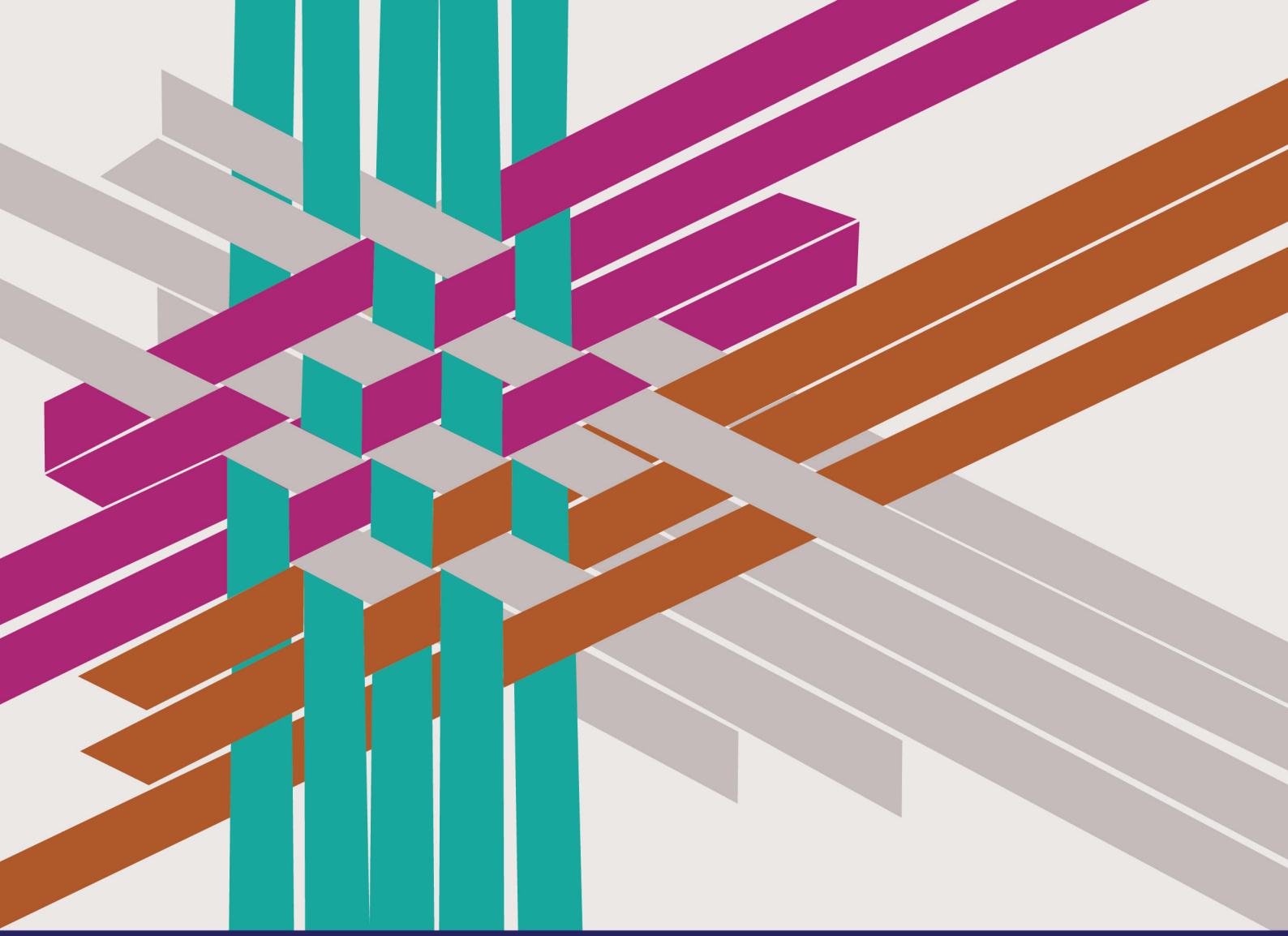

Integrating Gender in the Monitoring and Evaluation of Health Programs: A Toolkit

Jessica Fehringer, PhD, **Brittany Iskarpatyoti,** MPH, **Bridgit Adamou,** MPH, **and Jessica Levy,** PhD

September 2017

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PEPFAR
MEASURE Evaluation

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ABBREVIATIONS

BCC	behavior change communication
CDC	United States Centers for Disease Control and Prevention
DHS	Demographic and Health Survey
FGM/C	female genital mutilation/cutting
FP	family planning
FSW	female sex worker
GEM	Gender Equitable Men [Scale]
GHI	Global Health Initiative
GBV	gender-based violence
IGWG	Interagency Gender Working Group
KP	key population
LGBT	lesbian, gay, bisexual, and transgender
M&E	monitoring and evaluation
MHU	mobile health unit
MOH	Ministry of Health
MSM	men who have sex with men
PEP	postexposure prophylaxis
PEPFAR	United States President's Emergency Plan for AIDS Relief
PLHIV	people living with HIV
PMP	performance management plan
PPT	Microsoft PowerPoint presentation
QA	quality assurance
RH	reproductive health
SGBV	sexual and gender-based violence
SMART	specific, measurable, achievable, relevant, and time-bound
STI	sexually transmitted infection
UNAIDS	Joint United Nations Programme on HIV/AIDS
USAID	United States Agency for International Development
USG	United States government
WGGE	Women, Girls, and Gender Equality
WHO	World Health Organization

INTRODUCTION

Purpose

This toolkit aims to help international health programs integrate a gender perspective in their monitoring and evaluation (M&E) activities, measures, and reporting. It is designed for use by health program staff (such as project directors, gender focal persons, program officers, and M&E officers), working in various health sectors (such as HIV; malaria; reproductive, maternal, newborn, and child health; and tuberculosis [TB]), and for various health agencies and initiatives (such as the United States President's Emergency Plan for AIDS Relief [PEPFAR], the President's Malaria Initiative, Feed the Future, and Family Planning 2020). The toolkit will support health program staff to integrate gender in their programs, projects, and M&E activities. Its objectives are to provide:

- Processes and tools for integrating gender in a health program's M&E activities
- Guidance on facilitating communication with primary stakeholders on the importance of gender and M&E
- Additional resources on gender-integrated programming and M&E

Although the focus is on United States government (USG)-funded programs, the main concepts and information in this toolkit are relevant to any health program supported by any donor.

Background

Gender, Health, and M&E

Gender refers to a culturally-defined set of economic, social, and political roles, responsibilities, rights, entitlements, obligations, and power relations associated with being female and male, and the relationships between and among women and men. Gender norms, or the socially defined roles and expectations of what it means to be a man or a woman, and sanctions for not adhering to expectations, vary across cultures and over time. They often intersect with other factors, such as race, class, age, and sexuality. (Appendix A provides more information on essential gender-related definitions and concepts.)

Gender expectations have a significant impact on a person's health, by shaping behaviors and beliefs related to risk and vulnerability, and on health-seeking behavior (e.g., obtaining family planning [FP] services and adhering to HIV testing and treatment). Gender also shapes the way in which health services are structured and provided. Many health policies and initiatives focus on women because the burden of disparities is largely borne by women and girls. However, this is changing in response to the recognition of men's own unique health requirements (e.g., the need for voluntary medical male circumcision, FP services, treatment of sexually transmitted infections), and the role men play in women's health (e.g., couples communication, health decision making, power dynamics).

Lesbian, gay, bisexual, and transgender (LGBT) people and key populations (KPs), such as men who have sex with men (MSM) and female sex workers (FSWs), are also subject to and are often disadvantaged by gender expectations. As such, the USG and international agencies increasingly require programs to focus on harmful gender norms, expand equality between men and women, address gender-based violence (GBV), and promote the inclusion of LGBT people and KPs in development efforts.

The assessment of whether programs achieve intermediate and long-term objectives related to gender norms and health status requires gender-relevant information. The integration of gender in the M&E activities of health programs is important for the collection of the required information; for understanding the effectiveness of gender-integrated programming in changing gender norms; reducing

The Value of Gender-Sensitive Data

Underlying gender norms and inequalities often result in disparities in healthcare and health status between men and women, and boys and girls (Caro, 2009). For example, tobacco use is increasing more quickly among younger women than younger men; transgender populations and MSM bear a higher burden of HIV infections; and one in three women worldwide have experienced physical and/or sexual intimate partner violence or nonpartner sexual violence at some time in their lives (World Health Organization [WHO, 2016).

Sex-disaggregated data reveal when and where disparities exist. Gender-sensitive data help you understand why the disparities exist by:

- Examining gender norms and inequalities affecting access to and use of health services
- Illustrating gendered attitudes towards health behaviors
- Exploring whether health program approaches contribute to gender equality or exacerbate gender disparities

Gender-sensitive data therefore help you improve your health programs, and ultimately, health outcomes.

gender inequalities; and improving service delivery, access to services, and health outcomes.

The collection of high-quality sex- and age-disaggregated data and the use of gender-sensitive indicators help to identify program successes and gender barriers. Gender-based analysis of data and results can also provide effective support for gender-related advocacy, and help decision makers develop and refine evidence-informed policies and programs that address specific gender-related problems (Senftova, n.d.; World Health Organization [WHO], 2009a).

Principles, Policies, and Frameworks on Gender Integration

Several USG and international agencies have developed specific policies promoting the integration of gender in M&E activities and in health programs. The initiatives encourage gender-integrated programming to have intermediate objectives on gender norms; equality and equity in access to health, economic, educational, and political resources; and long-term objectives on health behaviors and health status (Caro, 2009; PEPFAR, 2014; WHO, n.d.; United States Agency for International Development [USAID], n.d.a).

For example, a central component of PEPFAR is the integration of gender in HIV/AIDS prevention, care, and treatment activities (PEPFAR, 2014). The importance of this approach was reinforced in an evaluation of PEPFAR undertaken by the Institute of Medicine in 2013. The evaluation recommended that PEPFAR develop M&E activities to assess the implementation and outcomes of gender-related efforts across its portfolio (Institute of Medicine, 2013). In 2015, PEPFAR instituted a requirement that all PEPFAR-funded programs undergo a gender analysis. USAID also has a long history of addressing gender equality issues. The Interagency Gender Working Group (IGWG) was established in 1997 as a network comprising nongovernmental organizations, the United States Agency for International Development (USAID), cooperating agencies, and the Bureau for Global Health of USAID. In 2012, USAID adopted the Gender

Figure 1. 12 components of a functional HIV monitoring and evaluation system

Source: UNAIDS, 2008

Equality and Female Empowerment Policy (USAID, 2012), under which USAID reformed budgeting and reporting requirements to capture gender equality results. The policy holds agency staff accountable for tracking outputs and outcomes related to gender equality and female empowerment (USAID, 2012).

Several frameworks and other resource materials have been developed or adapted to operationalize the integration of gender in health programs and M&E activities. For example, the Joint United Nations Programme on HIV/AIDS (UNAIDS) prepared the Organizing Framework for a Functional HIV Monitoring and Evaluation System, which focuses on 12 essential components of a functional M&E system for HIV programs (Figure 1). The outer ring represents the people, partnerships, planning, and structures required to support data collection and information system processes. The middle ring represents the mechanisms used to collect, verify, analyze, and transform data into useful information. The inner ring represents the central purpose of an M&E system—to disseminate data for use in programmatic decision making. MEASURE Evaluation's *Guidelines for Integrating Gender into an M&E Framework and System Assessment* (available at https://www.measureevaluation.org/resources/publications/tr-16-128-en) offers concrete guidance on how organizations can comprehensively and explicitly integrate gender in their M&E systems using this framework. It describes how to make each component of a functioning M&E system gender-sensitive and provides guidance on how to assess an M&E system to ensure that gender is fully integrated.

This toolkit shows how to put these principles and frameworks into action, with practical guided activities.

Audience for the Toolkit

The toolkit is designed for health program personnel who are responsible for integrating gender in M&E activities, measures, and reporting (such as health program officers, gender focal persons, and M&E officers). Using the activities in the toolkit, they will serve as facilitators to train staff and stakeholders (see How to Use this Toolkit). We suggest that a health program establish a two- to three-person team (preferably one program officer, one M&E officer, and one gender focal person or gender advisor) to be responsible for organizing and facilitating this process. If a team is not possible, a single person may act as the sole facilitator.

Because the gender policies of USAID and the United States Department of State require the integration of gender in health programs, the toolkit has been designed with USG-funded implementing partners in mind (e.g., organizations implementing health programs funded by the United States Centers for Disease Control and Prevention [CDC], USAID, and PEPFAR). It may also be used by organizations and programs funded by other donors conducting gender-integrated health programming.

To assess whether your organization or program is ready to use this toolkit, complete the rapid assessment checklist.

The Tools

Most of the modules contain tools:

- The handouts highlight important information for each module. They may be distributed to your stakeholders or other interested parties that the team involves in the process.
- The Microsoft PowerPoint (PPT) presentations are designed to guide your discussions, ensuring that essential points on each topic are covered. Speaker notes are included with the PPTs.
- The spreadsheets are designed to help you organize program and M&E information.

You can modify these tools for your own situation (e.g., simplify the spreadsheet to reflect your programming or M&E activities).

Depending on your needs, you may choose to use all or a few of the tools in each module. Tools 2, 5, 7, and 9 are available here: **https://www.measureevaluation.org/our-work/gender/toolkit-for-integrating-gender-in-m-e-of-health-programs**

All others are contained in this manual.

Rapid Assessment Checklist

PROGRAMS

- Are you implementing programs for which there is some degree of gender integration in activities (e.g., by health area; by type of intervention across the health portfolio)?
- Do you have documents related to your organization/program's gender-integrated programming?
- Has your organization/program identified the gender- and health-related outcomes expected from gender-integrated programming?

MONITORING AND EVALUATION

- Are you conducting any M&E activities?
- Does your organization/program have an M&E plan or an M&E framework?

If you answered **YES** to all questions, you are ready to use this toolkit! Note that the toolkit is most helpful at the start of a new program or a new program component.

If the rapid assessment determines that your organization/program is not ready to use this toolkit, because gender has not yet been integrated in your program(s), your next step is to conduct a gender analysis to assess the barriers to and

facilitators of the integration of gender in your program. Several frameworks and resources are available to help you conduct the gender analysis (see the text box). Module A is also a resource to help identify policies, plans, and frameworks that can guide your program's efforts to integrate gender considerations. For example, the USAID policy on Gender Equality and Female Empowerment is designed to enhance women's empowerment and reduce gender gaps. Implementing partners, such as FHI 360 and Care International, have posted gender frameworks and gender policy on their websites, documenting how they integrate gender in their work.

After you have done a gender analysis, the next step is to develop an M&E plan or an M&E framework that is informed by the principles in applicable gender policies (e.g. government or funder policies on gender) and that reflects the results of your gender analysis.

Additional resources on gender analysis

- Interagency Gender Working Group (IGWG). (n.d.). Training: Gender analysis and integration. Retrieved from https://www.igwg.org/training/gender-analysis-and-integration/
- Jhpiego. (2015). *Gender analysis toolkit for health systems*. Retrieved from https://gender.jhpiego.org/analysistoolkit/gender-integration/
- March, C., Smyth, I., & Mukhopadhyay, M. (2005). *A guide to gender-analysis frameworks*. Oxford, UK: Oxfam Publishing. Retrieved from http://wafira.org/onewebmedia/Guide%20to%20Gender%20Analysis%20Frameworks.pdf
- Overholt, C., Anderson, M. B., Cloud, K., & Austin, J. E. (1985). *Gender roles in development projects: A case book*. West Hartford, CT, USA: Kumarian Press. Retrieved from http://pdf.usaid.gov/pdf_docs/Pnaas025.pdf
- United States Agency for International Development (USAID). (2017). *ADS chapter 205. Integrating gender equality and female empowerment in USAID's program cycle*. Functional Series 200—Programming. Retrieved from http://www.usaid.gov/ads/policy/200/205

How to Use This Toolkit

The toolkit is organized into five modules. The modules may be used in sequence or independently of one another. Where your program begins and how the modules are used depends on the program's capacity and available resources, where it is in the development of M&E activities, and the extent of its gender integration goals.

Each module contains practical activities and tools to promote contextual understanding and active engagement, to foster a culture of collective responsibility, and to facilitate the process of integrating gender in M&E activities. Modules A and B review the processes for organizing the necessary documents, information, and stakeholders. Modules C, D, and E provide practical activities, discussion questions, and tools on gender concepts to work through with your stakeholders, guiding them to apply the concepts to their own work.

As mentioned, this process is enabled by a facilitation team or a single facilitator from the program. The facilitator(s) will be responsible for organizing the process: collecting documents, setting up meetings, and enabling discussion and learning. The facilitator(s) should devote substantial time and effort to this activity. The process may take several weeks to several months to complete, depending on how frequently you meet with stakeholders, your M&E situation, and the number of modules you plan to complete. Review the next section on the materials in the toolkit for the list of the modules, when the modules may be appropriate to use, and the tools that may be useful as you move through a given module.

Additional resources on USG policies about integrating gender

- United States Agency for International Development (USAID). (2016). *United States strategy to prevent and respond to gender-based violence globally*. Washington, DC, USA: USAID. Retrieved from https://www.state.gov/documents/organization/258703.pdf
- United States Agency for International Development (USAID). (2017). ADS chapter 205. *Integrating gender equality and female empowerment in USAID's program cycle*. Functional Series 200—Programming. Washington, DC, USA: USAID. Retrieved from http://www.usaid.gov/ads/policy/200/205
- United States President's Emergency Plan for AIDS Relief (PEPFAR). (2013). *Updated gender strategy*. Washington, DC, USA: PEPFAR. Retrieved from https://www.pepfar.gov/documents/organization/219117.pdf

Materials in the Toolkit

Tools 2, 5, 7, and 9 are available on MEASURE Evaluation's website, here: https://www.measureevaluation.org/our-work/gender/toolkit-for-integrating-gender-in-M&Em-e-of-health-programs. All others are contained in this manual.

