— Compendium of —

Gender Equality and HIV Indicators

MEASURE Evaluation
MANUAL

— Compendium of —

Gender Equality and HIV Indicators

by

Shelah S. Bloom

and

Svetlana Negroustoueva

This research has been supported by the President's Emergency Plan for AIDS Relief (PEPFAR) through the United States Agency for International Development (USAID) under the terms of MEASURE Evaluation cooperative agreement GHA-A-00-08-00003-00 which is implemented by the Carolina Population Center, University of North Carolina at Chapel Hill with Futures Group, ICF International, John Snow, Inc., Management Sciences for Health, and Tulane University. Views expressed are not necessarily those of PEPFAR, USAID, or the United States government. ms-13-82 (February 2014). Cover photo courtesy of Arne Hoel, World Bank.

MEASURE Evaluation is extremely grateful to all who participated in the development of the Compendium of Gender Equality and HIV Indicators. This includes representatives of government institutions, civil society organizations, the UN family, bilateral and multilateral agencies, international NGOs, and other partners who contributed to a participatory consultation process. Please see Annex A for a full list of participants.

Special thanks go members of the Core Planning Group for their insights and guidance through the process:
Kyeremeh Atuahene, Ghana AIDS Commission
Seng Sut Wantha, Cambodia National AIDS Authority
Alessandra Nilo, GESTOS
Luisa Orza and Ebony Johnson, ATHENA Network
Avni Amin, World Health Organization
UNAIDS Staff
Sara Hou and Leyla Sharafi, UNFPA
Joanna Barczyk, Global Fund for AIDS, TB, and Malaria
Daniela Ligiero, the Office of the Global AIDS Coordinator
Diana Prieto, USAID
Nazneen Damji, UN Women

We would also like to thank Nazneen Damji, UN Women; Diana Prieto, USAID; and Daniela Ligiero, the Office of the U.S. Global AIDS Coordinator (OGAC), for leading this effort.

We are grateful to Jill Gay, Melanie Croce-Galis, Katherine Bourne, and Saba Moussavi for their invaluable research support; and to UN Women and UNFPA for the financial support towards the technical convenings and consultations.

Recommended Citation:
Bloom SS, Negroustoeva S. *Compendium of Gender Equality and HIV Indicators.* MEASURE Evaluation. November 2013.

The full document can be downloaded from the publications section of the MEASURE Evaluation site. http://www.cpc.unc.edu/measure/publications/ms-13-82

TABLE OF CONTENTS

Acronyms ***v***

Definitions ***vi***

Preface ***1***
Gender Equality and HIV 1
Development and Purpose of the Compendium 1
Organization of the Compendium 2
Program Monitoring and Evaluation 5
What Makes a Good Indicator 8
Where to Go for More Information on M&E 9

List of Indicators ***10***
Tier 1 Indicators 10
Tier 2 Indicators 11
Tier 3 Indicators 13

Indicator 1—Societal Context ***15***
1.1—Legal and Policy Framework 15
1.2—Stigma and Discrimination 18
1.3—Gender-Based Violence 24
1.4—Gender Norms 30
1.5—Economic Autonomy and Literacy 35
1.6—Humanitarian Emergencies 37

Indicator 2—Intervention Programs ***40***
2.1—Treatment 40
2.2—Counseling and Testing 43
2.3—Service Integration and Linkages 47
2.4—Male Engagement 51

Indicator 3—Populations Warranting Special Attention ***53***
3.1—People Living with HIV 53
3.2—Key Populations 57
3.3—Other Vulnerable Populations 62

Indicator 4—Behavior and Knowledge ***66***
4.1—Sexual Behavior 66
4.2—Knowledge About HIV and AIDS 68

Indicator 5—Disease Prevalence and Reproductive Health ***70***
5.1—Disease Prevalence 70
5.2—Reproductive Health 71

Areas for Future Indicator Development ***74***
Enabling Environment 74
Gender Norms, Women's Empowerment and Rights 75
Reproductive Health 77
Behavior 78
Key Populations and Populations At Greater Risk of Infection 79
Humanitarian and Emergency Settings 80
Health Service/Outcome Indicators 80
Trafficking Indicators 82

Annex A: List of Participants ***83***

ARVs	antiretrovirals
DHS/AIS	Demographic and Health Survey/ AIDS Indicator Survey
GARPR	Global AIDS Response Progress Report
GBV	gender-based violence
GEM	The Gender-Equitable Men (GEM) Scale
GFATM	The Global Fund to fight AIDS, Tuberculosis and Malaria
IPV	intimate partner violence
KAPs	key affected populations
M&E	monitoring and evaluation
MARPs	most-at-risk populations
MDGs	Millennium Development Goals
MERG	(UNAIDS) Monitoring and Evaluation Reference Group
NCPI	National Commitments and Policy Instrument
OGAC	United States Office of the Global AIDS Coordinator
OVC	orphans and vulnerable children
PEP	post-exposure prophylaxis
PEPFAR	The U.S. President's Emergency Plan for AIDS Relief
PLHIV	People Living With HIV
PMTCT	prevention of mother-to-child transmission
SEA	sexual exploitation and abuse
SES	socioeconomic status
STI	sexually transmitted infection
TB	tuberculosis
UN	United Nations
UNAIDS	The Joint United Nations Program on HIV/AIDS
UNDP	United Nations Development Program
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session on AIDS
UNHCR	Office of the United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UN Women	United Nations Entity for Gender Equality and the Empowerment of Women
VAW/G	violence against women/girls
WHO	World Health Organization

Gender
is a social and cultural construct, which distinguishes differences in the attributes of men and women, girls and boys, and accordingly refers to the roles and responsibilities of men and women.[1] The definition and expectations of what it means to be a man or a woman, and sanctions for not adhering to those expectations, vary across cultures and over time, and often intersect with other factors such as race, class, and age. Transgender individuals, whether they identify as men or women, are subject to the same set of expectations and sanctions.

Sex
refers to biologically determined differences which define humans as female or male. These sets of biological characteristics are not mutually exclusive as there are individuals who possess both, but these characteristics tend to differentiate humans as males and females.[2]

Gender Equality
is the concept that all human beings, both men and women, are free to develop their personal abilities and make choices without the limitations set by stereotypes, rigid gender roles or prejudices. Gender equality means that the different behaviors, aspirations and needs of women and men are considered, valued and favored equally. It does not mean that women and men have to become the same, but that their rights, responsibilities and opportunities will not depend on whether they are born male or female.[3]

Gender Equity
means fairness of treatment for women and men, according to their respective needs. This may include equal treatment or treatment that is different but considered equivalent in terms of rights, benefits, obligations and opportunities. In the development context, a gender equity goal often requires built-in measures to compensate for the historical and social disadvantages of women.[3]

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

Gender Analysis
is a systematic way of looking at the different impacts of development, policies, programs and legislation on women and men that entails, first and foremost, collecting sex-disaggregated data and gender-sensitive information about the population concerned. Gender analysis can also include the examination of the multiple ways in which women and men, as social actors, engage in strategies to transform existing roles, relationships, and processes in their own interest and in the interest of others.[3]

[1] http://www.unicef.org/gender/training/content/scoIndex.html
[2] http://www.who.int/reproductivehealth/topics/gender_rights/sexual_health/en/
[3] Global Fund Gender Equality Strategy

A Gender-Transformative AIDS Response
seeks not only to address the gender-specific aspects of HIV and AIDS but also to change existing structures, institutions, and gender relations into ones based on gender equality.[3] Policies and programs that seek to transform gender relations to promote equality and achieve program objectives. This approach attempts to promote gender equality by: 1) fostering critical examination of inequalities and gender roles, norms and dynamics, 2) recognizing and strengthening positive norms that support equality and an enabling environment, 3) promoting the relative position of women, girls and marginalized groups, and transforming the underlying social structures, policies and broadly held social norms that perpetuate gender inequalities.

Gender-Sensitive Indicators
refer to quantitative measures that have been disaggregated by sex as well as other stratifiers (e.g., age, Socioeconomic Status [SES]) that show if there are differences in outcomes, behaviours, uptake of services and other gaps between and among sub-groups of women and men.

Gender-Equality Indicators
refer to measures that track changes in the power dynamics in sexual relations between men and women, individual norms or attitudes towards gender equality (i.e., gender norms), access to and control over economic resources, employment, household decision-making among women, women's status, community norms towards gender equality, and legal and policy frameworks for gender equality at the national level.[4]

Key Populations
are those populations that have significantly higher levels of risk of acquiring and transmitting HIV, and those with higher rates of mortality and/or morbidity within a defined epidemiological context. Key populations often have significantly lower access to or uptake of relevant services than the rest of the population. Depending on the type of epidemic and the country context, some population groups may require explicit attention (for example, people who inject drugs, sex workers, men who have sex with men, and transgender individual).[5]

Other Vulnerable Populations
are those groups of individuals who may be vulnerable to HIV compared with others in the population, and who also have lower access to or uptake of relevant services. Vulnerability refers to unequal opportunities, social exclusion, unemployment, or precarious employment and other social, cultural, political, and economic factors that make a person more susceptible to HIV infection and to developing AIDS. The factors underlying vulnerability may reduce the ability of individuals and communities to avoid HIV risk and may be outside the control of individuals. These include women and girls, transgender persons, partners of clients of sex workers, prisoners, refugees, migrants or internally displaced populations; people living with HIV, adolescents, and young people, orphans and vulnerable children, people with disabilities, ethnic minorities, people in low-income groups, people living in rural or geographically isolated settings or other group(s) specific to the country context.[5]

---

[4] http://www.oecd.org/dataoecd/46/47/43041409.pdf
[5] Global AIDS Response Progress Reporting 2013 Construction of Core Indicators for monitoring the 2011 UN Political Declaration on HIV/AIDS. http://www.unaids.org/en/media/unaids/contentassets/documents/document/2013/GARPR_2013_guidelines_en.pdf

Gender Equality and HIV

Gender is the manifestation of socially constructed roles and expectations that are placed on human beings based on their sex. The parameters of socially acceptable behavior for women and men vary widely between societies and are dynamic over time. Decades of research from around the world have demonstrated that gender inequality and violations of women's human rights have a negative impact on a range of health outcomes for adults and children, including HIV, through direct and indirect effects. Unequal power relations and inequities in access to and control over resources between women and men, violence against women and girls (VAW/G), or the threat of violence, and the perceived lower status of women compared to men increase women and girls' vulnerability to HIV. Equally, harmful gender norms and practices related to what is considered as masculine also play a key role in men's and boys' risk and vulnerability to HIV. These gender norms also cause differentials in health services uptake, the ability to adhere to medical regimens, and various other factors that contribute to HIV-related risks and outcomes. Gender inequality has been recognized as a key driver of the HIV epidemic by all multilateral and bilateral organizations focused on the global pandemic.[1] It has been acknowledged that programs and policies developed in response to HIV must address gender inequality in order to be effective.

Increasingly, key stakeholders and actors in the HIV response have highlighted the need for indicators focused on gender inequality in the context of HIV, i.e., gender sensitive indicators. While indicators were already available, there was a need to provide further guidance in regards to what constitutes standard indicators to measure the gender dimensions of HIV. This compendium seeks to provide such guidance, as detailed below.

Development and Purpose of the Compendium

At the request of UN Women, UNAIDS, WHO, UNFPA, OGAC, USAID, UNDP, and Global Fund MEASURE Evaluation developed this compendium, following a collaborative process that included a large stakeholder meeting in September 2011. The list of indicators was compiled by MEASURE Evaluation in collaboration with a Core Planning Group that included representatives of UN Women, UNAIDS, WHO, GFATM, USAID, OGAC, government partners, and civil society. This list was then presented to the stakeholders at the September 2011 meeting. The meeting involved international representatives from bodies of government and non-government organizations at the multilateral, bilateral, and country levels, and representatives from civil society. The objective of the meeting was to provide guidance on the list of indicators that would be included in the compendium. Following the meeting, comments on the draft were solicited from participants. The Core Planning Committee members made final decisions about the list of indicators and the structure of the compendium, based on their expertise, as well as feedback from participants. Through this process, consensus was gained

[1] Global Fund Gender Equality Strategy: http://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&cts=1331251723204&ved=0CCgQFjAA&url=http%3A%2F%2Fwww.theglobalfund.org%2Fdocuments%2Fcore%2Fstrategies%2FCore_GenderEquality_Strategy_en%2F&ei=MkpZT-SUBYTm0QHezPGcDw&usg=AFQjCNGS9PZwV8Pytc2pPTdfS71P7vs4Ng&sig2=H6qSyT3K2r-BngmOSFU5BQ
WHO Gender Policy: http://www.who.int/gender/documents/policy/en/
UNAIDS, Eliminating Gender Inequalities:
http://www.unaids.org/en/targetsandcommitments/eliminatinggenderinequalities/

around a menu of monitoring and evaluation indicator options to be used by program managers, organizations, and policy makers who are working to address gender equality within the context of the HIV response. The list of meeting participants is available in Annex A; Core Planning Group members are denoted with an asterisk by their names.

The compendium of indicators covers programmatic areas vital to the intersection of gender and HIV. Each of these programmatic areas includes a number of indicators that may be used at national, regional or programmatic levels. The indicators in the compendium are all either part of existing indicators used in studies or by countries or have been adapted from existing indicators to address the intersection of gender and HIV. The indicators can be measured through existing data collection and information systems (e.g. routine program monitoring, surveys) in most country contexts, though some may require special studies or research. The intended purpose of this compendium is to provide program managers, organizations, and policy makers with a menu of indicators to better "know their HIV epidemic/know their response" from a gender perspective in order to:

- strengthen national and subnational stakeholders' understanding of their HIV epidemic and response from a gender equality perspective,
- monitor progress towards eliminating gender-based inequities in HIV responses, and
- monitor and evaluate programs that address specific types of gender equality interventions in the context of HIV.

Organization of the Compendium

The indicators in the compendium are organized into chapters reflecting the five major areas depicted in the adapted Proximate Determinants Framework shown in Figure 1 (Societal Context, Intervention Programs, Populations Warranting Special Attention, Behavior and Knowledge, and Disease Prevalence/Reproductive Health) and into sub-sections within these chapters. Each sub-section begins with a brief description of why that area is relevant to gender and HIV. The indicators measure various aspects of these sub-sections. The lists are varied so as to give program managers, organizations, and policy-makers choice to select indicators that pertain to their needs and can be measured within their context (i.e., based on available data), which will enable them to measure aspects of gender within the context of HIV.

Framework for Mapping Gender Equality and HIV Indicators

The areas pertaining to the intersection of gender and HIV that were used to organize the indicators in this compendium are shown in Figure 1 on the following page. In the previous iterations of the proximate determinants of health models, gender has been implied or explicitly included as an underlying factor. For example in Boerma and Weir,[2] gender roles and norms are part of the socio-cultural context for knowledge and behaviors that lead to the risk of HIV. The adapted model in this guide depicts a different perspective on how gender interacts with the factors that influence HIV-related risks. Gender norms and roles are part of the underlying context for health, but their effects on the risk of HIV can be traced along all levels in the pathway of influence. The model was selected and adapted to demonstrate the importance of addressing gender at all levels of HIV programming, and thus the need of measuring the influences of gender at the underlying, proximate, and outcome levels.

[2] J. Ties Boerma and Sharon Weir, *Journal of Infectious Disease* 2005: 191 (Suppl 1): S61–7.

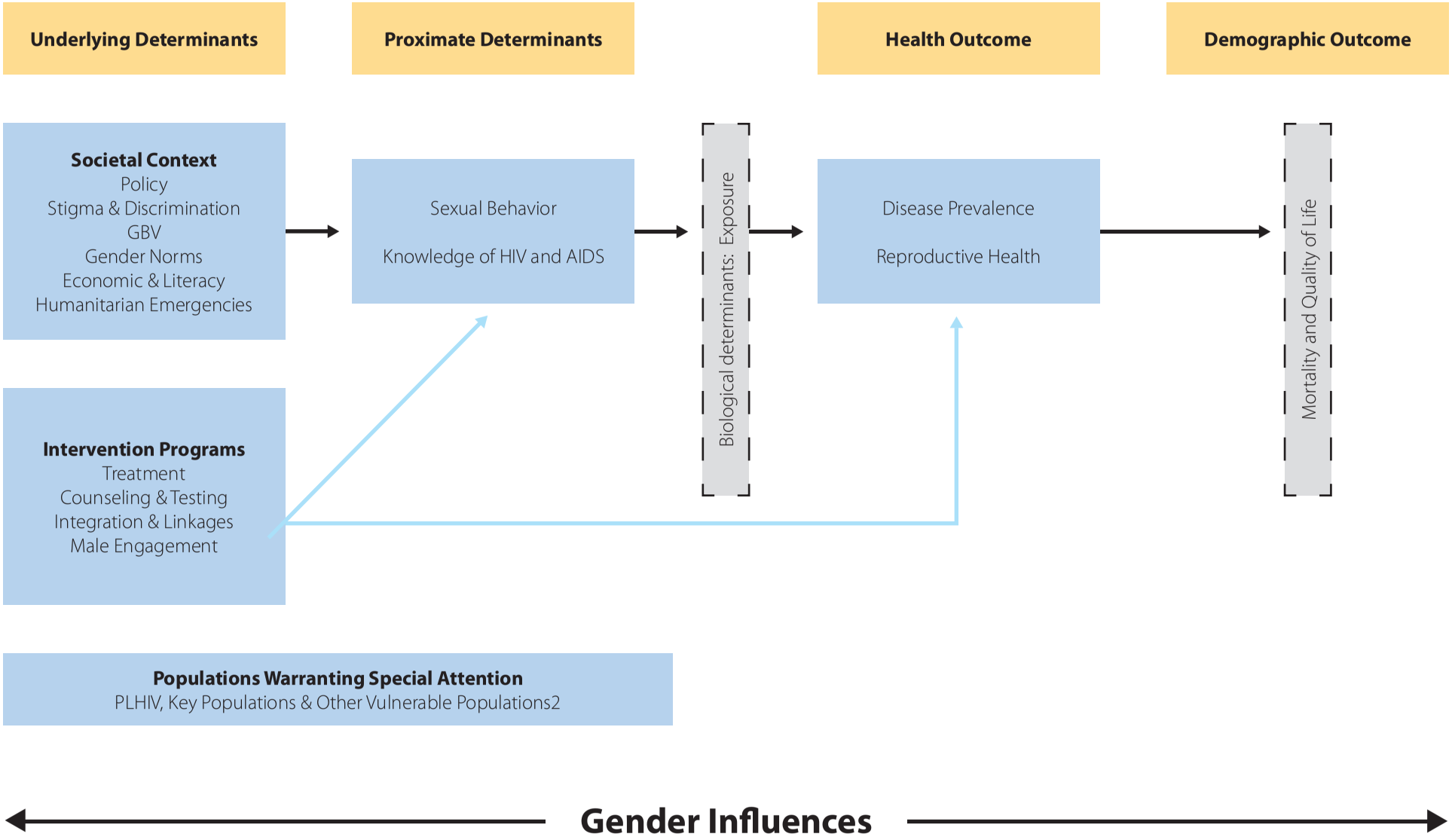

Figure 1: Adapted Proximate Determinants Framework for mapping Gender and HIV indicators, based on Boerma & Weir, 2005[2]

[1] Key populations (PLHIV, IDUs, MSM, SW) and other populations at higher risk (OVCs, migrants, etc.) are highlighted in this box as these groups warrant special attention.
[2] J. Ties Boerma and Sharon Weir, *Journal of Infectious Disease* 2005: 191 (Suppl 1): S61–7.

The compendium's indicators have been mapped to the five major programmatic areas defined in the framework: Societal Context, Intervention Programs, Populations Warranting Special Attention, Behavior and Knowledge, and Disease Prevalence/Reproductive Health. Gender-related factors can be measured across all the programmatic areas. Some indicators reflect the most basic aspect of gender by highlighting the differences between women and men and girls and boys by using sex disaggregated data. Other indicators are direct measures of gender inequality, such as those relating to societal norms and beliefs, or to issues such as gender based violence, which in turn affect HIV-related risks, program/service uptake, and outcomes.

The five groups identified in the framework represent key overarching areas that should be measured in order to assess where progress in achieving a gender-sensitive response to HIV can be demonstrated. The sub-groups in each area were identified by stakeholders at the September 2011 meeting. They were based on the availability of existing indicators and on the importance of these areas for monitoring and evaluating the intersection of gender and HIV. Indicators related to underlying determinants, such as those under "societal context" are important because they drive the patterns of behavior and circumstances that put people at risk for HIV.[3] The collection and analysis of indicators pertaining to more proximate determinants and the outcomes contributes information needed to document progress in addressing gender in HIV and AIDS programming. The compendium offers a selection of measures in all of these areas to help program managers at the national and sub-national levels understand how their approaches are addressing gender and what gaps remain in order to more effectively tackle their response.

Indicator Format

All indicators in the compendium include the title, definition (comprised of the numerator, denominator and recommended disaggregation) and assigned a "Tier". For indicators that are fully explained elsewhere, a link is provided to source of the full reference sheet. These reference sheets describe data needs, method of calculation, and issues to be taken into consideration when measuring the indicator. The remaining indicators, which have been adapted for the compendium, include full reference sheets in this document.

Tier Definitions

The Tiers were defined by members of the Core Planning Group, and Tiers were assigned to the indicators by stakeholders at the September 2011 meeting.

- **Tier 1** indicators are those already in use to monitor national and sub-national programs. Data collected from Tier 1 indicators should be routinely considered for further analysis and interpretation in terms of what it says about inequities between women and men or among sub-groups of women and men.
- **Tier 2** is an expanded list of indicators that might be used by countries, specific projects, programs, special studies and interventions that can be used to monitor and evaluate the gender equality dimensions of HIV and AIDS responses. Where data are available from Tier 2 indicators, they should be included to better understand and monitor progress on gender equality. Where such information is not available, consideration should be given to how these data from these indicators can be collected and monitored.
- **Tier 3** indicators were considered important in the context of gender and HIV, and suggested to be considered for program needs and in specific contexts or require field-testing as they were deemed essential in the emerging areas of measurement.

[3] UNIFEM, Promoting gender equality in HIV/AIDS responses: http://www.unifem.org/attachments/products/gender_equality_in_hiv_aids_responses.pdf

These indicators may need to be refined and validated for future use. In order to facilitate adaptation at country level with those indicators already in use, a separate table of all Tier 1 indicators is presented on page 10.

Areas for Future Indicator Development

The last chapter, "Areas for Future Indicator Development", is a list of areas for which there are no existing measures currently available, but which constitute important aspects of gender equality and HIV. A few of these areas have been briefly described to demonstrate why monitoring and evaluation indicators would be helpful in ensuring that countries and programs address the gender equality aspects of their responses to HIV.[4]

Program Monitoring and Evaluation

Monitoring and evaluation (M&E) is the process by which data are collected, analyzed and presented in order to provide information to program managers, policy makers and others related to the progress and results of program implementation. The goal of M&E is to assess and improve the implementation of programs, as well as to demonstrate the effectiveness of those programs. The way a program collects, analyzes and reports data is systematically described in a document called an M&E plan. For example, a good M&E plan will help keep violence against women and girls (VAW/G) programs (or VAW/G components of more general programs) on track, guide the process needed to achieve their stated objectives, and describe how they will demonstrate the effectiveness of their strategies.

Program Monitoring

Monitoring is the system of routine tracking of program used to understand how well programs are running on a daily, weekly, monthly or quarterly basis, and where any bottlenecks may exist in overall implementation. Monitoring shows that the program inputs are being used effectively and whether they are leading to expected program outputs. For example, a program designed to raise awareness and decrease stigmatization about the level of intimate partner violence (IPV) in a community will want to keep track of (or monitor) the level of inputs such as funding, staff time, and material development as well as outputs such as how many times workers went out to speak at community meetings. Changes detected in the expected performance levels in these inputs and outputs will alert program managers to possible problems.

Program Evaluation

Evaluation is used to demonstrate how effective programs have been in achieving their targets and results. The data used for program evaluation will be drawn from a number of different sources, such as periodic data collection from surveys (DHS, MICS), program indicators, or special studies. The information from program evaluations can be used to revise program practices, to achieve better desired outcomes, as well as to report to donors (Global AIDS Reporting, Millennium Development Goals, etc.).

