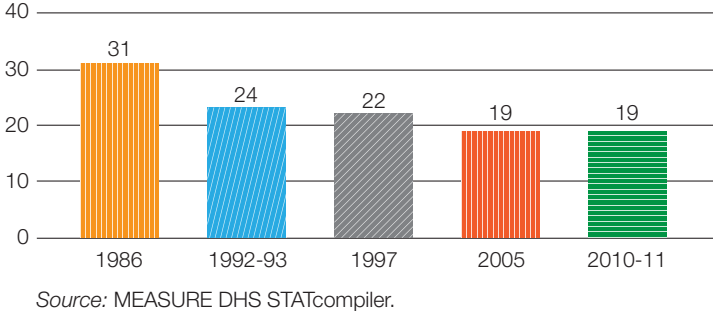


Fig. A2. Proportion of adolescent women (15–19) who have begun their reproductive lives, Senegal



Still, as Fig. A1 and A2 show, despite a steady decline in overall fertility in the country, including among adolescents, rates of adolescent pregnancy remain high. Fig. A2 shows that decreases since 1997 in the proportion of adolescents who have begun their reproductive lives are smaller than those that occurred between 1986 and 1997, suggesting a stall in fertility reductions in this age group.

Declines in adolescent fertility have been accompanied by increases in the median age of sexual debut among women ages 25–49 (from 16 in 1992–93 to 19 in 2010–11) and in the median age at first marriage (from 16 in 1992–93 to 19 in 2010–11). The median age at first childbirth among Senegalese women has also increased, from 19 in 1992–93 to 21 in 2010–11. This highlights the importance of preventing early marriage and sexual debut as well as unprotected sexual activity among adolescents.

Use of modern contraceptives has increased among married women in Senegal over the past 20 years (Fig. A3a), including among married adolescents, especially between 2005 and 2010–2011 (Fig. A3b).

Fig. A3a. Trends in percentage of women (ages 15-49) in union using modern contraceptive methods, Senegal

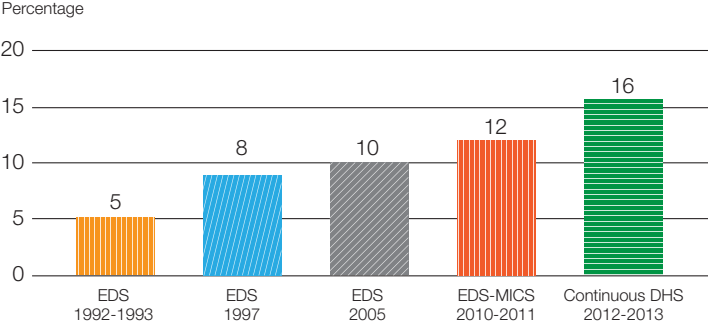
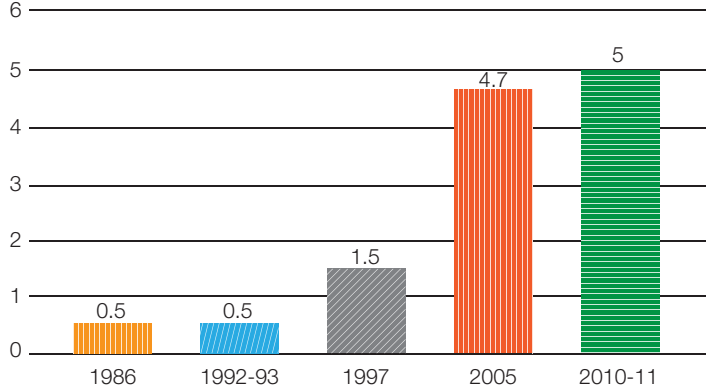


Fig. A3b. Percentage of married women (ages 15-19) using modern contraceptive methods, Senegal



Source: Senegal DHS.

Step 2b. Analysis across subgroups

Thus far, we have considered only aggregated statistics, not taking into account possible differences among groups of adolescent girls based on their place of residence, educational attainment or household wealth. Table A6 provides such information.