MODULE	Potential Use	Gender-Related M&E Activities	Gender-Related Tools
MODULE A: Developing a Rationale for Integrating Gender in M&E	Begin the process of integrating gender in M&E	**Activity A.1:** Gathering background information	**Tool 1:** Handout—Checklist of Sources of Information for the Integration of Gender in M&E Efforts
		Activity A.2: Organizing background information	**Tool 2:** Spreadsheet—Organizing Gender Integration Information (Excel)
MODULE B: Identifying and Engaging Stakeholders	Choose your stakeholders and/or assign tasks	**Activity B.1:** Identifying stakeholders **Activity B.2:** Engaging stakeholders	**Tool 3:** Stakeholder Analysis Matrix
MODULE C: Setting the Stage for Gender Integration in M&E	Provide guidance on what to cover in an initial stakeholder meeting on gender integration in M&E	**Activity C.1:** Reviewing gender-integrated programming	**Tool 4:** Stakeholder Meeting Agenda for Module C **Tool 5:** PPT A: Fundamentals of Gender-Integrated Programming **Tool 6:** Handout—Gender-Integrated Programming Basics
		Activity C.2: Introducing the fundamentals of M&E	**Tool 7:** PPT B: Fundamentals of Monitoring and Evaluation **Tool 8:** Handout—Monitoring and Evaluation Basics

MODULE	Potential Use	Gender-Related M&E Activities	Gender-Related Tools
		Activity C.3: Introducing gender-integrated M&E	**Tool 9:** PPT C: Fundamentals of Gender-Integrated Monitoring and Evaluation **Tool 10:** Handout—Gender and Health Monitoring and Evaluation Basics
		Activity C.4: Presenting the country's gender context, gender-related programming, and M&E situation	**Tool 11:** Handout—Gender in Context
MODULE D: Building a Gender-Integrated M&E Plan	Identify and develop the gender-integrated elements of your M&E plan and create a gender-integrated results framework	**Activity D.1:** Adapting program goals and objectives, and reviewing the scope of the M&E system	**Tool 12:** Meeting Agenda, Module D **Tool 13:** Checklist for Defining Evaluation Questions
		Activity D.2: Building your gender-integrated M&E results framework	
		Activity D.3: Defining indicators to measure gender-related outputs and outcomes	**Tool 14:** Indicators
		Activity D.4: Creating your gender indicators to measure gender-related outputs and outcomes	**Tool 15:** Gap Analysis **Tool 16:** Indicator Reference Sheets
		Activity D.5: Identifying data sources	
MODULE E: Developing an Implementation, Dissemination, and Use Plan	Determine methods for data collection, analysis, dissemination, and interpretation	**Activity E.1:** Determining methods for data collection	**Tool 17:** Meeting Agenda, Module E **Tool 18:** What, Who, and How of Data Collection
		Activity E.2: Developing a plan for analyzing, disseminating, and using your data	**Tool 19:** What to Do with Your Data

MODULE A.
Developing a Rationale for Integrating Gender in M&E

INTRODUCTION

To gain support for and begin the process of integrating gender in your M&E activities, measures, and reporting, your team first needs to identify and assess gender-integration programming efforts. Important questions to consider are these:

- Has a gender analysis been commissioned or conducted to identify, understand, and explain gaps between men and women in your country? Did the analysis identify gender norms, power relations, and/or inequalities in access to health information and services? Did the analysis identify gender-related goals and objectives for health programming (e.g., changes in specific gender norms)?
- What are your plans to integrate gender in your health program(s)? Have you started to implement your plans?
- Have you modified your M&E system to better track gender-integrated programming?

OBJECTIVES

By the end of Module A, you will have more knowledge about the gender-integrated health programs and M&E efforts (or the lack thereof) in your country, and you will have documented this information so that it is available for use throughout the steps in this toolkit and for future reference.

ACTIVITIES

- **Activity A.1:** Gathering background information
- **Activity A.2:** Organizing background information

TOOLS

- **Tool 1:** Checklist of Sources of Information for the Integration of Gender in M&E Efforts
- **Tool 2:** Organizing Gender Integration Information

Activity A.1. Gathering Background Information

To answer the questions listed in the Introduction section above, you need to gather information on the gender context in your country and your program's gender-related activities and their measurement. The resource materials that you consult should be selected based on their usefulness and strategic importance. There are many possible sources of information, including gender analysis or gender assessment reports, program logic models, program work plans, and performance monitoring plans. To assemble this information, you should reach out to diverse people in your program, your donors, and contacts you or your program may have in local or national government.

Tool #1 is a checklist to help you identify possible sources of information.

TOOL 1

Handout: Checklist of Sources of Information for the Integration of Gender in M&E Efforts

At the start of the gender integration process, you need to locate information on the gender context in your country, its gender-related policies, and other guiding frameworks or policies on gender equality (such as those developed by donors). You will also review your program's health- and gender-related activities and their measurement. The information from these documents will provide context and will guide your prioritization as you integrate gender in your health program(s). The following are potential sources of information:

- Strategic plans
- Operational plans
- Performance monitoring plans
- Evaluation plans
- List of evaluation indicators
- Data collection plans
- Plans for use and dissemination of data
- Monitoring and evaluation (M&E) system self-assessments
- Gender assessment/analysis reports
- Gender mapping exercises
- Baseline and/or endline survey reports
- Funding frameworks
- Central policy documents
- National laws in your country
- Annual reports
- Donor progress reports
- Reports from population-based surveys, such as the Demographic and Health Survey (DHS) or Reproductive Health Survey
- Results frameworks/logic models
- Project/activity proposals (from implementing partners)
- Activity documents/plans

Activity A.2. Organizing Background Information

As you collect the relevant information, it is helpful to consolidate the main points in one document. This activity ensures that you are considering the programmatic approaches in each of your health programs and activities. As you investigate the status of gender integration in your health program(s), you will have gender objectives and health objectives, with activities that correspond to both objectives.

Tool 2 provides a structure for organizing the important aspects of your program's gender and health activities and their measurement.

TOOL 2

Spreadsheet: Organizing Gender Integration Information

It is important to map what is being done to identify gaps and to plan. The spreadsheet provided in Tool 2 facilitates the process of systematically looking through the documents you have collected, identifying where gender is already integrated in M&E, and revealing gaps to be addressed. Once you have entered the information in the spreadsheet, the overall picture provided helps you to identify which modules in this toolkit will be helpful. For example, if you note that you have a program activity for which there are no gender-related indicators, you can conduct the activities in Module D (e.g., Activities D.3 or D.4). You do not necessarily need to complete the spreadsheet at one time; it can be added to as you work through the modules and revise your M&E plans and other activities to better integrate gender.

To use the spreadsheet, see the Microsoft Excel document entitled **"Tool 2: Organizing Gender Integration Information."**

The tool is designed such that information for one health program may be entered in two worksheets: one worksheet for the **health-related aspects of the program,** and the other worksheet for the **gender-related aspects of the program.** Each worksheet has the following information:

- Program name
- Implementers
- Timeline
- Coverage/population target
- Program objectives
- Inputs, outputs, and outcomes, by activity
- Indicators
- Data collection methods/sources
- Frequency and schedule for data collection
- Parties responsible for data collection
- When data will be available
- Plans for data analysis
- Parties responsible for data analysis
- Plans for information dissemination
- Plans for data use

Although the column and row headings for both worksheets are identical, the objectives, activities, indicators, and so forth that you enter will correspond to whether it is a health-related program aspect or a gender-related program aspect. Both aspects are important to address integration across the full M&E plan.

This is a program management tool; it should therefore be tailored to your needs. If you need additional rows or columns, you are encouraged to modify the spreadsheet accordingly. Likewise, if you have more than two health programs, make additional worksheets to capture the information.

MODULE B.
Identifying and Engaging Stakeholders

INTRODUCTION

Information on the integration of gender in M&E activities, measures, and reporting is valuable only if prospective users see it as relevant and useful. When considered useful, it is more likely to be "owned" by those who need it to inform decision making for health programs. To build ownership of the data, your team should identify a group of stakeholders and engage them in proposing, designing, implementing, and reporting on gender-integrated M&E (MEASURE Evaluation, 2011a; CDC, 2011).

OBJECTIVES

By the end of Module B, you will have identified, prioritized, and reached out to your main stakeholders.

ACTIVITIES

- **Activity B.1:** Identifying stakeholders
- **Activity B.2:** Engaging stakeholders

TOOLS

- **Tool 3:** Stakeholder Analysis Matrix

Activity B.1. Identifying Stakeholders

Stakeholders are the people or organizations who are invested in your program. They benefit from or are affected by your program, evaluation, or research; are interested in the results of your activities; and/or have a stake in what is done with your results. Some of your stakeholders are people external to your program. The process of stakeholder identification and engagement is led by you.

Identifying stakeholders tends to be an iterative process. You may begin by asking a key informant to identify your primary stakeholders. Those stakeholders will likely identify other stakeholders. For health programs, there may be representation from the following categories:

1. Program technical M&E specialists, such as an M&E officer
2. Program technical gender specialists or gender focal person (other than the facilitators)
3. Program officers and staff, such as health officers or program managers responsible for making decisions about programming and/or ensuring that programs are implemented
4. Data officers and staff, such as those responsible for collecting and analyzing data
5. In-country organizations/offices that need/request gender-sensitive data, such as women's activist groups or LGBT groups
6. In-country organizations, offices, agencies, etc. that are empowered to implement planned improvements in both M&E systems and in programming
7. Government offices, such as a Ministry of Women's Affairs, Ministry of Women's Development, Ministry of Gender Equality and Child Welfare, Ministry of Health (MOH), etc. that address gender or women
8. People representing program beneficiaries and others directly affected by your programs. Do not consider only program beneficiaries, because other groups may also be affected somehow by the intervention that should be included, too.

Identify stakeholders from various levels of your program and segments of the population—including both sexes and multiple gender identities—as appropriate. Stakeholders who have interest, expertise, resources, or influence should be considered.

Important questions to ask when identifying stakeholders are these:

- Who needs to use the data and/or will benefit from the data, and what questions do they want to answer?
- Who is actively seeking these data? Human rights groups, LGBT groups and KPs, women's rights groups, civil society groups, government offices, health institutions, etc.?
- Who has the influence and resources that can help integrate gender in your M&E plan and activities?
- Who will be directly or indirectly and positively or negatively affected by the implementation of and/or outcome of the gender-integrated health programs?
- Who will support your gender-integrated M&E plan and activities? Who will oppose them? Why? How will you deal with this?
- What does each stakeholder contribute to your M&E activities?
- Is the proposed stakeholder outreach process, venue, and timing appropriate and safe for all stakeholders? Would some people (e.g., GBV victims, LGBT people, people living with HIV [PLHIV]) perhaps benefit from personal consultations?

A stakeholder analysis matrix (Tool 3) helps to organize your thoughts when you're deciding who your stakeholders are. Think about the ways in which each stakeholder can be involved in integrating gender in the M&E process. Specify how you will engage them at different points in your M&E activities. Start by listing your M&E activities and then decide whether/how each stakeholder can contribute.

What not to do when choosing stakeholders

- DO NOT invite only those stakeholders who agree with the proposed work.
- DO NOT select only those stakeholders who are directly involved in your projects.
- DO NOT invite stakeholders only to the preliminary briefing; also involve them in adapting the M&E plan and system, and in using data for programmatic decision making.
- DO NOT engage only the required minimum number of stakeholders to obtain formal approvals.
- DO NOT invite only USAID representatives and/or implementing partner representatives. You want representation from all people who could benefit from the data.

TOOL 3

Stakeholder Analysis Matrix

Name of stakeholder	**Stakeholder description** (Primary purpose, affiliation, funding)	**Potential role in the activity** (Vested interest in the activity)	**Knowledge level on the issue** (Specific areas of expertise)	**Level of commitment** (Support or oppose the activity, to what extent and why?)	**Available resources** (Staff, volunteers, money, technology, information, influence)	**Constraints** (Limitations: needs funds to participate, lack of personnel, political or other barriers)
Government sector						
Program Representatives						
Implementing Partners						
Representatives of people affected (positively or negatively) by the program (disaggregated by sex and gender)						
International donor (including program funder) and advocacy groups						

Source: MEASURE Evaluation, 2011a

This tool provides a guide to asking the right questions; there is not just one way or specific protocol for gathering the necessary information. Information that is useful for the matrix can surface during any interaction, not just in meetings specifically designed to collect information for this tool. You may therefore add more categories, as needed.

Activity B.2. Engaging Stakeholders

It is important to engage stakeholders throughout the process of integrating gender in M&E activities. Stakeholders are usually not involved in the whole M&E cycle. Instead, they may be consulted at the beginning to endorse a plan that is already formulated, or involved later in the process to disseminate information and/or receive feedback. For your efforts to be most effective, your team should try to engage stakeholders in the design, execution, and application of integrating gender in M&E activities (MEASURE Evaluation, 2011a; CDC, 2011). Establishing buy-in and ownership in the early stages of programming not only raises awareness of ongoing gender-integrated program activities and gender-related M&E activities, but also facilitates ongoing commitment and the use of data produced by those activities.

You may want to consider dividing your stakeholders into two groups based on their level of engagement. For example:

Group	Task	Potential Participants
Steering Committee	• Make overarching decisions. • Represent the group at higher-level meetings to communicate gender-integrated M&E activities. • Oversee any actions that have budget implications. • Guide and maintain the process. • Ensure that gender is integrated in M&E through review of plans prepared by the working group. * Meet at regular intervals.	• Representative(s) from the MOH, U.S. Department of State, and/or civil society • MOH staff member • Agreement Officer of a USAID project • Directors of USG implementing partners
Working Group	• Review indicator reference sheets for new indicators. • Adapt data collection tools to collect data for gender-sensitive indicators. • Review analysis of gender-integrated M&E data. • Contribute specific skill sets to carry out the integration of gender in M&E activities. * Meet at benchmarks toward completion of your integration of gender in M&E work.	• Gender focal person • MOH M&E officer • Program officer • M&E or gender staff from implementing partners • Program beneficiary

Note to the facilitator

It is important to reflect gender equity in how sessions are organized and facilitated. You may need to purposively reach out to people to ensure equity in representation. Depending on the composition of your team and the stakeholders involved, it may be necessary to intentionally involve members of one sex or gender. It is important to ask for and receive input from different subgroups, because they will bring distinct perspectives to the discussions.

Additional resources for identifying and engaging stakeholders

- MEASURE Evaluation. (2011). *Tools for data demand and use in the health sector: Stakeholder engagement tool* (ms-11-46e.pdf). Chapel Hill, NC, USA: MEASURE Evaluation, University of North Carolina. Retrieved from https://www.measureevaluation.org/resources/publications/ms-11-46-e
- United States Department of Health and Human Services, United States Centers for Disease Control and Prevention (CDC), Office of Strategy and Innovation. (2011). *Introduction to program evaluation for public health programs: A self-study guide.* Atlanta, GA, USA: CDC. Retrieved from http://www.cdc.gov/eval/guide/CDCEvalManual.pdf

MODULE C.

Setting the Stage for the Integration of Gender in M&E

INTRODUCTION

Now that you have your stakeholder group, it is time to convene a meeting or workshop with your steering committee and working group to set the stage for how to integrate gender in your M&E activities. Your team should prepare an agenda/outline of topics and issues you want to discuss. An illustrative stakeholder meeting agenda is provided on the next page for this purpose. Three presentations (PPT slides) are also provided as guidance for workshop sessions.

You may need to adjust the time allotted and the content of the four activities according to the size of your audience, the amount of interaction expected, and the background knowledge of your stakeholders. You should also build in time and flexibility to pursue unexpected, but relevant, issues.

OBJECTIVES

By the end of Module C, you will have conducted a meeting or workshop with stakeholders to gain a collective understanding of the fundamentals of gender concepts, gender-integrated programming, and gender-integrated M&E.

ACTIVITIES

- **Activity C.1:** Reviewing gender-integrated programming
- **Activity C.2:** Introducing the fundamentals of M&E
- **Activity C.3:** Introducing gender-integrated M&E
- **Activity C.4:** Presenting the country's gender context, gender-related programming, and M&E situation

TOOLS

- **Tool 4:** Stakeholder Meeting Agenda for Module C
- **Tool 5:** PPT A—Fundamentals of Gender-Integrated Programming
- **Tool 6:** Handout—Gender-Integrated Programming Basics
- **Tool 7:** PPT B—Fundamentals of Monitoring and Evaluation
- **Tool 8:** Handout—Monitoring and Evaluation Basics
- **Tool 9:** PPT C—Fundamentals of Gender-Integrated Monitoring and Evaluation
- **Tool 10:** Handout—Gender and Health Monitoring and Evaluation Basics
- **Tool 11:** Handout—Gender in Context

TOOL 4

Stakeholder Meeting Agenda for Module C

Name of Meeting

Date

Place where meeting is being held

Meeting Objectives

1. Work with a shared understanding of what it means to address gender in health programming and M&E.
2. Identify steps to integrate gender in M&E plans.
3. Identify indicators for gender and health.
4. Define criteria for indicator selection and data sources for gender-sensitive indicators.
5. Review gender policies and programming that are applicable to the context.

Agenda

I. Welcome, introductions, and review of meeting objectives

II. Review of gender-integrated programming

- Definition of gender and related terms
- Why considering gender is important to health outcomes and programming
- Criteria for and ways in which gender is addressed in programs
- The process used for developing gender-integrated programming

III. Introduction to the fundamentals of M&E

- The definitions of M&E
- The purpose of M&E
- How M&E fits in the program life cycle
- The importance of an M&E plan and its components

IV. Introduction to gender-integrated M&E

- What it means to integrate gender in M&E plans and activities
- Why would you want to integrate gender in M&E plans?
- How do you integrate gender in M&E plans, including data and indicator requirements?

V. Presentation on the country's gender context, gender-related programming and M&E situation, and gender and M&E policies

a. Facilitated discussion with stakeholders on how programs and M&E plans do/do not address gender

b. Discussion with stakeholders on how they can be involved in improving gender integration in the program's M&E

VI. Next steps (continuation next day? Or a future meeting? etc.) and closing

Strategic steps to a gender-integrated program

STEP 1:

Assess: Collect and analyze data to identify gender-based constraints (e.g., gender norms, differences in access to resources and services), and opportunities relevant to program objectives.

STEP 2:

Plan: Develop program objectives that strengthen synergy between gender equity and health goals; identify participants, clients, and stakeholders.

STEP 3:

Design: Identify the main program strategies to address gender-based constraints, stigma, and discrimination, and opportunities.

STEP 4:

Monitor: Develop indicators that measure gender-specific outcomes; monitor implementation and effectiveness in addressing program objectives.

STEP 5:

Evaluate: Measure the impact of the program on health and gender equity outcomes; adjust the design accordingly to enhance successful strategies.

Activity C.1. Reviewing Gender-Integrated Programming

Gender-integrated programs assume that gender norms, unequal power relations, and differences in access to resources influence health and mediate how programs achieve their objectives. Such programs examine and address possible gender-related issues throughout the project cycle. The goal of gender-integrated programming is to achieve desired health outcomes while simultaneously transitioning to greater equality. At a minimum, gender-integrated programs are "gender-accommodating" (i.e., they recognize and work around gender inequalities and norms). At best, they are "gender-transformative" (i.e., they seek to reduce gender inequality and modify norms). They should never be "gender-exploitative" (i.e., take advantage of rigid gender norms and imbalances in power).

Research suggests that integrating gender in health programs facilitates many positive health outcomes, such as reducing HIV transmission, violence against women, unmet need for contraception, and maternal and neonatal mortality (see, for example: Rottach, E. Schuler, S.R., and Hardee, K. [2009]. *Gender perspectives improve reproductive health outcomes: new evidence. Washington, DC: Population Reference Bureau.* Available at https://www.k4health.org/toolkits/igwg-gender/gender-perspectives-improve-reproductive-health-outcomes-new-evidence.) Gender integration maximizes access to and the quality of health information and services, and subsequently facilitates decision making among women, men, and LGBT people about their own health and that of their families. Your stakeholders may not understand what it means to integrate gender in health programs. It is the facilitator's role to explain gender integration and why it is important.

PPT Presentation A (Tool 5) provides an overview of this information. It will lead your stakeholders through a discussion of:

- The definition of gender and related terms
- Why gender is important to health outcomes and programming

- The criteria for including gender in programs
- The ways that gender is addressed in programs
- The steps used to develop gender-integrated programming (see sidebar)

The PPT presentation is provided in a downloadable format with speaker notes at https://www.measureevaluation.org/our-work/gender/toolkit-for-integrating-gender-in-M&Em-e-of-health-programs.