---

[4] In addition to the indicators highlighted in the compendium , the Inter-Agency and Expert Group on Gender Statistics at the request of the UN Statistical Commission has developed a minimum set of 52 gender indicators. The list was formally endorsed by the UN in February 2013. Methodological work is underway to refine this list.The indicators can be found here:
http://unstats.un.org/unsd/statcom/doc13/2013-10-GenderStats-E.pdf

Process evaluations measure the quality and integrity of the program and focus on program implementation and assess coverage, rather than desired results or outcomes. In order to be useful, process evaluations must be planned to occur at frequent enough periods to allow for changes to be made, but after a long enough time to demonstrate what is needed. Process evaluation is generally easier than measuring results or outcomes. For example, the community HIV prevention awareness program may count how many people attended the community meetings, and make adjustments as necessary.

Outcome evaluations measure whether or not the desired change or result has been attained. Data used for this type of evaluation usually come through a special study and are collected periodically, not on a routine basis. The goal of an outcome evaluation is to show that the changes observed in the targeted population occurred as a result of the program being implemented. Outcome evaluations are used to assess changes in knowledge, behavior, skills, community norms, utilization of services, and health status indicators in the population, such as the prevalence of HV testing or knowledge of HIV prevention methods. In order to measure change, baseline data from the target population, in other words, data collected *before* the program was implemented, must be available to compare with data collected *after* the program took place. This is why planning is so important to a strong evaluation design. When data are not collected before a program begins an evaluation can utilize a different type of design that compares a community which has been exposed to the program with one that has not, but these are less desirable because it may be hard to find comparable communities who have truly not been exposed to the program in question, for example HIV prevention messages in hospitals or schools.

Impact evaluations show how much of the change can be attributed to the program, for example improvements in the quality of life of PLHIV. These evaluations are harder to conduct and require very specific study designs to measure the extent of the observed change in the desired outcome that can be attributed to the program. These evaluations require the special level of technical assistance and significant financial resources.

Information from outcome and impact evaluations will demonstrate promising strategies for prevention and response that can be implemented in other settings. The information provided by programs should feed into a larger M&E system in a country or internationally, consistent with the "Three Ones" principle.[5] Information reported at this level is likely to garner enough attention and support to influence international policy and sustained funding.

Gender M&E of HIV and AIDS Responses

The importance of gender-sensitive monitoring and evaluation of HIV programs is underscored by the need to track the difference in HIV outcomes and impact of programs among different sub-groups of women and men as well as to better understand how gender inequality acts as a determinant of HIV among women and men, including transgender men and women. Such information is not only needed by policy makers and program managers for effective decision-making, but is increasingly demanded by donors on the progress and results of HIV programming in reducing vulnerabilities of women and men.

Gender-sensitive indicators refer to quantitative measures that have been disaggregated by sex as well as other factors (e.g., age, SES) that show if there are differences in outcomes, behaviors and uptake of services between and among sub-groups of women and men. In addition to HIV in-

[5] UNAIDS, http://data.unaids.org/una-docs/three-ones_keyprinciples_en.pdf

dicators that are appropriately disaggregated, there is also a need to collect, compile and monitor indicators that either directly or through proxy measures provide information about gender inequality as an underlying determinant of women and men's vulnerability to HIV. Measures of gender equality can track changes in the power dynamics in sexual relations between men and women, individual norms or attitudes towards issues such as intimate partner violence, access to and control over economic resources, employment, household decision-making among women, women's status, community norms towards gender equality, and legal and policy frameworks for gender equality at the national level.[6] At the most basic level, gender-sensitive indicators:

- help identify inequalities between and/or among sub-groups of women/girls and men/boys that need to be redressed;
- require the collection of data disaggregated by sex, as well as by age and socio-economic and ethnic groups;
- must be developed to collect data on factors that can measure change over time since it takes time for societal structures and values pertaining to gender to change; and
- are developed, collected, and used through participatory approaches that involve affected communities of women and men.

Gender-sensitive M&E in the context of HIV is consistent with the "Three Ones" principles, guiding national responses to HIV/AIDS.[7] One (gender-sensitive) M&E system should strengthen ability of information systems to collect and report data disaggregation and analysis by sex and other stratifiers (e.g., age, SES, ethnicity, etc.).[8] In order to address the roots of these differentials, gender equality indicators that capture structural factors, such as gender-related power dimensions between women and men, must be measured. Using gender-sensitive and gender equality indicators will inform how programs, policies and services should best be designed to address the specific needs of the people most affected. Gender-sensitive indicators also monitor and evaluate progress made by programs in reducing the inequities that lead to differentials in HIV risk and impact.[9]

This resource offers quantitative gender equality and HIV indicators. It should be noted that only part of the picture will be captured by quantitative measures. Qualitative research provides deeper insight into the gender equality dimensions of HIV and AIDS. Qualitative methodologies record people's experiences, opinions, attitudes and feelings that are not possible to measure with quantitative methods, but are often needed to understand what is observed in a quantitative measure. For example, qualitative data may explain why a differential in ART adherence is observed between adult men and women. Qualitative studies complement quantitative findings, and should be undertaken to enable a culturally sensitive and more comprehensive response.[10]

Gender Analysis examines the differences in men's and women's lives and applies this understanding to policy development and service delivery.[11] A gender analysis applied to HIV

---

[6] http://www.oecd.org/dataoecd/46/47/43041409.pdf

[7] http://data.unaids.org/una-docs/three-ones_keyprinciples_en.pdf

[8] Transforming the National AIDS Response, Mainstreaming Gender Equality and Women's Human Rights into the "Three ones": http://www.unifem.org/attachments/products/TransformingTheNationalAIDSResponse_eng.pdf

[9] Why Sex/Gender And Age Matter For Evidence-Based Programming And Response: https://wikis.uit.tufts.edu/confluence/download/attachments/46081625/SADD.pdf?version=1&modificationDate=1313521808000

[10] UNIFEM, Promoting gender equality in HIV/AIDS responses.

[11] CIDA, Gender Analysis: http://www.acdi-cida.gc.ca/acdi-cida/acdi-cida.nsf/eng/JUD-31194519-KBD

programming might begin with an examination of the data that measures inequalities between men/boys and women/girls and how these inequalities interact with the spread and impact of HIV and AIDS. Women may have fewer rights and lower access to information than men in some contexts. Inheritance rights, for example, are very pertinent because they may offer women a source of economic independence; if these rights are denied, she may be forced to turn elsewhere for income, which may put her at risk for HIV. Gender sensitive and gender equality indicators therefore, provide the data needed to do a gender analysis of HIV situation and of programs. A gender analysis would show decision-makers how programs and policies can address inequalities based on gender. Programs that place undue hardship on women (e.g., home-based care) or that ignore women's vulnerability to infection, can be avoided. In their place, gender transformative programs can be implemented that will challenge inequitable norms, or take advantage of the contributions that can be made by women and men in their respective roles in society in the response to HIV and AIDS.

What Makes a Good Indicator

An indicator is a variable that measures a specific aspect of a program or project. To be effective, indicators should reflect the stated goals and objectives of a program. They are used to show that activities were implemented as planned, or that the program has influenced a change in a desired outcome. The specific program aspect measured by an indicator can be an input, output, or expected outcome. Several criteria describe a good indicator. Indicators must be valid, reliable, comparable (over time or between settings), non-directional, precise, measurable, and programmatically important.

- **Valid:** Indicators should measure the aspects of the program that they are intended to measure.
- **Specific:** Indicators should only measure the aspect of the program that they are intended to measure.
- **Reliable:** Indicators should minimize measurement error and should produce the same results consistently over time, regardless of the observer or respondent.
- **Comparable:** Indicators should use comparable units and denominators that will enable an increased understanding of impact or effectiveness across different population groups or program approaches.
- **Non-directional:** Indicators should be developed to allow change in any direction, and not specify a direction in their wording (for example: an indicator should be worded as "the level of awareness" instead of "an increased awareness").
- **Precise:** Indicators should have clear, well-specified definitions.
- **Feasible:** It must be possible to measure an indicator using available tools and methods.
- **Programmatically relevant:** Indicators should be specifically linked to a programmatic input, output or outcome.

Additionally, the UNAIDS Monitoring and Evaluation Reverence group (MERG) agreed to a set of standards and developed a tool to assess the extent to which these standards are applied to different indicators in various settings when reporting is desired or required of countries who sign onto global commitments such as the 2011 Political Declaration on HIV/AIDS.[12]

[12] UNAIDS: http://www.unaids.org/en/media/unaids/contentassets/documents/document/2010/4_3_MERG_Indicator_Standards.pdf

The standards are intended to make it easier to develop and revise indicators that are relevant, useful, and feasible. The guidelines stipulate that an indicator should meet the following five standards:

1. The indicator is needed and useful
2. The indicator has technical merit
3. The indicator is fully-defined
4. It is feasible to collect and analyze data for this indicator
5. The indicator has been field-tested or used in practice

Indicators are only as good as the quality of the data used to measure them. Data quality begins with careful protocols guiding data collection, but it can be affected at any point afterwards, including the way it is entered on forms (computerized or not), tallied at higher levels, and analyzed to calculate specific indicators. Many factors contribute to poor data quality, including:

- double (or over) counting, when a person, service or other programmatic aspect is counted more than once;
- lack of coverage to assure representation of the targeted population or services to be included in the indicator;
- the accuracy with which records are created and reported to a higher system;
- precision used to record the data; whether or not the data reflect current information (timeliness); and
- integrity with which the data are recorded (do people have an interest in not reporting accurately?).

People collecting and processing the data need to be trained to understand how important data quality is to the success of the program, as well as empowered with the skills they need in order to preserve it. Data quality should be addressed in the M&E Plan by describing the standards used for collection, storage, analysis and reporting.

Where to Go for More Information on M&E

The information in this section provides an introduction to the rationale behind M&E and basic definitions of its basic concepts. For more detailed information on M&E, you can visit:

- MEASURE Evaluation website (http://www.measureevaluation.org) which includes online courses, and links to publications and other websites pertaining to specific aspects of the field.
- UNAIDS and the MERG (Monitoring and Evaluation Reference Group) tools and guidelines(http://www.unaids.org/en/dataanalysis/monitoringandevaluationguidance/)
- AIDSinfo (http://www.unaids.org/en/dataanalysis/tools/aidsinfo/) a data visualization and dissemination tool to facilitate the use of AIDS-related data in countries and globally. Data for key indicators from many countries are presented in a user-friendly format.
- Global HIV M&E portal (http://www.globalhivmeinfo.org), designed for monitoring and evaluation (M&E) specialists supporting HIV/AIDS initiatives, offers information for capacity building and professional development opportunities related to M&E in the context of HIV.
- The Indicator Registry (http://www.indicatorregistry.org) a central repository of information on indicators used to track the AIDS epidemic and the national, regional and global response. Selected indicators in this compendium would refer to the registry for obtaining full indicator information.

Tier 1 indicators are those already in use to monitor national and sub-national programs. Tier 2 is an expanded list of indicators that might be used by countries, specific projects, programs, special studies and interventions that can be used to monitor and evaluate the gender equality dimensions of HIV and AIDS responses. Tier 3 indicators are considered important in the context of gender and HIV, and suggested to be considered for program needs and in specific contexts or require field-testing as they were deemed essential in the emerging areas of measurement. These indicators may need to be refined and validated for future use.

Tier 1 Indicators

1	SOCIETAL CONTEXT	PAGE
1.1	**Legal and Policy Framework**	
1.1.1	Existence of a multisectoral strategy to respond to HIV which has a specific HIV women's budget	15
1.1.2	Existing laws, regulations, or policies that present obstacles to effective HIV prevention, treatment, care and support for key populations and vulnerable groups	16
1.3	**Gender-Based Violence**	
1.3.1	Prevalence of recent intimate partner violence (IPV)	24
1.3.2	Prevalence of ever intimate partner violence	25
1.4	**Gender Norms**	
1.4.1	Proportion of women and men who say that wife beating is an acceptable way for husbands to discipline their wives	30
1.4.2	Proportion of respondents 15–49 years old who believe that, if her husband has an STI, a wife can propose condom use	31
1.4.3	Percentage of currently married women aged 15–49 who usually make a decision about their own health care either by themselves or jointly with their husbands	31
1.4.4	Child marriage	32
1.5	**Economic Autonomy and Literacy**	
1.5.1	The percentage of women aged 15–49 who own property or resources for production of goods, services, and/or income in their own name	35
1.5.2	The proportion of women in wage employment in the non-agricultural sector	35
1.5.3	Total primary net enrollment ratio (NER) in primary education	36

2	INTERVENTION PROGRAMS	PAGE
2.1	**Treatment**	
2.1.1	HIV treatment: antiretroviral therapy	40
2.1.2	Twelve-month retention on antiretroviral therapy	41
2.1.3	Prevention of mother-to-child transmission	41
2.2	**Counseling and testing**	
2.2.1	Percentage of women and men aged 15–49 who received an HIV test in the past 12 months and know their results	43
2.3	**Service integration and linkages**	
2.3.1	Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV	47

3	POPULATIONS WARRANTING SPECIAL ATTENTION	PAGE
3.2	**Populations warranting special attention**	
3.2.1	Percentage of key populations reached with HIV prevention programs	57
3.2.2	Sex workers: prevention programs	57
3.2.3	HIV prevalence in key populations	58
3.2.4	People who inject drugs: safe injecting practices	58
3.2.5	Sex workers: condom use	58
3.2.6	People who inject drugs: condom use	59
3.3	**Other vulnerable populations**	
3.3.1	Orphans school attendance	62
3.3.2	External economic support to the poorest households	63
3.3.3	Proportion of children under age 15 who are working	65

4	BEHAVIOR AND KNOWLEDGE	PAGE
4.1	**Sexual Behavior**	
4.1.1	Sex before the age of 15	66
4.1.2	Condom use at last sex among people with multiple partnerships	66
4.1.3	Cross-generational sex among young women	67
4.2	**Knowledge about HIV/AIDS**	
4.2.1	Young people: knowledge about HIV prevention	68
4.2.2	Knowledge of a formal source of condoms among young people	69

5	PREVALENCE AND REPRODUCTIVE HEALTH	PAGE
5.1	**Prevalence**	
5.1.1	HIV prevalence in young people	70
5.2	**Sexual and Reproductive Health**	
5.2.1	Adolescent fertility rates	71
5.2.2	Contraceptive prevalence in women	72

Tier 2 Indicators

1	SOCIETAL CONTEXT	PAGE
1.1	**Legal and Policy Framework**	
1.1.3	Proportion of law enforcement units following a nationally established protocol for VAW/G complaints	16
1.2	**Stigma and Discrimination**	
1.2.1	Proportion of PLHIV who recently experienced stigma and discrimination related to their HIV status	18
1.2.2	Percentage of workplaces that have non-discriminatory policies that address HIV status, gender equality, and sexual orientation	19
1.2.3	Proportion of clients who felt comfortable discussing their sexual practices with providers at facilities	20
1.2.4	Discriminatory attitudes towards people living with HIV	20

1.3	**Gender-Based Violence**	
1.3.3	Percent of eligible rape survivors who report to health facilities within 72 hours and receive appropriate medical care	25
1.3.4	Number of HIV service providers trained to identify, refer, and care for VAW/G survivors	26
1.3.5	Proportion of women aged 15–49 who report sexual violence below age 15	26
1.6	**Humanitarian Emergencies**	
1.6.1	Number of women/girls reporting incidents of sexual violence per 10,000 population of the emergency area over a specific time period	37
1.6.2	Proportion of reported sexual exploitation and abuse incidents resulting in prosecution and/or termination of humanitarian staff	38
1.6.4	Protocols that are aligned with international standards that have been established for the clinical management of sexual violence survivors within the emergency area at all levels of the health system	38
1.6.5	Percent of rape survivors in the emergency area who report to health facilities/workers within 72 hours and receive appropriate medical care	38

2	INTERVENTION PROGRAMS	PAGE
2.1	**Treatment**	
2.1.4	Percentage of HIV infected patients with co-infection HIV/viral hepatitis B who receive treatment of hepatitis B	42
2.2	**Counseling and Testing**	
2.2.2	Percentage of sexually active young women and men aged 15–24 who received an HIV test in the last 12 months and who know their results	44
2.2.3	Number of people living with HIV (PLHIV) whose sexual partner(s) received onsite HIV testing and counseling services and received their test results	44
2.3	**Service Integration and Linkages**	
2.3.2	Proportion of clients referred who completed referral	48
2.4	**Male Engagement**	
2.4.1	Number of visits made by young men to specified sexual and reproductive health services	51
2.4.2	Percentage of pregnant women attending ANC services whose male partner was tested for HIV	52

3	POPULATIONS WARRANTING SPECIAL ATTENTION	PAGE
3.1	**People Living with HIV**	
3.1.1	Percentage of ART patients benefiting from microenterprise or microfinance schemes	53
3.2	**Populations Warranting Special Attention**	
3.2.7	People who inject drugs: prevention programs	59
3.2.8	Percentage of key populations with active syphilis	61
3.2.9	Number of injecting drug users on opioid substitution therapy (OST)	61

5	PREVALENCE AND REPRODUCTIVE HEALTH	PAGE
5.1	**Prevalence**	
5.1.2	Young people who have a sexually transmitted infection	70
5.2	**Sexual and Reproductive Health**	
5.2.3	Cervical cancer screening	72

Tier 3 Indicators

1	SOCIETAL CONTEXT	PAGE
1.1	**Legal and Policy Framework**	
1.1.4	Existence of gender equality HIV-related areas in one or more of a general country development plans	17
1.1.5	The proportion of seats held by women in national parliaments	17
1.2	**Stigma and Discrimination**	
1.2.5	Proportion of workers reporting fear of losing jobs or professional opportunities if sought VCT services	22
1.2.6	Number of staff members trained on the purpose and application of non-discrimination policies on sexual orientation, gender identity, or HIV status	23
1.3	**Gender-Based Violence**	
1.3.6	Proportion of women who were asked about physical and sexual violence during a visit to a health unit	27
1.3.7	Proportion of social services that offer GBV services within an accessible distance	27
1.3.8	Percentage of schools that have procedures to take action on reported cases of sexual abuse	28
1.3.9	Percentage of schools that train their staff on sexual and physical VAW/G issues	28
1.3.10	Proportion of health units that have commodities for the clinical management of VAW/G	29
1.3.11	Proportion of law enforcement units following a nationally established protocol for VAW/G complaints	29
1.4	**Gender Norms**	
1.4.5	Women's autonomy indicators	33
1.4.6	Proportion of people who know any of the legal rights of women	34
1.4.7	Number of adults and children reached by an individual, small group, or community-level intervention or service that explicitly addresses the legal rights and protections of women and girls impacted by HIV/AIDS	34
1.5	**Economic Autonomy and Literacy**	
1.5.4	Percent of women who earn cash	36
1.5.5	Percentage of the population 15–24 years old who can both read and write with understanding a short simple statement on everyday life	36
1.6	**Humanitarian Emergencies**	
1.6.3	Percentage of military manuals, national security policy frameworks, codes of conduct and standard operating procedures/protocols of national security forces that include measures to protect women's and girls' human rights, available in the emergency area	39

2	INTERVENTION PROGRAMS	PAGE
2.2	**Counseling and Testing**	
2.2.4	Percentage of individuals aged 15+ years who received couples/partner HTC and learned the results of their HIV test together with their partner(s) in the past 12 months	46
2.3	**Service Integration and Linkages**	
2.3.3	Number of HIV-positive women and of HIV-positive men with female partners who received onsite provision of modern contraceptive methods	49
2.4	**Male Engagement**	
2.4.3	Availability of accessible, relevant, and accurate information about sexual and reproductive health (SRH) which is tailored to young men	52

3	POPULATIONS WARRANTING SPECIAL ATTENTION	PAGE
3.1	**People Living with HIV**	
3.1.2	Proportion of people aged 15+ years living with HIV who received onsite delivery of alcohol reduction counseling and support	53
3.1.3	Percentage of PLHIV who have heard of the Declaration of Commitment on HIV/AIDS	55
3.1.4	Percentage of PLHIV who are aware of their rights and how to protect them	56

4	BEHAVIOR AND KNOWLEDGE	PAGE
4.1	**Sexual Behavior**	
4.1.4	Condom use at last premarital sex	67
4.2	**Knowledge about HIV/AIDS**	
4.2.3	School-based life skills information for young people	69

5	PREVALENCE AND REPRODUCTIVE HEALTH	PAGE
5.2	**Sexual and Reproductive Health**	
5.2.4	Contraceptive prevalence among HIV-positive women	73

1.1 Legal and Policy Framework

To achieve universal access to prevention, treatment, care and support, the HIV and AIDS response needs policy development that addresses gender-related concerns. Gender discrimination, gender-based violence, homophobia, and misinformation are powerful drivers of the HIV epidemic. People of diverse sexual orientation and individuals who depart from accepted gender norms have faced discrimination in the form of execution, extra-judicial killing, torture, rape, arbitrary detention, unfair trials, and in the case of women, coerced sterilization, forced pregnancy, and forced or early marriage. These human rights violations occur at the hands of State officials and authorities, or at the hands of non-State actors, but with the actual or implied complicity of State impunity. Additionally women are often negatively impacted because of discriminatory inheritance laws or customary practices denying women access and right to land and property. Many women without land and property rights are left economically insecure and susceptible to poverty, which in turn make them vulnerable to violence and HIV, as they rely on spouses or male relatives for survival.[13]

Indicators on gender equality at the national level will assess if policies and programs reflect structural inequalities (such as policy commitment, legal frameworks and national legislation). They may measure manifestations of gender inequalities (such as lower retention rates of girls in education compared to boys or the prevalence of violence against women), or they could refer to the impact of a lack of government provision of basic services on women and men. Although policy and laws pertaining to gender will not solve these issues, they are the foundation on which they can begin to be addressed. The indicators in this section cover various policy objectives related to gender and HIV. Monitoring these issues is instrumental for the development, review and periodic updating of national AIDS action frameworks (i.e., strategic visions or plans).

TIER 1

1.1.1 Existence of a multisectoral strategy to respond to HIV which has a specific HIV women's budget

Definition: In a country that has developed a multisectoral strategy to respond to HIV, a specific budget has been included for the women's sector.

Yes: The country has a multisectoral strategy to respond to HIV and has a specific budget included for the women's sector activities.

No: The country has a multisectoral strategy to respond to HIV and does not have a specific budget included for the women's sector activities.

Full reference sheet (p.84): Global AIDS Response Progress Reporting 2012, part of the NCPI instrument: http://www.unaids.org/en/media/unaids/contentassets/documents/document/2011/JC2215_Global_AIDS_Response_Progress_Reporting_en.pdf

[13] Swaminathan H, Rugadya M, Walker C. *Women's property rights, HIV and AIDS and domestic violence: Research findings from two districts in South Africa and Uganda*. South Africa : HSRC Press, 2008.

1.1.2 Existence of laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for key populations and vulnerable groups

Definition: The country has laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for key populations and vulnerable groups.

Yes: The country has at least one law, regulation or policy exists that presents obstacles to effective HIV prevention, treatment, care and support for at least one identified key p opulation and/or vulnerable group.

No: The country does not have any laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for at least one identified key population and/or vulnerable group.

Full reference sheet (p.84): Global AIDS Response Progress Reporting 2012, part of the NCPI instrument: http://www.unaids.org/en/media/unaids/contentassets/documents/document/2011/JC2215_Global_AIDS_Response_Progress_Reporting_en.pdf

TIER 2

1.1.3 Proportion of law enforcement units following a nationally established protocol for VAW/G complaints

Definition: The proportion of law enforcement units that follow nationally established protocols pertaining to the management of VAW/G complaints.

Numerator: Number of law enforcement units in a region or country that follow a nationally established VAW/G protocol when handling complaints. If there is no national protocol pertaining to the management of VAW/G cases, this indicator cannot be measured. The protocol should cover the following areas:

- how and where VAW/G survivors should be interviewed
- how confidentiality is ensured
- type of investigation and follow-up that should take place following a report
- how women and girls are protected following a complaint

Denominator: Total number of law enforcement units surveyed.

Disaggregate by: Region; province.

Full Reference Sheet: VAW/G Compendium 5.3.1 (p. 114): http://www.measureevaluation.org/publications/ms-08-30

TIER 3

1.1.4 Existence of gender equality HIV-related areas in one or more of a general country development plans

Definition: The country has integrated HIV into a general development plan and specifically, HIV-related gender inequality reduction and women's economic empowerment are included in the plan.

Yes: The following specific HIV-related areas are included in one or more of the country development plans:

- Reduction of gender inequalities as they relate to HIV prevention/treatment, care and/or support.
- Women's economic empowerment (e.g., access to credit, access to land, training).

No: These HIV-specific gender-related elements are not included in the general development plan.