Table A6. Adolescent (15-19 years) fertility rates, by place of residence, education and wealth, Senegal, 2005

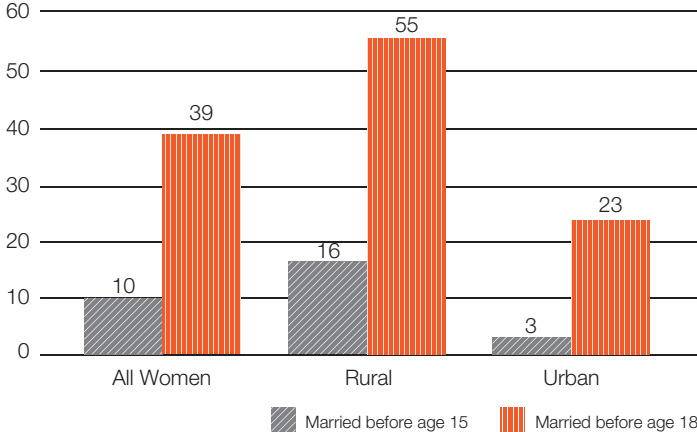
	Births per 1000 women		
Adolescent fertility rate (national)	93		
By place of residence		By household wealth	
Urban	64	Lowest quintile	163
Rural	137	Second quintile	148
		Third quintile	116
By educational attainment		Fourth quintile	75
No schooling	142	Highest quintile	37
Primary	80		
Secondary or more schooling	20		

Source: www.devinfo.org/mdg5b, based on data from 2005 Senegal EDS.

Differences in fertility rates across subgroups of Senegalese adolescent girls are striking. The fertility rate among teenage girls in rural areas is more than twice that in urban areas. The rates also vary markedly by educational background and household wealth. Adolescent girls with at least a secondary education had one-quarter the birth rate of those with only primary education and one-seventh that of girls with no education. Teenagers from the poorest households had more than four times the birth rate of those from the richest households.

These disparities are also evident in the average ages at which various groups of women enter into marriage, become sexually active and give birth for the first time. According to 2010–2011 data, 59% of women ages 20–24 are currently married, compared with 5% of men the same age (Senegal EDS-MICS, 2010–11). Fig. A4 shows the proportion of women ages 20–24 who, according to 2005 data, were already married by the ages of 15 and 18, by place of residence. Overall, 39% of Senegalese women ages 20–24 were married by age 18, and 10% were married by the age of 15. Early marriage is much more common among women in rural areas than in urban areas.

Fig. A4. Percentage of women age 20–24 who were married before age 15 and before age 18, Senegal, 2005



Source: Senegal 2005 DHS, downloaded from www.devinfo.org/mdg5b.

➤ **How to interpret these data?**

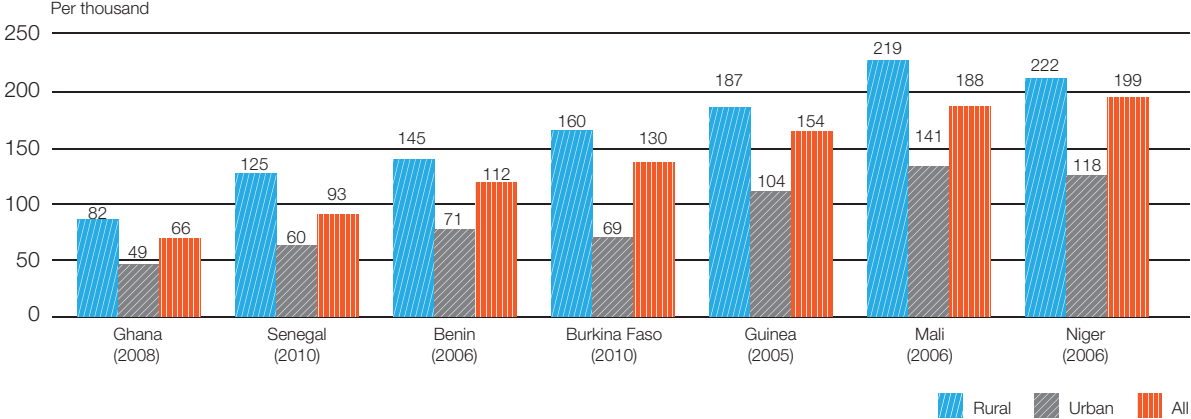
Disaggregating fertility and teenage pregnancy data by subgroups of women shows clear patterns of inequality. Women who live in rural areas, who come from poor families and who have no education tend to begin bearing children earlier and to have more children than women from urban areas, those with more education, and those from wealthier families.