All others are contained in this manual.

A handout (Tool 6) is also provided so that your stakeholders may follow along.

Note to the facilitator

The concepts of sex and gender can be controversial or may become linked to issues that are controversial in certain contexts. As the facilitator, your role is to be neutral while ensuring that incorrect information is not spread, and that discussions are not derailed.

Some of the activities and topics can spark a larger discussion about gender equality and society. They are important conversations to have; however, it may be necessary to move on from such conversations while the discussion is still occurring. Encourage participants to continue the discussions during breaks and after the workshop.

TOOL 5

PPT Presentation A: Fundamentals of Gender-Integrated Programming

Fundamentals of Gender- Integrated Programming

Tool 5
Activity C.1

Integrating Gender in the Monitoring and Evaluation of Health Programs:
A Toolkit

USAID PEPFAR MEASURE Evaluation

Learning Objectives

- Define gender and related terms
- Identify why gender is important to health outcomes and programming
- Identify criteria for how gender is addressed in programs

Activity

Vote with Your Feet

- This activity will help us explore gender concepts.
- Our own beliefs about gender make a difference.
- We need to keep this in mind when we ask people to address gender.

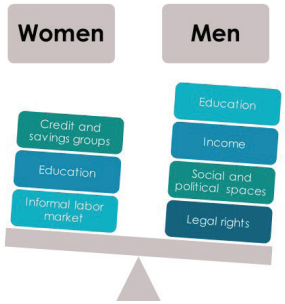
Key Definitions

SEX	GENDER
Biological difference between males & females: • Universal for all human beings • Unchanging • Determined at birth	Beliefs about the appropriate roles, duties, rights, responsibilities, accepted behaviors, opportunities, and status of women and men in relation to one another: • Constructed by society • Differs between cultures • Dynamic; changes over time • Acquired

Definitions

Gender Gap

- Adherence to rigid gender roles can create a gender gap, which means unequal access to and participation in opportunities that women and men experience.



Definitions

Gender Equality:

The state or condition that affords women and men equal enjoyment of human rights, socially valued goods, opportunities, and resources. Genuine equality means more than parity in numbers or laws on the books; it means expanded freedoms and improved overall quality of life for all people.

Gender Equity:

The process of being fair to women and men. To ensure fairness, measures should be taken to compensate for cumulative economic, social, and political disadvantages that prevent women and men from operating on a level playing field.

What is gender integration?

Identifying
specific gender-related differences and resulting inequalities

Addressing the differences
in the design, implementation, and M&E of a program

Why do we think about gender & health?

➢Gender equality is associated with positive health outcomes:
- •Lower child mortality; lower rates of stunting and wasting
- •Higher rates of health care use for maternal, child, and RH services (including STI and HIV services)
- •Lower rates of maternal mortality
- •Lower rates of gender-based violence

➢Gender inequality is associated with poorer health outcomes.

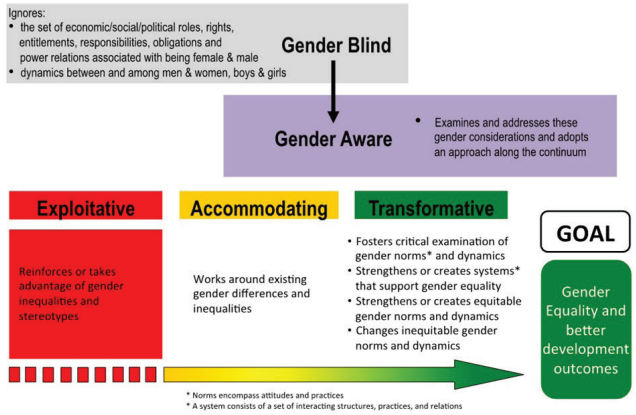
➢It is a matter of human rights that everyone has access to the care they need and are able to live free from discrimination.

➢As part of medical ethics (Hippocratic Oath), healthcare must be provided to all.

Why do we integrate gender in programming efforts?

- To gradually challenge existing gender inequities, and to promote positive changes in gender roles, norms, and power dynamics
- To maximize access to and the quality of health services, support individual decision making about reproductive health, and increase the sustainability of programs and policies

Gender Equality Continuum Tool



Activity

How would you categorize the following projects?

Exploitative? Accommodating? or Transformative?

Example Project 1: How would you categorize it?

Condom Social Marketing in Colombia

The goal of a social marketing campaign in Colombia was to increase condom sales and promote "safe sex". The campaign launched a television ad featuring a young man who said very proudly that he used a different color condom with each of his several girl friends. The intended message was that he used condoms whenever he had sex.

Example Project 1:
Exploitative

Condom Social Marketing in Colombia

Explanation:
The TV ad exploited social and cultural values supporting men's virility, sexual conquest, and control. It reinforced the expectation/stereotype that "macho" men have multiple female sexual partners and undercut the notion that joint communication and decision-making, negotiation, and mutual respect are important for safe sex behaviors. It also contradicted other health efforts to promote safe sex practices through partner reduction.

Example Project 2:
How would you categorize it?

Youth Roles in Care and Support for People Living with HIV/AIDS (PLWHA)

The goal of a project in Malawi was to involve young people in the care of PLWHA. They conducted formative research to assess the interest of young people in being caregivers, and to explore the gender dimensions of care. Young people were asked what care-giving tasks male and female youth feel more comfortable and able to carry out, and asked PLWHA what tasks they would prefer to have carried out by male or female youth. Based on this research, the project developed youth care and support activities for PLWHA which incorporated tasks preferred by young women and young men.

Example Project 2:
Accommodating

Youth Roles in Care and Support for People Living with HIV/AIDS (PLWHA)

Explanation:
The program successfully engaged both young women and young men in providing care and support for PLWHA. However, the program accommodated existing gendered divisions of labor and missed an opportunity to engage young men for the first time in a non-gender-traditional care-giving role. The program missed an opportunity for a more gender transformative outcome.

Example Project 3:
How would you categorize it?

Female Genital Mutilation/Cutting (FGM/C) Intervention

A FGM/C intervention in Uganda sought to stop the practice. Project staff realized that simply enacting a law prohibiting the practice would not address the cultural and social motivations supporting it within the community, and would likely cause people to do it covertly. Considering the symbolic nature of the ritual, the project staff and community members designed a ritual for girls that maintained meaningful cultural elements, such as a week-long seclusion, life-skills education, dance and storytelling, however it eliminated the cutting. The new rite-of-passage ritual was accepted by the entire community.

Example Project 3:
Transformative

Female Genital Mutilation/Cutting (FGM/C) Intervention

Explanation

The project engaged community members in a process of critical reflection, leading to an understanding that the long-accepted cultural practice of FGM /C violated the rights of girls to health and bodily integrity. By working with communities to identify an alternative, culturally acceptable ritual, the project challenged gender norms and eliminated a harmful cultural practice. Ultimately, the project had a transformative impact on participant communities.

Gender Integration in Programming
References & Resources

- Caro, D. (2009). A manual for integrating gender into reproductive health and HIV programs: from commitment to action (2nd Edition). Washington, DC, USA: USAID and IGWG. Retrieved from http://www.culturalpractice.com/wp-content/downloads/4-2009-2.pdf.
- Doggett, E., Krishna, A., Robles, O.J., & Betron, M. (2016, March 28) Global Health eLearning Center course on Gender and sexual and reproductive health 101. Retrieved from http://www.globalhealthlearning.org/course/gender-and-sexual-and-reproductive-health-101.
- Gender Practitioners Collaborative. (n.d.). Minimum standards for mainstreaming gender equality. Retrieved from http://genderstandards.org/
- IGWG. Gender and Reproductive Health 101. Retrieved from https://www.igwg.org/wp-content/uploads/2017/07/gender101facguide.pdf

Gender Integration in Programming
References & Resources

- Spevacek, A.M. (2012). Resources on gender integration/mainstreaming: toolkits, manuals, evaluations, lessons learned, and best practices. Washington, DC, USA: USAID. Retrieved from http://pdf.usaid.gov/pdf_docs/pnadm073.pdf
- USAID. (2012). *USAID Gender equality and women's female empowerment policy*. Washington, DC, USA: USAID. Retrieved from https://www.usaid.gov/sites/default/files/documents/1865/GenderEqualityPolicy_0.pdf.
- USAID. 2010. Guide to Gender Integration and Analysis. Additional Help for ADS Chapters 201 and 203. Retrieved from: http://pdf.usaid.gov/pdf_docs/Pdacp506.pdf
- World Health Organization (WHO). (2009). Integrating gender into HIV/AIDS programmes in the health sector: tool to improve responsiveness to women's needs. Geneva, Switzerland: WHO. Retrieved from http://www.who.int/gender/documents/gender_hiv_guidelines_en.pdf.

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www.measureevaluation.org

Additional resources on gender-integrated programming

- Caro, D. (2009). *A manual for integrating gender into reproductive health and HIV programs: From commitment to action* (2nd Edition). Washington, DC, USA: USAID and IGWG. Retrieved from http://www.culturalpractice.com/wp-content/downloads/4-2009-2.pdf
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TOOL 6

Handout: Gender-Integrated Programming Basics

What is gender integration?

- Gender integration is the identification of gender differences and resulting inequalities pertaining to specific programs and projects. Gender integration is the process of addressing these differences and inequalities in the design, implementation, monitoring, and evaluation of a program.

What are the objectives of gender-integrated programming?

- To gradually challenge gender inequities and promote positive changes in gender roles, norms, and power dynamics
- To maximize access to and quality of health services (for men, women, and transgender people); support individual and couple (family) decision making about health; improve health behaviors and health outcomes; and increase the sustainability of programs and policies

Why is gender-integrated programming important?

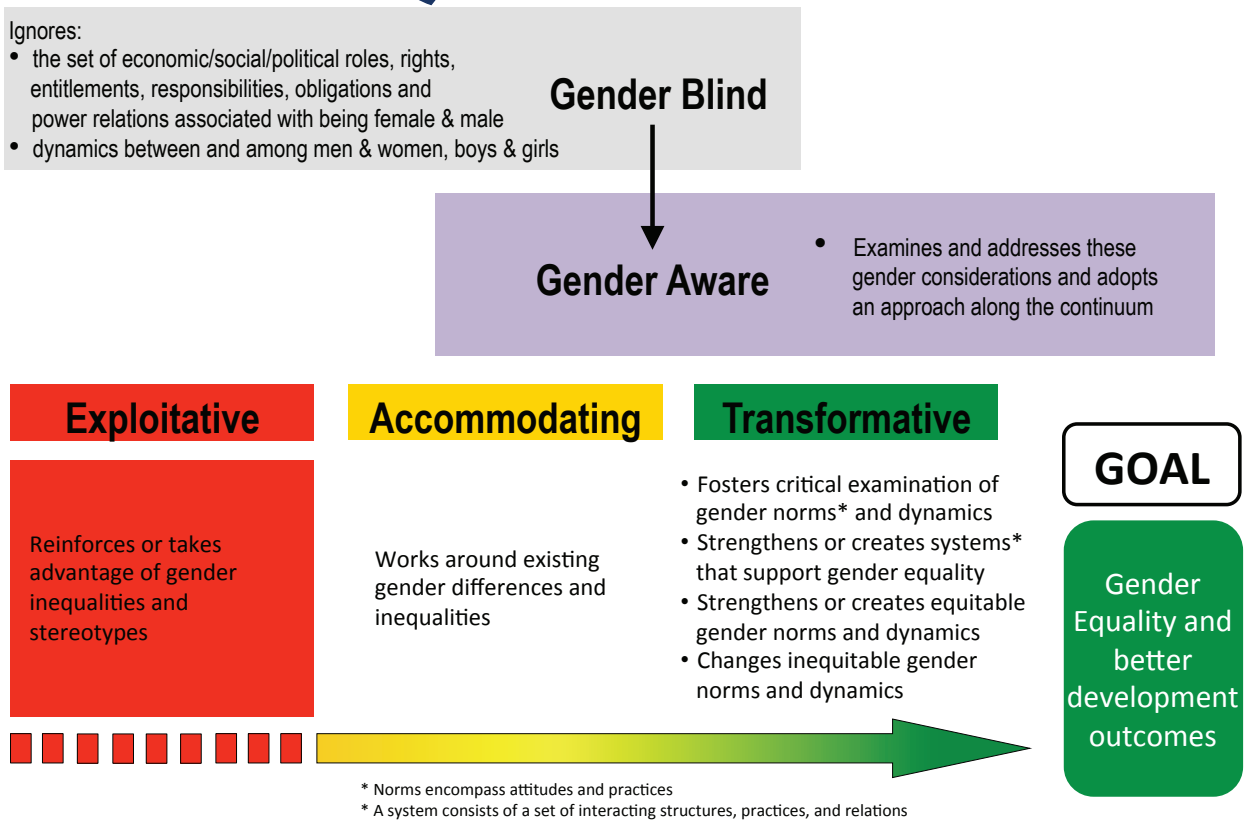
Gender equity contributes to positive gender and health outcomes:

- Reduced unmet need for contraception
- Improved access to care and treatment
- Reduced violence against women
- Reduced violence against lesbian, gay, bisexual, and transgender people
- Decreased maternal mortality
- Improved women's empowerment to make/act on decisions affecting health and life
- More communication between partners about sexual and reproductive health
- Greater involvement of men in decisions around and greater male support for antenatal care, facility delivery, and breastfeeding
- More decision making by wives and husbands jointly

How do we think about gender integration in programming?

The Gender Equality Continuum Tool on the next page is designed for use by planners and implementers to integrate gender in their programs and policies. It categorizes approaches by how to treat gender norms and inequities in the design, implementation, and evaluation of a program or policy.

GENDER EQUALITY CONTINUUM TOOL



Source: IGWG, no date

Gender-blind policies and programs are designed without a prior analysis of the culturally-defined set of economic, social, and political roles, responsibilities, rights, entitlements, obligations, and power relations associated with being female and male, and the dynamics between and among men and women and boys and girls. The project ignores gender considerations entirely.

Gender-aware policies and programs examine and address the set of economic, social, and political roles, responsibilities, rights, entitlements, obligations, and power relations associated with being female and male, and the dynamics between and among men and women and boys and girls.

Gender-exploitative policies and programs intentionally or unintentionally reinforce or take advantage of gender inequalities and stereotypes in pursuit of a project outcome, or whose approach exacerbates inequalities. This approach is harmful and can undermine the objectives of the program in the long run.

Gender-accommodating policies and programs acknowledge but work around gender differences and inequalities to achieve project objectives. Although this approach may result in short-term benefits and the achievement of outcomes, it does not attempt to reduce gender inequality or address the gender systems that contribute to the differences and inequalities.

Gender-transformative policies and programs 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; and (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.

COMMON DEFINITIONS RELATED TO GENDER	
Concept	**Definition**
Gender	A culturally-defined set of economic, social, and political roles, responsibilities, rights, entitlements, obligations, and power relations associated with being female and male, and the relationships between and among women and men. The definition and expectations of what it means to be a man or a woman, and sanctions for not adhering to expectations, vary across cultures and over time, and often intersect with other factors, such as race, class, age, and sexuality. LGBT people, whether they identify as men or women, can be subject to the same set of expectations and sanctions.
Sex	The classification of people as male or female. At birth, infants are assigned a sex based on a combination of bodily characteristics, including chromosomes, hormones, internal reproductive organs, and genitalia.
Gender Equality	The state or condition that affords women and men equal enjoyment of human rights, socially valued goods, opportunities, and resources. Genuine equality means more than parity in numbers or laws on the books; it means expanded freedoms and improved overall quality of life for all people.
Gender Equity	The process of being fair to women and men. To ensure fairness, measures should be taken to compensate for cumulative economic, social, and political disadvantages that prevent women and men from operating on a level playing field.
Gender-Based Violence	In the broadest terms, GBV is violence that is directed at people based on their biological sex, gender identity, sexual orientation, or perceived nonadherence to culturally-defined expectations of what it means to be a woman and man, or girl and boy. It includes physical, sexual, and psychological abuse; threats; coercion; arbitrary deprivation of liberty; and economic deprivation, whether occurring in public or private.
Gender-Integrated Programming	Gender-integrated programs assume that gender norms, unequal power relations, and differences in access to resources influence health and confound how programs achieve their objectives; hence, they examine and address possible gender-related issues throughout the project cycle. The goal of gender-integrated programming is to achieve desired health outcomes while simultaneously transitioning to greater equality.

Activity C.2. Introducing the Fundamentals of M&E

M&E is the processes by which data are collected, analyzed, and used to improve programs and to inform decision making. M&E should be incorporated in all stages of the program cycle—from the needs assessment and program planning at the beginning, through routine monitoring of program implementation, and finally with an end-of-program evaluation. This ongoing feedback and analysis allow for the necessary and timely program changes, increasing the likelihood that program objectives and improved health outcomes will be achieved. Feedback and analysis also help to identify the evolving

gender and health issues that may need to be incorporated in programming or may require additional health programming (CDC, 2011; Frankel & Gage, 2007, rev. 2016).

It is important to clarify M&E concepts with your stakeholders and to emphasize the role of M&E in providing a better understanding of how your programs are working.

Powerpoint Presentation B (Tool 7) provides an overview of M&E fundamentals. The presentation will help you lead your stakeholders through a discussion of:

- The definition of M&E
- The purpose of M&E
- How M&E fit in the program life cycle
- The importance of an M&E plan and its components

The PPT presentation is provided in a downloadable format with speakers notes at https://www.measureevaluation.org/our-work/gender/toolkit-for-integrating-gender-in-m-e-of-health-programs.

A handout (Tool 8) is also provided so that your stakeholders may follow along.