Full reference sheet (p.84): Global AIDS Response Progress Reporting 2012, part of the NCPI instrument: http://www.unaids.org/en/media/unaids/contentassets/documents/document2011/JC2215_Global_AIDS_Response_Progress_Reporting_en.pdf

1.1.5 The proportion of seats held by women in national parliaments

Definition: The number of seats in national parliaments that are held by women among all occupied seats.

Numerator: Number of seats in a national parliament within a given country that are held by women.

Denominator: Number of occupied seats in a national parliament within a given country.

Full Reference Sheet: MDG #12: 'Women, girls, gender equality and HIV' A scorecard for the Eastern & Southern African region, Draft as of June 2011, UNAIDS (p. 29): http://mdgs.un.org/unsd/mdg/Resources/Attach/Indicators/HandbookEnglish.pdf

1.2 Stigma and Discrimination

Non-discrimination and equal opportunity have been part of the international community's key principles for decades. Documented in numerous international instruments, including United Nations conventions, these concepts are rooted in universal principles of human rights, fundamental freedoms, and equality. These principles have been emphasized as especially important within the context of the HIV epidemic and its response from the early 1990s.[14] In places where HIV and AIDS-related stigma is high due to the way HIV is transmitted or because some groups are especially affected within particular contexts, the response to the epidemic is less effective than in those places that have made progress in addressing stigma.

Women living with HIV may face double stigma and discrimination, both because they are women and because of their status. They may be blamed for their partner's and children's illness and/or death, and may face barriers in accessing health care. In some societal contexts, it is commonplace for women to be accused by their partner's family of bringing HIV into the household. Women are reluctant to get tested for HIV or to obtain their results for fear or actual occurrence of domestic violence, abuse or abandonment. In some cases, women living with HIV are negatively judged for their reproductive and sexual health choices, are counseled to avoid pregnancy, sometimes forcibly sterilized, or forced to terminate their pregnancy.

Various interventions that require monitoring in this context aim at the elimination of all forms of stigma and discrimination on the basis of HIV status, gender, and sexual orientation and practices, in communities, health facilities and at the workplace. The indicators in this section pertain to gender within the context of HIV stigma.[15]

TIER 2

1.2.1 Proportion of PLHIV who recently experienced stigma and discrimination related to their HIV status

Definition: The proportion of PLHIV who, because of their HIV status, experienced negative repercussions in the last 12 months.

Numerator: Number of PLHIV in an area or region who experienced stigma and discrimination in the last 12 months from other people for reasons that were connected to their HIV status. People answering affirmative to any of the prompts are place in the numerator.

Ask: Have you experienced any of the following:

- Verbally insulted, threatened
- Denied health services
- Forced to move to another house
- Denied sexual and reproductive health services
- Threatened to have their children taken away
- Denied contraceptives and or condoms

[14] Mann, JM. AIDS and human rights: Where do we go from here? *Health Hum Rights*. 1998;3(1):143–9.

[15] There is ongoing work to develop better Stigma indicators for the general population and for the health care sector, which will also enhance the ability to measure gender domains of stigma. With the exception of Stigma Index Indicators, other indicators from section 1.2 will likely change

- Received negative messages, harassments or actions from law enforcement/legal bodies
- Forced to submit to a health or medical procedure (including HIV testing)
- Divorced or abandoned by spouse

Denominator: Number of PLHIV surveyed.

Disaggregate by: Age, sex, key population/vulnerable group, particular components of stigma.

What It Measures: This indicator measures stigma experienced or perceived by PLHIV because of their HIV status.

Measurement Tool: HIV stigma index survey.

How to Measure It: Both men and women are asked to respond to a question about whether they have experienced a particular manifestation of example of stigma and discrimination. If they answer yes to any of the prompts, they are placed in the numerator. The numerator is then divided by the denominator.

Considerations: Some of the probes may be more pertinent in some contexts than in others. People are answering based on their own perceptions, but whether real or perceived, stigma and the fear of stigma are extremely disempowering, and disproportionately so to women.

Source: HIV Stigma Index: http://www.stigmaindex.org/32/analysis/introduction.html

1.2.2 Percentage of workplaces that have non-discriminatory policies that address HIV status, gender equality, and sexual orientation

Definition: The proportion of workplaces that have written policies that address HIV status, gender equality and sexual orientation, delineating a set of actionable workplace rights and obligations regarding HIV/AIDS to employees. This indicator measures compliance with HIV/AIDS policy principles.

Numerator: Number of work places with a written policy addressing HIV. Components must include a non-discrimination statement and may address other issues, such as gender equality and sexual orientation.

Denominator: Number of workplaces surveyed.

Full Reference Sheet: "Indicators to monitor the implementation and impact of HIV/AIDS workplace policies and programs in the UN system" ILO, 2004 #1.1 (p. 5): http://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---ilo_aids/documents/publication/wcms_117826.pdf

1.2.3 Proportion of clients who felt comfortable discussing their sexual practices with providers at facilities

Definition: The proportion of clients at a facility who report that they felt comfortable discussing their sexual practices, including their sexual lives, HIV risk and status, with health providers.

Numerator: Number clients in a facility who respond "yes" to either subject related to what they would discuss with the practitioner they saw that day.

Ask: In your visit with X practitioner, did you feel comfortable talking about your sexual life?… HIV status and/or risk for HIV?

Denominator: The total number of clients participating in the exit survey.

Disaggregate by: Sex, age.

Full Reference Sheet: Services indicator 5 (p. 11): http://www.ippfwhr.org/en/node/797

TIER 3

1.2.4 Discriminatory attitudes towards people living with HIV

What It Measures: It measures progress towards reducing discriminatory attitudes, and support for discriminatory policies.

Rationale: Discrimination is a human rights violation and is prohibited by international human rights law and most national constitutions. Discrimination in the context of HIV refers to unfair or unjust treatment (an act or an omission) of an individual based on his or her real or perceived HIV status. Discrimination exacerbates risks and deprives people of their rights and entitlements, fuelling the HIV epidemic.

This indicator is not a direct measure of discrimination but rather a measure of discriminatory attitudes which may result in discriminatory actions (or omissions). One item in this indicator measures the potential support by the respondents for discrimination that takes place at an institution while the other measures social distancing or behavioural expressions of prejudice. The composite indicator can be monitored as a measure of a key manifestation of HIV-related stigma and the potential for HIV-related discrimination within the general population. This indicator could provide further understanding and improve interventions in the area of HIV discrimination by: (1) showing change over time in the percentage of people with discriminatory attitudes, (2) allowing comparisons between national, provincial, state and more local administrations, and (3) pointing to priority areas for action.

Numerator: Number of respondents (aged 15–49 years) who respond "No" or "It depends" to any of the two questions.

Denominator: Number of all respondents aged 15–49 years who have heard of HIV.

Calculation: Numerator / Denominator.

Method of Measurement: Population-based surveys (Demographic and Health Survey, AIDS Indicator Survey, Multiple Indicator Cluster Survey or other representative survey). This indicator is constructed from responses of respondents in a general population survey who have heard of HIV to the following set of prompted questions:

- Would you buy fresh vegetables from a shopkeeper or vendor if you knew that this person had HIV? (Yes; No; It depends; Don't know/ Not sure)1
- Do you think children living with HIV should be able to attend school with children who are HIV negative? (Yes; No; It depends; Don't know/ Not sure)

Measurement Frequency: Every 3–5 years

Disaggregation: Responses for each of the individual questions (based on the same denominator) are required as well as the consolidated response for the composite indicator.

Explanation of Numerator: Those who have never heard of HIV and AIDS should be excluded from the numerator and denominator. Participants who respond "Don't Know/Not sure" and those who refuse to answer should also be excluded from the analyses. It is important to assess the proportion of eligible survey participants who respond "Don't Know/Not sure" or who refuse to answer the questions. A high proportion of Don't Know/Not sure responses and refusals will reduce the precision of the results and may indicate problems with applicability of the question within the survey setting.

Strengths and Weaknesses: This indicator directly measures discriminatory attitudes and support for discriminatory policies. The question about buying vegetables is virtually identical to the question that has been used within DHS surveys for monitoring "accepting attitudes" towards people living with HIV, thereby enabling continued monitoring of trends. These measures improve upon the previously used measures for the "accepting attitudes" indicator as they are applicable in both high and low HIV prevalence settings, in both high and low income countries and are relevant across a wide cultural range. Individual measures and the composite indicator do not rely on the respondent having observed overt acts of discrimination against people living with HIV, which in many contexts are rare and difficult to both characterize and quantify. Rather, the individual measures and the composite indicator assess individuals' attitudes, which may have a more direct role in influencing behaviour. The recommended questions assess agreement with hypothetical situations rather than measuring events of discrimination witnessed, and therefore social desirability bias may occur, leading to under-reporting of discriminatory attitudes. There is no mechanism for examining the frequency with which discrimination occurs, or the severity of the forms of discrimination. In addition to conducting surveys that measure the prevalence of discriminatory attitudes in a community, where possible it would be ideal to collect qualitative data to inform the origins of discrimination. It would also be advisable to routinely collect data from people living with HIV about actual experiences of stigma and discrimination via the PLHIV Stigma Index process (www.stigmaindex.org) and compare findings with the data derived from the discriminatory attitudes indicator.

Further Information: For further information on stigma and discrimination, and efforts to measure their prevalence, please see:

- Thematic Segment on Non-Discrimination, 31st meeting of the UNAIDS Programme Coordinating Board. Background Note. (http://www.unaids.org/en/media/unaids/contentassets/documents/pcb/2012/20121111_PCB%2031_Non%20Discrimination_final_newcoverpage_en.pdf)

- Stangl, A., Brady, L., Fritz, K. Technical Brief: Measuring HIV Stigma and Discrimination. Washington DC and London: International Center for Research on Women and London School of Tropical Medicine; STRIVE, 2012 (http://strive.lshtm.ac.uk/system/files/attachments/STRIVE_stigma%20brief-A4.pdf).
- Stangl, A., Lloyd, J., Brady, L. et al. A systematic review of interventions to reduce HIV-related stigma and discrimination from 2002 to 2013: how far have we come? Journal of the International AIDS Society. 2013, vol 16 Supplement (http://www.jiasociety.org/index.php/jias/issue/view/1464).
- http://www.stigmaactionnetwork.org

For further information on DHS/AIS methodology and survey instruments, please visit: http://www.measuredhs.com

Special Note for the 2014 Reporting Round:
As this indicator is new, it is likely that many countries will not be able to report on the indicator during the 2014 reporting round. Instead countries are requested to report data from the previous version of question 1, 'Would you buy fresh vegetables from a shopkeeper or vendor if you knew that this person had the AIDS virus?'. This question has been routinely collected in DHS in many countries. • In future reporting rounds, countries should report on the full indicator.

1.2.5 Proportion of workers reporting fear of losing jobs or professional opportunities if sought VCT services

Definition: The proportion of workers who report that they would fear losing their jobs or professional opportunities if they sought to obtain VCT services, information about such services or if they were known to be HIV positive.

Numerator: Number of workers who report they would fear losing their jobs or professional opportunities if they sought to obtain VCT services or information about such services or if they were known to be HIV positive (disaggregated by sex).

Denominator: Number of workers in the sample.

Disaggregate by: Age, sex.

Full Reference Sheet: Indicators to monitor the implementation and impact of HIV/AIDS workplace policies and programs in the UN system, ILO, 2004 (p. 8): http://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---ilo_aids/documents/publication/wcms_117826.pdf

1.2.6 Number of staff members trained on the purpose and application of non-discrimination policies on sexual orientation, gender identity, or HIV status

Definition: The number of staff in an organization who have been trained in its existing non-discrimination policies that relate to any or all of the following: sexual orientation, gender identity, HIV status.

Count: Number of staff trained on non-discrimination policies relating to sexual orientation, gender identity and HIV status.

Disaggregate by: Type of staff, sex.

Full Reference Sheet: IPPF Sexual Diversity Indicators: Internal policies indicator 3 (p. 3): http://www.ippfwhr.org/en/node/797

1.3 Gender-Based Violence

Globally, and particularly in sub-Saharan Africa, the observed high rates of HIV in women have brought into sharp focus the problem of violence against women. Intimate partner violence (IPV) is rooted in gender inequality. For over a decade, research world-wide has documented the evidence linking GBV with HIV. Countless studies have demonstrated an association between GBV and HIV as both a risk factor for infection as well as a consequence of infection. [16]This relationship operates through a variety of direct and indirect mechanisms.[17] The measures in this section around various aspects of GBV are critical in order to address gender inequality within the context of HIV.

TIER 1

1.3.1 Prevalence of recent intimate partner violence (IPV)

Definition: 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. An intimate partner is defined as a cohabiting partner, whether or not they had been married at the time. The violence could have occurred after they had separated.

Numerator: Women aged 15–49 who currently have or ever had an intimate partner, who report experiencing physical or sexual violence by at least one of these partners (based on the checklist below) in the past 12 months. The woman is included in the numerator if she reports that in the past 12 months a current or past intimate partner:

- slapped her or threw something at her that could hurt her;
- pushed her or shoved her;
- hit her with a fist or something else that could hurt;
- kicked, dragged, or beat her up;
- choked or burnt her;
- threatened her with—or actually used—a gun, knife, or other weapon against her;
- physical forced her to have sexual intercourse against her will;
- forced her to do something she found deg rading or humiliating;
- made her afraid of what he would do if she did not have sexual intercourse with him.

Denominator: Total women surveyed aged 15–49 who currently have or had an intimate partner.

Disaggregate by: Age (15–19, 20–24, 25–49 years), HIV status (if available).

Full Reference Sheet: Global AIDS Progress Reporting 2013, Construction of Core Indicators for monitoring the 2011 UN Political Declaration on HIV/AIDS: http://www.unaids.org/en/media/unaids/contentassets/documents/document/2013/GARPR_2013_guidelines_en.pdf

---

[16] Dunkle KL, Head S, Garcia Moreno C. *Current intervention strategies at the intersection of gender-based violence and HIV: A systematic review of the peer-reviewed literature describing evaluations of interventions addressing the interface between gender, violence and HIV*. Geneva, WHO, 2009 (in press), and Program on International Health and Human Rights at Harvard School of Public Health (2009). Gender-Based Violence and HIV, final draft report.

[17] Maman, Suzanne, Jacquelyn Campbell, Michael D. Sweat, Andrea C. Gielen. (2000) The intersections of HIV and violence: directions for future research and interventions Social Science & Medicine 50 459-478.

1.3.2 Prevalence of ever intimate partner violence (IPV)

Definition: The proportion of ever-married or partnered women aged 15–49 who have ever experienced physical or sexual violence from a male intimate partner. An intimate partner is defined as a cohabiting partner, whether or not they had been married at the time. The violence could have occurred after they had separated.

Numerator: Women aged 15–49 who currently have or ever had an intimate partner, who report ever experiencing physical or sexual violence by at least one of these partners (based on the checklist below). The woman is included in the numerator if she reports a current or past intimate partner has ever:

- slapped her or threw something at her that could hurt her;
- pushed her or shoved her;
- hit her with a fist or something else that could hurt;
- kicked, dragged, or beat her up;
- choked or burnt her;
- threatened her with—or actually used—a gun, knife, or other weapon against her;
- physical forced her to have sexual intercourse against her will;
- forced her to do something she found degrading or humiliating;
- made her afraid of what he would do if she did not have sexual intercourse with him.

Denominator: Total women surveyed aged 15–49 who currently have or had an intimate partner.

Disaggregate by: Age, HIV status (if available).

Full Reference Sheet: VAW/G Compendium, combination of indicators #4.2.1 (p. 43) and 4.2.4 (p. 49): http://www.measureevaluation.org/publications/ms-08-30

TIER 2

1.3.3 Percent of eligible rape survivors who report to health facilities within 72 hours and receive appropriate medical care

Definition: The proportion of sexual violence survivors who present for care at a health facility within 72 hours and who receive appropriate care, within a defined time period.

Numerator: Number of rape survivors who present for care within 72 hours of the incident and who receive appropriate care within a defined time period (e.g., past 12 months). Appropriate care for rape survivors who present within 72 hours includes: HIV post-exposure prophylaxis (PEP), emergency contraception, sexual transmitted infection and HIV testing, psycho-social services, information about access to legal abortion. Other elements, such as a female health worker being present for any medical exam, are outlined in detail in the UNHCR interagency field manual.

Denominator: Number of rape survivors who report an incident within 72 hours, during the same defined time period.

Disaggregate by: Age (under 15, 15–20, 20+), geographic location.

Full Reference Sheet: VAW/G Compendium, indicator 6.1.7 (p.162) http://www.measureevaluation.org/publications/ms-08-30; UNHCR. 1999. *Reproductive health in refugee settings: an inter-agency field manual*. Geneva: UNHCR, WHO, UNFPA.

1.3.4 Number of HIV service providers trained to identify, refer, and care for VAW/G survivors

Definition: The number of HIV service providers trained in a VAW/G training program during a specific time period (e.g., during the past 12 months).

Count: Number of HIV providers trained in the past year or other period (the length of time would depend on how often the program holds trainings).

Disaggregate by: Type of provider, region or province, area in which they work (urban or rural).

Full Reference Sheet: VAW/G Compendium 5.1.5 (modified from general health practitioners to HIV service providers): http://www.measureevaluation.org/publications/ms-08-30

1.3.5 Proportion of women aged 15–49 who report sexual violence below age 15

Definition: The proportion of women surveyed who report experiencing sexual violence at age 14 or below from anyone other than an intimate partner, which can include a family member, friend, acquaintance or stranger. This indicator captures child sexual abuse as well as sexual violence perpetrated by a stranger.

Numerator: Women aged 15–49 who report experiencing sexual violence when they were 14 years old or younger (based on the checklist below). The woman is included in the numerator if she reports that below age 15, someone:

- physically forced her to have sexual intercourse against her will,
- forced her to do something she found degrading or humiliating, or
- made her afraid of what he would do if she did not have sexual intercourse.

Denominator: Total women surveyed aged 15–49.

Disaggregate by: Age, HIV status (if available).

Full Reference Sheet: VAW/G Compendium, indicator 4.3.5 (p. 61): http://www.measureevaluation.org/publications/ms-08-30

TIER 3

1.3.6 Proportion of women who were asked about physical and sexual violence during a visit to a health unit

Definition: In health units where screening for VAW/G is available, the proportion of women who presented to the clinic for any reason who were asked about physical or sexual violence, during a specific period of time (e.g., during the past 12 months).

Numerator: Number of women who were asked, during the course of receiving a services at the unit, about any violence that had ever occurred, either physical or sexual, in the geographic area of study (nation, province, state, community). If this is being measured with a medical record review, all women's charts which noted that they were screened by a provider would be entered into the numerator. If this is being measure in a survey of women based on exit interviews from the health unit, all women leaving the clinic would be asked if a provider asked them if they had ever experienced any physical or sexual violence. All women answering yes would be entered into the numerator.

Denominator: If the indicator is measured through a record review: All women's records that were reviewed at the health unit. If the indicator is being measured through an exit interview, this is the total number of women interviewed.

Disaggregate by: Type of health unit, geographic area (region, province, urban or other community).

Full Reference Sheet: VAW/G Compendium #5.1.7 (p. 97):
http://www.measureevaluation.org/publications/ms-08-30

1.3.7 Proportion of social services that offer GBV services within an accessible distance

Definition: The number and type of organizations in a community that provide social-welfare based services pertaining to the prevention and response to GBV, at one point in time. Social-welfare based services include but are not limited to

- safe space, or shelters, for women and children;
- crisis hotlines for intimate partner and sexual violence;
- case management services including counseling, support groups, safety planning, legal aid/support, child welfare, and recreational programs for abused girls;
- crisis intervention skills including training, income generation, and self defense; and
- perpetrator programs and reintegration.

Accessibility needs to be locally defined, depending on the geographic area and the modes of transportation and communication that are readily available to most of the population.

Count: Number of organizations that provide any social-welfare services directed at the prevention of and response to VAW/G in a specified geographic area (community, province, region).

Disaggregate by: Type of services provided, per checklist above.

Full Reference Sheet: VAW/G Compendium 5.4.1—modified to include denominator (p. 130): http://www.measureevaluation.org/publications/ms-08-30

1.3.8 Percentage of schools that have procedures to take action on reported cases of sexual abuse

Definition: The percent of schools in a country or region that have established procedures to investigate and take action on reported cases of sexual abuse.

Numerator: Number of schools that have procedures to both investigate and take action on reported cases of sexual abuse among students In order to be included in the numerator, a school must have procedures in place to both investigate and take action on reports. In addition, a school's protocols should be current (revised within 5 years), formally documented and readily available. The procedures should align with the National Teachers' Code of Conduct and/or any Ministry of Education policies or protocols for sexual abuse cases. If there are none in place at the country level, this indicator cannot be measured.

Denominator: Total number of schools surveyed.

Disaggregate by: Level of school (i.e., primary, secondary, vocational, university); type (e.g., English-medium, religious focus, all-girls, co-ed, etc); geographic area (e.g., country/region, urban/rural); public/private-funded.

Full Reference Sheet: VAW/G Compendium #5.2.1 (p. 106): http://www.measureevaluation.org/publications/ms-08-30

1.3.9 Percentage of schools that train their staff on sexual and physical VAW/G issues

Definition: The percent of schools in a country or region that conduct trainings on sexual and physical VAW/G issues for school staff, at least once every two years. School staff includes teachers, administrators, and other people who work within schools.

Numerator: Number of schools that conduct trainings on VAW/G at least once every two years. Schools included in the numerator must have training programs for school staff that have curriculums including components focused on sexual and physical violence against women and girls. Schools can be included if they only train one type of school staff (e.g., teachers), but this should be clearly noted in the interpretation.

Denominator: Total number of schools surveyed.

Disaggregate by: Type of staff trained, level of school (i.e., primary, secondary, vocational, university); type (e.g., English-medium, religious focus, all-girls, co-ed, etc); geographic area (e.g., country/region, urban/rural); public-/private-funded.

Full Reference Sheet: VAW/G Compendium # 5.2.3 (p. 110): http://www.measureevaluation.org/publications/ms-08-30

1.3.10 Proportion of health units that have commodities for the clinical management of VAW/G

Definition: The proportion of health units who have the commodities needed for the clinical management of VAW/G, at a specific point in time in the geographic area of interest.

Numerator: Number of health facilities in the geographic region of study (nation, province, state, community) reporting that they have commodities for the clinical management of VAW/G. Necessary commodities may include the following resources within the unit itself, or a referral system to ensure women's access to the following resources in the community:

- Protocol for detection and treatment
- Private area for exam/interview
- Supplies for STI and HIV testing
- Supplies for STI and HIV post-exposure prophylaxis
- Rape kit and supplies for collecting forensic evidence
- Staff trained to detect, counsel, carry out needed clinical procedures, and refer
- Emergency contraception
- Safe abortion
- Referral list of community resources

Denominator: Total number of health units surveyed in the geographic region of study (nation, province, state, community).

Disaggregate by: type of health unit, region or province (if national study), urban or rural area.

Full Reference Sheet: VAW/G Compendium # 5.1.3 (p. 91):
http://www.measureevaluation.org/publications/ms-08-30

1.3.11 Proportion of law enforcement units following a nationally established protocol for VAW/G complaints

Definition: The proportion of law enforcement units that adhere to nationally established protocols pertaining to the management of VAW/G complaints.

Numerator: Number of law enforcement units in a region or country that follow a nationally established VAW/G protocol when handling complaints. If there is no national protocol pertaining to the management of VAW/G cases, this indicator cannot be measured. The protocol should cover:

- how and where VAW/G survivors should be interviewed,
- how confidentiality is ensured,
- the type of investigation and follow-up that should take place following a report, and
- how women and girls are protected following a complaint.

Denominator: Total number of law enforcement units surveyed.

Disaggregate by: region; province.

Full Reference Sheet: VAW/G Compendium 5.3.1 (p. 114):
http://www.measureevaluation.org/publications/ms-08-30

1.4 Gender Norms

Social norms around what is considered acceptable behavior for women/girls and men/boys are the root of gender inequities in health. Studies have found that higher levels of women's autonomy is associated with lower fertility and greater contraceptive use,[18] better care during pregnancy and delivery,[19] higher HIV-related knowledge,[20] and indirect effects on a range of HIV-related outcomes.[21]

Norms related to masculinity in many settings socialize men and boys to taking sexual risks, using violence to assert their authority, and feeling entitled to sex with their partners. On the other side, norms related to femininity encourage some women and girls to be passive in negotiating safe sex or refusing unwanted sex, as well as in reporting violence. Such norms are reinforced by policies, laws, and legal practices that discriminate against women and girls. So for example, in many countries, marital rape or rape within marriage is not recognized and considered as a criminal offence. The indicators in this section pertaining to gender norms and unequal power relationships between and among women and men in different contexts are important to monitor within the context of HIV.