Step 2c. Comparison with other countries

As we have seen, in Senegal there is a gradual transition towards lower fertility, including among adolescents, as well as increases in the median age of women at first marriage, sexual intercourse and childbirth. How do these patterns compare with those of other countries in the region?

Senegal's overall adolescent fertility rate, at 93 per 1000 women, is lower than that of many of its neighbours in West Africa, including Benin (112 births per 1000 women), Burkina Faso (130), Guinea (154), Mali (188) and Niger (199) (Fig. A5).

Fig. A5. Adolescent fertility rates in selected West African countries, by place of residence

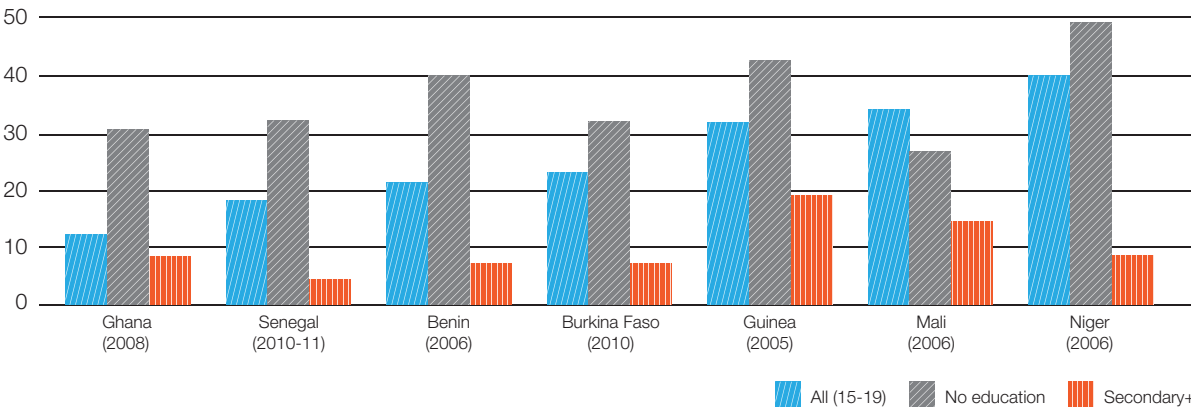


Source: MEASURE DHS StatCompiler.

Throughout the region teenage pregnancy is much more common in rural areas than in urban centres. This difference is greatest in Burkina Faso, where the rural rate is 2.3 times higher than the urban one, and second greatest in Senegal, where it is 2.1 times higher.

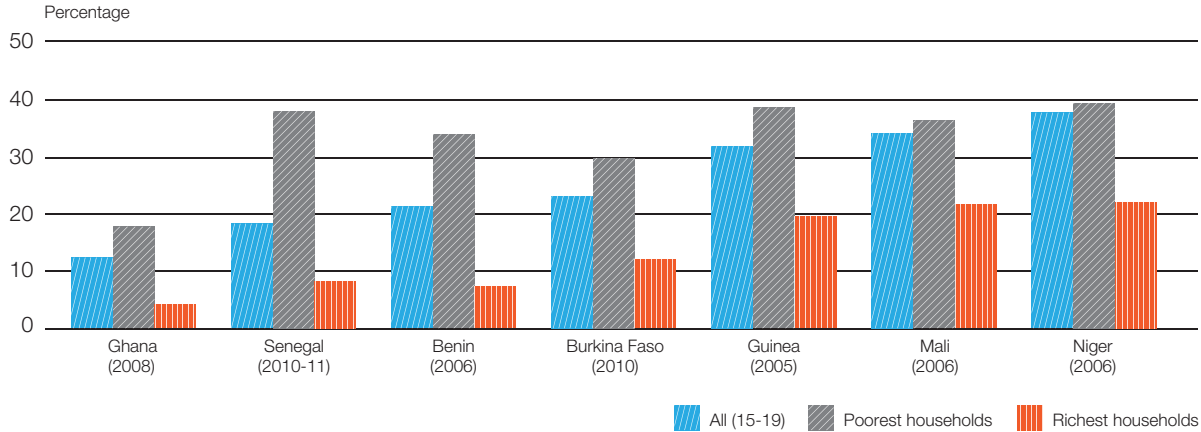
Fig. A6 shows the proportion of teenagers who have already begun childbearing in each of the seven countries, broken down by educational attainment. The pattern of substantial inequalities across educational and wealth subgroups seen in Senegal also occurs in other countries in the region. Although teenage pregnancy in general is less common in Senegal than in most other countries in the region, inequalities based on educational background are more pronounced here than in any other country. Girls in Senegal with no education are 7.1 times more likely than those with a secondary education to have started childbearing in adolescence. Education-based inequalities are also stark in Benin (6.3) and Niger (5.6) and least pronounced in Guinea (2.5) and Mali (2.7).