Additional resources on M&E plans

- Frankel, N., & Gage, A. (2006). Global Health eLearning Center course on M&E fundamentals. Retrieved from http://www.globalhealthlearning.org/course/m-e-fundamentals
- Frankel, N., & Gage, A. (2007, rev. 2016). *M&E fundamentals: A self-guided minicourse* MS-07-20_rev2016.pdf). Chapel Hill, NC: MEASURE Evaluation, University of North Carolina. Retrieved from http://www.measureevaluation.org/resources/tools/health-information-systems
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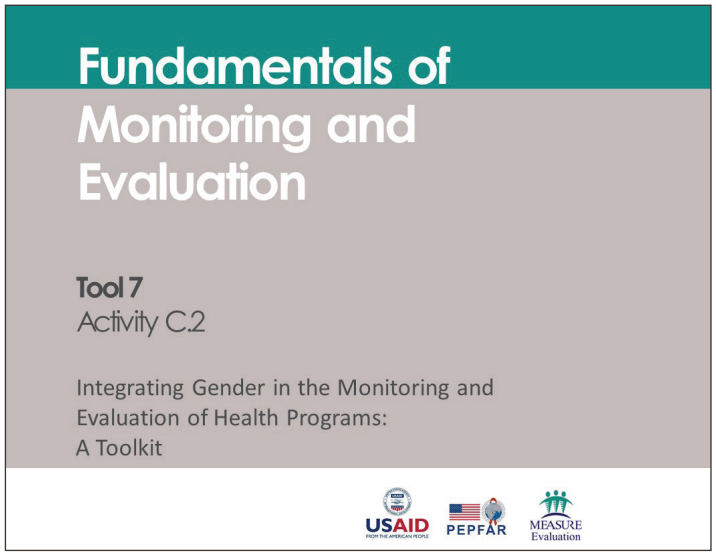
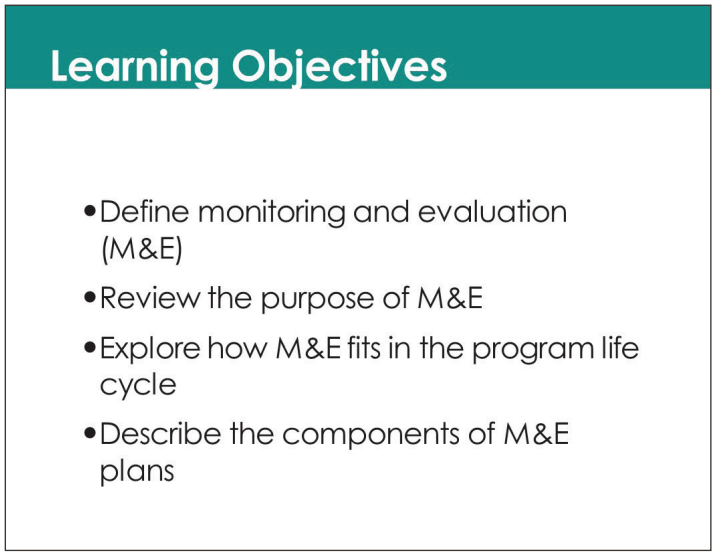
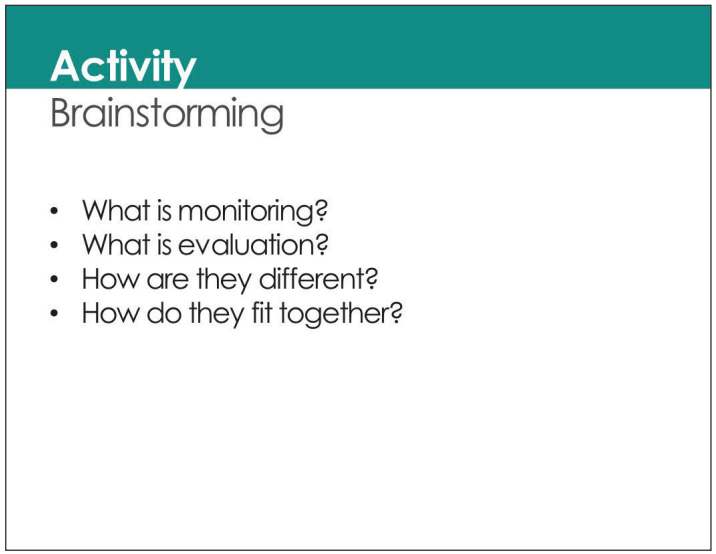
- Social Impact, Inc. (2013). *Performance management plan (PMP) toolkit. A guide for Missions on planning for, developing, updating, and actively using a PMP.* Washington, DC, USA: Social Impact, Inc. Retrieved from http://usaidprojectstarter.org/sites/default/files/resources/pdfs/PMP-Toolkit.pdf

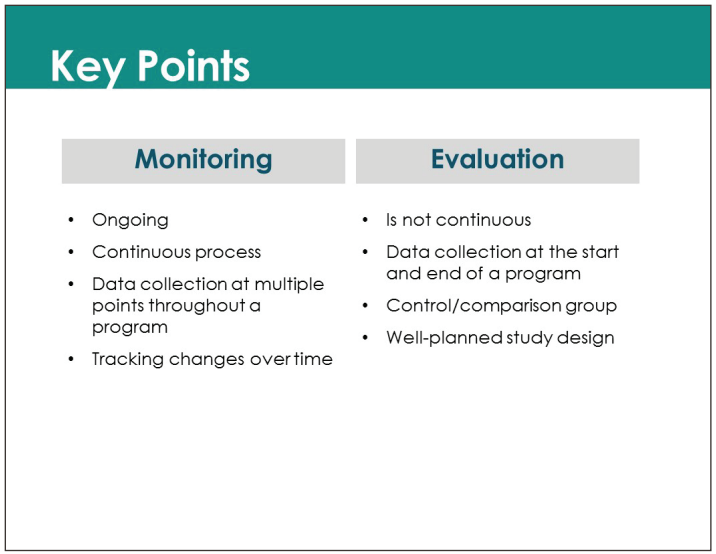
TOOL 7

PPT Presentation B: Fundamentals of Monitoring and Evaluation









Definition
Monitoring

Performance monitoring reveals whether desired results are occurring and whether implementation is on track. In general, the results measured are the direct and near-term consequences of project activities.

- Performance monitoring is used to gauge whether activities need adjustment in the course of the intervention to improve the use of resources and the achievement of desired outcomes.
- It requires the collection of data at multiple points throughout the program cycle, including at the beginning to provide a baseline.

Definition
Evaluation

Evaluation is the systematic collection and analysis of information about the characteristics and outcomes of a program or project as a basis for judgments, to improve effectiveness, and/or to inform decisions about current and future programming.

Evaluation is distinct from assessment, which may be designed to examine country or sector context to inform project design or an informal review of a project.

Types of Evaluations

Performance evaluation focuses on descriptive and normative questions: what has a particular project or program achieved; how it is being implemented; how is it perceived and valued; are expected results occurring; and other questions that are pertinent to program design, management, and operational decision making.

- Performance evaluations often incorporate before-after comparisons, but generally lack a rigorously defined counterfactual.
- They involve the collection of data at the start of a program (to provide a baseline) and again at the end.

Types of Evaluations

Impact evaluation measures the change in a development outcome that is attributable to a defined intervention; impact evaluations are based on models of cause and effect and require a credible and rigorously defined counterfactual to control for factors other than the intervention that might account for the observed change.

- Impact evaluations in which comparisons are made between beneficiaries that are randomly assigned to either a treatment or a control group provide the strongest evidence of a relationship between the intervention under study and the outcomes measured.

Why is M&E Important?

- M&E provide objective evidence to inform decision making.
- M&E ensure the most effective and efficient use of resources.
- M&E objectively assess the extent to which a program is having or has had the desired impact, in what areas it is effective, and where corrections need to be considered.
- M&E produce information that can help convince donors that their investments have been worthwhile or that alternative approaches should be considered.

When should M&E take place?

- M&E are continuous processes that occur throughout the life of a program.
- To be most effective, M&E should be planned at the design stage.
- Monitoring should be conducted at every stage of the program, with data collected, analyzed, and used on a continuous basis.
- Evaluations are usually conducted at the end of programs. However, they should be planned at the start because baseline data are important for end-of-program comparisons.

What is an M&E Plan?

An M&E plan is a fundamental document that describes:

- A program's objectives.
- The interventions developed to achieve these objectives.
- The activities that will determine whether or not the objectives are met.
- How the expected results of a program relate to its goals and objectives.
- The data needed and how the data will be collected, analyzed, and used.
- The resources required to conduct the plan.
- How the program will be accountable to stakeholders.

What makes an M&E Plan?

M&E plans can be organized in a variety of ways. The plan typically includes:

- Underlying assumptions
- Anticipated relationships
- Measures and definitions
- Monitoring schedule
- Data sources
- Cost estimates
- List of partnerships and collaborations
- A plan for dissemination and use of information gained

Monitoring & Evaluation

References & Resources

- Gage, A.J., & Dunn, M. (2010). Module II: Monitoring and evaluating gender-based violence prevention and mitigation programs: a facilitator's training guide. Chapel Hill, NC, USA: MEASURE Evaluation, University of North Carolina. Retrieved from https://www.measureevaluation.org/resources/training/capacity-building-resources/gbv.
- Frankel, N., & Gage, A. (2007, rev. 2016). M&E fundamentals: a self-guided minicourse MS-07-20_rev2016.pdf). Chapel Hill, NC, USA: MEASURE Evaluation, University of North Carolina. Retrieved from http://www.cpc.unc.edu/measure/publications/ms-07-20.
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Monitoring & Evaluation

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TOOL 8

Handout: Monitoring and Evaluation Basics

Purpose

Monitoring and evaluation (M&E) is the processes by which data are collected and analyzed to provide information for program planning and project management.*

Performance monitoring reveals whether desired results are occurring and whether implementation is on track. In general, the results measured are the direct and near-term consequences of project activities.

- Performance monitoring is used to gauge whether activities need adjustment during the intervention to improve the use of resources and the achievement of desired outcomes.
- It requires the collection of data at multiple points throughout the program cycle, including at the beginning to provide a baseline.

Performance evaluation focuses on descriptive and normative questions: what a specific project or program has achieved; how the project is being implemented; how it is perceived and valued; whether expected results are occurring; and other questions that are pertinent to program design, management, and operational decision making.

- Performance evaluations often incorporate before-after comparisons, but generally lack a rigorously defined counterfactual, which is a comparison between what happened and what would have happened in the absence of the intervention.
- It involves the collection of data at the start of a program (to provide a baseline) and again at the end.

M&E helps program implementers

- Make informed decisions about program operations and service delivery based on objective evidence
- Ensure the most effective and efficient use of resources
- Objectively assess the extent to which the program is having or has had the desired impact, in what areas it is effective, and where corrections need to be considered
- Meet organizational reporting and other requirements, and convince donors that their investments have been worthwhile or that alternative approaches should be considered

* There are multiple definitions of M&E-related terms. For performance monitoring, some measure the process of program implementation (e.g., is the program doing what is expected concerning activities and outputs?) and some focus on outcome monitoring (e.g., has the program done what was expected concerning outcomes?). Likewise, for performance evaluation, some call it process evaluation (e.g., addressing program operations, namely the who, what, when, and how many of program activities and program outputs) or outcome evaluation (e.g., are the outcomes attributable to the intervention?).

Process of Developing an M&E Plan

- To be most effective, an M&E plan should be created at the design stage of a program, so that the time, money, and personnel that will be required are calculated and allocated in advance. However, it is never too late to plan to collect and use data to help improve programs.
- Monitoring should be conducted at every stage of the program, with data collected, analyzed, and used on a continuous and regular basis.
- Data collection definitions, methods, and timing should not change during the program, otherwise the data may not be comparable and therefore will not be useful.
- Evaluations are usually conducted at the end of programs. However, they should be planned at the start because they rely on data collected throughout the program, with baseline data being especially important.

Six Steps for Developing an M&E Plan*

1. Define the program goals and objectives
2. Define the purpose of M&E
3. Build a conceptual framework for the specific intervention
4. Identify the indicators
5. Identify appropriate methodological approaches and sources of data
6. Develop an implementation and dissemination plans

* Note that this is an iterative process.

M&E plans can be organized in a variety of ways. The components typically are:

- Introduction
- Program description and framework
- Detailed description of the plan indicators
- Data collection plan
- Plan for monitoring
- Plan for evaluation
- Plan for the use of the information obtained
- Mechanism for updating the plan

Source: This handout is based on Frankel & Gage, 2007, rev. 2016, and on USAID. (2011). *USAID evaluation policy.* Washington, DC: USAID. Retrieved from http://pdf.usaid.gov/pdf_docs/Pdacq800.pdf.

Activity C.3. Introducing Gender-Integrated M&E

What does it mean to integrate gender in M&E activities?

Gender-integrated M&E considers the influence of the gender-integrated program on the priority population(s), especially on the gender-related and health-related objectives. Gender-integrated M&E ensures that gender is addressed throughout the program cycle and that it is a measurable component of program inputs, outputs, and outcomes. Information obtained from data that are analyzed and interpreted through a gender lens can provide evidence to raise awareness about gender imbalances, work for change, address the gender dimensions of health, and demonstrate program progress and impact (Caro, 2009; Frankel & Gage, 2007, rev. 2016; Knowledge for Health [K4Health], 2012).

Mythbuster

Just because you are collecting data from women does not mean you are practicing gender-integrated M&E.

Gender-integrated M&E requires deliberate efforts to monitor and evaluate the implications of an intervention, program, or policy for men, women, and LGBT people in all areas and at all levels. It recognizes the need to take social, economic, and biological differences among men, women, and LGBT people into consideration during the program's design and implementation stages to ensure that the proposed program or policy has the intended results for different subgroups.

With gender-integrated M&E, we ask questions such as these: Are programs adequately addressing gender? Are gender-integrated programs making a difference in gender-related health outcomes, behaviors, norms and/or inequalities? What did or did not work and why?

To answer these questions:

- **Multiple indicators** are used to measure progress over time, showing changes in intermediate gender outcomes and in improved equality in health outcomes.
- **At a minimum, data are collected, analyzed, and reported by sex and age (i.e., sex disaggregation and age disaggregation).** This information highlights possible differences in program influences and health outcomes between the sexes because the data are presented for both men and women and/or boys and girls. It can also draw attention to differences in the use of services and in the outcomes of program interventions by age (e.g., use of HIV counseling and testing services among ages 15-24 versus ages 25 and older). Sex- and age-disaggregated data are essential to monitor whether gaps between the sexes are closing, such as differences related to health behaviors, access to and use of services, and health outcomes. In some cases, disaggregating data between male and female is not sufficient. For example, HIV programs often focus on KPs, such as transgender people, who may not necessarily self-identify as male or female.
- **Gender-sensitive indicators should be used** (for example, the experience of intimate partner violence, or attitudes and beliefs about the roles of women and men in the community), and indicators should also be used for more complex constructs (gender norms, power differences between men and women, female autonomy, etc.). (Appendix B, the Women, Girls, and Gender Equality [WGGE] M&E Framework and its illustrative indicators, provides additional examples of gender-sensitive indicators.) Such indicators try to directly measure changes in gender relations.

Examples of gender-related M&E questions and illustrative indicators are:

Has there been an increase in male involvement in maternal health?

- **Illustrative indicator:** Percentage of men sampled who were present at the health facility during the birth of last child

Has the program influenced norms around GBV?

- **Illustrative indicator:** Percentage of people who agree that rape can take place between a man and woman who are married

Both quantitative and qualitative data should be collected and analyzed in gender-integrated M&E. The disaggregation of indicators by sex or the use of gender-sensitive indicators helps to identify gender differences in program implementation and impact. However, quantitative indicators alone cannot explain why or how men and women may experience different outcomes. For example, sex-disaggregated data on the number of people using TB treatment services may show that more men than women are using services, but the data will not tell you why this is the case. The collection of qualitative data is especially helpful in uncovering why there are such differences.

Powerpoint Presentation C (Tool 9) provides an overview on gender-integrated M&E. It will help you lead your stakeholders through a discussion of these points:

- What it means to integrate gender in M&E plans and activities
- Why you want to integrate gender in your M&E plans and activities
- How you integrate gender in M&E plans, including data and indicator requirements

The PPT presentation is provided in a downloadable format with speakers notes at https://www.measureevaluation.org/our-work/gender/toolkit-for-integrating-gender-in-M&Em-e-of-health-programs. A handout (Tool 10) is also provided so that your stakeholders may follow along.

Additional resources on gender-integrated M&E

- Bloom, S.S. (2008). *Violence against women and girls: A compendium of monitoring and evaluation indicators* (ms-08-30.pdf). Chapel Hill, NC, USA: MEASURE Evaluation, University of North Carolina. Retrieved from https://www.cpc.unc.edu/measure/publications/ms-08-30
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- Caro, D. (2009). *A manual for integrating gender into reproductive health and HIV programs: from commitment to action* (2nd Edition). Washington DC: USAID and IGWG. Retrieved from http://www.culturalpractice.com/wp-content/downloads/4-2009-2.pdf
- Communication for Change (C-Change). (n.d.). Compendium of gender scales. Retrieved from http://www.c-changeprogram.org/content/gender-scales-compendium/index.html
- Interagency Gender Working Group (IGWG). (2012). IGWG gender and health toolkit. Retrieved from http://www.k4health.org/toolkits/igwg-gender

Additional resources on gender-integrated M&E (continued)

- Joint United Nations Program on HIV/AIDS (UNAIDS). UNAIDS. HIV indicator registry Retrieved from http://www.indicatorregistry.org/
- MEASURE Evaluation. (n.d.). Ask the gender M&E expert. Retrieved from https://www.measureevaluation.org/our-work/gender/ask-the-gender-expert
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- United States Agency for International Development (USAID) ASSIST Project. (2017). *A guide to integrating gender in improvement.* Retrieved from https://www.usaidassist.org/resources/integrating-gen
- World Health Organization (WHO). (2011). *Gender mainstreaming for health managers: A practical approach.* Facilitator's guide. Geneva, Switzerland: WHO. Retrieved from http://apps.who.int/iris/bitstream/10665/44516/1/9789241501071_eng.pdf
- World Health Organization (WHO) & Joint United Nations Program on HIV/AIDS (UNAIDS). (2016). *A tool for strengthening gender-sensitive national HIV and sexual and reproductive health (SRH) monitoring and evaluation systems.* Geneva, Switzerland: WHO. Retrieved from http://www.who.int/reproductivehealth/publications/gender_rights/hiv-srhr-monitoring-systems/en/

TOOL 9

PPT Presentation C: Fundamentals of Gender-Integrated Monitoring and Evaluation

Fundamentals of Gender Integrated M&E

Tool 9
Activity C.3

Integrating Gender in the Monitoring and Evaluation of Health Programs:
A Toolkit

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Learning Objectives

- Define gender-integrated monitoring and evaluation (M&E)
- Identify why we want to integrate gender in M&E
- Explain how gender is integrated in M&E

What is gender-integrated M&E?

- Gender-integrated M&E considers the impact of gender on the health program, target population(s), and results.
- It integrates gender in all aspects of the M&E plan, including the conceptual framework, logic model, indicators, and data analyses/use.

What is gender-integrated monitoring?

Monitoring:

- Measures gender-specific outputs
- Tracks progress of gender-specific elements of programming
- Disaggregates data collection and analyses
- Collects data on attitudes and behavior that reflect gender norms

What is gender-integrated evaluation?

Evaluation:

- Measures impact on outcomes that relate to gender-specific programming
- Identifies elements that address gender equality
- Uses data to demonstrate progress and impact; influences demand for richer data

Why do we want to integrate gender in M&E efforts?

- To ensure that gender is addressed in programs in a measurable way
- To provide evidence to:
  - Raise awareness about gender inequity
  - Work for change
  - Address the gender dimensions of health
- To demonstrate program progress and impact

Gender M&E and Health Policies

- New international push led by the United States government, the United Nations, and other donors to address gender in programs
- Donor requirements
  - Gender should be a part of the M&E plan, reflecting how gender is addressed in all aspects of the program cycle.
  - Which donors require it?

USAID FROM THE AMERICAN PEOPLE · UNAIDS · World Health Organization · The Global Fund To Fight AIDS, Tuberculosis and Malaria · THE WORLD BANK

How is gender integrated in M&E?