TIER 1

1.4.1 Proportion of women and men who say that wife beating is an acceptable way for husbands to discipline their wives

Definition: Proportion of people who consider wife beating an acceptable way for a husband to discipline his wife for any reason, at a specified period in time.

Numerator: Number of respondents in an area (region, community, country) who respond "yes" to any of the following questions related to what justifies wife beating by husbands, as listed here.

Ask: Sometimes a husband is annoyed or angered by things that his wife does. In your opinion, is a husband justified in hitting or beating his wife if:

- she is unfaithful to him
- disobeys her husband
- argues with him
- refuses to have sex with him
- does not do the housework adequately

Denominator: Total number of people surveyed.

Disaggregate by: Sex, age.

Full Reference Sheet: VAW/G Compendium, 7.2.4 (p. 208):
http://www.measureevaluation.org/publications/ms-08-30

[18] Gage, A. *Stud Fam Plann*. 1995 Sep–Oct;26(5):264–77
[19] Bloom SS et al., *Demography* 2001;38:67–78
[20] Bloom SS et al., *Journal of Biosocial Science* 2007;39:557–73
[21] Agarwal, A, forthcoming

1.4.2 Proportion of respondents 15–49 years old who believe that, if her husband has an STI, a wife can propose condom use

Definition: The proportion of people aged 15–49 years who believe that a wife can refuse to have sex with her spouse or propose condom use if he has an sexually transmitted infection.

Numerator: The number of respondents who believe that, if her husband has an STI, the woman can refuse to have sex with him or propose condom use.

Ask: If a wife knows her husband has a disease that she can get during sexual intercourse, is she justified in asking that they use a condom when they have sex?

Denominator: Total number of people surveyed.

Disaggregate by: Sex, age.

Full Reference Sheet: UNAIDS/DHS, adapted:
http://hivdata.measuredhs.com/ind_detl.cfm?ind_id=46&prog_area_id=7

1.4.3 Percentage of currently married women aged 15–49 who usually make a decision about their own health care either by themselves or jointly with their husbands

Definition: Proportion of surveyed women who are currently married and who have the power to make a decision about their own health care, either jointly with their husbands, or by themselves.

Numerator: Number of currently-married women aged 15–49 years old who respond to the following question with "you" or "Both you and your husband/partner jointly".

Ask: Who usually makes decisions about health care for yourself?

- You
- Your husband/partner
- Both you and your husband/partner jointly
- Someone else

Denominator: All surveyed currently-married women.

Disaggregate by: Age.

What It Measures: This indicator measures the level of decision-making power married women have regarding obtaining their own health care in an area (region, country, community). A high proportion would indicate that most women in the targeted population are able to make, or contribute to making, the decision to seek health care for themselves.

Measurement Tool: Population-based survey such as the DHS.

How to Measure It: This indicator uses the question listed above. Anyone who responds with "you" or "Both you and your husband/partner jointly" is counted in the numerator. This number is then divided by the denominator, which includes all currently married women in the survey. The indicator should be disaggregated by age.

Considerations: The indicator has been measured using similar questions since late 1990s. The question used is easy to implement and understand. Use of standardized data collection and analysis methods, which allow for cross-country comparisons, enhance the usefulness of the indicator for measuring variations across countries and changes over time.

This indicator assesses progress in changing gender norms about women's roles, and provides an indication of the level of gender equality in the surveyed area. This means that an increase in women's direct participation in decisions about their own health care is reflective of a decline in gender inequality—which is one of the structural factors driving the HIV epidemic. Due to the fact that this indicator monitors change in norms, it may be expected to change only slowly over time, and would only be directly linked to programming that specifically addresses gender norms, but is indirectly related to any programming. It should be analyzed together with other indicators of gender norms, such as gender relations at the household and community level, women's legal and customary rights, gender inequalities in access to health care, education, and economic and social resources, and male involvement in reproductive and child health.

This indicator is based on a question put to respondents in a survey, which means it is self- reported and may be affected by social desirability or other biases. Since the question is asked only to currently married women, it directly indicates norms within marriage. However, such norms are likely to reflect gender inequality in the society as a whole.

Resources: UNAIDS Indicator Registry: http://www.indicatorregistry.org/node/888.
For further information on DHS/AIS methodology and survey instruments, visit http://www.measuredhs.com.

1.4.4 Child marriage

Definition: The proportion of women surveyed who were married when they were younger than the age of 18.

Numerator: Number of women aged 18–24 who report that they were married before age 18.

Denominator: Total number of women surveyed, aged 18–24.

Disaggregate by: Age group, region/area, ethnicity, religion.

Full Reference Sheet: VAW/G Compendium, 4.5.1 (p. 75):
http://www.measureevaluation/publications/ms-08-30

TIER 3

1.4.5 Women's autonomy indicators

Definition: Women's levels of autonomy in the following areas:

- being able to buy a condom herself
- decisions about using her earnings
- household decision-making
- being able to visit her relatives (as opposed to in-laws)
- knowledge and use of micro-credit programs freedom of movement
- each question is its own indicator

Numerator: Number of women answering affirmatively/that they decide or jointly decide with their husband based on any of the following questions.

Ask:

- If you wanted to, could you buy a condom yourself?
- Who usually decides how to spend your earnings (you, your husband, jointly, other)?
- Who usually decides on large household purchases (you, your husband, jointly, other)?
- Who usually decides about visiting your relatives/kin (you, your husband, jointly, other)?
- Are you aware of any micro-credit schemes in this area?
- Would you be able to decide to participate in the microcredit scheme if you wanted to?
- Are you able to leave the house without permission?

Denominator: Total number of women surveyed.

Disaggregate by: Age.

What It Measures: This indicator measures women's autonomy in a range of areas. Use of one set of questions or the other will depend on the context. Gender inequity of all kinds increases women's vulnerability to HIV infection in three closely linked ways. Lack of economic opportunity for women, reinforced by social-cultural practices and the legal system, leads to dependence on men whose interests do not always coincide with women's needs. Second, depriving women of the right to autonomy and control over their own bodies also deprives them of their right to refuse sex and to demand safer sex practices by men. Third, some cultural practices, many protected by or ignored by the law, are dangerous and can lead to HIV infection.

Measurement Tool: DHS or other population-based survey.

How to Measure It: Women answering affirmatively on the yes/no questions and those answering that they either decide by themselves or with their husbands are place in the numerator, for each area measured. The numerator is then divided by the denominator.

Considerations: Some of these areas are more applicable than others, depending on context. These indicators depend on self-reported behavior, which involves a number of potential biases.

Source: Demographic and Health Surveys, Women's Status Module:
http://www.measuredhs.com/pubs/pub_details.cfm?ID=709

1.4.6 Proportion of people who know any of the legal rights of women

Definition: Proportion of people who are aware of any specific constitutional and legal rights of women in a given country at a specific period in time.

Numerator: Ask individuals: Do you know that in (name of country), women have the right to (list of rights in that particular country, such as divorce, to work, to marry whom they choose)?

- X (e.g., divorce)
- Y (e.g., to work)

Denominator: Total number of people surveyed.

Disaggregate by: Geographical area, sex of respondent.

Full reference sheet: VAW/G Compendium, 7.2.1 (p. 202):
http://www.measureevaluation/publications/ms-08-30

1.4.7 Number of adults and children reached by an individual, small group, or community-level intervention or service that explicitly addresses the legal rights and protections of women and girls impacted by HIV/AIDS

Definition: The number of people surveyed who state that they were reached by a program or service that focuses on the legal rights and protections of women and girls who are impacted by HIV/AIDS. The "reach" could be made by an individual, small group, community-level intervention or service.

Count: Number of people who report that they heard a message about the legal rights and protections of women and girls who are impacted by HIV/AIDS from any type of intervention mechanism focusing on this area.

Disaggregate by: Sex, age.

Full Reference Sheet: http://www.pepfar.gov/documents/organization/206097.pdf

1.5 Economic Autonomy and Literacy

Education and economic independence influence a wide range of HIV outcomes directly and indirectly. Women's economic empowerment is considered necessary for equitable and sustainable economic growth and development at regional, national, district, and local levels.[22] Even in countries with a high unemployment rate and insecure working conditions, males usually have more financial stability than females. Gender inequality conspicuously obstructs human and social development, and intensifies the spread of HIV. The indicators in this section focus on the economic and literacy aspects of gender differentials that contribute to HIV outcomes.

TIER 1

1.5.1 The percentage of women aged 15–49 who own property or resources for production of goods, services, and/or income in their own name

Definition: The percentage of women aged 15 to 49 who own property and productive resources in their own name. Various surveys have defined such resources as land, house, company or business, livestock, produce or crops, durable goods, tools, money, and bank accounts.

Numerator: Number of women ages 15 to 49 who report that they own property or productive resources (definitions of which depend on particular survey being used) in their own name.

Denominator: Total number of women respondents aged 15 to 49.

Disaggregate by: Age.

Full Reference Sheet: MEASURE Evaluation PRH FP/RH Indicators Database:
http://www.measureevaluation.org/prh/rh_indicators/crosscutting/wgse/percent-of-women-who-own-property-or-productive

1.5.2 The proportion of women in wage employment in the non-agricultural sector

Definition: The proportion of women in wage employment in the non-agricultural sector. The non-agricultural sector includes industry and services. As defined by the International Standard Industrial Classification (ISIC) of All Economic Activities, industry includes mining and quarrying including oil production), manufacturing, construction, electricity, gas and water. Services includes wholesale and retail trade; restaurants and hotels; transport, storage and communications; financing, insurance, real estate and business services; and community, social and personal services.

Numerator: Number of women in wage employment in the non-agricultural sector.

Denominator: Number of people in wage employment in the non-agricultural sector included in the survey.

Full Reference Sheet: MDG #11 (p. 27):
http://mdgs.un.org/unsd/mdg/Resources/Attach/Indicators/HandbookEnglish.pdf

[22] UN Beijing +15, 2010

1.5.3 Total primary net enrollment ratio (NER) in primary education

Definition: The NER is the ratio of the number of children of official school age (as defined by the national education system in each country) who are enrolled in primary school to the total population of children of official school age. Primary education provides children with basic reading, writing, and mathematics skills along with an elementary understanding of such subjects as history, geography, natural science, social science, art and music.

Numerator: Number of enrolled students within the appropriate age cohort according to school records as reported to ministries of education.

Denominator: Number of children of primary school age.

Disaggregate by: Sex.

Full Reference Sheet: MDG #6:
http://mdgs.un.org/unsd/mdg/Resources/Attach/Indicators/HandbookEnglish.pdf

TIER 3

1.5.4 Percent of women who earn cash

Definition: This indicator measures the percent of women aged 15–49 who work either at home or outside the home and earn cash. No minimum quantity is specified.

Numerator: Number of women aged 15–49 earning cash.

Denominator: Total number of women surveyed aged 15–49

Full Reference Sheet: MEASURE Evaluation PRH FP/RH Indicators Database: http://www.measureevaluation.org/prh/rh_indicators/crosscutting/wgse/percent-of-women-who-earn-cash

1.5.5 Percentage of the population 15–24 years old who can both read and write with understanding a short simple statement on everyday life

Definition: Literacy rate of 15- to 24-year-olds, or the youth literacy rate, is the percentage of the youth population who can both read and write with understanding a short simple statement on everyday life. The definition of literacy sometimes extends to basic arithmetic and other life skills.

Numerator: Number of people ages 15–24 who are literate.

Denominator: Total population in the same age group.

Disaggregate by: Age, sex.

Full Reference Sheet: MDG #8 (p. 22):
http://mdgs.un.org/unsd/mdg/Resources/Attach/Indicators/HandbookEnglish.pdf

1.6 Humanitarian Emergencies

Conflict and humanitarian crisis put people at elevated risk of acquiring HIV. The factors that influence HIV transmission during these extreme situations are complex and vary with the specific context of the emergency. The characteristics that define a complex emergency, such as conflict, social instability, poverty, environmental destruction and powerlessness, can increase affected populations' vulnerability and risk to HIV by:

- reducing access to HIV prevention services and information,
- break down of infrastructure,
- disrupting social support networks,
- increasing exposure to sexual violence and sexual abuse, and
- population movement to an area of higher HIV prevalence.

Women and children are particularly vulnerable to HIV as a result of sexual violence and exploitation by armed groups, and rape may be used as a means of warfare. The United Nations Security Council recently adopted Resolution 1983/2011 on HIV. The resolution calls for increased efforts by UN Member States to address HIV in peacekeeping missions. It also calls for HIV prevention efforts among uniformed services to be aligned with efforts to end sexual violence in conflict and post-conflict settings.[23] For men and women moving in search of economic opportunities new sexual networks are often formed that increase vulnerabilities as well. The indicators in this section will be helpful to address the intersection of gender and HIV in humanitarian emergencies.

TIER 2

1.6.1 Number of women/girls reporting incidents of sexual violence per 10,000 population of the emergency area over a specific time period

Definition: Reported incidents of sexual violence over a specific period of time (to be defined within the context of the emergency situation).

Numerator: Number of incidents of sexual violence reported in the specified period.

Denominator: The total camp/area/country population during the same time period.

Calculation: Divide the numerator by the denominator and multiply the result by 10,000.

Disaggregate by: Age (under 15, 15–20, 20+), geographic location.

Full Reference Sheet: VAW/G Compendium #6.1.6, (p. 159):
http://www.measureevaluation.org/publications/ms-08-30

[23] HIV in Humanitarian situations: http://www.un.org/News/Press/docs/2011/sc10272.doc.htm

1.6.2 Proportion of reported sexual exploitation and abuse incidents resulting in prosecution and/or termination of humanitarian staff

Definition: Among sexual exploitation and abuse (SEA) incidents in which the perpetrator works within the humanitarian organizations responding to the emergency, the proportion of reports which result in the prosecution of the perpetrator and termination of their position. This includes all UN personnel including peacekeepers, staff at bilaterals, as well as those who work in governmental or non-governmental organizations.

Numerator: The number of reported SEA incidents involving a humanitarian staff serving the emergency area, that are both investigated and prosecuted, and result in the prosecution and/or termination of this perpetrator's position.

Denominator: The total number of reported SEA incidents that involve humanitarian workers.

Full Reference Sheet: VAW/G Compendium #6.1.4 (p. 155):
http://www.measureevaluation.org/publications/ms-08-30

1.6.4 Protocols that are aligned with international standards that have been established for the clinical management of sexual violence survivors within the emergency area at all levels of the health system

Definition: The clinical management of sexual violence survivors is complex, involving multiple aspects of care and support. In order to ensure that women receive appropriate care, a protocol that is aligned with international standards should exist at all levels of the health system within the emergency area.

Yes: A protocol for the clinical management of sexual violence survivors exists at all levels of the defined health system within the given emergency area. This protocol is also aligned with international standards, such as the Minimum Initial Service Package (MISP) and the WHO protocol on the clinical management of rape survivors.

No: A protocol does not exist at all, or exists at some levels of the health system but not all, or exists at all levels but is not aligned with international standards.

Full Reference Sheet: VAW/G Compendium #6.1.1 (p. 148):
http://www.measureevaluation.org/publications/ms-08-30

1.6.5 Percent of rape survivors in the emergency area who report to health facilities/ workers within 72 hours and receive appropriate medical care

Definition: The proportion of sexual violence survivors who present for care at a health facility within 72 hours and who receive appropriate care, within a defined time period.

Numerator: Number of rape survivors who present for care within 72 hours of the incident and who receive appropriate care within a defined time period (e.g., past three months). Appropriate care for rape survivors who present within 72 hours includes: HIV post-exposure prophylaxis (PEP), emergency contraception, sexual transmitted infection and HIV testing, psycho-social services,

information about access to legal abortion. Other elements, such as a female health worker being present for any medical exam, are outlined in detail in the UNHCR interagency field manual.

Denominator: Number of rape survivors who report an incident within 72 hours, during the same defined time period.

Disaggregate by: Age (under 15, 15–20, 20+), geographic location.

Full Reference Sheet: VAW/G Compendium #6.1.7 (p. 162)—related to PEPFAR Essential P6.1.D; IAWG, #33: http://www.measureevaluation.org/publications/ms-08-30

TIER 3

1.6.3 Percentage of military manuals, national security policy frameworks, codes of conduct and standard operating procedures/protocols of national security forces that include measures to protect women's and girls' human rights, available in the emergency area

Definition: The proportion of all these items available in the emergency area which include measures to protect women's and girls' human rights.

Numerator: Number of military manuals, national security policy frameworks, codes of conduct and standard operating procedures/protocols of national security forces being used within the emergency area that include measures to protect women's and girls' human rights.

Denominator: Number of military manuals, national security policy frameworks, codes of conduct and standard operating procedures/protocols of national security forces being used within the emergency area.

What It Measures: The indicator assesses the extent to which international, national and non-State security actors are responsive to, and are held accountable for, any violations of the rights of women and girls, in line with international standards.

Measurement Tool: Special survey.

How to Measure It: Information is available from existing and easily accessible documents (through desk review), but these need to be collected and systematically analyzed. The number of materials containing references to the rights of women and children are counted in the numerator. The numerator is then divided by the denominator.

Considerations: The indicator addresses the responsiveness of security forces to the specific security needs of women in particular contexts by identifying specific measures included in directives, manuals, codes of conduct, standard operating procedures and other resources aimed at preventing violations of women's and girls' human rights. This indicator captures the adequacy of information provided to uniformed and civilian peacekeepers, as well as military and civilian police personnel. Data should indicate types of measures included.

Source: UN Security Council, Output indicator 5b (p. 5, p. 16):
http://www.peacewomen.org/assets/file/Indicators/sg_report_on_1889-op17.pdf

2.1 Treatment

The specific diagnosis, treatment and care needs of women affected by or living with HIV indicate a need for gender–transformative programming. Fear of stigma, discrimination and violence often impede women's access to testing, treatment and care. These factors can also have an adverse impact on women's adherence to anti-retroviral treatment.[24] Gender may be an important factor influencing the uptake of antiretroviral therapy, which requires further study.[25]Norms around masculinity may present barriers for men accessing treatment, and women who have not disclosed their HIV status may fear entering treatment programs due to repercussions, including violence and abandonment. Either way, treatment coverage should reflect the patterns of infection observed among both adults and children. If there are differentials in treatment, they should mirror the same observed differentials in infection patterns, or some groups may face unequal access to services. Indicators in this section are disaggregated by sex and age to encourage focus on differentials in their interpretation.

TIER 1

2.1.1 HIV treatment: antiretroviral therapy

Definition: Percentage of eligible adults and children currently receiving antiretroviral therapy. This demonstrates progress towards providing antiretroviral combination therapy to all people eligible for treatment.

Numerator: Number of eligible adults and children currently receiving antiretroviral combination therapy in accordance with the nationally approved treatment protocol (or WHO/UNAIDS standards) at the end of the reporting period.

Denominator: Estimated number of adults and children living with HIV.

Disaggregate by: Age (<15, 15+ years), sex, where possible the indicator should be further disaggregated by 1 year, 1–4, 5–9, 10–14, 15–19, 20–24, 25–49, 50+.

Full Reference Sheet: Global AIDS Progress Reporting 2013, Construction of Core Indicators for monitoring the 2011 UN Political Declaration on HIV/AIDS.
http://www.unaids.org/en/media/unaids/contentassets/documents/document/2013/GARPR_2013_guidelines_en.pdf; http://www.pepfar.gov/documents/organization/206097.pdf

[24] UNAIDS: http://www.unfpa.org/webdav/site/global/shared/documents/publications/2010/unaids_action_framework.pdf

[25] Hirsch, JS. Gender, sexuality, and antiretroviral therapy: using social science to enhance outcomes and inform secondary prevention strategies. *AIDS*. 2007 Oct;21 Suppl 5:S21–9

2.1.2 Twelve-month retention on antiretroviral therapy

Definition: The percentage of people with HIV who have stayed on antiretroviral therapy (ART) for at least 12 months after initiation. It measures progress in increasing survival among infected adults and children by maintaining them on antiretroviral therapy.

Numerator: Number of adults and children who are still alive and on antiretroviral therapy at 12 months after initiating treatment.

Denominator: Total number of adults and children who initiated antiretroviral therapy who were expected to achieve 12-month outcomes within the reporting period, including those who have died since starting antiretroviral therapy., those who have stopped antiretroviral therapy, and those recorded as lost to follow-up at month 12.

Disaggregate by: Age (<15, 15+), sex, pregnancy status at start of therapy, breastfeeding status at start of therapy.

Full Reference Sheet: Global AIDS Progress Reporting 2013, Construction of Core Indicators for monitoring the 2011 UN Political Declaration on HIV/AIDS.
http://www.unaids.org/en/media/unaids/contentassets/documents/document/2013/GARPR_2013_guidelines_en.pdf; http://www.pepfar.gov/documents/organization/206097.pdf

2.1.3 Prevention of mother-to-child transmission

Definition: Percentage of HIV-positive pregnant women who received antiretrovirals to reduce the risk of mother-to-child transmission. It measures progress in preventing mother-to-child transmission of HIV during pregnancy and delivery through the provision of antiretroviral medicines.

Numerator: Number of HIV-positive pregnant women who received antiretroviral drugs during the past 12 months to reduce mother-to-child transmission.

Denominator: Estimated number of HIV-positive pregnant women within the past 12 months.

Disaggregate by: by the six options (the first three are recommended) for HIV-positive pregnant women for the prevention of mother-to-child transmission.

Full Reference Sheet: Global AIDS Progress Reporting 2013, Construction of Core Indicators for monitoring the 2011 UN Political Declaration on HIV/AIDS.
http://www.unaids.org/en/media/unaids/contentassets/documents/document/2013/GARPR_2013_guidelines_en.pdf; http://www.pepfar.gov/documents/organization/206097.pdf

TIER 2

2.1.4 Percentage of HIV infected patients with co-infection HIV/viral hepatitis B who receive treatment of hepatitis B

Definition: This indicator measures the number of HBV/HIV co-infected patients receiving treatment for hepatitis B or both, hepatitis B and HIV if effective for both viruses ARVs are used, among patients enrolled in HIV care who were evaluated on hepatitis disease progression and found eligible for treatment.

Numerator: Number of HIV-positive hepatitis B cases eligible for hepatitis B treatment who received treatment for hepatitis B or for both, hepatitis B and HIV if effective for both viruses ARVs are used, during the reporting year.

Denominator: Number of HIV-positive hepatitis B cases who were eligible for hepatitis B treatment during the reporting year.

Disaggregate by: Age, sex.

Full Reference Sheet: Indicator # 7.8/EUR16 (p. 97) 'A Guide on Indicators for Monitoring and Reporting on the Health Sector Response to HIV/AIDS, Adaptation for the European Region' WHO/UNAIDS, 01/2001:
http://www.indicatorregistry.org/sites/default/files/UA2011_indicator_guide_EURO_en_3.pdf

2.2 Counseling and Testing

HIV testing raises numerous human rights and other issues related to stigma, discrimination and equity. Financial and accessibility barriers, concerns about stigma and violence, especially experienced by women, may prevent them from seeking testing and counseling services and disclosing their status.[26] Reports from sub-Saharan Africa observe that women are reluctant to get tested for HIV or to return for their results because of a fear of domestic violence. In settings where medical procedures performed on women require their husband's consent (including the need for permission to access health centers), a potential for conflict with confidentiality and informed consent arises.[27] In antenatal care settings, women are sometimes required to undergo HIV testing, whereas such testing should always be voluntary, confidential, and informed. On the other hand, norms around masculinity and day-time service hours may deter men from seeking HIV testing and counseling. It has been established that routine and provider initiated testing are likely to reduce barriers to HIV testing.[28] An approach to HIV testing policies, programs and practices, which ensures respect, protection and fulfillment of human rights is consistent with good public health practice and outcomes. Indicators in this section are disaggregated by sex to encourage focus on differentials in their interpretation.

TIER 1

2.2.1 Percentage of women and men aged 15–49 who received an HIV test in the past 12 months and know their results

Definition: The proportion of people who have been tested and know the results of the test measures the progress in implementing counseling and testing programs in countries or regions.

Numerator: Number of respondents aged 15–49 who have been tested for HIV during the last 12 months and who know their results.

Denominator: Number of all respondents aged 15–49.

Disaggregate by: Age (15–19, 20–24 and 25–49), sex.