Fig. A6. Teenage pregnancy, by educational background, in selected West African countries



Source: MEASURE DHS StatCompiler.

Fig. A7. Teenage pregnancy, by household wealth, in selected West African countries

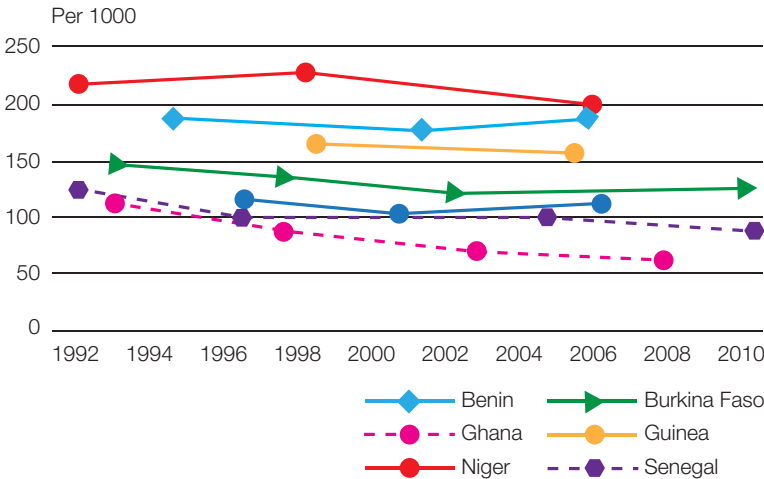


Source: MEASURE DHS StatCompiler.

As shown in Fig. A7, teenage pregnancy also varies greatly by household wealth across the countries in this region. Girls from the poorest households much more likely to become mothers during adolescence than those from the richest households. The greatest disparities are in Senegal and Benin, where girls in the lowest wealth quintile are more than five times more likely to become teenage mothers than those from the highest wealth quintile.

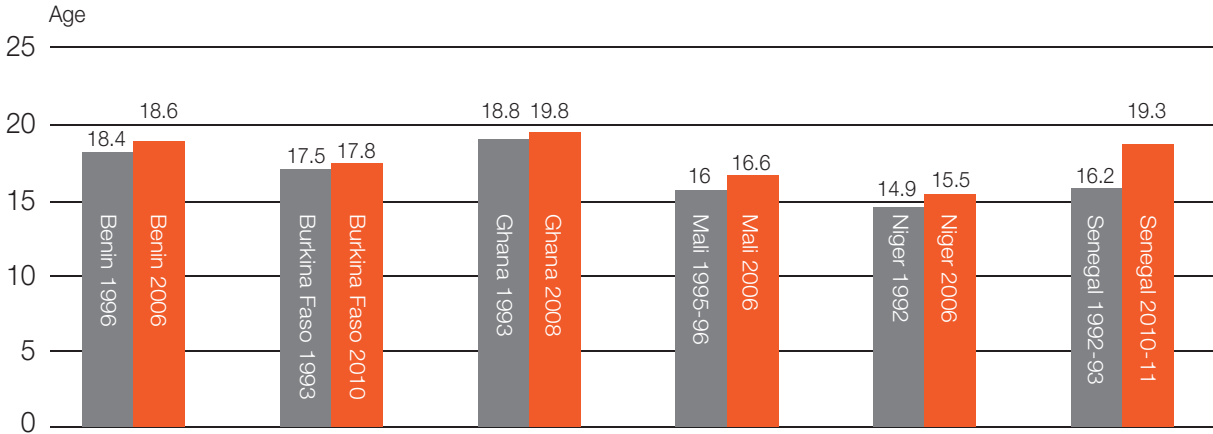
Over time, adolescent fertility has declined in the countries of the region, although the pace of change varied between countries. In Benin, Guinea, Mali and Niger, declines have been modest – less than 10% over the periods shown in Fig. A8; in Burkina Faso the decline was slightly larger (13%). The greatest declines were seen in Ghana and Senegal, where adolescent fertility rates declined by 43% and 29% over 15- and 18-year periods, respectively.