Gender is addressed in:

- Program conceptual framework, logic model, and indicators used for measurement
- Data collection and analysis:
  - Sex-disaggregated data
  - Gender-sensitive data
  - Gender and health indicators
  - Complex measures (e.g., attitudes, norms, power)
  - Voluntary disclosure of LGBT status
- Data reporting, including gender-related results in reports, tools, and publications

Sample Gender-integrated Monitoring Questions & Data

National Reproductive Health Strategy on Empowerment of Men and Women, Boys and Girls to Increase Utilization of Reproductive Health (RH) Services

Question: Has male involvement in RH programs increased?

Data needed: % of male clients receiving RH services (data collected at multiple points in time); health information system

Sample Gender-integrated Monitoring Questions & Data

National Guidelines on Medical Management of Rape and Sexual Violence

Question: For rape cases presenting within 72 hours, is appropriate medical care provided, including post-exposure prophylaxis (PEP), according to National Guidelines on Medical Management of Rape and Sexual Violence?

Data needed: Sex and age-disaggregated data from routine health information systems on the number of rape survivors presenting at the facility within 72 hours who receive services, including PEP; would need custom data collection if information cannot be obtained from a review of medical records.

Sample Gender-integrated Evaluation Questions

- Has the program reduced power differences in relations between men and women?
- Has the removal of gender-based constraints contributed to improved health outcomes?
- Has stigma and discrimination against people who do not follow traditional gender norms and behaviors been reduced?

Sample Gender-integrated M&E Questions Using Routine Data

Question: Are there gender differences in use of/access to services/treatment?
- Use of and adherence to antiretroviral therapy
- Detection of tuberculosis
- Referral for treatment
- Malaria testing and treatment

Data needed: sex- and age-disaggregated data from the health information systems

Question: Are GBV programs and services inclusive of men and the LGBT community? Is *everyone* able to access health services or do service providers turn people away because of stigma and discrimination?

Data needed: qualitative data on client experiences and provider attitudes; data disaggregated by sexual orientation and gender identity

Sample Gender-sensitive Indicators

Gender equality measures: Percentage of women who own property or productive resources in their own name.

$$\left[\frac{\text{Number of women ages 15 to 49 in an area (community, region, country) who report that they own property or resources for the production of goods, services, and/or income in their own name.}}{\text{Total number of women respondents ages 15 - 49 years old}}\right] \times 100$$

Gender-based violence: Percentage of people who agree that rape can take place between a man and woman who are married.

$$\left[\frac{\text{Number of people who agree with the statement: When a husband forces his wife to have sex when she does not want to, he is raping her.}}{\text{Total number of people surveyed}}\right] \times 100$$

Activity
Addressing Gender Barriers

Gender barrier: Health services and systems strain to accommodate differences in men's and women's time and mobility patterns, and their needs and preferences.

Programmatic response: Deploy five mobile health units (MHUs) to provide community-based health services in 10 districts.

Inputs: Funds allocated to purchase MHU vehicles.

Outputs: # of nurses trained for the MHUs
# of people accessing services from an MHU
# of pregnant clients receiving antenatal care

Outcomes: Premature birth rate in the 10 target districts.

Activity
Addressing Gender Barriers

Gender barrier: Lack of knowledge of HIV services

Programmatic response: Conduct awareness campaign in all project sites, particularly in areas frequented by female sex workers and men who have sex with men, advertising specific sites and clinics where HIV services are provided.

Process: Awareness campaign message developed

Outputs: # of fliers distributed
% of project sites airing radio public service announcements notifying people about where to obtain HIV services

Outcomes: Knowledge of local HIV services

Gender M&E
References & Resources

- MEASURE Evaluation. (n.d.). Gender. Retrieved from www.measureevaluation.org/gender.
- MEASURE Evaluation. (2016). Guidelines for integrating gender into an M&E framework and system assessment (tr-16-128-en-pdf). Chapel Hill, NC, USA: MEASURE Evaluation, University of North Carolina. Retrieved from https://www.measureevaluation.org/resources/publications/tr-16-128-en.
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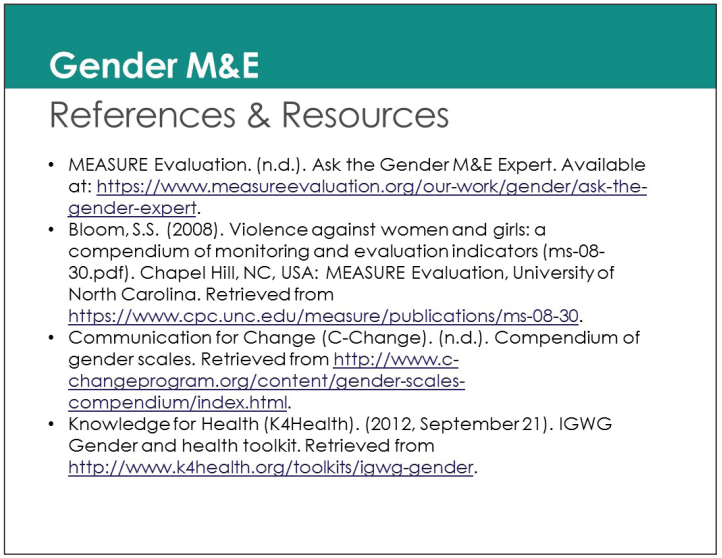

Integrating Gender in KP Programs and M&E

KPs, including FSWs, MSM, and transgender women, are often subject to stigma, discrimination, and violence, because they do not conform to traditional gender expectations or norms. It is important to use indicators that assess change in gender norms, including but not limited to GBV, in KP programs. Gender-sensitive indicators can help identify the gender norms and beliefs that lie at the root of the stigma, discrimination, and violence that KPs face. Sex- and gender-disaggregated data can identify people not yet reached with services. For example, are transgender people unintentionally excluded from a sex worker program? Are men? Simply working with KPs does not necessarily mean a program is "gender integrated."

TOOL 10

Handout: Gender and Health Monitoring and Evaluation Basics

What is gender and health monitoring and evaluation (M&E)?

Monitoring

- Uses indicators that measure gender-specific outputs
- Uses indicators that track progress of gender-specific elements of programming
- Disaggregates data collection and analyses by sex and age, at a minimum
- Collects data to measure gender outcomes, such as attitudes and behavior that reflect gender norms

Evaluation

- Identifies elements that address gender norms and gender equality
- Measures impact on outcomes that relate to gender-specific programming
- Uses data to demonstrate progress and impact; influences demand for richer data

Examples of gender and health M&E questions

Monitoring

- Are we implementing gender and health programming as planned?
- If applicable, are men and women both receiving benefits from/participating in the program?
- Are institutional and organizational policies more supportive of gender equity?
- Have the changes identified contributed to increasing access to healthcare and information?

Evaluation

- Has the program reduced power differences in relations between men and women? (For example, is decision making more equitable? Do men and women have more equal opportunities?)
- Have stigma and discrimination against people who do not follow traditional gender norms and behaviors been reduced? Are the programs and services inclusive of the lesbian, gay, bisexual, and transgender community? Are men, gay men, lesbian women and girls, and transgender people able to access services provided by the health centers, or do service providers turn these people away because of stigma and discrimination?
- Has the removal of gender-based constraints contributed to improved health outcomes?

Issues to consider when selecting gender and health indicators

- Are the indicators disaggregated by sex, ethnicity, age, and socioeconomic status?
- Are baseline data collected on women and men of different demographics?
- Are there specific indicators to measure changes in gender norms, gender relations, access to services and resources, and power and other inequalities?
- Is there a systematized way to collect and analyze information on a regular basis?
- Does the project have policies on what to do when M&E data reveal gender inequities?
- How do gender-specific objectives link to impact on health?

Illustrative Indicators

- **Gender Equality Indicator:** Percentage of women who own property or productive resources in their own name

  Numerator: The number of women ages 15 to 49 in an area (community, region, country) who report that they own property or resources to produce goods, services and/or income in their own name

  Denominator: Total number of women respondents ages 15 to 49 years old

- **Gender-based violence:** Proportion of people who agree that rape can take place between a man and woman who are married

  Numerator: # of people who agree with the statement: When a husband forces his wife to have sex when she does not want to, he is raping her.

  Denominator: Total number of people surveyed

Gender and Health M&E Resources and Tools

- Alkire, S…Vaz, A. (2013). *The women's empowerment in agriculture index*. Oxford Poverty & Human Development Initiative Working Paper No. 58. Oxford, UK: University of Oxford. Retrieved from http://www.ophi.org.uk/wp-content/uploads/ophi-wp-58.pdf
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- MEASURE Evaluation. (n.d.). Gender. Retrieved from https://www.measureevaluation.org/gender.

Source for handout: Caro, 2009

Activity C.4. Presenting the Country's Gender Context, Gender-Related Programming, and M&E Situation, and Gender and M&E Policies

Once your stakeholders understand what it means to integrate gender in M&E plans and activities, the next step is to review information on the gender norms and attitudes in your country, ongoing and planned gender and health programming, and information on what the M&E system involves (Caro, 2009).

It may be helpful to review the materials collected in Module A and/or invite stakeholders to present what they know about this topic. You may do this through a formal presentation or a breakout discussion (Tool 11).

The following questions should be addressed:

1. Concerning the gender context in your country:
   - What gender norms and power dynamics influence relevant health behaviors and outcomes?
   - What are the most prevalent health-related gender inequalities/inequities? Are there problems with unequal access to certain health services? Or with mortality or morbidity for certain diseases and populations?
   - How widespread and accepted is GBV?

2. Concerning gender-related programming in your country:
   - Are any gender-integrated programs being implemented?
   - What are their goals and objectives, and how do they address gender?
   - How do the goals and objectives relate to the gender context in your country?

3. Concerning USG and local gender- and M&E-related policies:
   - Are you familiar with USG policies on gender and M&E?
   - How are these policies being implemented in your country?
   - What are the national laws and policies related to gender (e.g., on GBV, same-sex sexual relations, inheritance of property, legal recognition of transgender people), and to what extent are they implemented and enforced?

4. Concerning information on your M&E situation:
   - What are the objectives of your M&E plans?
   - What inputs, outputs, and outcomes are being measured?
   - Do you have a plan for using the data you collect? How are the data supposed to be used?
   - Are there M&E staff trained in how to address gender in M&E?
   - Is gender being integrated in your M&E plan? If so, what gender-related indicators exist? (See Activity D.3 if you need more information/examples of indicators.) How are the gender-related indicators being measured?

TOOL 11

Handout: Gender in Context

To bring your core group of stakeholders up to speed on gender norms and attitudes in your country, ongoing and planned gender and health programming, and information on what your monitoring and evaluation (M&E) system involves, break up into small groups, and discuss the following questions. (Use the back of the sheet, as needed.) You may want to reconvene as a larger group at the end to share responses.

Discussion 1: Gender Norms and Attitudes in Your Country

What gender norms and power dynamics influence relevant health behaviors and outcomes? In what ways? Are there problems with unequal access to certain health services? Or with mortality or morbidity for certain diseases and populations? Are there certain gender norms that stigmatize certain populations, such as lesbian, gay, bisexual, and transgender people, men who have sex with men, or female sex workers? How widespread and accepted is gender-based violence (GBV)?

Discussion 2: Gender- and M&E-related policies

What are the national laws and policies related to gender (e.g., on GBV, same-sex sexual relations, inheritance of property, legal recognition of transgender people), and to what extent are they implemented and enforced? Are there any specific gender policies (government or donor) that you adhere to as a project/program?

Discussion 3: Gender-integrated programs and activities

Have there been any specific gender-related efforts in your project/program? If yes, explain, and if no, consider opportunities with your group.

Discussion 4: Gender-related M&E

What gender-sensitive data are being collected by your project/program? Are these data adequate to measure progress toward your gender goals and objectives as a project/program?

MODULE D.

Building a Gender-Integrated M&E Plan

INTRODUCTION

If your stakeholders have a good understanding of gender-integrated programming, the basics of M&E, gender-integrated M&E, and country and USG gender- and M&E-related policies, you are ready to work through a gender-integrated M&E plan with their help (MEASURE Evaluation, n.d.a.). You should convene a meeting or workshop with your working group to complete Module D. (Note: It is recommended that you conduct Modules D and E together as a two-day workshop.).

Where you begin with these steps depends on the amount of gender integration you hope to achieve in your M&E activities, and where you are in the development and implementation of those activities.

Because this toolkit assumes that you already have some form of an M&E plan, this module does not walk your team through the process of creating one. Rather, it makes note of special considerations needed under each of the five steps to integrate gender in your M&E plan. For help with building an M&E plan, MEASURE Evaluation's M&E fundamentals course (https://www.measureevaluation.org/resources/publications/ms-07-20-en) is useful, as is USAID's Performance Management Plan (PMP) Toolkit (https://usaidlearninglab.org/library/performance-management-plan-pmp-toolkit-guide-missions), which helps to establish guidelines for the collection of specific information to be used to assess program progress.

OBJECTIVES

By the end of Module D, you will have conducted a workshop with stakeholders to review your program's M&E framework, and identify and/or create indicators to measure gender-related outputs and outcomes.

ACTIVITIES

- **Activity D.1:** Adapting program goals and objectives, and reviewing the scope of the M&E system
- **Activity D.2:** Building your gender-integrated M&E results framework
- **Activity D.3:** Defining indicators to measure gender-related outputs and outcomes
- **Activity D.4:** Creating your gender indicators to measure gender-related outputs and outcomes
- **Activity D.5:** Identifying data sources

TOOLS

- **Tool 12:** Meeting Agenda for Module D
- **Tool 13:** Checklist for Defining Evaluation Questions
- **Tool 14:** Handout—Indicators
- **Tool 15:** Handout—Gap Analysis
- **Tool 16:** Handout—Indicator Reference Sheet Template

TOOL 12

Stakeholder Meeting for Module D

Name of Meeting

Date

Place where meeting is being held

Meeting Objectives

1. Identify gender-related program goals and objectives
2. Conduct a gap analysis of M&E information and identify missing indicators
3. Create indicator reference sheets

Agenda

I. Welcome, introductions, and review of meeting objectives

II. Review your problem statement and program goals and objectives
- Account for gender-related factors important to your stakeholders
- Discuss both the gender and health-related aspects of your program
- Adapt your program goals and objectives
- Define your gender-related M&E questions

III. Build the gender-integrated M&E framework
- Describe the gender-related results you expect to achieve in the program
- Link available resources and planned activities to the results

IV. Review indicators needed to measure your gender-related outputs and outcomes
- Review the "what," "why," and "how" of indicators
- Review the M&E information that you have gathered, and identify what indicators already exist
- Conduct a gap analysis to determine what indicators you have versus those that are needed

V. Select indicators
- Develop indicator reference sheets to define the indicators, determine data sources, identify the frequency of data collection, how the data will be used, etc.

Activity D.1. Adapting the Program Goals and Objectives, and Reviewing the Scope of the M&E Plan

At this point, your stakeholders should have a clear understanding of the program(s) that will be monitored and evaluated. Now your team needs to work on adapting your M&E plan so that gender is integrated (MEASURE Evaluation, n.d.a, MEASURE Evaluation, n.d.b; Gage & Dunn, 2010). In this activity, we discuss more general goals, objectives, and questions. Then, in Activity D.2, we delve into greater detail through discussion of the results framework.

You can start by reviewing the problem statement and program goals and objectives in your M&E plan to be sure that they account for gender-related factors important to your stakeholders. You may have one problem statement for each program or activity, or a problem statement for multiple programs or activities.

The problem statement should note the nature of the health issues being addressed in the program/activity, AND how gender is related to the health issues. For example, for gender-integrated HIV prevention programming, a **problem statement** could be as follows:

Note to the facilitator

Have a conversation with representatives of local civil society. Ask them what problems they see and what should be measured or monitored to promote and quantify meaningful changes. It is a valuable way to engage important stakeholders and further understand the local context.

Young men and women engage in sexual behaviors that put them at risk of an unintended pregnancy or the acquisition or transmission of HIV, because of the following factors:

- Prevailing gender norms that encourage multiple sexual partners for men
- Prevailing gender norms that limit women's ability to insist on condom use or other contraceptives, and LGBT people's ability to access healthcare
- Low perceived risk for HIV acquisition and pregnancy
- Lack of risk reduction knowledge and skills
- Other determinants, as applicable

Based on these factors, the program's objectives could be these:

- Reduce risky sexual behaviors among young men and women.
- Increase condom and other modern contraceptive use.
- Reduce unintended pregnancy.
- Reduce HIV incidence.

The goal is a change in health outcomes. To achieve these changes, **short- and intermediate-term objectives focusing both on health and gender are required.** They could be the following:

- HEALTH: Increased knowledge about condoms and modern contraception among young men and women
- HEALTH: Improved household food security
- HEALTH: Increase in HIV testing
- HEALTH: Increased use of FP services
- GENDER: Increase in gender-equitable norms
- GENDER: Decreased stigma toward LGBT people
- HEALTH: Increased condom use for dual protection
- GENDER: Increase in couple communication around contraceptive use
- GENDER: Increased equity in distribution of high-quality, nutritious food between girls and boys
- GENDER: Decrease in the percentage of men and women reporting attitudes supportive of the use of violence by a husband against a wife in multiple situations
- GENDER: Increase in the age at first sex among women and men
- Other objectives, as applicable

Next, keeping in mind your adapted goals and objectives, you and your stakeholders should rethink what you want to measure. The following questions will be helpful for this discussion:

- What do we want to know at the end of the program(s)?
- What do we expect to change by the end of the program(s)?
- Will we need to engage in advocacy or awareness-raising efforts to secure commitment and resources for gender-equitable programs?

Note to the facilitator

There may be many questions of interest. However, it is important to narrow the list to those that will be most helpful for monitoring, evaluating, and advancing your program, and that can be answered given available program resources, including staff expertise, funding, and time.

Answering these questions will also determine the scope of your program's M&E plan. For example, if at the end of your program you want to know whether health status has changed (e.g., from the above example, a reduction in HIV incidence), you will need population-based data. If all you want to know is that the target population benefitted (e.g., if men who participated in gender sensitization activities changed their perceptions of the acceptability of having multiple partners), you may only need monitoring data (i.e., the number of men participating in gender sensitization activities, and pre- and post-intervention data on participant's attitudes toward having multiple partners). The rigor and scope of your M&E plan will depend on what you commit to and how your program is meant to be held accountable.

Defining your gender-related M&E questions (Frankel & Gage, 2007, rev. 2016; Gage & Dunn. 2010):

It is important to define your main gender-related M&E questions with your stakeholders. These questions should focus on the short-, intermediate-, and long-term results of your program. The following are examples of M&E questions.*

* See Activity D.3 for definitions of inputs, outputs, outcomes, and impact.

Output-related questions:

- To what extent are planned gender program activities achieved/implemented?
- Do men, women, and LGBT people participate equally in the program?
- What percentage of health units have documented and adopted a protocol for the clinical management of sexual and gender-based violence (SGBV) services, including referrals?
- What percentage of health providers have received training on sensitivity to LGBT and KP issues in the provision of healthcare?

Outcome-related questions specific to **gender:**

- Have there been changes over time in gender norms (e.g., norms related to couple communication or couple decision making; norms related to GBV)?
- Have there been changes in women's access to and control of social and economic resources?
- Have there been changes in male participation in FP and antenatal, delivery, and postnatal care?
- Have the instances of GBV among women decreased because of the programs implemented?
- Have the instances of GBV among LGBT people and KPs decreased because of the programs implemented?
- Has the gap in food security between male-headed households and female-headed households decreased?