Full Reference Sheet: Global AIDS Progress Reporting 2013, Construction of Core Indicators for monitoring the 2011 UN Political Declaration on HIV/AIDS.
http://www.unaids.org/en/media/unaids/contentassets/documents/document/2013/GARPR_2013_guidelines_en.pdf; http://www.pepfar.gov/documents/organization/206097.pdf

[26] Maman, Suzanne, Jacquelyn Campbell, Michael D. Sweat, Andrea C. Gielen. (2000) The intersections of HIV and violence: directions for future research and interventions. *Social Science & Medicine* 50 459–478.

[27] Joseph, S. Examining sex differentials in the uptake and process of HIV testing in three high prevalence districts of India. *AIDS Care*. 2010 Mar;22(3):286–95

[28] Weiser SD, Heisler M, Leiter K, Percy-de Korte F, Tlou S, et al. (2006) Routine HIV Testing in Botswana: A Population-Based Study on Attitudes, Practices, and Human Rights Concerns. *PLoS Med* 3(7): e261. doi:10.1371/journal.pmed.0030261

TIER 2

2.2.2 Percentage of sexually active young women and men aged 15–24 who received an HIV test in the last 12 months and who know their results

Definition: The proportion of people who have been tested and know the results of the test measures the progress in implementing counseling and testing programs among sexually active young people in countries or regions.

Numerator: The number of respondents aged 15–24 years who had an HIV test in the preceding 12 months and who know the results.

Denominator: Respondents aged 15–24 years who have had sex in the preceding 12 months.

Disaggregate by: Age (15–19, 20–24), sex.

Full Reference Sheet: http://www.indicatorregistry.org/node/179

2.2.3 Number of people living with HIV (PLHIV) whose sexual partner(s) received onsite HIV testing and counseling services and received their test results

Definition: A count of the number of PLHIV who had sexual partners who received onsite HIV testing and counseling services and received their results.

Count: Number of people living with HIV (PLHIV) whose sexual partner(s) received onsite HIV testing and counseling services and received their test results.

Disaggregate by: Sex, setting (facility/clinic, community/home).

What It Measures: Provision of partner HIV testing and counseling is a key component of the minimum package of prevention with PLHIV (PwP) interventions (PEPFAR NFI Indicator #P7.1.D), which supports evidence-based, comprehensive HIV prevention services for PLHIV. This indicator attempts to measure the extent to which programs are integrating partner HIV testing and counseling services into their service delivery to PLHIV. Sex partners of PLHIV are at high risk for HIV infection. Identification of partner's HIV status determines which prevention services are appropriate not only for the sex partner as an individual but also for the PLHIV and sex partner as a couple.

For sex partners known to be HIV negative, discordant couples counseling is a critical intervention, providing couples with necessary information and opportunities for skills building to reduce the risks of HIV acquisition by the negative partner. It also facilitates among couples who are interested in childbearing the uptake of prevention of mother-to-child transmission of HIV care. Similarly, among sex partners who are living with HIV, HIV care and treatment services for the infected partner becomes a priority, coupled with comprehensive prevention services for PLHIV. Counseling and support for PLHIV to encourage testing of their sexual partners should be ongoing, rather than solely at intake, to accommodate new sexual partnerships, as well as repeat testing needs of HIV-negative partners. Clinic/facility-based interventions should be reinforced through community-based programs. All community-based programs should incorporate appropriate linkages and referrals to clinic/facility-based programs.

Partner HIV testing should always be accompanied by the following:

- HIV care and treatment services for HIV-positive partners of PLHIV.
- Discordant couples counseling and support services for those in HIV-discordant partnerships.
- Repeat HIV testing among HIV-negative partners, conducted according to national HIV testing guidelines.

Measurement Tool: Data can be obtained from existing or modified program monitoring tools, such as facility registers/databases or patient/client records and registers.

How to Measure It:

Explanation of Numerator: The numerator can be generated by counting the number of PLHIV who have at least one sexual partner who received an HIV test result during the reporting period in either a clinic/facility-based or community/home-based program. To count under this indicator, testing of sexual partners includes initial testing of sexual partners and repeat testing for HIV negative partners, according to national HIV testing and counseling guidelines.

Explanation of Denominator: Refer to PEPFAR NFI Recommended PwP indicator #P7.11.D for explanation of the denominator.

Note on Disaggregation: Given that the same individual may be reached with services in both a facility and community based setting, when aggregating this indicator across multiple partners, country teams may choose to allow the double counting, in which case the "Number reached in community" + "Number reached in facility" ≥ "Total number reached."

Considerations: This indicator provides information on the total number of unduplicated individuals that received onsite counseling and testing services for partners of PLHIV. In determining reach of service (use of numerator only), the indicator will help demonstrate the extent to which PLHIV's sexual partners are receiving HIV testing. The strength of this indicator depends on the quality of the records used to generate it.

Source: http://www.pepfar.gov/documents/organization/206097.pdf

TIER 3

2.2.4 Percentage of individuals aged 15+ years who received couples/partner HTC and learned the results of their HIV test together with their partner(s) in the past 12 months

Definition: The proportion of individuals aged 15 years or older who have received couples/partner HIV counseling and testing, and learned the results of the test together, in the past 12 months. This indicator monitors trends in the uptake of couples/partner HTC services by individuals over time within a country.

Numerator: People aged 15+ years who were received HTC counseling and testing with their spouse/partner, and who learned the results of the test with their spouse/partner, during the past 12 months.

Denominator: Respondents aged 15 or above.

Disaggregate by: Age (15–19, 20–24, 25+), sex.

Full Reference Sheet: WHO, G1a (p. 36):
http://whqlibdoc.who.int/publications/2011/9789241501347_eng.pdf

2.3 Service Integration and Linkages

Increasing attention has been placed on the need to integrate gender into HIV and AIDS services and programs. Part of the emphasis has been laid on the integration of HIV and AIDS services with other types of health care linked to the needs of people living with HIV.[29] Women will particularly benefit from such an approach as they have less time, mobility and resources to access separate services; men can benefit as well as in many settings they more likely to be employed outside of their homes, hence have limited opportunities to attend health services during the work hours. For example, both women and men's health can be debilitated by HIV and tuberculosis (TB) co-infection. Pregnant women living with HIV have a 10-fold higher risk of developing active tuberculosis compared with HIV-negative pregnant women.[30] TB case detection rates are significantly lower in women because women delay seeking treatment, are missed by health promotion programs, and face stigma and discrimination, and at the same time, in Africa, approximately 20% more HIV-associated TB deaths occur among women then among men.[31]

In addition, the integration of HIV and AIDS services with sexual and reproductive health services (e.g., family planning and antenatal care) can help address women's different needs and potentially reduce stigma. Women living with HIV are often negatively judged for their reproductive and sexual health choices, counseled to avoid pregnancy, sometimes forcibly sterilized, or forced to terminate their pregnancy. On the other hand, men are often influenced by societal pressures that can make it difficult for them to adopt protective behaviors, both for themselves and their sexual partners. For example, as men are more likely to use TB and STI services, integration of HIV and AIDS services may facilitate greater coverage and access to treatment for men and boys. The indicators in this section are targeted at examining patterns to measure progress in this area.[32]

TIER 1

2.3.1 Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV

Definition: The proportion of HIV-positive people with TB that received treatment for both TB and HIV. The indicator measures progress in detecting and treating TB in people living with HIV.

Numerator: Number of adults and children with HIV infection who received antiretroviral combination therapy in accordance with the nationally approved treatment protocol (or WHO/UNAIDS standards) and who were started on TB treatment (in accordance with national TB program guidelines), within the reporting year.

Denominator: Estimated number of incident TB cases in people living with HIV.

Disaggregate by: Age (<15, 15+), sex.

---

[29] UNAIDS/WHO, http://www.who.int/hiv/pub/advocacy/en/policy%20statement_gwh.pdf

[30] Pillay T et al. The increasing burden of tuberculosis in pregnant women, newborns and infants under 6 months of age in Durban, KwaZulu-Natal. *The South African Medical Journal*, 2001, Nov;91:983–7.

[31] WHO, *Global Tuberculosis Report*, 2012.

[32] Further work on developing indicators on integration is currently under way and when they are finalized will be available in the Indicator Registry (http://www.indicatorregistry.org)

Full Reference Sheet: Global AIDS Progress Reporting 2013, Construction of Core Indicators for monitoring the 2011 UN Political Declaration on HIV/AIDS.
http://www.unaids.org/en/media/unaids/contentassets/documents/document/2013/GARPR_2013_guidelines_en.pdf; http://www.pepfar.gov/documents/organization/206097.pdf

TIER 2

2.3.2 Proportion of clients referred who completed referral

Definition: Proportion of clients of HIV service referred who completed referral
In the context of gender equality and HIV: The proportion of clients presenting at HIV services who were referred to various other types of services and who sought and received care at the referred service. The referral services could include GBV, nutrition, mental health, economic activities, etc.

Numerator: Number of clients who complete referral at receiving service. Services areas to include: GBV, nutrition, mental health, economic activities, etc.

Denominator: Number of clients referred from referring services.

Disaggregate by: Sex.

What It Measures: In this increasingly complex service environment, integrating HIV services among themselves and with other services is important for making those services accessible for clients and their delivery efficient for the health system and ultimately for improving individual and family outcomes. There has been interest in integrating various HIV services into a seamless continuum (e.g., VCT with ARV treatment); in integrating HIV services with other health services (e.g., family planning [FP], tuberculosis [TB], and antenatal care [ANC]); and with integrating various HIV services with services outside of the health system (e.g., educational services, social and protection services, etc.). For example, referral for HIV testing is part of the comprehensive package for integrated FP/HIV services, and is an important component for HIV prevention, including PMTCT. Women will particularly benefit from such an approach as they have less time, mobility and resources to access separate services. Therefore formalizing and monitoring linkages between services with particular attention to access for women and marginalized communities is essential.

Measurement Tool: Records of referrals or activities/services; Registers at referring service, client-tracking slips, community outreach worker logs.

How to Measure It: Records need to include:

- the number of referrals and/or counter-referrals made and completed (if it is possible to collect this information),
- the type de referral (the service referred to), and
- the place to which/from where the referral was made.

The numerator is generated by counting the number of clients for whom there is evidence of a completed referral, based on record either in the original referring service register, when the client comes back, or in the receiving service, where client tracking slip is collected and returned to the referring service, at the end of the reporting period.

The denominator is a count of all clients who were referred from referring service/facility for any type of care, according to the register at the end of the reporting period. To be most useful for management decisions, the data should be examined in disaggregated form by service. For instance, referrals of VCT clients with positive tests specifically for ART initiation should be tracked in a granular way and not mixed with other unrelated referrals like referrals for tuberculosis INH preventive therapy and the like.

Considerations: Generally, in order to develop a formal mechanism to record referrals it is necessary to work with partner organizations to obtain all the relevant data. However, it is sometimes not possible to obtain data on referrals and counter-referrals made and completed. With more information (ex. the % of referrals completed) it is possible to identify problems and improve the referral system.

This indicator does not measure the appropriateness of individual referrals made by a provider/outreach worker, nor the quality of services received by the individual. This indicator does not measure whether or not the referral protocols are implemented as intended, nor if the referral data is of high quality.

Source: Global Fund CSS 3.2, (M&E Toolkit: Part 5 Health and Community Systems Strengthening, Global Fund, 2011); Adapted from IPPF Sexual Diversity Indicators: Partnerships indicator 4 (p. 5): http://www.ippfwhr.org/en/node/795; Referral System Assessment and Monitoring Toolkit

TIER 3

2.3.3 Number of HIV-positive women and of HIV-positive men with female partners who received onsite provision of modern contraceptive methods

Definition: The number of HIV positive women and female partners of HIV-positive men who received onsite provision of contraceptives.

Count: Number of HIV-positive women and HIV-positive men with female partners who received onsite provision of modern contraceptive methods.

Disaggregate by: Setting (clinic/facility, community/home).

What It Measures: This indicator provides information on the total number of unduplicated individuals that received onsite delivery of modern contraceptive methods. In determining reach of service, the indicator will help demonstrate the extent to which PLHIV are receiving modern contraceptive methods. It will not reveal the specific type of methods nor the success of those methods in preventing pregnancy. In determining coverage, the denominator will overestimate those in need of contraceptive methods because it may include women beyond child bearing age, women who desire pregnancies, women who do not desire to use contraceptives and women and their partners who are not assessed for pregnancy intention. This indicator generally refers to the use of facility-based SRH services only, however evaluators may choose to include SRH service provision from peer providers or community health workers. Health services of particular interest include those concerned with HIV counseling, testing, and treatment; diagnosis and treatment or sexually transmitted infections (STIs); and counseling, provision, male circumcision services.

Measurement Tool: Data can be obtained from existing or modified program monitoring tools, such as facility registers/databases or patient/client records and registers.

How to Measure It: The indicator can be generated by counting the number of HIV-positive women and HIV-positive men with female partners who received onsite delivery of a modern contraceptive method during the reporting period in a clinic/facility-based or community/home-based program. Modern contraceptive method includes: combined oral contraceptive pills, progestin-only injectables, intra-uterine devices, progestin-only pills, and hormonal implants. Vasectomy and female sterilization are also included.

In the case of HIV-positive men, the HIV-positive man may initially be assessed for family planning needs of he and his partner, and when indicated, the female sexual partner(s) of the HIV-positive man would receive a contraceptive method (either at the clinic or community based site or at another point of service delivery). However, only the HIV-positive man should be counted under this indicator. Since the HIV-positive man serves as the index client, do not additionally count the female partner unless she is an HIV positive client of the program.

Note on Disaggregation: Given that the same individual may be reached with services in both a facility and community based setting, when aggregating this indicator across multiple partners, country teams may choose to allow the double counting, in which case the "Number reached in community" + "Number reached in facility" ≥ "Total number reached."

Considerations: Family planning and contraceptive services (funded through wrap around programs) is a key component of the minimum package of prevention with PLHIV (PwP) interventions (Indicator #P7.1.D), which supports evidence-based, comprehensive HIV prevention services for PLHIV. This indicator attempts to measure the extent to which program are integrating modern contraceptive services into service delivery for HIV-positive women, as well as to HIV-positive men via their female partners.

Assessment for pregnancy intentions of PLHIV should ideally be integrated within most program services and conducted at each client encounter with a health care provider or counselor. For those who wish to delay pregnancy, prevention of unplanned pregnancy in HIV-positive women is key to prevention of maternal-to-child transmission of HIV (PMTCT). As high numbers of unwanted pregnancy among HIV-positive women have been documented, there is a critical need for assessing PLHIV's fertility desires coupled with appropriate contraceptive counseling and support services.

Family planning counseling and provision of contraception ideally should be integrated into programs, allowing immediate access to ongoing counseling and support services. Clinic/facility-based interventions should be reinforced through community-based programs. All community-based programs providing PwP services should incorporate appropriate linkages and referrals to clinic/facility-based programs.

The onsite provision of modern contraceptive methods should always be accompanied by:

- an assessment of pregnancy intentions,
- an assessment of contraceptive needs, and
- medical eligibility screening of women for contraceptive method.

Source: http://www.pepfar.gov/documents/organization/206097.pdf

2.4 Male Engagement

In addition to contributing to women's risk and vulnerability, gender norms and unequal power relations between women and men may also influence men's risk of acquiring HIV. Cultural norms of masculinity often present barriers to an effective HIV and AIDS response, particularly in terms of changing power relations between men and women and in hindering men from seeking information, treatment and support or assuming their share of the burden of care. Traditional and stereotypical norms and views of women, men, and the relations between them hinder an effective HIV response. A growing body of evidence suggests that carefully designed gender transformative interventions with men and boys can bring about important improvements in men's and boy's gender-related attitudes and practices, which in turn have an effect on HIV risks and the impact of interventions. Rigid and contemporary gender roles have driven men and boys to equate risky behavior with masculinity and conversely, to regard health seeking behaviors as emasculating. Therefore, the engagement of men and boys is critical to addressing gender inequalities in the context of HIV: as partners and family members of women and girls, as community leaders and decision-makers, as perpetrators of discrimination and violence, and as people with male specific sexual and reproductive health needs. Working with men and boys to change norms related to fatherhood, sexual responsibility, decision-making and violence should be included in programming in reproductive health, HIV and other services. Addressing men's sexual and reproductive health is good for both men's and women's health outcomes. For example, age and sex-appropriate HIV/AIDS education for young people that have the potential to change views that will influence behavior.[33] It can also be an important entry point for educating men about women's vulnerability to HIV infection and promoting their roles as agents of change.

TIER 2

2.4.1 Number of visits made by young men to specified sexual and reproductive health services

Definition: The number of visits to specified sexual and reproductive health (SRH) services by young men, as measured through facility-based records (measuring service utilization only).

Count: Number of young people aged 10–24 using an SRH service, disaggregated by service received, in a defined period.This indicator generally refers to the use of facility-based SRH services only, however evaluators may choose to include SRH service provision from peer providers or community health workers. Health services of particular interest include those concerned with HIV counseling, testing, and treatment; diagnosis and treatment or sexually transmitted infections (STIs); and counseling, provision, male circumcision services.

Disaggregate by: Type of service

Full Reference Sheet: Adapted from MEASURE Evaluation PRH FP/RH Indicators Database: http://www.measureevaluation.org/prh/rh_indicators/specific/arh/use-of-specified-rh-health-services-by-young

[33] EngenderHealth & Planned Parenthood Association of South Africa, 2001. Men as Partners. http://www.engenderhealth.org/files/pubs/gender/ppasamanual.pdf

2.4.2 Percentage of pregnant women attending ANC services whose male partner was tested for HIV

Definition: The percentage of pregnant women attending ANC services whose male partner was tested during the female partner's pregnancy in the past 12 months.

Numerator: Number of pregnant women attending ANC services whose male partner was tested in the past 12 months.

Denominator: Estimated number of pregnant women in the past 12 months.

Disaggregate by: Age.

Full Reference Sheet: WHO, G1b (p. 38): A Guide on Indicators for Monitoring and Reporting on the Health Sector Response to HIV/AIDS:
http://whqlibdoc.who.int/publications/2011/9789241501347_eng.pdf

TIER 3

2.4.3 Availability of accessible, relevant, and accurate information about sexual and reproductive health (SRH) which is tailored to young men

Definition: Number and types of sources providing accessible, relevant, and accurate information about sexual and reproductive health (SRH) that are designed specifically for adolescent boys and young men ages 10 to 24. Sources can include media, health programs and facilities, peer education and mentoring programs, sexuality education programs for schooled and for out-of-school young men, workplace, and community-based reproductive health education and services. Accessibility needs to be locally defined, depending on the geographic area and the modes of transportation and communication that are readily available to most of the population.

A geographic or programmatic catchment area needs to be defined. Materials and opportunities for program participation need to be readily available and accessible, ideally in male-focused and/or male welcoming formats and environments. Relevant and accurate information addresses SRH needs, concerns, and risks for the target population with appropriate educational and motivational guidelines, materials, media messages, training, and educational curricula that have been rigorously researched, designed, and tested for the target age groups.

Count: Number of information sources of SRH directed towards young men.

Disaggregate by: Type.

Full Reference Sheet: MEASURE Evaluation PRH FP/RH Indicators Database:
http://www.measureevaluation.org/prh/rh_indicators/specific/me/availability-of-accessible-relevant-and-accurate-information-about-sexual-and-reproductive-health-tailored-to-young-men

3.1 People Living with HIV

There are a range of issues affecting people living with HIV that result in consequences arising from gender inequalities. Insufficient funds, or lack of control over household expenditures, frequently prevent women from accessing ART. Many women, especially those living with HIV, lose their homes, inheritance, possessions, livelihoods and even their children when their partners die. Thus cost-sharing schemes often disadvantage women more than men. Programs promoting economic opportunities for women (e.g., through microfinance and micro-credit, vocational and skills training and other income generation activities), can protect and promote their inheritance rights, and expand efforts to keep girls in school. The indicators in this section cover issues that need to be addressed for PLHIV within the context of gender.

TIER 2

3.1.1 Percentage of ART patients benefiting from microenterprise or microfinance schemes

Definition: Proportion of patients receiving ART who benefit from any microfinance scheme, in a region or country.

Numerator: Number of ART patients benefiting from microenterprise or microfinance schemes.

Denominator: Total number of ART patients surveyed.

Disaggregate by: Sex.

Full Reference Sheet: WHO, Monitoring Equity in Access to AIDS Treatment Programs, Intersectoral Action 8b (p.73):
http://apps.who.int/bookorders/anglais/detart1.jsp?sesslan=1&codlan=1&codcol=15&codcch=801

TIER 3

3.1.2 Proportion of people aged 15+ years living with HIV who received onsite delivery of alcohol reduction counseling and support

Definition: The proportion of people living with HIV who received alcohol reduction counseling and support at their encounter with a health provider.

Numerator: Number of people (15+ years of age) living with HIV who received onsite delivery of alcohol reduction counseling and support.

Denominator: Number of HIV-positive individuals (15+ years of age) receiving a minimum of one clinical service.

Disaggregated by: Sex, setting (facility/clinic, community/home).

What It Measures: This indicator provides information on the total number of unduplicated individuals that received alcohol reduction counseling and support as part of onsite service delivery. In determining reach of service (use of numerator only), the indicator will help demonstrate the extent to which PLHIV receive alcohol reduction counseling and support as part of their package of care. Alcohol reduction counseling and support are components of comprehensive prevention with PLHIV (PwP) services. Alcohol use is associated with both increased risky sexual behavior, reduced adherence to ARVs and GBV, which increase the risk of transmission of and exposure to HIV. The rate of alcohol use in many HIV-positive persons in sub-Saharan Africa is high, yet there have been minimal efforts to assess alcohol use among PLHIV and to incorporate support for reduction (if not elimination) of alcohol use as part of PLHIV care. Alcohol use is associated with both increased risky sexual behavior and reduced adherence to ARVs.

The rate of alcohol use in many HIV-positive persons in sub-Saharan Africa is high, yet there have been minimal efforts to assess alcohol use among PLHIV and to incorporate support for reduction (if not elimination) of alcohol use as part of PLHIV care. The need for such services is substantial and warrants attention. Programs should include routine assessment of alcohol use in each client encounter with health care providers and counselors. Alcohol reduction counseling and support ideally should be integrated into programs to allow access to counseling and support services. All clinic/facility-based interventions should be reinforced through community-based programs. Patients with drug and alcohol problems should be linked to substance abuse treatment programs, where available. All community-based programs providing services should incorporate appropriate linkages and referrals to clinic/facility-based programs.

Measurement Tool: Data can be obtained from existing or modified program monitoring tools, such as facility registers/databases or patient/client records and registers.

How to Measure It: The numerator can be generated by counting the number of PLHIV who received onsite alcohol reduction information, counseling and support for elimination or reduction of alcohol use during the reporting period in either a clinic/facility-based or community/home-based program. Alcohol reduction counseling and support can be delivered through: provider and/or counselor delivered messages to encourage abstinence from alcohol or reduction in its use, individual counseling sessions, or support services including, but not limited to, small group education sessions and support groups. The denominator is the number of HIV-positive individuals (15+ years of age) receiving a minimum of one clinical service. The numerator is divided by the denominator.

Note on Disaggregation: Given that the same individual may be reached with services in both a facility and community based setting, when aggregating this indicator across multiple partners, country teams may choose to allow the double counting, in which case the "Number reached in community" + "Number reached in facility" ≥ "Total number reached."

Considerations: The soundness of the indicators will depend on the quality of facility and program related data.

Source: http://www.pepfar.gov/documents/organization/206097.pdf

3.1.3 Percentage of PLHIV who have heard of the Declaration of Commitment on HIV/AIDS

Definition: Proportion of PLHIV who have heard of the Declaration of Commitment on HIV/AIDS in a region or county.

Numerator: Number of PLHIV surveyed in a region or country who have heard of the Declaration of Commitment on HIV/AIDS at a specific point in time.

Denominator: Total number of PLHIV surveyed.

Disaggregated by: Sex (or self-identified gender), social groups (key populations), age.

What It Measures: Many PLHIV either are not aware of what their rights are and how to protect them or do not believe their rights can be upheld. This indicator measures the level of awareness in the population of PLHIV of this important Declaration that protects their rights.

Measurement Tool: HIV stigma index survey.

How to Measure It: Respondents are asked if they have heard of the declaration. Those who answer yes are placed in the numerator. All respondents are place in the denominator. The numerator is then divided by the denominator.

Considerations: This indicator measures awareness among PLHIV, but not whether they feel empowered enough to exercise their rights. It also does not measure how much real weight the Declaration has in a country, or whether it is being enforced at all.