Fig. A8. Changes in adolescent fertility rate (1992–2010)



Source: MEASURE DHS StatCompiler.

Fig. A9. Median age at first marriage



Source: MEASURE DHS StatCompiler.

The greater decline in adolescent fertility in Ghana and Senegal is consistent with increases in the average age at which women first marry in these countries. As Fig. A9 shows, in both Ghana and Senegal, the median age at first marriage has risen above 19. Senegalese women, in particular, are entering into marriage much later than before.

➤ **How to interpret these data?**

Senegal’s patterns of adolescent fertility show both similarities with and differences from those of other countries in the region. The similarities include a gradual decline in adolescent fertility over time and marked variations in the prevalence of teenage pregnancy according to place of residence, wealth and educational background. Senegal’s rates of teenage pregnancy have been falling more quickly than in most of the other countries, and the median age at first marriage has risen steeply. The inequalities in pregnancy rates among the different subgroups of Senegalese adolescent girls are more pronounced than those in other countries in the region. The implication is that Senegal needs a much more targeted approach, focusing on the most vulnerable groups of adolescent girls, whereas some of the other countries in the region need to focus more on reducing overall adolescent fertility rates.



Step 3: Data triangulation: analysis of gender inequality as a social determinant of health

Now we examine the role of social, cultural and legal factors, which not only are determinants of overall rates of adolescent fertility, but also contribute to the patterns of inequality across the different groups of Senegalese adolescent girls. This analysis includes both proximate determinants of adolescent fertility, including knowledge of contraception, attitudes towards family size and family planning, and availability of services, and structural factors such as marriage patterns, gender roles and power relationships.



Step 3a. Analyse proximate determinants: attitudes towards family size, family planning and contraception

On average, Senegalese men desire larger families than Senegalese women. In 2010–11 the ideal number of children among men was 7.4, compared with 5.2 among women (Senegal EDS-MICS, 2010–11). Ethnographic research in Senegal has shown that men's desire for many offspring relates both, to the traditional view that children are a gift from God and to the more modern idea that children are an economic investment in the future. Women are less likely than men to link family size to religious concerns (Randall et al., 2011).

About 90% of Senegalese women know of at least one method of modern contraception. Only 9% of women (and 2% of those ages 15–19) currently use a modern method of contraception, however, and only 20% (3% of those 15–19) have ever used a modern form of contraception. The main reasons cited by women under 30 years for not using contraception include the desire to have more children, disapproval of contraception by self or spouse, religious prohibition, and fear of side-effects (Senegal EDS-MICS, 2010–11).

Myths and misperceptions about the safety and effects of contraception are widespread and may contribute to low contraceptive uptake. In a 2012 survey, 30% of women in Dakar agreed or strongly agreed with the false statement that contraceptive injections can make women sterile, while 52% agreed that contraceptive users end up with health problems. In some other regions of the country, even larger proportions of women agreed with these statements (Fotso et al., 2013).

Many Senegalese of both sexes report that they do not approve of the use of contraception. In 2005 only 50% of women (38% of 15–19 year-old girls) and 25% of men said that they approve of the use of contraception. Approval rates were higher among both, men and women in urban areas than in rural areas (Senegal EDS-MICS, 2010–11). Some 58% of women and 81% of men report that they have never discussed contraception with their spouse. Among married teenage girls, 72% had never discussed contraception with their spouse (Senegal DHS, 2005).