Outcome-related questions specific to **health:**

- Have there been any changes over time related to protective sexual behaviors, such as contraceptive use, including condoms? By women? By men? By transgender people?
- Has there been an increase in the number or percentage of women or men using FP services?
- Has there been a change in the percentage of female clients who report receiving quality services? In the percentage of LGBT clients?

Impact-related questions on **health status:**

- Has there been a change over time in the total fertility rate?
- Has there been a change in HIV prevalence? Does it differ by sex, gender identity, or employment/livelihood (e.g., sex work)?
- Has there been a change in nutrition status among children under five? Does it differ by sex?

Human and financial resources for evaluations are usually limited. Therefore, you should choose your evaluation questions carefully based on:

- **Specificity:** What questions are USG headquarters staff, development partners, host governments, etc., asking?
- **Utility:** What questions will provide information that will be most useful in helping with program improvement and success?
- **Feasibility:** How much time and human and financial resources are available for the evaluation? What questions are easier or more feasible to answer?

Think about who is asking the questions and what will be done with the information. This will be your guide for choosing the right questions for your unique program evaluation.

TOOL 13

Handout: Checklist for Defining Evaluation Questions

The development of good evaluation questions is essential, because the questions focus the evaluation on issues that decision makers and stakeholders care about, and can help to critically analyze the performance or results of an intervention (Essama-Nssah, 2013). Evaluations should answer these overarching questions:

- Are we doing the right things?
- Are we doing those things right?
- Is the intervention working?
- Is the program worth the cost?
- What explains the observed results?

This handout is designed to help you in developing a list of evaluation questions and refining them for a specific evaluation. It should be used in the design stage of an evaluation. It is important to note that the development of evaluation questions should be an iterative and collaborative process.

Sources of Questions

When developing a list of evaluation questions, there are several resources from which to draw, including those listed below.

	Evaluation questions specified in program documents, including project design documents, performance management plans (PMPs), and evaluation plans
	Evaluation users' questions and concerns about the program
	Questions and concerns about the program from other evaluation stakeholders
	Findings from earlier evaluations of this intervention/program
	Findings from earlier evaluations of similar gender-integrated interventions/programs
	Assumptions and contextual factors identified in the theory of change/logic model
	Professional standards, checklists, criteria
	Experts' views
	Your own knowledge and experience

Source for tool: USAID. (n.d.b). Checklist for defining evaluation questions Version 1.0. Retrieved from https://usaidlearninglab.org/sites/default/files/resource/files/2-checklist_for_defining_evaluation_questions.pdf.

Prioritization

Evaluations cannot aspire to answer all possible questions, especially given time and resource constraints. As such, the prioritization of your questions is crucial. The following list has questions you should ask yourself to identify those that are most important to incorporate in your evaluation.

	Would the information change or impact the course of events in your program? In other words, will the data improve your development work and results?
	Who would use the information? Who would be upset if the evaluation questions were dropped? What's the level of interest in this information by your primary stakeholders?
	Is the question of interest or does it meet an information need?
	Would the evaluation be compromised if this question were dropped?
	Is it feasible to answer the question? (Note: For research on sensitive topics, such as gender-based violence or with vulnerable and/or stigmatized populations, such as men who have sex with men, consider whether you have the resources to answer the question using required ethical and safety protocols.)
	Can those interested in this evaluation envision how they would use the evidence in response to each question?
	The personal factor: Do the primary users really care about the evaluation questions and are they really committed to acting on the changes recommended by the evaluation?

Tips for Writing Good Evaluation Questions

Evaluation questions form the basis of the statement of work and the evaluation, in general. As such, well-written questions are essential to ensure a successful evaluation. Have a small number of essential questions and specific issues. One or more of them should address gender relations and/or gender-based constraints that your program seeks to change. Then look at your questions to be sure that they:

	Each link to the evaluation purpose
	Avoid asking two questions in one
	Avoid yes/no questions
	Include relevant subquestions, when applicable (they could be relevant for looking at differences between men and women)
	Are feasible to answer given the stage of the program/policy cycle
	Are answerable with empirical evidence
	Take into account gender considerations according to the program's gender analysis
	Are realistic given the time and budget constraints of the evaluation

Activity D.2. Building Your Gender-Integrated M&E Results Framework

An M&E results framework makes it easier to see how the pieces of your program fit together. It is meant to clearly define the relationships between the primary factors related to the implementation of a program. It is the foundation for selecting appropriate and useful M&E indicators (which are discussed in detail in Activity D.3) (CDC, 2011; Frankel & Gage, 2007, rev. 2016; USAID, 2011).

In this activity, the steps for integrating gender in your results framework are described.

Steps for building a gender-integrated results framework (CDC, 2011; Frankel & Gage, 2007, rev. 2016; USAID, 2011)

Based on the previous work (e.g., Module A and Activity D.1), you should already know the goals and objectives that your gender-integrated program(s) is/are attempting to achieve, and you should be aware of the resources or inputs that went into the design of your program(s).

Now, it is time to identify the desired gender-related results, or your vision for the future, by describing what you expect to achieve in the short, intermediate, and long term. This is an iterative process. As you work on your results framework, you may note gaps and thus decide to modify your program objectives and activities.

STEP 1: Describe the gender-related results you are aiming to achieve in your program.

STEP 2: Identify what essential activities you have planned to carry out to reach your program's objectives.

STEP 3: Reexamine the activities you have planned for your program; make sure they correlate with the new gender-integrated results, and decide whether they need to be modified. If so, determine what additional or alternative resources will be required.

Frameworks

The three most common types of frameworks for developing M&E plans are:

- Conceptual frameworks
- Logic models
- Results frameworks

Although these frameworks sometimes have distinct components of M&E, it is not uncommon to hear people use the terms interchangeably. The resulting confusion can make it difficult to understand what is involved in an M&E plan.

To clarify, programs that begin with abstract or conceptual goals that are built on theory and are sometimes pictorially depicted may use a **conceptual framework.** By contrast, **logic models** link the resources that a program needs to address its goals (inputs) to how it will address those goals (the activities) to the expected results (immediate and intermediate outcomes, and long-term outcomes). Finally, a **results framework** clarifies the points at which results can be monitored and evaluated; shows the causal relationships between the incremental results of the main activities all the way up to the overall objective or goal; and measures the effectiveness of the project-related activities every step of the way.

Depending on the number of USG-supported/funded gender-integrated programs in your country, the variety of health outcomes addressed, and other contextual factors, you may choose to combine all your programming into one overarching results framework for gender-integrated programs or one framework for each health program area. Your stakeholders should decide what makes the most sense for your situation.

An illustrative gender-integrated M&E framework, the WGGE results framework, is provided in Appendix B.

Additional resources on building a results framework

- Frankel, N., & Gage, A. (2007, rev. 2016). *M&E fundamentals: A self-guided minicourse* (MS-07-20_rev2016.pdf). Chapel Hill, NC, USA: MEASURE Evaluation, University of North Carolina. Retrieved from http://www.cpc.unc.edu/measure/publications/ms-07-20
- Measurement, Learning & Evaluation Project. (2013). Measuring success toolkit: Frameworks. Retrieved from https://www.urbanreproductivehealth.org/toolkits/measuring-success/frameworks
- United States Agency for International Development (USAID). (2011). USAID evaluation policy. Washington, DC: USAID. Retrieved from http://pdf.usaid.gov/pdf_docs/Pdacq800.pdf
- United States Department of Health and Human Services, United States Centers for Disease Control and Prevention, Office of Strategy and Innovation. (2011). *Introduction to program evaluation for public health programs: A self-study guide*. Atlanta, GA, USA: CDC. Retrieved from http://www.cdc.gov/eval/guide/CDCEvalManual.pdf
- W. K. Kellogg Foundation. (2004). *Using logic models to bring together planning, evaluation, and action: Logic model development guide*. Battle Creek, MI, USA: W.K. Kellogg Foundation. Retrieved from http://www.wkkf.org/knowledge-center/resources/2006/02/wk-kellogg-foundation-logic-model-development-guide.aspx

Activity D.3. Defining Indicators to Measure Gender-Related Outputs and Outcomes

Once you have finalized your gender-related M&E questions and framework, you need a way to measure the results. This is the purpose of indicators. They measure a specific characteristic or dimension of your program results, and provide M&E information for decision making at every level and stage of program implementation (Frankel & Gage, 2007, rev 2016; Gage & Dunn, 2010).

What are gender M&E indicators?

Many indicators can be used to look at potential gender differences in health, and at the effect of gender-integrated programs on health and gender outcomes. They may be categorized in two ways:

- **Sex-disaggregated indicators:** These are regular health indicators that are presented for both men and women or boys and girls; for example, the percentage of women and men who receive HIV counseling and testing, or the percentage of women versus men sleeping under insecticide-treated bed nets. In some countries, national laws recognize more than two sexes (or genders). In these instances, demographic data should be further disaggregated.

- **Gender-sensitive indicators:** These indicators address gender directly and go beyond sex disaggregation alone (gender-sensitive indicators may still be disaggregated by sex, however). They may address diverse aspects of GBV and other more complex indicators, such as changes in gender attitudes and norms, power differences, female autonomy, access to educational and economic opportunities, etc.

What are the levels of indicators needed?

Program results are usually measured by outputs and outcomes. Indicators of **outputs** measure the immediate results as a direct product of the program's activities. For example:

- Number of women trained in small business skills by community-based programs
- Number of messages related to gender and malaria broadcast by local radio stations

Indicators of **outcomes** measure whether changes have occurred in the desired direction and whether the changes signify a program "success." They represent the program's short-term and intermediate results. For example:

- Number of women who now own and operate a small business because of community-based business skills training
- Percentage of women and men using bed net

Indicators of **impact** are very high-level and measure changes in long-term health status. They are usually not the result of a single program or initiative. Some examples are:

- Increased financial independence among women
- Reduction in malaria prevalence

Illustrative Gender-Sensitive Indicators

Illustrative Gender-Sensitive Indicators

- % of the target population that agrees with the following statements:
  - Women who carry condoms on them are easy.
  - Men should be outraged if their wives ask them to use a condom.
  - It is a woman's responsibility to avoid getting pregnant.
  - Only when a woman has a child is she a real woman.
  - A real man produces a male child. (Gender Equitable Men [GEM] Scale)
- % of women who mainly decide how their own income will be used (MEASURE Evaluation's Family Planning/Reproductive Health Indicators Database)
- % of the target population that agrees with the concept that males and females should have equal access to social, economic, and political opportunities (USAID & Department of State)
- % of ever married or partnered women (ages 15–49) who experienced physical or sexual violence from a male intimate partner in the past 12 months (UNAIDS Monitoring and Evaluation Reference Group [MERG])
- # of people completing an intervention pertaining to gender norms that meet minimum criteria (PEPFAR)
- % of facilities that have support systems (e.g., human resource policies, support groups) in place for staff providing GBV services (WGGE)
- Gender equity in organizational context (MEASURE Evaluation Family Planning/Reproductive Health Indicators Database)

For additional examples, see the WGGE illustrative indicators in the Appendix B.

Measuring Sexual Orientation/Gender Identity

Some programs, such as those that work with KPs, may want to collect information about sexual orientation and gender identity. This is especially important for MSM and transgender people. This information can also be useful for sex workers and people who use injection drugs or transgender people. Capturing data on KPs is challenging, because of the stigmatization of these groups and the need to protect their rights and safety as you design data collection protocols for your own programmatic M&E needs. It is also inherently difficult, because of differences cross-culturally in how groups are defined. This makes it impossible to design a "one size fits all" approach, although there is an appeal to achieving consistency across programs. In Appendix 1 of the Monitoring, Evaluation and Reporting (MER) 2.0 Indicator Reference Guide provided to PEPFAR programs, an illustrative form provides recommendations and examples of how to categorize KPs for reporting. As you can see in the excerpt below, the form captures sexual behavior and gender identity; it does not have information on sexual identity, sexual attraction, or gender expression. Programs may need to develop cultural and context-specific indicators of these constructs.

Appendix 1: Key population classification document

Key Population Classification (core)	**6/14/2016**
This assessment was developed to be used in both community and facility health care settings for the purpose of helping providers identify the types of services needed by the client. The complete form should be offered to all clients, regardless of providers' assumptions about whether the client is a key population member or not. Note- all script in normal text should be read out loud to the client, italicized text is instruction to the provider. **Health Care Provider script to Client:** "I will be asking you about some sexual and drug using risk behaviors. Your responses will help me/us provide you with better care. Your answers to these questions will be kept in your confidential clinic record. Answering these questions is voluntary and you can refuse to answer any question and still receive the service you've come here for today."	
1. Do you consider yourself: male, female, transgender or other? □ MALE □ FEMALE □ TRANSGENDER (male to) FEMALE □ TRANSGENDER (female to) MALE □ _____OTHER □ REFUSE TO ANSWER	*If TRANSGENDER (male to) FEMALE: client was born a boy, but identifies as a woman* *If TRANSGENDER (female to) MALE: client was born a girl, but identifies as a man*
2. What was your sex at birth: male or female?	□ MALE □ FEMALE □ _____OTHER □ REFUSE TO ANSWER
3. Do you have sex with: men, women or both?	□ MEN ONLY □ WOMEN ONLY □ BOTH MEN AND WOMEN □ REFUSE TO ANSWER
4. Is selling sex your main source of income?	□ YES □ NO □ REFUSE TO ANSWER
5. In the last 6 months, have you injected illicit or illegal drugs?	□ YES □ NO □ REFUSE TO ANSWER

Source: PEPFAR MER 2.0 Appendix 1: Key Population Classification: https://www.pepfar.gov/documents/organization/263233.pdf

TOOL 14

Tool 14 provides more information about indicators for you and your stakeholders.

Handout: Indicators

One of the most critical steps in designing a monitoring and evaluation (M&E) plan is the selection of appropriate indicators. The M&E plan should have descriptions of the indicators that will be used to monitor program implementation and the achievement of program goals and objectives.

Question 1: What is an indicator?

An indicator is a variable that measures one aspect of a program or project that is directly related to the program's objectives.

Let's take a moment to go over each piece of this definition:

- An indicator is a **variable** whose value changes from the baseline level at the time a program begins to a new value after the program and its activities have made their impact felt. At that point, the variable, or indicator, is calculated again.
- Second, an indicator is a **measurement.** It measures the value of the change in meaningful units that can be compared to past and future units. This is usually expressed as a percentage or a number.
- An indicator focuses on a **single aspect** of a program or project. This aspect may be an input, an output, or an overarching objective, but it should be narrowly defined in a way that captures this one aspect as precisely as possible.
- A reasonable guideline recommends one or two indicators per result, at least one indicator for each activity, but no more than 10 indicators per area of significant program focus.

Question 2: Why are indicators important?

Indicators provide M&E information crucial for decision making at every level and stage of program implementation.

- Indicators of program **inputs** measure the specific resources that go into carrying out a project or program.

  For example, *the amount of funds allocated to gender-based violence prevention programs.*

- Indicators of **outputs** measure the immediate results obtained by the program.

  For example, *the number of program participants or number of workshops given in X community.*

- Indicators of **outcomes** measure change in the outcome. Interpreting these indicators will reveal whether the change was in the desired direction and whether this change signifies program "success."

  For example, *the percentage of ever married or partnered women (ages 15–49) who have experienced physical violence from a male intimate partner in the past two months.*

Source: This handout is based on Frankel & Gage, 2007, rev. 2016; and Caro, 2009.

Question 3: How are indicators measured?

Indicators may be either quantitative or qualitative.

- **Quantitative** indicators are numeric. They are presented as numbers or percentages, ratios, or the results of other calculations.
- **Qualitative** indicators are descriptive observations. They may be used to supplement the numbers and percentages provided by quantitative indicators. They complement quantitative data by adding a richness of information about the context in which the program has been operating. An example is "quality of care expressed by clients during exit interviews."

Question 4: What are characteristics of a "good indicator"?

These characteristics apply to quantitative indicators. A good indicator should be **SMART** (specific, measurable, achievable, relevant, and time-bound). Specifically, it should:

- Reliably measure a specific output or outcome consistently and dependably when used repeatedly
- Measure only the condition or event it is intended to measure
- Accurately represent the desired outcome, preferably separately for men and women (if men and women are program beneficiaries)
- Reflect changes in the state or condition over time
- Represent reasonable measurement costs (i.e., be financially and logistically feasible to measure)
- Rely on available data
- Be defined in clear and unambiguous terms
- Be comparable across relevant populations, geography, and other program factors
- Be consistent with international standards and other reporting requirements
- Be *independent,* meaning that they are nondirectional and can vary in any direction. For instance, an indicator should be expressed as "the number of clients receiving counseling," rather than "increase in the number of clients receiving counseling"

Question 5: What are the guidelines for selecting indicators?

- Select indicators requiring data that can realistically be collected with the resources available.
- Select at least one indicator per essential activity or result (ideally, from multiple data sources).
- Select at least one indicator for each core activity (e.g., training event, social marketing message).
- Select no more than 10 indicators per area of significant program focus.

Indicators need to be clear and unambiguous

In many cases, indicators need to be accompanied by clarifications of the terms used. For instance, look at the indicator: **Number of antenatal care providers trained.**

Providers would need to be defined, perhaps as *any clinician providing direct clinical services to clients seeking antenatal care at a public health facility.* For the purposes of this indicator then, *providers* would not include clinicians working in private facilities.

Trained would also need to be defined, perhaps as *those staff who attended every day of a five-day training course and passed the final exam with a score of at least 85 percent.*

- Use a mix of data collection sources when possible.

Question 6: What are considerations when selecting gender-based indicators?

- Are the indicators disaggregated appropriately (e.g., by sex, gender, ethnic group, age, socioeconomic status, key populations)? (See the box above for information about measuring sexual orientation/gender identity.)
- Are baseline data collected on women and men of different ages, socioeconomic status, and ethnicity?
- Are there specific indicators to measure changes in gender relations, and in access to services, resources, and power?
- Does the project have a systematic way to collect and analyze information on a regular basis?
- Does the project have policies about what to do when M&E data reveal gender inequities?
- How do gender-specific objectives link to impact on reproductive health?

Activity D.4. Creating Your Indicators to Measure Gender-Related Outputs and Outcomes

Now it is time to select appropriate indicators to measure gender-related outputs and outcomes for your M&E plan. This activity covers the steps in that process.

STEP 1: Review the M&E information you have gathered. (Refer to Tool 2.)

1. What (if any) indicators already exist for measuring gender-related outputs and outcomes?
2. What are the systems/data from which your gender-related indicators are derived?
    - Routine data (i.e., health information systems data, program data)
    - Program "surveys" or special studies
    - National surveys
    - National surveillance
3. How functional are these systems? What resources would be needed to change/add to them?
4. Which indicators can be adapted for gender-integrated programs (e.g., routine health information system collecting and reporting sex-disaggregated data; special surveys adding gender indicators, such as gender norms)?

STEP 2: Carry out a "gap analysis" (Tool 15). Determine what indicators you already collect versus your priority gender-related outputs and outcomes (according to the main M&E questions you want to answer).