Source: HIV Stigma Index: http://www.stigmaindex.org/32/analysis/introduction.html; http://www.stigmaindex.org/317/press-releases/piecing-it-together-for-women-and-girls-the-gender-dimensions-of-hivrelated-stigma.html

3.1.4 Percentage of PLHIV who are aware of their rights and how to protect them

Definition: The proportion of PLHIV who are aware of their rights as defined in existing laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for vulnerable populations, and aware of how to protect them.

Numerator: Ask individuals: Do you know that in (name of country) PLHIV have the right to (list of rights in that particular country, such as right to treatment, to employment, etc.)?

- X (e.g., employment)
- Y (e.g., to treatment)

Denominator: Total number of PLHIV surveyed.

Disaggregate by: Sex (or self-identified gender) of respondent, social groups (MARPs), age.

What It Measures: Knowledge of PLHIV's legal rights remains low particularly among women in many countries. UNGASS NCPI collects information from governments on the existence of such laws, regulations and policies, while this indicator would allow assessing its knowledge by the affected population. Program managers and evaluators may be interested in knowing the extent to which PLHIV are aware of their rights under national laws and policies. This outcome indicator measures the extent to which PLHIV are aware of such rights.

Measurement Tool: Population-based survey.

How to Measure It: This indicator is measured by asking a set of questions, as in the above definition, that is tailored for each country to reflect the constitutional and legal rights of that country. If a person responds yes to any of the questions, they are counted in the numerator. This number is then divided by the denominator, which includes everyone surveyed.

Considerations: Measurement of this indicator only reflects people's awareness of a law and does not provide a measure of how well the respondents understand the legal rights of PLHIV, and to what they are entitled. In places where there are few legal rights for women, this indicator may not be useful. However, it may be used to track changes over time as legislation begins to include more rights for PLHIV.

Source: HIV Stigma Index: http://www.stigmaindex.org/32/analysis/introduction.html; http://www.stigmaindex.org/317/press-releases/piecing-it-together-for-women-and-girls-the-gender-dimensions-of-hivrelated-stigma.html

3.2 Key Populations

Gender inequality is a topic of growing importance in programming for Key Populations. In order to be effective, the gender dynamics of sex work and IDU must be integrated into programming in order to respond to epidemics based on these drivers. Male and female IDUs have different drug use and injecting patterns, different access to substitution therapy, and counseling and testing services.[34] For example, female IDUs often inject after their partners because of power relations or because they don't know how to inject and often are injected by their partners. In addition, female IDU face particular human rights violations, including the forceful removal of their children, which may hinder their willingness to seek services. The female partners of male IDUs may not recognize the need to access HIV testing and services or may be hesitant to because of the fear of violence. The indicators in this section were selected to focus on gender issues affecting Key Populations.

TIER 1

3.2.1 Percentage of key populations reached with HIV prevention programs

Definition: The proportion of key populations who are reached by HIV prevention programs in a region or country (the following definition is applied:

Numerator: Number of key populations who have received a basic (minimum) package of HIV prevention service.

Denominator: Estimated number of the targeted key population.

Disaggregate by: Key population (young people, ethnic minorities, sex workers, etc.) and then age, sex (for sex workers for male/female and transgender).

Full Reference Sheet: http://www.indicatorregistry.org/node/760

3.2.2 Sex workers: prevention programs

Definition: Percentage of sex workers reached with HIV prevention programs.

Numerator: Number of sex workers who replied "yes" to both questions:

- Do you know where you can go if you wish to receive an HIV test?
- In the last twelve months, have you been given condoms (e.g., through an outreach service, drop-in centre or sexual health clinic)?

Denominator: Total number of sex workers surveyed.

Disaggregated by: Sex (female, male and transgender), age (<25, 25+ years).

[34] Kozul K et al. Risk behavior of customers in centers for free voluntary HIV counselling and testing in two Croatian cities--Osijek and Zadar. *Coll Antropol*. 2010 Jun;34(2):509–13

Full Reference Sheet: Global AIDS Progress Reporting 2013, Construction of Core Indicators for monitoring the 2011 UN Political Declaration on HIV/AIDS: http://www.unaids.org/en/media/unaids/contentassets/documents/document/2013/GARPR_2013_guidelines_en.pdf; # 1.7 'M&E toolkit. HIV, TB, Malaria and HSS+CSS' 2011, #HIV-P5: http://www.theglobalfund.org/en/me/documents/toolkit/

3.2.3 HIV prevalence in key populations

Definition: Percentage of key population who are living with HIV. The proportion should be calculated for each population group separately.

Numerator: Number of (IDU, or MSM, or TG, or SW) who test positive for HIV

Denominator: Number of people in a key population tested for HIV

Disaggregate by: Key population (SW, IDU, MSM, TG) and sex, age.

Full Reference Sheet: Global AIDS Progress Reporting 2013, Construction of Core Indicators for monitoring the 2011 UN Political Declaration on HIV/AIDS: http://www.unaids.org/en/media/unaids/contentassets/documents/document/2013/GARPR_2013_guidelines_en.pdf; http://www.pepfar.gov/documents/organization/206097.pdf

3.2.4 People who inject drugs: safe injecting practices

Definition: The proportion of people who inject drugs who report using sterile injecting equipment the last time they injected drugs.

Numerator: Number of people who inject drugs who report using sterile injecting equipment the last time they injected drugs.

Denominator: Number of people who inject drugs who report injecting drugs in the last month.

Disaggregated by: Age (<25, 25+ years), sex.

Full Reference Sheet: Global AIDS Progress Reporting 2013, Construction of Core Indicators for monitoring the 2011 UN Political Declaration on HIV/AIDS #2.3 (p. 52): http://www.unaids.org/en/media/unaids/contentassets/documents/document/2013/GARPR_2013_guidelines_en.pdf

3.2.5 Sex workers: condom use

Definition: Percentage of sex workers reporting the use of a condom with their last client

Numerator: Number of sex workers who reported that a condom was used with their last client.

Denominator: Number of sex workers who reported having commercial sex in the last 12 months.

Disaggregate by: Sex (female, male and transgender), age (<25, 25+ years).

Full Reference Sheet: Global AIDS Progress Reporting 2013, Construction of Core Indicators for monitoring the 2011 UN Political Declaration on HIV/AIDS #1.8 (p. 32): http://www.unaids.org/en/media/unaids/contentassets/documents/document/2013/GARPR_2013_guidelines_en.pdf

3.2.6 People who inject drugs: condom use

Definition: The proportion of people who inject drugs who report that they used a condom at last sexual intercourse within the last month.

Numerator: Number of people who inject drugs who reported that a condom was used the last time they had sex.

Denominator: Number of people who inject drugs who report having injected drugs and having had sexual intercourse in the last month.

Disaggregate by: Sex, age (<25, 25+ years).

Full Reference Sheet: Global AIDS Progress Reporting 2013, Construction of Core Indicators for monitoring the 2011 UN Political Declaration on HIV/AIDS #2.2 (p. 50): http://www.unaids.org/en/media/unaids/contentassets/documents/document/2013/GARPR_2013_guidelines_en.pdf

TIER 2

3.2.7 People who inject drugs: prevention programs

Definition: Number of needles and syringes distributed per person who injects drugs per year by needle and syringe programs.

What It Measures: It measures progress in improving coverage of an essential HIV prevention service for people who inject drugs.

Rationale: Injecting drug use is the main route of transmission for approximately 10% of HIV infections globally and 30% of infections outside of sub-Saharan Africa. Preventing HIV transmission through injecting drug use is one of the key challenges to reducing the burden of HIV. Needle and syringe programmes (NSPs) are one of nine interventions in the WHO, UNODC and UNAIDS comprehensive package for the prevention, treatment and care of HIV among people who inject drugs. Needle and syringe programmes greatly affect HIV prevention for people who inject drugs. and there is a wealth of scientific evidence supporting its efficacy in preventing the spread of HIV (see http://www.who.int/hiv/topics/idu/needles/en/index.html).

Numerator: Number of needles and syringes distributed in past 12 months by NSPs.

Denominator: Number of people who inject drugs in the country.

Calculation: Numerator / Denominator

Method of Measurement: Programme data used to count the number of needles and syringes distributed (numerator)
Size estimation of the number of people who inject drugs in the country (denominator)

Measurement Frequency: Every two years

Disaggregation: None

Strengths and Weaknesses: Some difficulties regarding how to count needles and syringes are reported. Some commonly used syringes are 1 or 2ml needle and syringe units while others are syringes to which additional needles need to be fitted. In most cases only data on the number of syringes distributed via NSPs but not pharmacy sales will be available. Estimating the size of IDU populations at country level is not without its challenges. Many different definitions of people who inject drugs exist in the literature and there are ranges of estimates. The reference group to the United Nations on HIV and injecting drug use undertakes reviews of the available literature to produce estimates of the number of people who inject drugs and these can be used in the absence of size estimates. Countries can monit or this indicator against the following coverage levels:

- Low: <100 syringes per IDU per year
- Medium: >100–<200 syringes per IDU per year
- High: >200 syringes per IDU per year

These levels are based upon studies in developed country settings investigating the levels of syringe distribution and impact on HIV transmission. Note that the levels required for the prevention of hepatitis C are likely to be much higher than those presented here.

Further Information: A full description of this indicator can be found in: WHO, UNODC and UNAIDS. Technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users. Geneva, World Health Organization, 2009 (http://www.who.int/hiv/pub/idu/targetsetting/en/index.html). For further information, please consult the following references:

- *Effectiveness of sterile needle and syringe programming in reducing HIV/AIDS among IDUs.* Geneva, World Health Organization, 2004 (http://www.who.int/hiv/pub/idu/e4a-needle/en/index.html).
- UNODC Global Assessment Programme on Drug Abuse. *Estimating prevalence: indirect methods for estimating the size of the drug problem.* Vienna, UNODC, 2003.
- Hickman M et al. Estimating the prevalence of problematic drug use: a review of methods and their application. *Bulletin on Narcotics*, 2002, 54:15–32.
- *Most at risk populations sampling strategies and design tool.* Atlanta, United States Department of Health and Human Services, Centers for Disease Control and Prevention, GAP Surveillance Team, 2009 (http://globalhealthsciences.ucsf.edu/sites/default/files/content/pphg/surveillance/CDC-MARPs/index.htm).
- http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2011/2011_Estimating_Populations_en.pdf (the WHO/UNAIDS working group on global HIV/AIDS and STI surveillance 2010 guidelines on estimating the size of populations most at risk to HIV).

- WHO/UNAIDS Working Group on Global HIV/AIDS and STI Surveillance. *Guidelines on surveillance among populations most at risk for HIV*. Geneva, UNAIDS, 2011 (http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2011/20110518_Surveillance_among_most_at_risk.pdf)

3.2.8 Percentage of key populations with active syphilis

Definition: The proportion of key populations (sex workers, men who have sex with men, transgender individuals, and injecting drug users) who are infected with syphilis. The proportion should be calculated for each population group separately.

Numerator: Number of (IDU, or MSM, or SW) who test positive for syphilis.

Denominator: Number of same group who have been tested for syphilis.

Disaggregate by: Sex, age.

Full reference sheet based on HIV infection in: A Guide on Indicators for Monitoring and Reporting on the Health Sector Response to HIV/AIDS, Feb. 2012. #1.17 STIs: Percentage of sex workers (SWs) with active syphilis; 1.17 STIs: Percentage of men who have sex with men with active syphilis: http://www.who.int/hiv/data/UA2012_indicator_guide_en.pdf

3.2.9 Number of injecting drug users on opioid substitution therapy (OST)

Definition: The number of injecting drug users who are on an opioid substitution therapy.

Count: Number of injecting drug users who are on an OST.

Disaggregate by: Age, sex.

Full Reference Sheet: A Guide on Indicators for Monitoring and Reporting on the Health Sector Response to HIV/AIDS, Feb. 2012, # 2.6:
http://www.who.int/hiv/data/UA2012_indicator_guide_en.pdf

3.3 Other Vulnerable Populations

Other vulnerable populations are groups of individuals who may be vulnerable to HIV compared with others in the population, and who also have lower access to or uptake of relevant services. One example of such a population is orphans and vulnerable children. Orphans and Vulnerable Children (OVCs) has been a population of concern since the early days of the epidemic. Available data indicate that boys are more likely to be economically active than girls, and that girls are more often engaged in household services and care, including providing care for younger siblings when one or both parents are alive. School attendance is of particular concern, because girls who drop out early are at risk for HIV through a variety of pathways. The indicators in this section focus on gender differentials among OVCs with regard to school and economic support.

TIER 1

3.3.1 Orphans school attendance

Definition: Current school attendance among orphans and non-orphans (10–14 years old, primary school age, secondary school age). The indicator is split up in two parts so comparisons can be made between orphans and non orphans:

- Part A: current school attendance rate of orphans aged 10–14 primary school age, secondary school age.
- Part B: current school attendance rate of children aged 10–14 primary school age, secondary school age both of whose parents are alive and who live with at least one parent.

Numerator:

- Part A: Number of children who have lost both parents and who attend school aged 10-14, primary school age, secondary school age.
- Part B: Number of children both of whose parents are alive, who are living with at least one parent and who attend school aged 10–14, primary school age, secondary school age.

Denominator:

- Part A: Number of children who have lost both parents.
- Part B: Number of children both of whose parents are alive who are living with at least one parent.

Disaggregated by: Sex.

Full Reference Sheet: Global AIDS Progress Reporting 2013, Construction of Core Indicators for monitoring the 2011 UN Political Declaration on HIV/AIDS:
http://www.unaids.org/en/media/unaids/contentassets/documents/document/2013/GARPR_2013_guidelines_en.pdf; http://www.pepfar.gov/documents/organization/206097.pdf

3.3.2 External economic support to the poorest households

Definition: Proportion of the poorest households who received external economic support in the last 3 months

What It Measures: It measures progress in providing external economic support to poorest households affected by HIV and AIDS.

Rationale: Economic support (with a focus on social assistance and livelihoods assistance) to poor and HIV-affected households remains a high priority in many comprehensive care and support programmes. This indicator reflects the growing international commitment to HIV-sensitive social protection. It recognizes that the household should be the primary unit of analysis since many of the care and support services are directed to the household level. Tracking coverage of households with orphans and within the poorest quintile remains a developmental priority.

Numerator: Number of the poorest households that received any form of external economic support in the last 3 months External economic support is defined as free economic help (cash grants, assistance for school fees, material support for education, income generation support in cash or kind, food assistance provided at the household level, or material or financial support for shelter) that comes from a source other than friends, family or neighbours unless they are working for a community-based group or organization. This source is most likely to be the national government or a civil society organization.

Denominator: Total number of poorest households. Poorest households are defined as a household in the bottom wealth quintile. Countries should use the exact indicator definition and method of measurement for standardized progress monitoring and reporting at national and global levels. This will allow monitoring of changes over time and comparisons across different countries. However, countries can add or exclude other categories locally (for example, other wealth quintiles) depending on the country needs with respect to national programme planning and implementation.

Calculation: Numerator / Denominator

Method of Measurement: Population-based surveys such as Demographic and Health Survey, AIDS Indicator Survey, Multiple Indicator Cluster Survey or other nationally representative survey.

An assessment of the household's wealth (through an assessment of asset ownership) is completed at the data analysis stage using the wealth quintile to identify the poorest 20% of households. However, since it is not possible to identify the poorest households at the time of data collection, questions on economic support should be asked to all households. Only those who fall in the lowest wealth quintile will be included in the indicator.

As part of a household survey, a household roster should be used to list all members of the household together with their ages, and identify all households with children less than 18 years of age, and with orphans, in the last year before the survey. Questions are then asked for each such household about the types of economic support received in the last 3 months, and the primary source of the help. The household heads or respondents are asked the following questions about the type of external economic support they have received in the last 3 months: Has your household received any of the following forms of external economic support in the last 3 months?:

- Cash transfer (e.g., pensions, disability grant, child grant, to be adapted according to country context)
- b) Assistance for school fees
- c) Material support for education (e.g., uniforms, school books etc)
- d) Income generation support in cash or kind e.g. agricultural inputs
- e) Food assistance provided at the household or external institution (e.g., at school)
- f) Material or financial support for shelter
- g) Other form of economic support (specify)

An assessment of the household's wealth (through an assessment of asset ownership) is completed at the data analysis stage using the wealth quintile at which point it will possible to assess the extent to which the poorest households are receiving external support.

Measurement Frequency: Every 4–5 years

Disaggregation: It is recommended that the indicator is disaggregated by type of external economic support in order to track the different types of economic support provided—particularly to be able to distinguish between access to free social assistance such as cash transfers (often specifically for poor labour-constrained households) and livelihoods support, which is often targeted at poor households which are less labor-constrained. It is also recommended that the indicator is disaggregated by whether or not households have orphans as orphaning remains a major determinant of vulnerability, particularly in relation to access to services. Where possible, data should also be disaggregated by rural versus urban residence. For countries which opt to add data collection on households in other wealth quintiles in addition to those in the bottom quintile, the indicator can also be compared with other wealth quintiles to track whether external economic support is reaching the bottom quintile compared to wealthier quintiles.

Strengths and Weaknesses: This indicator reflects new evidence of the need for a greater focus on wealth dimensions of vulnerability and the fact that that targeting on the basis of extreme poverty in high prevalence contexts ensures good coverage of poor households affected by HIV.[35] Proxy indicators of AIDS affectedness (such as "chronic illness") have often been poorly associated with HIV, have weak associations with adverse developmental outcomes, and have proven difficult to define in household questionnaires.

This indicator demonstrates changing levels of economic support for the poorest households. In high prevalence contexts, in particular, the majority are likely to be HIV affected. The indicator also demonstrates changes in the composition of external support (e.g. cash, food, livelihoods) received by poor households. The indicator does not measure directly economic support to HIV infected and affected households, which is difficult to establish during a survey, but implicitly suggests that households living in the bottom wealth quintile in high prevalence contexts are more likely to be negatively impacted by HIV and AIDS and in need of economic assistance. In order to keep measurement as simple as possible, the indicator does not attempt to identify the different sources of support to households but this should be partly captured in National AIDS Spending Assessments (NASA).

[35] Evidence from social assistance programmes in Malawi and Zambia has shown the effectiveness of using vulnerability criteria without specific reference to AIDS to target children and families affected by AIDS. These programmes target the ultra poor and labour constrained and in using these criteria researchers found that 80% of all households directly affected by HIV and AIDS that are ultra poor and labour constrained were reached.

The collection of data through population-based surveys, particularly DHS and MICS, means that the indicator does not capture the status of people living outside of households such as street children, children in institutions and internally displaced populations. Separate surveys are needed to track coverage for such vulnerable populations.

Further Information: For further information, please consult the following website: http://www.unicef.org/aids/index_documents.html

3.3.3 Proportion of children under age 15 who are working

Definition: Proportion of children under age 15 who are working refers to children who are employed in an economic activity for pay, profit or family gain. Economic activity covers the production of goods and services for pay or profit or for use by own household. Employed means being engaged in an economic activity during a specified reference period or being temporarily absent from such an activity.

Numerator: Number of employed children under the age of 15.

Denominator: Total number of children under the age of 15, covered by the survey.

Disaggregate by: Age, sex.

Full Reference Sheet:
http://mdgs.un.org/unsd/mdg/Resources/Attach/Indicators/HandbookEnglish.pdf

4.1 Sexual Behavior

Globally, the vast majority of HIV infections that occur are transmitted through sexual contact. Gender dynamics mediate the conditions under which all sexual activity occurs and the degree to which women and men practice safer sex. Most heterosexual relationships take place within the context of gender inequality, and gender power dynamics affect same sex relationships as well. This is true whether the partnerships taking place in general populations or within populations such as among sex workers or injecting drug users. In addition, sex among young people is likely to be more risky, especially for girls since they often initiate sex with an older, and potentially HIV-positive, partner. The indicators in this section focus on factors affecting risky sex within the context of gender.

TIER 1

4.1.1 Sex before the age of 15

Definition: Proportion of young women and men aged 15–24 who have had sexual intercourse before the age of 15.

Numerator: Number of respondents (aged 15–24 years) who report the age at which they first had sexual intercourse as under 15 years.

Denominator: Number of all respondents aged 15–24 years.

Disaggregate by: Age (15–19, 20–24), sex.

Full Reference Sheet: Global AIDS Progress Reporting 2013, Guidelines Construction of Core Indicators for monitoring the 2011 Political Declaration on HIV/AIDS: http://www.unaids.org/en/media/unaids/contentassets/documents/document/2013/GARPR_2013_guidelines_en.pdf; http://www.pepfar.gov/documents/organization/206097.pdf

4.1.2 Condom use at last sex among people with multiple partnerships

Definition: Percentage of adults aged 15–49 who have had more than one sexual partner in the past 12 months and who report the use of a condom during their last intercourse.

Numerator: Number of respondents (aged 15–49) who reported having had more than one sexual partner in the last 12 months who also reported that a condom was used the last time they had sex.

Denominator: Number of respondents (15–49) who reported having had more than one sexual partner in the last 12 months.

Disaggregate by: Age (15–19, 20–24, 25–49 years), sex.

Full Reference Sheet: Global AIDS Progress Reporting 2013, Guidelines Construction of Core Indicators for monitoring the 2011 Political Declaration on HIV/AIDS:

http://www.unaids.org/en/media/unaids/contentassets/documents/document/2013/GARPR_2013_guidelines_en.pdf; http://www.pepfar.gov/documents/organization/206097.pdf

4.1.3 Cross-generational sex among young women

Definition: Proportion of young women 15–24 who have had sex in the preceding 12 months with a partner who is 10 or more years older than themselves.

Numerator: The number of female respondents 15–24 who have had sex in the preceding 12 months with a partner who is 10 or more years older than themselves.

Denominator: Female respondents 15–24 who have had sex in the last 12 months.

Disaggregate by: Age (15–19, 20–24), sex.

Full Reference Sheet: MEASURE DHS online tools:
http://hivdata.measuredhs.com/ind_detl.cfm?ind_id=122&prog_area_id=9

TIER 3

4.1.4 Condom use at last premarital sex

Definition: Percentage of young never married people (aged 15–24) who used a condom at last sex.

Numerator: The number of never married respondents aged 15–24 who report using a condom the last time they had sex in the last 12 months.

Denominator: Total number of never married respondents aged 15–24 who report having had sex in the last 12 months.

Disaggregate by: Age (15–19, 20–24), sex.

Full Reference Sheet: http://hivdata.measuredhs.com/ind_detl.cfm?ind_id=58&prog_area_id=9; http://www.pepfar.gov/documents/organization/206097.pdf

4.2 Knowledge About HIV and AIDS

Knowledge about HIV and AIDS is essential, even though not sufficient in of itself, for adoption of behaviors that reduce the risk of HIV transmission. Many studies have shown that men are more likely to be aware of and have more knowledge about HIV and AIDS, though knowledge about HIV amongst both young women and men remains low.[36] The indicators in this section are focused on the knowledge differentials among young people.

TIER 1

4.2.1 Young people: knowledge about HIV prevention

Definition: Percentage of young women and men aged 15–24 who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission.

Numerator: Number of respondents aged 15–24 years who gave the correct answer to all five questions. Ask the following set of prompted questions:

1. Can the risk of HIV transmission be reduced by having sex with only one uninfected partner who has no other partners?
2. Can a person reduce the risk of getting HIV by using a condom every time they have sex?
3. Can a healthy-looking person have HIV?
4. Can a person get HIV from mosquito bites?
5. Can a person get HIV by sharing food with someone who is infected?

Denominator: Number of all respondents aged 15–24.

Disaggregate by: Age (15–19, 20–24), sex.

Full Reference Sheet: Global AIDS Progress Reporting 2013, Guidelines Construction of Core Indicators for monitoring the 2011 Political Declaration on HIV/AIDS #1.1 (p. 22): http://www.unaids.org/en/media/unaids/contentassets/documents/document/2013/GARPR_2013_guidelines_en.pdf

[36] Hoang D. et al. Knowledge and Perceptions of HIV-Infected Patients Regarding HIV Transmission and Treatment in Ho Chi Minh City, Vietnam. *Asia Pac J Public Health*. 2011 Dec 23; Hurtado JJ et al., Knowledge of HIV transmission and condom use among HIV-positive heterosexual men and women in Guatemala. *J Int AIDS Soc*. 2011 Dec 19;14:58.

4.2.2 Knowledge of a formal source of condoms among young people

Definition: Percentage of young people age 15–24 who know of at least one formal source of condoms.