Qualitative research into men's attitudes toward family planning in Senegal has found that men see it as their role to sanction the use of contraception by their wives – and that few are inclined to do so, unless an argument can be made that it will protect the woman's health (Randall et al., 2011). Most men who are fundamentally opposed to family planning cite religious grounds for their objection, claiming that the number of children born is a matter of divine will. There is awareness,

however, that short birth intervals can create health problems for both mothers and children and should be avoided. Therefore, the use of family planning methods to space births – as opposed to limiting or avoiding births – is acceptable to some men under certain circumstances.

Availability of adolescent-friendly health services

Social norms in Senegal favour teenage sexuality within socially sanctioned relationships (marriage). A considerable proportion of young people, however, are sexually active prior to marriage. In 2005, 43% of women ages 20–24 reported that they had had their first sexual experience at marriage – among urban women the figure was 30% (Senegal DHS, 2005). According to a 2011 survey, among never-married young people ages 15–24, 7% of women and 18% of men reported having had sex within the previous year (Senegal EDS-MICS, 2010–11).

Unmarried, sexually active adolescents need sexual and reproductive health services, including access to family planning methods. Yet, studies have found that in Senegal, as in many other African countries, adolescents face barriers to services. For example, Naré et al. (1997) found that adolescents in Dakar had difficulty identifying locations offering family planning services, were made to feel unwelcome once there, were concerned about lack of confidentiality, and encountered counsellors who refused to give them information or supplies without parental or spousal consent. Adolescents reported that the main difficulties in accessing family planning were their unmarried status (among women), embarrassment, expense and moralistic or judgemental treatment by health-care workers. The researchers concluded that social norms that confine sex to marriage and childbearing mean that unmarried adolescents are not considered legitimate clients for family planning services and, thus, make it more difficult for them to protect themselves against unwanted pregnancies.

Step 3b. Analyse social/structural determinants: marriage and relationship patterns

Early marriages: Worldwide, most births among adolescents occur within marriage (UNFPA, 2013). The younger the girls marry, the earlier they are likely to begin childbearing. Girls who marry early are less likely than those who marry later to use contraception, are likely to have more children over the course of their lifetimes, are less likely to be literate, and are more vulnerable to HIV and gender-based violence (Walker, 2013).

Early marriage is common in Senegal. The legal minimum age for girls to marry is 16 (18 for boys); 10% of girls are married before age 15 and 39% before age 18 (see Fig. A4). Early marriage remains customary in many parts of West Africa, which has among the highest child marriage rates in the world. In conditions of extreme poverty, girls constitute an economic burden for parents. They have low social status and are valued primarily for their unskilled labour in domestic or agricultural settings. Household investments in education often favour male over female children. By marrying their daughters off early, parents can reduce their expenses, generate income from dowries and protect the family honour from potential out-of-wedlock pregnancies (Walker, 2013).

Polygamous marriages: These are legal under Senegalese law. A man may have up to four wives if he and his first wife agree, at the time of marriage, to register their union as polygamous. Some 35% of Senegalese women report that their husband has two or more wives. Rural women

(39%) are more likely than urban women (28%) to be in polygamous marriages (Senegal EDS-MICS, 2010–11). Although the relationship between polygamy and early marriage has not been fully explored, it is possible that the high prevalence of polygamy in Senegal contributes to early marriages, as each additional wife tends to be younger at marriage than the preceding one (Walker, 2013).

Age gap in marriages: As men in Senegal marry at a much later age than women, relationships between older men and younger girls are common. Nearly half (47%) of Senegalese women ages 15–24 have had a sexual partner in the previous year who was 10 or more years older. This large age gap is more common among women in rural areas (50%) than in urban areas (42%); and among women with no education (52%) than among women with secondary or more education (42%) (Senegal EDS-MICS, 2010–11). Unprotected sexual activity among adolescent girls is more common among girls who have a big age gap with their partners (that is, 5+ or 10+ years) than among those with partners in their own age group. This pattern may reflect the greater power of men and the social and economic dependency of girls in such relationships (Hope, 2007; UNFPA, 2013).