1. Are there any big gaps? For example, are there enough gender-sensitive indicators related to health, determinants of health, the health system, or the community?
2. Are there any areas that have unnecessary/irrelevant indicators?
3. Are there routine indicators that can be disaggregated by sex or gender?
4. What other indicators are needed?

STEP 3: Select indicators based on your existing indicators and your gap analysis. Tool 15 provides an overview of what the appropriate indicators might be. Select sex-disaggregated indicators (e.g., health outcomes for women and men) and gender-sensitive indicators (e.g., norms) to measure the gender-related outputs and outcomes identified in your gender-integrated results framework. Given your available resources, standard indicators should be used or modified rather than developing new ones.

Guidelines for selecting indicators to measure gender-related outputs and outcomes:

- Select indicators that are **SMART:** Specific, Measurable, Achievable, Relevant, and Time-bound.
- Select indicators that can be measured with your available data as possible.
- Select at least one indicator per essential activity and primary outcome (ideally, from multiple data sources).
- Select no more than 10 indicators per area of significant program focus.
- Use a mix of data collection sources when possible.
- Formulate measures that demonstrate removal of gender–related barriers.
    - For example, if a barrier to men accessing FP services is the perception that FP is "women's business," and your program is trying to counter this by promoting the idea that men share a responsibility for FP, you could measure the success of your program using such indicators as:
    - Percentage of men who support the use of modern contraception for themselves
    - Number of men accessing FP services
- Select indicators to capture both qualitative and quantitative gender information.
    - For example, rather than "number of service providers attending GBV training," select an indicator to capture the true participation and knowledge gained, such as:
    - Number/percentage of service providers who have mastered relevant knowledge in GBV counseling training
    - Percentage of trained service providers who perform to established GBV counseling standards
- Aim to measure change in inequality.
    - For example, instead of "20 women joined the farmers' association," use an indicator that captures the scale of change, such as:
        - Percentage of farmer association members who are women
        - Percentage of women in leadership positions

STEP 4: Develop indicator reference sheets, as needed, to describe your indicators in more depth. (See Tool 16 for a template and Appendix C for illustrative examples.)

- Suggested concepts/topics to have on your indicator reference sheets are the exact definition of the indicator; its unit of measurement; how the data will be disaggregated; type of result (i.e., output, outcome, or impact); direction of change; data source; any important notes; and how the information will be reported, disseminated, and used.

See Appendix B for additional illustrative indicators from the WGGE M&E Framework.

Additional resources on gender-related indicators

- Bloom, S.S. (2008). *Violence against women and girls: A compendium of monitoring and evaluation indicators* (ms-08-30.pdf). Chapel Hill, NC, USA: MEASURE Evaluation, University of North Carolina. Retrieved from https://www.cpc.unc.edu/measure/publications/ms-08-30
- Bloom, S.S., & Negroustoueva, S. (2014). *Compendium of gender equality and HIV indicators* (ms-13-82.pdf). Chapel Hill, NC, USA: MEASURE Evaluation, University of North Carolina. Retrieved from http://www.cpc.unc.edu/measure/publications/ms-13-82
- Cannon, A.C., Arcara, J., Arnoff, E., & Bloom, S.S. (2014). *Trafficking in persons and health: A compendium of monitoring and evaluation indicators* (ms-14-97.pdf). Chapel Hill, NC, USA: MEASURE Evaluation, University of North Carolina. Retrieved from http://www.cpc.unc.edu/measure/publications/ms-14-97
- CARE. (2016). WE-MEASR: A new tool for measuring women's empowerment in health programs. Retrieved from http://www.care.org/we-measr-new-tool-measuring-women%E2%80%99s-empowerment-health-programs
- Communication for Change (C-Change). (n.d.). Compendium of gender scales. Retrieved from http://www.c-changeprogram.org/content/gender-scales-compendium/index.html
- Golla, A.M., Malhotra, A., Nanda, & P., Mehra, R. (2011). *Understanding and measuring women's economic empowerment: Definition, framework and indicators.* Washington, DC, USA: International Center for Research on Women. Retrieved from https://www.icrw.org/wp-content/uploads/2016/10/Understanding-measuring-womens-economic-empowerment.pdf
- Joint United Nations Programme on HIV/AIDS (UNAIDS). (2017). Indicator registry. Retrieved from http://www.indicatorregistry.org/
- MEASURE Evaluation. (n.d.). Family planning and reproductive health indicators database, service delivery, gender equity/sensitivity. Chapel Hill, NC, USA: MEASURE Evaluation, University of North Carolina. Retrieved from http://www.cpc.unc.edu/measure/prh/rh_indicators/crosscutting/service-delivery-ii.h.4
- MEASURE Evaluation. (2013). *Facilitating data use for gender-aware health programming: Guidance for workshop facilitators* (ms-13-81.pdf). Chapel Hill, NC, USA: MEASURE Evaluation, University of North Carolina. Retrieved from http://www.cpc.unc.edu/measure/publications/ms-13-81

TOOL 15

Handout: Gap Analysis

To determine what, if any, extra indicators are needed to measure the gender-related outputs and outcomes of your monitoring and evaluation (M&E framework), break your core group of stakeholders into small groups and answer these questions: (Use the back of the sheet, as needed.)

Q1. What is your gender-related M&E question/objective?

Q2. What, if any, indicators already exist (e.g., indicators that you are collecting data on) that measure the gender-related outputs and outcomes of your M&E question? Are they gender-sensitive? Complete the below table:

		Can data be separated by sex or gender?		Is indicator gender-sensitive?*	
Indicators	**Type of indicator (output or outcome)**	**Yes**	**No**	**Yes**	**No**

*These are indicators that address gender beyond sex disaggregation and are related to health, determinants of health, the health system, or the community. They include gender norm-driven disparities in accessing healthcare.

Q3. Do your indicators (listed above) thoroughly measure/answer your gender-related M&E question? If not, brainstorm with your group to determine which indicator(s) might be missing? Complete the table below (use the back of the sheet for more room):

Potentially new/needed gender-sensitive indicators	Type of indicator (output or outcome)	Potential source for data collection?

* Refer to Activities D.3. and D.4 in the toolkit or to Tool 14 for more information on the "what," "why," and "how" of indicators, and how to create your own.

TOOL 16

Handout: Indicator Reference Sheet Template

Indicator Reference Sheet: What Should Be Included?	
INDICATOR • What is the indicator being measured? • Remember: A good indicator should be SMART (Specific, Measurable, Achievable, Relevant, and Time-bound)	
DEFINITION • Indicators need to be defined clearly and unambiguously. • In many cases, the terms used to define the indicator are accompanied by clarifications.	
TARGET • What is the population of interest? • What is the desired sample size?	
RATIONALE • Why should this indicator be in the M&E plan? • Why is this indicator important for decision making about program implementation?	
UNIT • Unit of measurement • Usually expressed as a number or percentage	**DISAGGREGATE BY** • How will the data be disaggregated? • For example: sex, age, socioeconomic status
TYPE • Is the indicator measuring a program input, output, or outcome?	**DIRECTION OF CHANGE** • Should the desired units of measurement be higher or lower than baseline?
DATA SOURCE • From where can one obtain the information needed to measure the indicator?	
MEASUREMENT NOTES Might include: • Level at which data is collected • Who collects data for this indicator • How it should be collected • Frequency of collection • Important assumptions	
DATA USE • How will the data be communicated to decision makers? • How will the data be used to make programmatic changes/adjustments?	

Activity D.3. Identifying Data Sources

Once you have decided on and created your list of indicators, you need to determine the sources of the data for these indicators (Frankel & Gage, 2007, rev. 2016; Judice, 2009). Consider these two questions:

- • How frequently or at what intervals do you need the information?
- • Do the data already exist and are they readily available for the gender-integrated indicators?

When possible, it is important to use data that already exist to answer your gender-related M&E questions. Data can come from two sources: **Routine** data sources provide data that are collected on a continuous basis, such as information that hospitals collect on the male and female patients who use their services. **Nonroutine** data sources provide data that are collected less frequently (i.e., at the beginning and end of a program or intervention, annually, every five years), which means that you can explore issues, such as attitudes and norms, which are generally not part of routine data. (The member of your team who is a strategic information or M&E officer can help you identify the available data sources.) Examples of data sources are:

Routine Data	Nonroutine Data
• Health management information systems • Sentinel surveillance systems • Project information systems/records • Hospital patient records • Health facility registers	• Demographic and Health Surveys: The following types of information are often available: educational and employment status; control over earnings; freedom of movement; control over finances; attitudes toward gender roles; spousal communication; attitudes toward the right to refuse sex; intimate partner violence; household and reproductive decision-making power. Some of these indicators are in the "core" survey and some are in modules (e.g., GBV module). • Population HIV Impact Assessment survey • Other nationally representative surveys (e.g., AIDS Indicator Survey) • UNICEF's Multiple Indicator Cluster Survey • World Bank Living Standards Measurement Study • Population census • Police records (GBV data) • Court records (GBV data) • Government budgets (for data on funding for gender-related programs) • Special studies/research (e.g., secondary analysis, focus groups or in-depth interviews, research studies, program or project evaluations) • Program surveys (pre- and post-)

If your data sources do not provide the data needed to answer your question(s), ask:

- Can your indicator be refined so that your data provide the needed insight? For example, can you disaggregate the indicator by sex with available data?
- Can items or questions in your data collection forms be refined to provide the needed insight?

  - If so, whose permission or buy-in is needed?
  - What would be the cost-benefit of making those changes?
  - What is the timeline for making the change?
- Is there a proxy indicator that can be used to begin to respond to the data needs? That is, are there other data being collected that could help answer the question?
- Is the question important enough to decision makers that it warrants a new data collection effort (e.g., new questionnaire for program participants, new community survey)?
  - If so, how can you get the data needed or where can the necessary information be found?
  - What is the most efficient method of collecting this information? Consider whether it can it be collected by adding a module to your data collections efforts to minimize the new effort.
- Are the data of sufficient quality?

When deciding on your data sources, **data quality** should be considered both for general health indicators and gender-sensitive indicators. The better the quality of the data, the more trustworthy they will be, and the more likely that stakeholders will use the data. There are several dimensions of data quality, as noted below. And there are several tools for assessing these dimensions and then strengthening them.

It is important to assess attention paid to sex and age disaggregation throughout the data quality and reporting process. In a routine data quality assessment, we suggest you have at least one indicator that is disaggregated by sex and/or age to allow for examination of data quality about sex and age. Some questions you may want to answer:

- Do indicator definitions have descriptions on data disaggregation by sex/age?
- Do data collection and reporting tools allow for disaggregation by sex/age? Is there a clearly documented instruction on this?
- Is this indicator disaggregated routinely by sex/age?
- Are data visualized and analyzed by sex/age?

You may also choose to have gender training or prepare guidelines for handling gender-sensitive data in a data systems assessment.

Note for the facilitator

Be mindful that data collected by local governments and partners may not be useable, because of inconsistent data collection methods, definitions, and/or biased sampling, especially as it relates to marginalized groups, such as ethnic minorities, LGBT people, and KPs. Stakeholders should have an open discussion about these limitations.

Data Quality Dimensions

Dimension of Data Quality	Operational Definition
Accuracy	Also known as validity. Accurate data measure what they are intended to measure and minimize errors (e.g., recording or interviewer bias, transcription error, sampling error) to a point of being negligible.
Reliability	The data generated by a program's information system are based on protocols and procedures that do not change according to who is using them, and when or how often they are used. The data are reliable because they are measured and collected consistently.
Precision	This means that the data have sufficient detail. For example, an indicator requires information on the number of people who received HIV counseling and testing and received their test results, by sex of the individual. An information system lacks precision if it is not designed to record the sex of the individual who received counseling and testing.
Completeness	Completeness means that an information system from which the results are derived is appropriately inclusive; it represents the complete list of eligible persons or units, not just a fraction of the list.
Timeliness	Data are timely when they are up-to-date and when the information is available on time. Timeliness is affected by (1) the rate at which the program's information system is updated; (2) the rate of change of actual program activities; and (3) when the information is used or required.
Integrity	Data have integrity when the system used to generate them is protected from deliberate bias or manipulation for political or personal reasons.
Confidentiality	Confidentiality means that clients are assured that their data will be maintained according to national and/or international standards for data. This means that personal data are not disclosed inappropriately, and that data in hard copy and electronic form are treated with appropriate levels of security (e.g., kept in locked cabinets and in password protected files).

Source: MEASURE Evaluation. (2008). *Data quality audit tool: Guidelines for implementation* (MS-08-29). Chapel Hill, NC, USA: MEASURE Evaluation, University of North Carolina. Retrieved from https://www.measureevaluation.org/resources/tools/health-information-systems/data-quality-assurance-tools/dqa-auditing-tool-implentation-guidelines.pdf

MODULE E.

Developing an Implementation and Dissemination Plan

INTRODUCTION

Now that you have refined your M&E results framework with a gender perspective, selected indicators to answer your gender-related M&E questions, and identified your data sources, it is time to revise (as needed) the implementation and dissemination component of your M&E plan to reflect the changes you made during gender integration (Frankel & Gage, 2007, rev. 2016; MEASURE Evaluation, 2011b). This can be done as a separate workshop or meeting with your working group, or in conjunction with the meeting covered in Module D. (For help with preparing a meeting agenda, see Tool 17, Meeting Agenda, Module E.)

OBJECTIVES

By the end of Module E, you will have determined methods for any new data collection; developed a plan for analyzing, disseminating, and using your data; planned for midcourse adjustments to your program; and finalized a timeline for launching your plan.

ACTIVITIES

- **Activity E.1:** Determining methods for data collection
- **Activity E.2:** Developing a plan for analyzing, disseminating, and using your data

TOOLS

- **Tool 17:** Meeting Agenda, Module E
- **Tool 18:** What, Who, and How of Data Collection
- **Tool 19:** What to Do with Your Data

Activity E.1. Determining Methods for Data Collection

If you have determined that new data collection is required, you should decide the "what," "who," "how," "when," and "where" of your new data collection.

The "WHAT" of data collection

Think about what data collection system, indictors, tools, and forms should be used. Identify what resources will be needed at each stage of implementation. Appendix D provides a list of illustrative data collection tools.

The "WHO" of data collection

A critical part of "who" involves training data collection and analysis staff on gender-integrated M&E. If staff do not understand the importance of sex (gender, if possible) and age-disaggregated data collection and analysis, they are less likely to collect, compile, and use sex and age-disaggregated data. If you are adding gender-sensitive indicators,

Note for the facilitator

To facilitate this activity, you may want to break your stakeholder team into smaller groups to discuss.

staff will also need training on how to collect and calculate the indicators and the importance of their measurement.

If data collection on GBV or on stigmatized populations, such as LGBT people, is to be carried out, there are special ethical considerations surrounding data collection to maintain the safety and security of respondents and staff.* Make a note in your M&E plan that staff will be trained on these topics, if applicable. Hiring a gender integration M&E expert to lead or consult on data collection efforts is especially important when dealing with such sensitive topics.

A final consideration is the gender of the data collector/interviewer; it may be especially important for getting valid, reliable, and accurate data and should therefore be an important consideration in the process of determining the "who" of data collection.

The "HOW" of data collection

The "how" of data collection considers how often data will be collected, compiled, and sent. How will data quality be checked at every stage? For gathering data on sexual orientation, see *Best Practices for Asking Questions about Sexual Orientation on Surveys* (The Williams Institute, 2009: https://williamsinstitute.law.ucla.edu/research/census-lgbt-demographics-studies/best-practices-for-asking-questions-about-sexual-orientation-on-surveys/.)

The "WHEN" of data collection

When interviewing men and women in the community about their experiences and opinions, you should choose data collection times that allow for participation of both men and women. For example, women's and men's opinions may not be well represented if you schedule meetings or interviews when most women are preparing the evening meal or when most men are out working in the fields.

Note for the facilitator

An M&E plan is a living document that needs to be adjusted when a program is modified. You may need to facilitate a discussion about roles and responsibilities in reviewing and revising the M&E plan.

Securing your collected data, and/or stripping all personally identifiable information, are essential for maintaining confidentiality and privacy. This is very important for LGBT people, PLHIV, and people experiencing GBV.

The "WHERE" of data collection

Women and men often occupy distinct spaces in the house and in the community, usually because of traditional gender roles and expectations. Certain times and spaces may not be suitable for recruitment or for conducting discussions or interviews with one sex or another. For example, a study may want to collect information from men and women at the community level. When deciding on where to hold community informant interviews, the research team should rule out certain local areas that are not socially acceptable places for women to frequent.

*For GBV, see Ellsberg, M., & Heise, L. (2005). Researching violence against women: a practical guide for researchers and activists. Geneva, Switzerland: World Health Organization and PATH. Retrieved from http://www.who.int/reproductivehealth/publications/violence/9241546476/en/

See also World Health Organization (WHO). (2016). Ethical and safety recommendations for intervention research on violence against women. Geneva, Switzerland: WHO. Retrieved from http://www.who.int/reproductivehealth/publications/violence/intervention-research-vaw/en/

A handout (Tool 18) provides information so that your stakeholders may discuss these concepts further.

Additional resources on gender M&E training materials and conducting research

- MEASURE Evaluation. (n.d.). M&E of gender and health programs. Retrieved from http://www.cpc.unc.edu/measure/training/materials/m-e-of-gender-and-health-programs.html
- MEASURE Evaluation. (n.d.). M&E of gender-based violence (GBV) prevention and mitigation programs. Retrieved from http://www.cpc.unc.edu/measure/training/materials/gbv

TOOL 17

Stakeholder Meeting for Module E

Name of Meeting

Date

Place where meeting is being held

Meeting Objectives

1. Identify the most important aspects of and responsibilities for data collection, including who, what, and how.
2. Develop a data use plan.

Agenda

I. Identify the most important aspects of and responsibilities for data collection, including who, what, and how.

II. Develop a data use plan.

TOOL 18

Handout: What, Who, How, When, and Where of Data Collection

When collecting new data, you should decide the "what," "who," "how," "when," and "where" of your data collection. To facilitate this activity, break your stakeholder team into smaller groups and follow the steps listed below. You may want to divide into groups by topic area or by specific indicator, depending on the volume of your proposed new indicators.

STEP 1: Identify the new data you want to collect

STEP 2: Describe the "WHAT" of data collection (answer the following questions to guide the discussion):

- What data collection system should you use? Does the system already exist?
- What indicators will be derived from each data source?
- What tools/forms will be used, if any? What tools need to be created?
- What resources—e.g., training on gender-integrated monitoring and evaluation (M&E), staff, office supplies, computers, transportation—will be needed at each stage of implementation?

STEP 3: Describe the "WHO" of data collection (answer the following questions to guide the discussion):

- Who will be responsible for data collection and its supervision?
- Who will be responsible for ensuring data quality at each stage?
- If you are collecting data on sensitive topics (for example, on gender-based violence or from lesbian, gay, bisexual, and transgender people), who on your team has expertise in this area and can advise on ethical procedures? If there is no one on your team, from where will you seek this help?

STEP 4: Describe the "HOW" of data collection (answer the following questions to guide the discussion):

- How often will the data be collected, compiled, and sent? Be sure to note that sex and age disaggregation should be maintained throughout.
- How will data quality be checked at every stage?
- How will the data be sent (raw, in summary form)?
- What will be done to ensure data confidentiality and security?