Numerator: All young people age 15–24 who can name at least one formal source of condoms
Denominator: All respondents aged 15–24.

Disaggregate by: Age (15–19, 20–24), sex.

Full Reference Sheet: WHO. National AIDS Programs. A guide to indicators for monitoring and evaluating national HIV/AIDS prevention programs for young people, 2004:
http://hivdata.measuredhs.com/ind_detl.cfm?ind_id=119&prog_area_id=2

TIER 3

4.2.3 School-based life skills information for young people

Definition: The number or percentage (if denominator is available) of young people aged 10–24 years reached by life skills–based HIV education in schools.

Numerator: Number of young people reached through any school-based effort, including peer education, class room, small group, and/or one-on-one information, education and communication or behavior change communication to promote change in behavior in a school setting.

Denominator: Number of young people attending targeted schools.

Disaggregate by: Age (, 10–14, 15–19, 20–24), sex.

Full Reference Sheet: Indicator Registry: http://www.indicatorregistry.org/node/361

5.1 Disease Prevalence

At older ages, changes in HIV prevalence are slow to reflect changes in the rate of new infections (HIV incidence) because of the long average duration of infection. Declines in HIV prevalence can reflect saturation of infection among those individuals who are most vulnerable and rising mortality rather than changes in incidence. At young ages, trends in HIV prevalence are a better indication of recent trends in HIV incidence and risk behavior. Thus, reductions in HIV incidence associated with behavior change can be reflected in the prevalence among 15–24 year olds (or even earlier in 15–19 year olds if this age breakdown is available). Gender differentials will emerge in this early age group and are important to monitor. The indicators in this section focus on young people.

TIER 1

5.1.1 HIV prevalence in young people

Definition: Percentage of young people aged 15–24 who are living with HIV.

Numerator: Number of antenatal clinic attendees (aged 15–24) tested whose HIV test results are positive.

Denominator: Number of antenatal clinic attendees (aged 15–24) tested for their HIV infection status.

Disaggregate by: None.

Full Reference Sheet: Global AIDS Progress Reporting 2013, Guidelines Construction of Core Indicators for monitoring the 2011 Political Declaration on HIV/AIDS #1.6 (p. 28): http://www.unaids.org/en/media/unaids/contentassets/documents/document/2013/GARPR_2013_guidelines_en.pdf

TIER 2

5.1.2 Young people who have a sexually transmitted infection

Definition: The proportion of young people with STIs that were detected during diagnostic testing. The type or types of STI taken into account should depend on what is locally important. If more than one type of STI is considered the results should be given for each separately, as well as aggregated total.

Numerator: The number of diagnostic tests carried out for persons aged 15–24 years confirming the existence of an STI.

Denominator: The total number of persons aged 15–24 years who had diagnostic tests for STIs.

Disaggregate by: Age, sex.

Full Reference Sheet: WHO. National AIDS Programs. A guide to indicators for monitoring and evaluating national HIV/AIDS prevention programs for young people, 2004:
http://www.indicatorregistry.org/node/309

5.2 Reproductive Health

Sexual and reproductive health services and conditions are directly related to HIV. The importance of linking reproductive health (RH) and HIV/AIDS policies, programs, and services has been acknowledged by major international agencies, as these linkages are considered essential for meeting international development goals and targets, including the MDGs.[37] Looking at RH in the context of HIV is important in order to increase access to contraception among clients of HIV services who do not want to become pregnant, or to ensure a safe and healthy pregnancy and birth for those who wish to have a child. The contraceptive prevalence rate is an indicator of health, population, development and women's empowerment. It also serves as a proxy measure of access to reproductive health services that are essential for meeting many of the MDGs, especially those related to child mortality, maternal health, HIV/AIDS, and gender equality. Among women and men with HIV who are sexually active and do not wish a pregnancy, contraception has the added benefit of reducing HIV-positive births and, by extension, the number of children needing HIV treatment, care, and support. In addition, condoms can prevent reinfection and reduce unintended pregnancies. Prevention of unintended pregnancies in HIV-positive women is one of the four cornerstones of a comprehensive approach to the prevention of vertical transmission of HIV, also known as prevention of mother to child transmission (PMTCT) of HIV.

One of the major causes of cervical cancer is the sexually transmitted human papillomavirus (HPV). Any woman who is sexually active is at risk for developing cervical cancer. The gender dynamics in reproductive health outcomes and uptake of services has been documented extensively. The indicators in this section pertain to fertility, contraception and cervical cancer.

TIER 1

5.2.1 Adolescent fertility rates

Definition: The fertility rate of 15–19 year olds.

Calculate: Number of births in a specific time period per 1,000 women aged 15–19 during the same time period.

Source: United Nations Population Division; World Bank; The World Bank's Reproductive Health Action Plan: 2010–2015; 'Women, girls, gender equality and HIV' A scorecard for the Eastern & Southern African region, Draft as of June 2011, UNAIDS:
http://data.worldbank.org/indicator/SP.ADO.TFRT/countries

[37] WHO "Strategic considerations for strengthening the linkages between Family planning and HIV policies, programs and services"
http://www.who.int/reproductivehealth/publications/linkages/fp_hiv_strategic_considerations.pdf

5.2.2 Contraceptive prevalence in women

Definition: The proportion of women of reproductive age who are using (or whose partner is using) a contraceptive method at a given point in time.

Numerator: Number of women aged 15–49 who report that they are using some type of modern contraceptive at a certain point in time.

Denominator: Total number of women aged 15–49 surveyed.

Disaggregate by: Age.

Full Reference Sheet: MDG 5.3; http://www.who.int/gho/publications/world_health_statistics/WHS2013_IndicatorCompendium.pdf
'Women, girls, gender equality and HIV' A scorecard for the Eastern & Southern African region, Draft as of June 2011, UNAIDS; The World Bank's Reproductive Health Action Plan: 2010–2015.

TIER 2

5.2.3 Cervical cancer screening

Definition: Prevalence of women between ages 30–49 screened for cervical cancer at least once.

Numerator: Percent of women 30–49 who have been screened at least once for cervical cancer.

Denominator: Total number of women 30–49 years surveyed.

Disaggregate by: Wealth index, region/area.

Full Reference Sheet: 'Health system response indicator # 1 "A comprehensive global monitoring framework, including indicators and a set of voluntary global targets, for the prevention and control of noncommunicable diseases": http://www.who.int/nmh/events/2012/discussion_paper3.pdf; http://www.measureevaluation.org/prh/rh_indicators/specific/cervical-cancer/percent-of-women-30-49-who-have-been-screened-at

TIER 3

5.2.4 Contraceptive prevalence among HIV-positive women

Definition: The proportion of HIV-infected women of reproductive age who are using (or whose partner is using) a contraceptive method at a given point in time.

Numerator: Number of HIV-infected women aged 15-49 who report that they are using some type of modern contraceptive at a certain point in time

Denominator: Total number of HIV-infected women aged 15–49 surveyed.

Disaggregate by: Age.

Source: 'M&E toolkit. HIV, TB, Malaria and HSS+CSS' 2011, #HIV-P11
http://www.theglobalfund.org/en/me/documents/toolkit/
Contraceptive prevalence. Indicator and measurement registry. WHO: Geneva. Available at:
http://apps.who.int/gho/indicatorregistry/App_Main/view_indicator.aspx?iid=5

This chapter outlines areas that are important to consider in the monitoring and evaluation of HIV and AIDS response in the context of gender equality. Since there are no existing indicators for these areas, the development and field-testing of indicators will be needed and will require the identification of specific domains and metrics in order to formulate useable measures to ensure a comprehensive and quality approach to gender equality and HIV.

Enabling Environment

Care Economy

Most of the care for HIV globally is done by women, reinforcing gender norms.[38] It is also true that some men have supported children living with HIV as well as partners, mothers, sisters and wives. How best to deliver long term care for those living with HIV and with access to treatment is still subject to debate. It is clear that women who provide care also need support. In addition, women's unpaid work needs to be counted rather than just deemed "cost-efficient." Women who provide care giving lose income, employment, experience food insecurity, and bear other burdens. Whether a country provides social protection mechanisms, cash transfers, stipends, etc. will be critical in assessing how women are supported to provide care. Older women, such as grandmothers who care for orphans and vulnerable children are in particular need of such aid. Assistance with income generation remains the most pressing need, but social support and increased information on HIV is also needed. For caregivers who are living with HIV, much more support is needed when they decide to disclose their HIV positive status. Stipends can also ease the burden of care giving, but it is critical to ensure that paying jobs go to women as well as men. Access to palliative care is also needed. Once on treatment, no single agreed on package constitutes care giving. Outside assistance for home or community based care must be provided.

Property Ownership

Laws which deny women the right to own property reinforce the subordinate status of women[39] and in countries where customary or national law does not allow women to own property, women may find it difficult to negotiate safe sex.[40] In some countries, women living with HIV have little access to the formal legal system. Women also need to know their legal rights pertaining to property ownership and equitable access to the justice system, but in some coun-

---

[38] Nyangara, F., T. Thurman, P. Hutchinson, and W. Obiero. 2009b. *Effects of Programs Supporting Orphans and Vulnerable Children: Key Findings, Emerging Issues, and Future Directions from Evaluations of Four Projects in Kenya and Tanzania*. Chapel Hill, NC: MEASURE Evaluation and Surkan, P., J. Mukherjee, D. Williams, E. Eustache, E. Louis, T. Jean-Paul, W. Lambert, F. Scanlan, C. Oswald and M. Fawzi. 2010. Perceived Discrimination and Stigma toward Children Affected by HIV/AIDS and their HIV-positive Caregivers in Central Haiti. *AIDS Care* 22 (7): 803–815 in Gay, J., Croce-Galis, M., Hardee, K. 2012. *What Works for Women and Girls: Evidence for HIV/AIDS Interventions.* 2nd edition. Washington DC: Futures Group, Health Policy Project.

[39] Ezer, T., A. Glasford, E. Hollander, L. Poole, G. Rabenn and A. Tindall. 2007. International Women's Human Rights Clinic Report: Divorce Reform: Rights Protections in the New Swaziland. *Georgetown Journal of Gender and the Law* 8 (883): 889 in Gay, J., Croce-Galis, M., Hardee, K. 2012. *What Works for Women and Girls: Evidence for HIV/AIDS Interventions.* 2nd edition. Washington DC: Futures Group, Health Policy Project.

[40] Strickland, R. 2004. To Have and To Hold: Women's Property and Inheritance Rights in the Context of HIV/AIDS in Sub-Saharan Africa. ICRW Working Paper. Washington, DC: International Center for Research on Women; Kilonzo, N., N. Ndung'u, N. Nthamburi, C. Ajema, M. Taegtmeyer, S. Theobald and R. Tolhurst. 2009b. Sexual Violence Legislation in Sub-Saharan Africa: The Need for Strengthened Medico-Legal Linkages. *Reproductive Health Matters* 17 (34): 10–19 in Gay, J., Croce-Galis, M., Hardee, K. 2012. *What Works for Women and Girls: Evidence for HIV/AIDS Interventions*. 2nd edition. Washington DC: Futures Group, Health Policy Project.

tries, women living with HIV have little access to the formal legal system.[41] Implementation of laws concerning property rights—including protection of legal rights for people living with HIV—is critical. When women are denied rights to property, either through death, divorce or abandonment, women can be plunged into poverty or homelessness. In polygamous marriages, only one wife may be entitled to property. A widow may be chased off property, denied access to her children, and may be forced into survival sex.[42]

Migration

Migration may increase risk for HIV acquisition, as the migrant may establish new sexual partnerships and then return home to the stay-at-home partners.[43] Migrant women often have poor access to information about even the basics of HIV transmission.[44] Women and men living with HIV experience restrictions on entry to certain countries as well as experiencing restrictions on residence. Migrants are often blamed for HIV transmission, compounding the stigma that women migrants living with HIV experience.

Education and HIV

UNESCO indicators have been pretested (Refer to UNESCO, 2009, HIV and Education indicators: http://unesdoc.unesco.org/images/0018/001850/185003E.pdf).

Gender Norms, Women's Empowerment and Rights

Empowerment of Women

Greater involvement of women, especially women living with HIV and those with gender expertise, is needed specifically in decision-making in national processes. Women living with HIV may be marginalized even within networks of people living with HIV, denied the lion's share of funding, training and impact. With women globally bearing the largest burden of HIV, and whether women living with HIV can impact policies will be critical to impacting the pandemic.

Women's Rights

Legislative and policy frameworks are needed that prohibit stripping women of their rights by spouses, families or other forces, with a special focus on widows, and legislation to support women who are survivors of violence.

---

[41] Kalla, K. and J. Cohen. 2007. *Ensuring Justice for Vulnerable Communities in Kenya: A Review of AIDS-related Legal Services.* New York, NY: Open Society Institute. http://www.soros.org in Gay, J., Croce-Galis, M., Hardee, K. 2012. *What Works for Women and Girls: Evidence for HIV/AIDS Interventions*. 2nd edition. Washington DC: Futures Group, Health Policy Project.

[42] Jürgens, R. and J. Cohen. 2007. *Human Rights and HIV/AIDS: Now More than Ever—10 Reasons Why Human Rights Should Occupy the Center of the Global AIDS Struggle*. New York, NY: Open Society Institute in Gay, J., Croce-Galis, M., Hardee. 2012. *What Works for Women and Girls: Evidence for HIV/AIDS Interventions.* 2nd edition. Washington DC: Futures Group, Health Policy Project.

[43] Abdool Karim, Q. and H. Humphries. 2010. *Reducing HIV Infection in Young Women in Southern Africa: The Key to Altering Epidemic Trajectories in a Generalized, Hyperendemic Setting.* Washington, DC: USAID, AIDSTAR-One in Gay, J., Croce-Galis, M., Hardee, K. 2012. *What Works for Women and Girls: Evidence for HIV/AIDS Interventions*. 2nd edition. Washington DC: Futures Group, Health Policy Project.

[44] UNDP. 2008. *HIV Vulnerability Faced by Women Migrants: From Asia to the Arab States. From Silence, Stigma and Shame to Safe Mobility with Dignity, Equity and Justice.* Colombo, Sri Lanka: UNDP. http://www.undprcc.lk in Gay, J., Croce-Galis, M., Hardee, K. 2012. *What Works for Women and Girls: Evidence for HIV/AIDS Interventions.* 2nd edition. Washington DC: Futures Group, Health Policy Project.

Male Gender Norms

Self-disclosure (specifically male disclosure status) of sensitive information is generally thought to have beneficial effects on an individual's health, lower stress, and lead to better psychological health. In the case of HIV/AIDS, individuals who disclose their status are in a better position in terms of reproductive choices as well as psychosocial support. Numerous factors have been associated with status disclosure.[45] Gender is also found to be one of the associated factors of HIV status disclosure.[46] In a study conducted in South Africa males were found to disclose their result more often to their partner than females.[47] In contrast, another South African study [48]revealed that male sex is associated with non-disclosure of HIV status.

Violence and Condom Use

Women who experience violence have been shown to be more likely to test HIV positive[49] and violence can increase women's risk of acquiring HIV. Violence against women is also associated with gender inequality.[50] Studies report a greater ability to negotiate condom use between sex workers and clients as compared to regular or married partners.[51] Studies have found that both sex workers and women in all partnerships fear negotiating condom use as suggesting condom use may result in violence.[52]

---

[45] Deribe et al., 2008. Disclosure experience and associated factors among HIV positive men and women clinical service users in southwest Ethiopia, *BMC Public Health* 2008, 8:81 doi:10.1186/1471-2458-8-81 http://www.biomedcentral.com/1471-2458/8/81/

[46] WHO. 2004. *Gender Dimensions of HIV Status Disclosure to Sexual Partners: Rates, Barriers and Outcomes—A Review Paper*. Geneva. http://www.who.int/gender/documents/en/genderdimensions.pdf

[47] Skogmar S, Shakely D, lans M, danell J, Andersson R, Tshandu N, Ode'n A, Roberts S, Francois Venter WD: *Effect of antiretroviral treatment and counseling on disclosure of HIV-serostatus in Johannesburg, South Africa.*

[48] Olley BO, Seedat S, Stein DJ. Self-Disclosure of HIV Serostatus in Recently Diagnosed Patients with HIV in South Africa. *African Journal of Reproductive Health* 2004, 8:71–76.

[49] Dude, A. 2009. Spousal Intimate Partner Violence Is Associated with HIV and other STIs among Married Rwandan Women. A*IDS & Behavior* 15 (1): 142–152 in Gay, J., Croce-Galis, M., Hardee, K. 2012. *What Works for Women and Girls: Evidence for HIV/AIDS Interventions.* 2nd edition. Washington DC: Futures Group, Health Policy Project. http://www.whatworksforwomen.org.

[50] Pulerwitz, J., S. Martin, M. Mehta, T. Castillo, A. Kidanu, F. Verani and S. Tewolde. 2010a. *Promoting Gender Equity for HIV and Violence Prevention: Results from the PEPFAR Male Norms Initiative Evaluation in Ethiopia.* Washington, DC: PATH in Gay, J., Croce-Galis, M., Hardee, K. 2012. *What Works for Women and Girls: Evidence for HIV/AIDS Interventions.* 2nd edition. Washington DC: Futures Group, Health Policy Project. http://www.whatworksforwomen.org.

[51] Raingruber, B., E. Uwazie and S. Bowie. 2010. Women's Voices: Attitudes and Behaviors of Female and Ghanaian Sex Workers regarding HIV Prevention and AIDS-related Stigma. *Issues in Mental Health Nursing* 31 (8): 514–519 in Gay, J., Croce-Galis, M., Hardee, K. 2012. *What Works for Women and Girls: Evidence for HIV/AIDS Interventions.* 2nd edition. Washington DC: Futures Group, Health Policy Project. http://www.whatworksforwomen.org.

[52] Maman, S., J. Campbell, M. Sweat and A. Gielen. 2000. The Intersections of HIV and Violence: Directions for Future Research and Interventions. *Social Science and Medicine* 50 (4): 459–478; Zablotska, I., R. Gray, D. Serwadda, F. Nalugoda, G. Kigozi, N. Weankambo, T. Lutalo, F. Mangen and M. Wawer. 2006. Alcohol Use Before Sex and HIV Acquisition: A Longitudinal Study in Rakai, Uganda. *AIDS* 20: 1191–1196; Miner, S., L. Ferrer, R. Cianelli, M. Bernales and V. Cabieses. 2011. Intimate Partner Violence and HIV Risk Behaviors among Socially Disadvantaged Chilean Women. *Violence against Women* 17 (4): 517–531; Townsend, L., R. Jewkes, C. Mathews, L. Johnston, A. Fisher, Y. Zembe and M. Chopra. 2011. HIV Risk Behaviours and their Relationship to Intimate Partner Violence (IPV) among Men Who Have Multiple Female Sexual Partners in Cape Town, South Africa. *AIDS & Behavior* 15: 132–141; Andersson, N., A. Cockcroft and B. Shea. 2008. Gender-based Violence and HIV: Relevance for HIV Prevention in Hyperendemic Countries of Southern Africa. *AIDS* 22 (Supplement 4): S73–S86 in Gay, J., Croce-Galis, M., Hardee, K. 2012. *What Works for Women and Girls: Evidence for HIV/AIDS Interventions.* 2nd edition. Washington DC: Futures Group, Health Policy Project. http://www.whatworksforwomen.org.

Violence and Testing & Treatment

Violence is both a risk factor for HIV and also a consequence of being identified as living with HIV.[53] A review for the US Institute of Medicine found that violence or fear of violence from an intimate partner is an impediment to or a consequence of HIV testing.[54] Violence can also be a barrier to treatment adherence. Studies have found that women who serodisclose may be subject to violence.[55] In many countries, more effective links between the health and justice systems is needed, particularly for women living with HIV. The access of women living with HIV to micro-finance, income and employment may allow women to leave abusive or violent relationships.

Reproductive Health

Capacity-Building and Negotiation Skills for Commodities

It is important to measure the success of promotion and distribution of HIV prevention and mitigation, commodities and services that empower women and girls to make choices on their own behalf, such as female condoms, water-based lubricants and other proven tools combined with developing capacities and skills in negotiating the use of such tools.

Access and Use of Female Condoms

Mathematical modeling indicates effectiveness of the female condom (a randomized control trial would be unethical) and is, to date, the only female-controlled method to prevent acquisition of HIV. Studies have found that the use of female condoms increases the number of protected sex acts, but access and availability of female condoms have been limited. Greater access, with effective training on use, is critical for women to have greater control in protecting themselves. Female condoms may be preferred by some men to use of male condoms.[56]

Access to HIV Prevention, Care, and Treatment Outside the Context of Childbirth (among WLHIV)

Globally, most women are tested for HIV in the context of antenatal care but sexual and reproductive health services may also serve as important locations for providing HIV services and reaching potential ART users[57] and these and other prevention, care and treatment op-

---

[53] World Health Organization (WHO) and UNAIDS. 2010f. *Addressing Violence against Women and HIV/AIDS: What Works?* Geneva, Switzerland: WHO and UNAIDS in Gay, J., Croce-Galis, M., Hardee, K. 2012. *What Works for Women and Girls: Evidence for HIV/AIDS Interventions.* 2nd edition. Washington DC: Futures Group, Health Policy Project.

[54] Campbell, J., Baty, M., R. Ghandour, J. Stockman, L. Francisco and J. Wagman. 2008b. The Intersection of Violence against Women and HIV/AIDS. Background paper for IOM. 2008. V*iolence Prevention in Low-and Middle-Income Countries: Finding a Place on the Global Agenda.* Washington, DC: National Academies Press. http://www.nap.edu in Gay, J., Croce-Galis, M., Hardee, K. 2012. *What Works for Women and Girls: Evidence for HIV/AIDS Interventions.* 2nd edition. Washington DC: Futures Group, Health Policy Project.

[55] Hale, F. and M. Vazquez. 2011. *Violence against Women Living with HIV/AIDS: A Background Paper*. Washington, DC: Development Connections, ICW Global, and UN Women. http://www.dcvn.aulaweb.org; http://www.icwglobal.org in Gay, J., Croce-Galis, M., Hardee, K. 2012. *What Works for Women and Girls: Evidence for HIV/AIDS Interventions*. 2nd edition. Washington DC: Futures Group, Health Policy Project.

[56] Gay, J., Croce-Galis, M., Hardee, K. 2012. *What Works for Women and Girls: Evidence for HIV/AIDS Interventions*. 2nd edition. Washington DC: Futures Group, Health Policy Project.

[57] World Health Organization (WHO). 2003a. *Entry Points to Antiretroviral Treatment*. Geneva, Switzerland: WHO and Interact Worldwide, International HIV/AIDS Alliance, Global AIDS Alliance, Population Action International, IPPF, and Friends of the Global Fund Africa. 2008. Guidelines for Integrating Sexual and Reproductive Health into the HIV/AIDS Component Country Coordinated Proposals to be Submitted to the Global Fund to Fight AIDS, Tuberculosis and Malaria: Round 8 and Beyond. in Gay, J., Croce-Galis, M., Hardee, K. 2012. *What Works for Women and Girls: Evidence for HIV/AIDS Interventions*. 2nd edition. Washington DC: Futures Group, Health Policy Project.

tions outside the context of childbirth must be explored. While testing during antenatal care can increase uptake of antiretroviral therapy if warranted or within national guidelines, pregnancy can be a very stressful time for a woman to learn that she is HIV-positive. If an infant tests HIV-positive, confidentiality of the mother's HIV-positive serostatus would be difficult to maintain. Women who access ARVs during pregnancy and who are eligible for ARVs according to national treatment guidelines may be lost to follow up when transitioning between maternal health services and HIV treatment services. HIV-positive adolescents do not have services tailored to their needs as most services are either pediatric services or for adults.[58]

Behavior

Men Who Have Sex with Men (MSM) Who Also Have Sex with Women

Research demonstrates that men reporting bisexual and homosexual behavior engage in more high-risk behaviors than males reporting heterosexual behavior. Findings demonstrate that homosexual and heterosexual networks are not mutually exclusive, and that they are linked via men who engage in bisexual behavior. HIV prevention programming among homosexual men will have an effect on the epidemic among the heterosexual population.

Treatment Literacy

Understanding that adherence to antiretroviral therapy can improve survival is critical to successful treatment. Understanding that HIV cannot be cured and can still be transmitted once one is on therapy is also a critical concept. How communities learn about antiretroviral therapy and the accuracy of what they learn is important to the AIDS pandemic. With women less likely to be literate than men in some societies, women face unequal knowledge in order to be treatment literate.