Gender roles and unequal power relations between men and women

Traditionally, Senegalese men have clearly defined roles and responsibilities in the domestic sphere. They are unambiguously in control of the household (a fact that is formalized in the Senegalese Family Code of 1972), are expected to exercise authority over women and children and are responsible financially for the well-being of family members (Randall et al., 2011).

Women's autonomy: Men's control over decision-making has customarily been so strong that many women have limited power to make autonomous decisions about a range of everyday issues. Only 40% of married women in Senegal make decisions about visiting family and friends, 31% make decisions about their own health care, and 26% make decisions about major household purchases. Over half (51%) of women report that they do not participate in any of these decisions (Senegal EDS-MICS, 2010–11).

The fact that less than one-third of married women ages 15–49 in Senegal – and only 20% of 15–19 year olds – have the “final say” in decisions relating to their own health care is critical for understanding the high rates of teenage pregnancy and its negative consequences. Without the support of their husbands, few married adolescents can choose to obtain family planning services, nor can they count on the benefits of antenatal care, skilled assistance at birth and postnatal care when they do fall pregnant. Women from wealthier households, women with at least a secondary education and older women (ages 45–49) are the most likely to have control over health-related decisions, while poorer, less educated and younger women have the least control (Senegal EDS-MICS, 2010–11).

Gender-based violence: Despite changes to the Criminal Code in 1999, which introduced tougher penalties for those convicted of violence against women, gender-based violence remains a problem in Senegal¹. Studies from other settings show that intimate partner violence against women is associated with higher levels of unintended pregnancies and induced abortions. This not only reflects sexual and reproductive coercion in such relationships, but also that violence may be a barrier for married women to obtain family planning services or other health-related services

¹ Population-based prevalence data on violence against women are not available.

(WHO et al., 2013). At least 40% of Senegalese women agree that wife-beating is justified when a wife goes out without informing her husband, argues with her husband or refuses to have sex with him; among women from the poorest households the proportion is 60%. Such attitudes are much more widespread in rural areas than in urban areas (Senegal EDS-MICS, 2010–11). Fear of violence may prevent many young women from asserting their own fertility preferences within marriage.

Legal and policy frameworks and their implementation

Senegal has ratified the main international instruments that protect and advance women's rights and has taken important steps to advance women's equality in the country, including by establishing gender quotas for parliament. There remain many aspects of law, however, that discriminate against women (for example, articles of the Family Code concerning custody of children, the time period in which women may remarry, the practice of men marrying their dead brothers' widows) and many customary practices that continue despite being illegal (for example, forced and early marriages, female genital cutting in certain areas of the country, women's unequal access to land).

Senegal has a well-developed set of laws, policies and frameworks in support of family planning and reproductive health, including a Youth and Adolescent Reproductive Health Strategy (2005) and a National Action Plan for Family Planning (2011–2015) (Futures Group, 2013). In practice, however, family planning services are reportedly not as well integrated into basic health services as they should be. Gaps in services are particularly acute in rural and remote areas. Barriers to family planning services include the high cost of health services for the poor, health-care workers' negative attitudes towards family planning, sociocultural and religious opposition to family planning and the medicalization of contraceptive provision (Futures Group, 2013). The 2011 Ouagadougou Call to Action – an initiative among eight francophone West African countries to increase the use of family planning – calls for the expansion of community-based family planning programmes that would de-medicalize the provision of contraception, involving non-medical and lower-level health-care workers as one way to increase access to sexual and reproductive health services for youth and other vulnerable populations (Ouagadougou Partnership, 2012).

► How to interpret these data?

The triangulation exercise to assess the proximate factors and social/structural context surrounding adolescent fertility in Senegal shows that social and cultural norms that support early marriage, large family size and male authority in the domestic sphere work together to create an environment that encourages adolescent childbearing. Along with deeply engrained desires for large families (rooted in both religious and economic rationales), scepticism among both men and women about the safety and long-term effects of contraception contributes to very low contraceptive prevalence among married women. Gender norms support the dominant role of men in both public and private spheres. Many women are unable to take routine decisions including those concerning their own health and health care. While officially criminalized, gender-based violence is tolerated in many situations. Against this backdrop the ability of young married girls to participate equally in decisions about their own fertility is severely constrained. At the same time, because customary beliefs link sexuality with marriage (particularly for females), unmarried sexually active adolescents face challenges in accessing sexual and reproductive health services that meet their needs.

These observations imply that, in addition to targeting the most vulnerable groups of adolescents, family planning and reproductive health policies and programmes to reduce adolescent fertility need to:

- address social and gender norms that sanction early marriage, large family size, male dominance and women’s limited autonomy in decision-making;
- increase knowledge of contraceptives and address concerns about their side-effects among women, their partners and communities;
- improve the “adolescent friendliness” of family planning services in order to reach sexually active unmarried adolescents.

Other questions to consider

We have shown above how an analysis of gender and other inequalities can be applied to better understand and address patterns of adolescent fertility in Senegal. There is no natural endpoint to such an analysis; there are always more questions that can be asked. To take this analysis further, next steps could include:

- examining overlapping determinants of inequalities in adolescent fertility patterns (for example, by conducting bivariate and multivariate analysis of social, economic and demographic factors shaping adolescent fertility);
- looking at indicators of education and literacy and exploring how sociocultural norms and expectations for girls shape school enrolment rates, progression through the educational system (that is, at primary, secondary and tertiary levels) and patterns of early marriage;
- reviewing data on women’s economic empowerment, including indicators of workforce participation, occupations and control over earnings, to see if inequalities exist across different subgroups of women and how these relate to patterns of adolescent fertility;
- considering data on young women’s access to sexual and reproductive services to see what inequalities exist among different subgroups of women and how these relate to patterns adolescent childbearing;
- consulting any qualitative studies of the sexual experiences of younger adolescent girls (ages 10–14);
- analysing data on adolescent girls and young women who are in polygamous marriages and their fertility patterns.

Annex 10

A template for conducting a gap analysis of your own HIV or SRH indicator set

1. Step	2. Relevant questions	3. Examples of gender-sensitive indicators	4. Gaps (available gender-sensitive or gender equality indicators to address gaps).
1 Assess gender inequalities	<ul style="list-style-type: none">• Do inequalities exist between women and men in specific health outcomes in your country?• Are these inequalities between women and men consistent across different population subgroups?• Are there specific subgroups that bear a disproportionate burden of the health problem because of gender inequality?		
2 Identify the contributing factors	<ul style="list-style-type: none">• What are the underlying social norms, and cultural, economic and legal factors that perpetuate gender inequality?• What are the pathways through which these underlying factors shape or influence health outcomes and inequalities?		
3 Identify promising interventions	<ul style="list-style-type: none">• What interventions have been shown to effectively address gender inequality as an underlying contributing factor to the health problem?• How should actions or interventions to improve gender equality be integrated into interventions that address the health problem?	<i>Not applicable</i>	

1. Step	2. Relevant questions	3. Examples of gender-sensitive indicators	4. Gaps (available gender-sensitive or gender equality indicators to address gaps).
4 Determine what is needed to implement interventions effectively	<ul style="list-style-type: none"> • What is needed to implement gender equality interventions? • How can we implement ongoing health interventions in a gender-responsive way? 		
5 Monitor the quality of gender-responsive programmes (process monitoring)	<ul style="list-style-type: none"> • Are programmes taking into account gender-related barriers faced by women and men when accessing programmes and services? • Are programmes being delivered in ways that promote equality, rights and choices for beneficiaries? 		
6 Monitor the outputs of gender-responsive programmes	<ul style="list-style-type: none"> • Are we implementing programmes as planned? • Are programmes reaching beneficiaries equitably, and do these programmes meet their specific needs? 		
7 Evaluate the outcomes of gender-responsive programmes	<ul style="list-style-type: none"> • Are the interventions improving gender equality-related outcomes (for example, power, decision-making, access to and control over resources, support for equitable norms and attitudes)? • Are the interventions improving health outcomes? 		
8 Evaluate the impact of gender-responsive programmes	<ul style="list-style-type: none"> • Have gender-responsive programmes improved health status, morbidity or mortality among women and men? • If so, are the declines similar among women and men or have the inequities between them decreased? 		

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