Self-Stigmatization

Jain and Nyblade (2012)[59] describe a number of types of stigma, including anticipated stigma, experienced stigma, secondary stigma, internalized stigma, compound/layered stigma, and observed stigma. Research indicates stigma affects prevention behaviors, test-seeking, care-seeking, quality of care provided to HIV-positive clients, and perceptions and treatment of people living with HIV and AIDS by communities and families.[60] Women face double stigma, both associated with HIV and from an inferior position in society relative to men.[61]

---

[58] Birungi, H., F. Obare, A. van der Kwaak and J. Namwebya. 2011a. Maternal Health Care Utilization among HIV-Positive Female Adolescents in Kenya. *International Perspectives on Sexual and Reproductive Health* 37 (3): 143–149 in Gay, J., Croce-Galis, M., Hardee, K. 2012. *What Works for Women and Girls: Evidence for HIV/AIDS Interventions.* 2nd edition. Washington DC: Futures Group, Health Policy Project.

[59] Jain, A. and L. Nyblade. 2012. *Scaling Up Policies, Interventions, and Measurement for Stigma-free HIV Prevention, Care, and Treatment Services.* Working Paper No. 3. Washington, DC: Futures Group, Health Policy Project in Gay, J., Croce-Galis, M., Hardee, K. 2012. *What Works for Women and Girls: Evidence for HIV/AIDS Interventions*. 2nd edition. Washington DC: Futures Group, Health Policy Project. http://www.whatworksforwomen.org.

[60] Brown, L., K. MacIntyre and L. Trujillo. 2003. Interventions to Reduce HIV/AIDS Stigma: What Have We Learned? *AIDS Education and Prevention* 15 (1): 49–69 in Gay, J., Croce-Galis, M., Hardee, K. 2012. *What Works for Women and Girls: Evidence for HIV/AIDS Interventions.* 2nd edition. Washington DC: Futures Group, Health Policy Project. http://www.whatworksforwomen.org.

[61] For more resources on stigma, see http://www.stigmaactionnetwork.org.

Key Populations and Populations At Greater Risk of Infection

Transmission of HIV between intimate partners in key populations and those populations that are at higher risk, such as sex workers, women who use drugs and those who partner with men who use drugs, female prisoners, men who have sex with men (MSM), and transgender people, among others is a critical issue. It will be important to develop standardized indicators reflecting human rights and legal frameworks for key populations and those at higher risk of HIV infection.

- While sex workers may use condoms with clients, many studies have shown that they are less likely to use condoms with their boyfriends or husbands. Yet sex workers may acquire HIV from unprotected sex with boyfriends and/or husbands. Since sex workers have universally some of the highest rates of HIV acquisition yet the lowest rates of access to services,[62] understanding how and when sex workers acquire HIV is critical to protecting their own health as well as addressing the HIV pandemic overall. Access to resources will also impact whether sex workers are empowered to use condoms with intimate partners. Women who use drugs and women who are intimate partners of men who use drugs are at higher risk of HIV acquisition than men, with less access to services that meet their needs.
- Women who use drugs can rarely negotiate condom use with intimate partners and suffer high rates of violence,[63] as do sex workers.[64]
- Prison populations and gender dynamics in prisons: In prisons across the world, the HIV/AIDS epidemic presents a major challenge. As of 2008, more than 9.8 million

---

[62] Baral, S., C. Beyrer, K. Muessig, T. Poteat, A. Wirtz, M. Decker, S. Sherman and D. Kerrigan. 2012a. Burden of HIV among Female Sex Workers in Low-income and Middle-income Countries: A Systematic Review and Meta-Analysis. *Lancet Infectious Diseases* 12 (7): 538–549 in Gay, J., Croce-Galis, M., Hardee, K. 2012. *What Works for Women and Girls: Evidence for HIV/AIDS Interventions.* 2nd edition. Washington DC: Futures Group, Health Policy Project. http://www.whatworksforwomen.org.

[63] Abdala, N., T. Kershaw, T. Krasnoselskikh and A. Kozlov. 2011. Contraception Use and Unplanned Pregnancies among Injection Drug-using Women in St. Petersburg, Russia. *Journal of Family Planning & Reproductive Health Care* 37: 158–164; Shapoval, A. and S. Pinkham. 2011. *Technical Report: Women and Harm Reduction in Central Asia. Quality Health Care Project in the Central Asian Republics*. Washington, DC: USAID, Abt Associates; Parry, C., T. Carney, P. Peterson, S. Dewing and R. Needle. 2009. HIV-risk Behavior among Injecting or Non-injecting Drug Users in Cape Town, Pretoria and Durban, South Africa. *Substance Use & Misuse* 44 (6): 886–904; Nieburg, P. and L. Carty. 2011. *HIV Prevention among Injection Drug Users in Kenya and Tanzania: New Opportunities for Progress.* Washington, DC: Center for Strategic & International Studies. http://www.csis.org in Gay, J., Croce-Galis, M., Hardee, K. 2012. *What Works for Women and Girls: Evidence for HIV/AIDS Interventions*. 2nd edition. Washington DC: Futures Group, Health Policy Project. http://www.whatworksforwomen.org.

[64] Tucker, J., X. Ren and F. Sapio. 2010. Incarcerated Sex Workers and HIV Prevention in China: Social Suffering and Social Justice Countermeasures. *Social Science & Medicine* 70 (1): 121–129; Munoz , J., A. Adedimeji and O. Alawode. 2010a. They Bring AIDS to Us and Say We Give it to Them: Socio-structural Context of Female Sex Workers' Vulnerability to HIV Infection in Ibadan Nigeria. *Journal of Social Aspects of HIV/AIDS Research Alliance* 7 (2): 52–61; Lafort, Y., D. Geelhoed, L. Cumba, C. Lázaro, W. Delva, S. Luchters and M. Temmerman. 2010. Reproductive Health Services for Populations at High Risk of HIV: Performance of a Night Clinic in Tete Province, Mozambique. B*MC Health Services Research* 10: 144; Okal, J., M. Chersich, S. Tsui, E. Sutherland, M. Temmerman and S. Luchters. 2011. Sexual and Physical Violence against Female Sex Workers in Kenya: A Qualitative Enquiry. *AIDS Care* 23 (5): 612–618; Go, V., A. Srikrishnan, M. Salter, S. Mehta, S. Johnson, S. Sivaram, W. Davis, S. Solomon and D. Celentano. 2010. Factors Associated with the Perpetration of Sexual Violence among Wine-shop Patrons in Chennai, India. *Social Science and Medicine* 71 (7): 1277–1284; Decker, M., A. Wirtz, S. Baral, A. Peryshkina, V. Mogilnyi, R. Weber, J. Stachowiak, V. Go and C. Beyrer. 2012. Injection Drug Use, Sexual Risk, Violence and STI/HIV among Moscow Female Sex Workers. *Sexually Transmitted Infections* 88 (4): 278–283; Gould, C. and N. Fick. 2008. *Selling Sex in Cape Town: Sex Work and Human Trafficking in a South African City*. Cape Town, South Africa: Institute for Security Studies and SWEAT. http://www.sweat.org.za; Arnott, J. and A.-L. Crago. 2009. *Rights Not Rescue: A Report on Female, Male and Trans Sex Workers' Human Rights in Botswana, Namibia and South Africa*. New York, NY: Open Society Institute. http://www.soros.org in Gay, J., Croce-Galis, M., Hardee, K. 2012. *What Works for Women and Girls: Evidence for HIV/AIDS Interventions*. 2nd edition. Washington DC: Futures Group, Health Policy Project. http://www.whatworksforwomen.org.

people were incarcerated;[65] of these more than half a million were women.[66] A review by UNODC found that even though women represent a small part of the total global prison population, these numbers are increasing faster than for men. Prisons have been designed primarily for men and thus women's health needs are often neglected, including needs for HIV prevention, treatment and care. Prevention programs that have been shown to reduce HIV transmission are rarely available for inmates, and many prisoners with HIV are unable to access life-saving antiretroviral treatment. When it comes to HIV testing, some prison authorities enforce mandatory testing, which is a breach of human rights.

- MSM activities in many countries are highly criminalized yet face tremendous risks in acquiring HIV. The need for HIV services is great, but criminalization means that MSM who access services can face death or jail.
- Transgendered persons are at very high risk of acquiring HIV, yet few outreach services specifically target this population.

Humanitarian and Emergency Settings

Tracking the Access to ARV Treatment that PLHIV Have in Humanitarian and Emergency Settings

Conflict can exacerbate gender inequalities, property rights and livelihoods,[67] thus impacting the access that people living with HIV have to antiretroviral therapy. Conflict may also prevent people living with HIV from accessing any kind of health service. However, antiretroviral therapy has been administered with successful outcomes in conflict settings, with study results showing sex disaggregated data.[68]

Health Service/Outcome Indicators

Quality of Life[69]

Most of the small amount of data on quality of life for women living with HIV demonstrates that women have decreased health related quality of life in comparison to men with HIV. Understanding gender and age differences (and how they interact) may provide potentially useful information for planning interventions to improve QoL and mental health among people living with HIV, especially when looked at by sex.

---

[65] Jürgens, R., M. Nowak and M. Day. 2011. HIV and Incarceration: Prisons and Detention. *Journal of the International AIDS Society* 14: 26 in Gay, J., Croce-Galis, M., Hardee, K. 2012. *What Works for Women and Girls: Evidence for HIV/AIDS Interventions.* 2nd edition. Washington DC: Futures Group, Health Policy Project. http://www.whatworksforwomen.org.

[66] United Nations Office on Drugs and Crime (UNODC). 2009. *Women's Health in Prison: Correcting Gender Inequity in Prison Health*. Copenhagen, Denmark: WHO Regional Office for Europe in Gay, J., Croce-Galis, M., Hardee, K. 2012. *What Works for Women and Girls: Evidence for HIV/AIDS Interventions*. 2nd edition. Washington DC: Futures Group, Health Policy Project. http://www.whatworksforwomen.org.

[67] Seckinelgin, H., J. Bigirumwami and J. Morris. 2011. Conflict and Gender: The Implications of the Burundian Conflict on HIV/AIDS Risks. *Conflict, Security & Development* 11 (1): 55–78 in Gay, J., Croce-Galis, M., Hardee, K. 2012. *What Works for Women and Girls: Evidence for HIV/AIDS Interventions.* 2nd edition. Washington DC: Futures Group, Health Policy Project. http://www.whatworksforwomen.org.

[68] O'Brien, D., S. Venis, J. Greig, L. Shanks, T. Ellman, K. Sabapathy, L. Frigati and C. Mills. 2010. Provision of Antiretroviral Treatment in Conflict Settings: The Experience of Medecins sans Frontieres. *Conflict and Health* 4: 12 in Gay, J., Croce-Galis, M., Hardee, K. 2012. *What Works for Women and Girls: Evidence for HIV/AIDS Interventions*. 2nd edition. Washington DC: Futures Group, Health Policy Project.

[69] http://icmr.nic.in/annual/2004-05/trc/social_research.pdf

Quality of Care and Quality of Services Indicators[70]

Whether women and men access health services has been correlated to quality of care of these services. In the family planning field, numerous guides have been developed to assess and measure quality of care (Bruce, 1990; Engenderhealth's COPE, etc.). While standards have been developed in some countries, these have not been universally shared, in part, because of global inequities in access to health services and HIV services. But quality of care can be critical in uptake and adherence of treatment as well as prevention. What would constitute quality of care that could be universally agreed and measured has not yet been developed. Women living with HIV often report poor quality of care in HIV services, particularly related to reproductive health services for women living with HIV.

Screening, Counseling, and Treatment for STIs

The rate of STIs is five times greater among women than men. While many studies have found an association between STIs and HIV, screening, treating and counseling concerning STIs has not necessarily been correlated with reduced risk of acquiring HIV. However, there is a significant reproductive health burden posed by STIs. Detecting and treating STIs is essential for any public health program. At the same time, those who attend STI clinics can be tested and treated for HIV. Women living with HIV also need to be counseled, screened and treated for STIs, as untreated STIs can lead to infertility and faster disease progression. To reduce the possibility of reinfection by some STIs, both partners should be screened, counseled and treated.

Counseling for Sero-discordance

In a number of countries, a significant proportion of the population live in sero-discordant partnerships. It is critical for these couples to understand the concept of serodiscordance so that the HIV-negative partner can remain HIV-negative, rather than assuming that if one partner tests positive, both partners are HIV-positive. Once both partners know that they are serodiscordant and understand serodiscordance, they need support to maintain their relationship and practice safe sex. If they want to have a child together, they need access to pre-exposure prophylaxis and knowledge of exactly when the woman is most fertile. Questions about a woman's fear of violence or abandonment must also be addressed. No current tested indicators exist for what counseling should be given and how to assess the quality of the counseling.

Survival After 12 Months Among WLHIV

The proportion of women who have access to triple therapy at which CD4 count or viral load will be critical to survival rates of women living with HIV. Adherence and support for adherence will impact survival after 12 months. In addition, gender norms that inhibit disclosure by women of their HIV positive serostatus can impact survival.

Proportion of Family Planning Service Delivery Points that Provide HIV Testing

Women who access contraceptive services may also be at risk of acquiring HIV. Therefore, it may be useful to assess which family planning services also provide HIV testing and whether women find it convenient to access HIV testing when accessing family planning services.

---

[70] See OECD Health Care Quality Indicators: http://www.oecd.org/document/34/0,3746,en_2649_37407_37088930_1_1_1_37407,00.html and Agency for Healthcare Research and Quality: http://www.qualityindicators.ahrq.gov

Trafficking Indicators

The United Nations defines trafficking as "The recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation." Trafficking in persons damages the lives, health and well-being of millions of people worldwide. Women and girls are particularly vulnerable to trafficking and to the terrible consequences of trafficking (e.g., gender-based violence, sexual exploitation) because of their sub-ordinate position. Root causes of trafficking include poverty, gender-based discrimination, seasonal scarcities of food and resources etc. Women, men and children are trafficked for a variety of purposes including prostitution and sexual exploitation, forced labour or services; slavery or practices similar to slavery; servitude; or the removal of organs.

Trafficked persons are highly vulnerable to health problems including HIV, mental health, gender-based violence and other negative consequences because of the very nature of the activity. Statistics and data about prevalence of HIV among trafficked persons are difficult to come by in part because it is difficult to even estimate the numbers of trafficked people, and in part because of the clandestine nature it is difficult to access this population. Trafficking was considered to be an important area of measurement for consideration in the compendium—both because of its implications for HIV vulnerability and because gender inequality is a key factor in driving the activity itself, and in shaping the experiences, vulnerabilities and HIV risks of trafficked individuals. Several indicators were proposed for inclusion in the compendium. However, these were not included in the compendium and it was decided to consider trafficking indicators in the category of indicators for further development. This decision was driven by several considerations.

- First, the indicators that were available on trafficking reflected a conflation of trafficking and sex work, which can leads to laws and interventions that can potentially negatively impact (e.g. harm or lead to further abuse and exploitation of) sex workers, and at the same time undermine efforts to stop trafficking. The UNAIDS Guidance Note on HIV and Sex Work clearly states that trafficking in persons for the purposes of sexual exploitation is a gross violation of human rights. At the same time, the Guidance Note strongly and clearly states that trafficking in persons or any distinct purpose, including commercial sexual exploitation, should never be implicitly or explicitly conflated with sex work.
- Second, the indicators on trafficking need to reflect the evidence on what is "good practice" or effective programming to prevent trafficking and respond to the HIV-related needs of trafficked individuals while at the same time not harming or violating sex worker rights. Currently, such evidence on "good practices" needs to be identified and compiled in order to then identify appropriate indicators for measuring progress.
- Third, discussions on trafficking indicators need to be subjected to a further consensus building process within a broader discussion on policy and programmatic responses to trafficking and with stakeholders engaged in preventing and responding to trafficking including relevant UN partners, civil society groups, researchers, donors and national stakeholders.

This compendium flags trafficking as a critical area for which indicators need to be developed in the future and in that process it is suggested that there also be attention paid to trafficked children—girls especially and to consultation with a wide range of stakeholders.

List of those who participated in The Technical Consultation on Developing Harmonized Indicators for Monitoring Progress on Gender Equality, Dimensions of the HIV and AIDS Responses, held September 21–23, 2011, in New York, USA. (Alphabetical by first name, * indicates that the person was on the core planning committee).

Abby Cannon
Gender Analyst
MEASURE Evaluation
United States
accannon@unc.edu

Adrienne Germain
President Emeria
International Women's Health Coalition
United States
agermain@iwhc.org

Akudo Ikpeazu
Director, Program Coordination
National Agency for the control of AIDS
Nigeria
aikpeazu@yahoo.com

Alexandra Garita
Program Officer, International Policy
International Women's Health Coalition
United States
agarita@iwhc.org

Alessandra Nilo*
Executive Director
GESTOS
Brazil
Alessandra.nilo@gestos.org

Anna Guthrie
Health and AIDS Adviser
Department for International Development (DFID)
United Kingdom
a-guthrie@dfid.gov.uk

Avni Amin*
Technical Officer
Department of Reproductive Health and Research
World Health Organization (WHO)
Switzerland
amina@who.int

Chiho Suzuki
Statistics and Monitoring Specialist
Division of Policy and Practice
United Nations Children's Fund (UNICEF)
United States
csuzuki@unicef.org

Claudia Ahumada
Technical Officer
Global Coalition on Women and AIDS
Joint United Nations Program on HIV/AIDS (UNAIDS)
Switzerland
ahumadac@unaids.org

Daniela Ligiero*
Senior Advisor for Gender
Office of the U.S. Global AIDS Coordinator
United States
ligierodp@state.gov

Dean Peacock
Co-founder and Director
Sonke Gender Justice Network
South Africa
dean@genderjustice.org.za

Diana Prieto*
Senior Gender Advisor
United States Agency for International Development (USAID)
United States
dprieto@usaid.gov

Ebony Johnson*
North American Delegate
UNAIDS PCB NGO Delegate
United States
femme_poz@yahoo.com

Gang Zeng
Research Assistant
National Center for AIDS/STD Control and Prevention
Chinese Center for Disease Control
China
hxydzg@163.com

Ivana Bozicevic
Executive Director
Collaborating Centre for Capacity Development in HIV surveillance
World Health Organization (WHO)
Croatia
Ivana.Bozicevic@lshtm.ac.uk

Jay Silverman
Professor of Medicine and Global Health
University of California, San Diego
United States
jgsilverman@ucsd.edu

Joan Kraft
Behavioral Scientist
United States Centers for Disease Control and Prevention
United States
jik4@cdc.gov

Joanna Barczyk*
Technical Officer, Monitoring & Evaluation
The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM)
Switzerland
Joanna.Barczyk@theglobalfund.org

Karolina Kvarnare
First Secretary
Regional Advisor, HIV&AIDS
Regional HIV&AIDS Team for Africa
Embassy of Sweden Lusaka
Swedish International Development Agency (Sida)
Zambia
karolina.kvarnare@foreign.ministry.se

Katherine Bourne
New York University Wagner School of Public Service, and Bard College
Consultant
United States
katebourne444@yahoo.com

Kavutha Mutuvi
Gender Advisor to the National AIDS Control Council
Kenya
kavutha.mutuvi@nacc.or.ke
Kavutha.mutuvi@unwomen.org

Kevin Osborne
Senior HIV Advisor
International Planned Parenthood Federation (IPPF)
United Kingdom
kosborne@ippf.org

Kristen Wares
Public Health Advisor
United States Agency for International Development (USAID), Global Health, Office of HIV/AIDS United States
kwares@usaid.gov

Kyeremeh Atuahene
Director of Research, Monitoring and Evaluation
Ghana AIDS Commission
Ghana
katuahene@ghanaids.gov.g

Lillian Mworeko
Regional Coordinator
International Community of Women (ICW) living with HIV Eastern Africa
Uganda
lmworeko@icwea.org

Linda Kupfer
Senior Advisor
US State Department, Office of the Global AIDS Coordinator (OGAC)
United States
linda.kupfer@nih.gov

Lola Yuldasheva
Monitoring and Evaluation Manager
United States Agency for International Development (USAID) Quality Health Care Project
Tajikistan
lola.yuldasheva@gmail.com

Luisa Orza
Program Coordinator
ATHENA/HEARD
United Kingdom
luisa.orza@gmail.com

Lynn Collins
Technical Adviser, HIV
United Nations Population Fund (UNFPA)
United States
Collins@unfpa.org

Mabel Bianco
President
Fundación Para Estudio e Investigación De la Mujer (FEIM)
Argentina
mbianco@feim.org.ar

Maribel Derjani Bayeh
Program Specialist
Gender and HIV/AIDS
United Nations Entity for Gender Equality and the Empowerment of Women (UN Women)
United States
maribel.derjani-bayeh@unwomen.org

Marleen van der Ree
Technical Specialist
United Nations Population Fund (UNFPA)
United States
vanderree@unfpa.org

Mary Ellsberg
Vice President, Research and Programs
The International Center for Research on Women (ICRW)
United States
mellsberg@icrw.org

Monica Alonso
Regional Advisor on HIV Surveillance
Pan American Health Organization/ World Health Organization (PAHO/WHO)
United States
alonsomon@paho.org

Nazneen Damji*
Policy Advisor, Gender Equality and HIV/AIDS
United Nations Entity for Gender Equality and the Empowerment of Women (UN Women)
United States
nazneen.damji@unwomen.org

Nchedi Maphokga-Moripe
Chief Director Intersection and International Relations
Department of Women, Children and People with Disabilities
South Africa
nchedi@dwcpd.gov.za

Oldri Mukuan
Regional Focal Point
International Community of Women Living with HIV/AIDS South East Asia (ICW)
Indonesia
alldree@yahoo.com

Olga Gvoztetska
Program Director
All-Ukrainian Network of People Living with HIV/AIDS
Ukraine
sova@network.org.ua

Patrick Kaburi
Head, Monitoring, Evaluation and Research
National AIDS Control Council
Kenya
pkaburi@yahoo.com

Per Strand
M&E Manager
Star for Life (a school-based HIV-prevention program)
South Africa
pmstrand@gmail.com

Priscilla Idele
Senior Adviser, Statistics and Monitoring
Division of Policy and Practice
United Nations Children's Fund (UNICEF)
United States
pidele@unicef.org

Rachel Albone
HIV and AIDS Policy Advisor
HelpAge International
United Kingdom
ralbone@helpage.org

Renee Mckenzie
Analyst
Canadian International Development Agency (CIDA)
Canada
renee.mckenzie@acdi-cida.gc.ca

Roberta Clarke
Regional Program Director
United Nations Entity for Gender Equality and the Empowerment of Women (UN Women Caribbean Office)
Barbados
Roberta.clarke@unwomen.org

Robin Gorna (facilitator)
Director
AIDS Strategy, Advocacy and Policy
United Kingdom
rgorna@gmail.com

Samantha Dovey
Monitoring and Evaluation Specialist
ICF Macro
United States
sdovey@icfi.com

Seng SutWantha
Gender and HIV Technical Adviser
National AIDS Authority
Cambodia
wanthas@yahoo.com

Shelah S. Bloom*
Senior Technical Gender Advisor
MEASURE Evaluation, University of North Carolina at Chapel Hill
United States
ssbloom@email.unc.edu

Sidonie Uwimpuhwe
Senior Advisor
Gender Equality and HIV
Rwanda Biomedical Center
Institute of HIV, Disease Prevention and Control Rwanda
Sidonie.uwimpuhwe@cnls.gov.rw

Susana Fried
Cluster Leader (a.i.): Mainstreaming, Gender and the MDGs
and Senior Gender Advisor
United Nations Development Program
HIV/AIDS Practice
United States
Susana.fried@undp.org

Svetlana Negroustoueva*
Senior M&E Associate
ICF Macro/Measure Evaluation
United States
snegroustoueva@icfi.com

Tobias Alfven*
M&E Technical Adviser
Response Monitoring & Analysis
Evidence Strategy & Results Department
Joint United Nations Program on HIV/AIDS (UNAIDS)
Switzerland
alfvent@unaids.org

Tonya Nyagiro
Senior Policy Adviser, Gender
The Global Fund to Fight / for AIDS, Tuberculosis and Malaria (GFATM)
Switzerland
tonya.nyagiro@theglobalfund.org

Vo Hai Son
Deputy Head
Department of Surveillance, Monitoring and Evaluation,
Vietnam Authority of HIV/AIDS Control
Vietnam
vohaison@gmail.com

MEASURE Evaluation

Carolina Population Center
University of North Carolina at Chapel Hill
206 W. Franklin Street
Chapel Hill, NC 27516

www.measureevaluation.org