STEP 5: Describe the "WHEN" of data collection (answer the following questions to guide the discussion):

- What time of day? Month? Year? Be sure to consider times in which men and women are available if your data collection involves work at the community level.

STEP 6: Describe the "WHERE" of data collection (answer the following questions to guide the discussion):

- Where will you carry out data collection? All program sites? At a selection of sites? How will you select your sites?
- Where will you interview people at your data collection sites? Be sure to consider that your subgroups may feel less comfortable in certain locations; also consider the need for confidentiality, such that others cannot hear the interview conversation.

Activity E.2. Developing a Plan for Analyzing, Disseminating, and Using Your Data

One of the goals of integrating gender in your M&E plan is to show the influence of your program on gender-related outcomes. In your dissemination activities, report your data by sex and age, any gender-sensitive data collected, and discuss any gender analyses you carried out. Consider the following steps to decide how you will analyze, disseminate, and use the information (MEASURE Evaluation, 2011b):

STEP 1: Plan for data analysis

The main questions to address in this step are:

- Who will analyze the data?
- How will the data be analyzed?
- How often will analysis occur?
- How often will the results be compiled in reports?

STEP 2: Analyze the data

Data analysis does not necessarily mean using a complicated computer analysis package. It means taking the data that you collect and looking at them in the context of the questions that you need to answer in your results framework.

For example, you have a project that is trying to increase participation in an HIV treatment program, especially among women. When you analyze your data, you see that there has been an increase in participation in the treatment program among both men and women equally. Although this is a change in the right direction, when you compare these results to the HIV prevalence in your country, which indicates that roughly two-thirds of HIV-positive people are female, the interpretation of the data becomes more meaningful. While the number reflects that 60 percent of HIV-positive men in the catchment area are participating in the treatment program, that same number of female participants represents only 20 percent of HIV-positive women in the target area. Rather than seeing women and men's "equality" in this instance as commendable, analyzing your data with a gender perspective indicates that program strategies and activities should be modified to improve female participation in the treatment program.

Integrating gender in analysis goes beyond examining data by sex and age to identifying patterns, examining potential issues in program implementation and outcomes, and asking questions, such as:

- Are gender outcomes occurring? Are health outcomes occurring?
- If health outcomes are not occurring but gender outcomes are, what might be going on in your program and/or in the context that is leading to this result?
- If health outcomes are occurring but gender outcomes are not, what might be leading to this result? Are the gender elements of programs happening?

STEP 3: Plan for dissemination and use of your data

The main questions to answer in this step are:

- Who will use your findings to press for new services, develop new programs, and improve those that already exist?
- In what format/through what medium will the data be disseminated?
- Who will disseminate the data to your stakeholders? How often?

- What fora will you convene/participate in to have your stakeholders discuss the data and develop recommendations for action?
- How will you follow-up on the recommendations that come from your findings?

You need to determine the best feedback mechanisms to meet your users' needs. You may need multiple means of dissemination, such as:

- Annual reports and data review meetings
- Database(s) to manage data and facilitate data users' access and use
- Data synthesis products that are tailored to specific stakeholders and decision makers with the authority to press for new services, allocate funds, develop new programs, and improve those that already exist
- Simple language summaries for lower literacy users

Disseminating your data and main findings—although a precursor to the data use process—is not "use" and is not sufficient to achieve data-informed decision making. You will need to consider additional activities to actively engage your primary stakeholders and decision makers to give them the opportunity to discuss the data and ask questions about the findings, such as through:

- Strategically timed data interpretation workshops
- One-on-one meetings with your main decision makers to discuss the data and their relevance to achieving program goals

Last, it is important to follow-up with important decision makers to determine whether they have implemented the recommendations supported by your gender-sensitive data. Understanding how the recommendations have or have not been implemented will help you to interpret the outcomes, or the absence of outcomes, indicated in the data you collect and analyze in the future. This will be help you improve your efforts and secure additional funds and resources to continue to support gender-sensitive M&E.

You may want to break your stakeholders into groups to determine "What to do with your data" (Tool 19).

Additional resources on gender analysis

- Haworth-Brockman, M., & Isfeld, H. (2009). *Guidelines for gender-based analysis of health data for decision making*. Washington, DC, USA: Pan American Health Organization. Retrieved from http://www2.paho.org/hq/dmdocu¬ments/2009/GBA-INGLES.pdf
- IGWG. (n.d.). Training: Gender analysis and integration for HIV and sexuality. Retrieved from https://www.igwg.org/training/gender-analysis-and-integration/

Additional information on general data analysis, reporting, interpretation and use

- MEASURE Evaluation. (2011). *Introduction to basic data analysis and interpretation for health programs: A training tool kit*. Chapel Hill, NC, USA: MEASURE Evaluation, University of North Carolina. Retrieved from http://www.cpc.unc.edu/measure/training/materials/basic-data-analysis-for-health-programs
- MEASURE Evaluation. (2009). *Making research findings actionable: a quick reference to communicating health information for decisionmaking* (ms-09-39.pdf). Chapel Hill, NC: MEASURE Evaluation, University of North Carolina. Retrieved from http://www.cpc.unc.edu/measure/publications/ms-09-39
- MEASURE Evaluation. (2011). *Framework for linking data with action* (ms-11-46b.pdf). Chapel Hill, NC, USA: MEASURE Evaluation, University of North Carolina. Retrieved from http://www.cpc.unc.edu/measure/publications/ms-11-46-b

TOOL 19

What to Do with Your Data

After determining your methods for data collection, you should decide how you will analyze, disseminate, and use the information. To facilitate this activity, break your stakeholder team into smaller groups and brainstorm the following questions by indicator:

PLANS FOR DATA ANALYSIS				
Who will analyze the data?	**How will the data be analyzed?**	**How often will analysis occur?**	**How often will results be compiled in reports?**	**What reports will be shared with those who collected the data?**
PLANS FOR DATA DISSEMINATION AND USE				
Who will use the findings?	**What data synthesis and feedback products will you develop for each data user group?**	**Who will develop products and how often will they be disseminated?**	**What active data use activities will you implement to communicate and discuss data with decision makers?**	**How often will you follow up with decision makers to determine actions on recommendations?**

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APPENDIX A.
Essential Concepts and Definitions

Gender

A culturally-defined set of economic, social, and political roles, responsibilities, rights, entitlements, obligations, and power relations associated with being female and male, and the relationships between and among women and men. The definition and expectations of what it means to be a man or a woman, and sanctions for not adhering to expectations, vary across cultures and over time, and often intersect with other factors, such as race, class, age, and sexuality. LGBT people, whether they identify as men or women, can be subject to the same set of expectations and sanctions (K4Health, n.d.a).

Gender analysis

Gender analysis is a social science tool used to identify, understand, and explain gaps between males and females that exist in households, communities, and countries. It is also used to identify the relevance of gender norms and power relations in a specific context (e.g., country, geographic, cultural, institutional, economic). The analysis typically involves examining: differences in the status of women and men and their differential access to assets, resources, opportunities, and services; the influence of gender roles and norms on the division of time between paid employment, unpaid work (including subsistence production and care for family members), and volunteer activities; the influence of gender roles and norms on leadership roles and decision making; constraints, opportunities, and entry points for narrowing gender gaps and empowering females; and potential differential impacts of development policies and programs on males and females (USAID, 2017).

Gender-based violence

In the broadest terms, GBV is violence that is directed at people based on their biological sex, gender identity, sexual orientation, or perceived non-adherence to culturally-defined expectations of what it means to be a woman and man, girl and boy. It includes physical, sexual, and psychological abuse; threats; coercion; arbitrary deprivation of liberty; and economic deprivation, whether occurring in public or private (Gage & Dunn, 2010).

Gender equality

The state or condition that affords women and men equal enjoyment of human rights, socially valued goods, opportunities, and resources. Genuine equality means more than parity in numbers or laws on the books; it means expanded freedoms and improved overall quality of life for all people (K4Health, n.d.a).

Gender equity

The process of being fair to women and men. To ensure fairness, measures should be taken to compensate for cumulative economic, social, and political disadvantages that prevent women and men from operating on a level playing field (K4Health, n.d.a).

Gender identity

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

Gender-integrated programming

Gender-integrated programs assume that gender norms, unequal power relations, and differences in access to resources influence health and confound how programs achieve their objectives; hence, they examine and address possible gender-related issues throughout the project cycle. The goal of gender-integrated programming is to achieve desired health outcomes while simultaneously transitioning to greater equality (USAID, 2012).

Gender-sensitive indicators

Indicators that address gender directly and go beyond sex disaggregation alone; for example, GBV and other more complex indicators, such as gender attitudes and norms, power differences, female autonomy, and access to educational and economic opportunities. Gender-sensitive indicators should be disaggregated by sex, when possible. Gender-sensitive indicators make it easier to assess how effectively gender dynamics that negatively influence access to health services and health outcomes have been addressed (USAID, 2017).

Sex

The classification of people as male or female. At birth, infants are assigned a sex based on a combination of bodily characteristics, including chromosomes, hormones, internal reproductive organs, and genitalia (USAID, 2012).

Sex- and age-disaggregated indicators

Health indicators that are presented for both men and women or boys and girls. We emphasize disaggregating by sex because most data are collected according to male and female sex. However, some surveys are beginning to include other identities, such as transgender, in which case the data would be disaggregated by gender identity (Yinger, et al., 2002).

Sexual orientation

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

Women's empowerment

Women's empowerment focuses attention on the degree of women's control over their own lives and environments and over the lives of those in their care, such as their children. It is about improving women's status to enhance their decision-making capacity, agency, and autonomy (K4Health, n.d.b).

APPENDIX B.
Women, Girls, and Gender Equality Results Framework and Illustrative Indicators

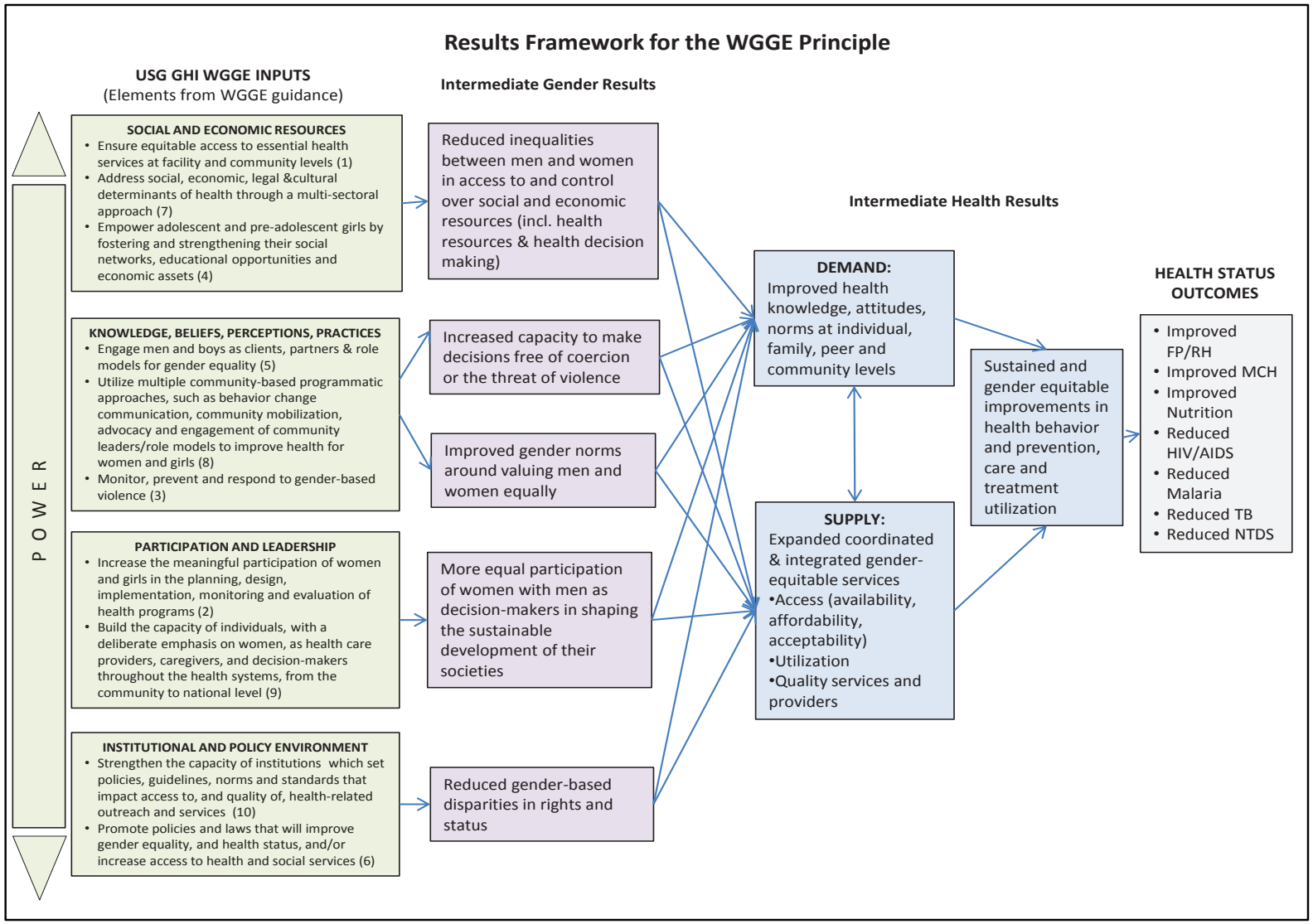
The "Women, Girls, and Gender Equality (WGGE) Principle" of the USG's Global Health Initiative (GHI) aims to address gender-related disparities that disproportionately compromise the health of women and girls, which, in turn, negatively affects families and communities (Caro, 2009). The WGGE principle considers gender norms and compensates for gender-based inequalities, integrating gender throughout planning, implementation, and M&E.

The WGGE Principle suggests that programs and policies aim to address the following 10 gender-related program elements:*

1. Ensure equitable access to essential health services at the facility and community levels.
2. Increase the meaningful participation of women and girls in the planning, design, implementation, and M&E of health programs.
3. Monitor, prevent, and respond to GBV.
4. Empower adolescent and pre-adolescent girls, by fostering and strengthening their social networks, educational opportunities, and economic assets.
5. Engage men and boys as clients, supportive partners, and role models for gender equality.
6. Promote policies and laws that will improve gender equality and health status and/or increase access to health and social services.
7. Address social, economic, legal, and cultural determinants of health through a multi-sectoral approach.
8. Use multiple community-based approaches, such as behavior change communication, community mobilization, advocacy, and engagement of community leaders/role models to improve health for women and girls.
9. Build the capacity of individuals—with a deliberate emphasis on women—as healthcare providers, caregivers, and decision makers throughout the health system, from the community to the national level.
10. Strengthen the capacity of institutions to improve health outcomes for women and girls and promote gender equality.

Building on this principle, the GHI's WGGE results framework describes pathways by which addressing gender in programs may affect health outcomes. The framework groups the 10 WGGE program elements of implementation into four distinct but interrelated domains of program activities, and highlights the importance of addressing power differentials across the four domains. It then illustrates the pathways from the four domains of program activities—through both intermediate gender and health results—to the desired GHI health status outcomes (e.g., improved FP/reproductive health [RH]). This tool can be adopted in whole or in part, or just used as an example on which to base your own results framework.

*Source: Michal Avni, Joan Marie Kraft, Diana Santillan, Ana Djapovic Scholl, Amani Selim, & The Global Health Initiative's Women, Girls, and Gender Equality Principle M&E Technical Working Group.



Source: Michal Avni, Joan Marie Kraft, Diana Santillan, Ana Djapovic Scholl, Amani Selim, & the M&E Technical Working Group. (2013). Results framework for the WGGE principle. Washington, DC, USA: The Global Health Initiative's Women, Girls, and Gender Equality Principle M&E Technical Working Group.

It is important to note the following:

- Programs produce multiple gender-related results; however, arrows in the framework show which results are most likely from programs in a specific domain.
- The framework is not intended to be a full causal model.
- Actual results may not be as "linear" as they are depicted in the framework.
- This framework is only one way of thinking about gender-integrated outputs and outcomes. It may be too detailed—or not detailed enough—for your specific program.

The indicators on the next few pages are examples of the range of results (outputs and outcomes) associated with program activities in each domain. The GHI's M&E technical working group recommended this range of indicators to illustrate what a more comprehensive M&E plan might contain. Several data sources (e.g., routine program/service use data, pre-post surveys of program participants, national survey data) would be needed to provide such a comprehensive understanding. As such, the illustrative indicators may be used as a tool (along with others) to clarify and specify program activities and objectives, identify and specify (e.g., ensure that indicators are SMART, specify when to collect sex-disaggregated data) output and outcome indicators, and develop your M&E plan.

Examples of Indicators for Each Domain of the Results Framework

Social and Economic Resources

Elements and illustrative activities or programs	Immediate outputs	Reduced inequalities in access to and control over social and economic resources	Demand	Supply	Behavior and prevention, care and treatment use
Element 1: Ensure equitable access to essential health services at facility and community levels • Reduce barriers to access (e.g., hours, transportation, financial, language, confidentiality) • Provide alternatives for clients unable to reach facilities • Train providers on respectful care and preferences (e.g., type of provider, style of decision making) • Integrate services; build robust referral mechanisms • Develop accountability mechanisms; solicit clients' perspectives on services • Mobilize communities to support essential health services for all **Element 7: Address social, economic, legal, and cultural determinants of health through a multi-sectoral approach** • Coordinate with efforts and promote linkages to rograms outside the health sector that support gender equity, girls/women (e.g., education, economic opportunity, fair and safe employment, legal services, land reform) • Raise awareness among families, communities, and government decision makers about determinants of health • Address harmful traditional practices, (e.g., child/forced marriage, abduction, FGM/C, "honor" crimes) and support traditional practices that promote gender equality • Address resource and health needs of women and girls in lowest economic quintiles.	• # of trainings by topic (e.g., gender and health) • # of women trained • % of women among trainees • # of changes to improve access (e.g., hours, confidentiality, referral/integration, insurance) • # of referrals made • # of new community service provision alternatives (e.g., community health workers, health fair) • # of facilities that establish quality assurance (QA) systems • # of QA systems that seek feedback • # of community-based programs addressing gender-equitable access (e.g., women's health, awareness of services)	**Economic empowerment** • % who earn cash* • % of women who mainly decide how their own income will be used • % of target population* that agrees with the concept that males and females should have equal access to social, economic, and political opportunities (USAID & Department of State) **Reproductive empowerment** • # of community leaders who disavow harmful traditions, such as early marriage, FGM/C, etc. • % of target population that disavows harmful traditions • % of females who marry at age 18 or older **Sociocultural empowerment** • % of families who provide adequate nutrition, education, care, and protection to children (including girls) (Children in Adversity)	**Awareness/knowledge** • % of target population that is aware of services (e.g., # who are aware of youth-friendly services) • % of target population that reports fewer barriers to service use • # of women/girls who receive support from support group/social network for safer behaviors and/or service use (e.g., % of men who are supportive of their partners' RH practices/service use)	**Knowledge and attitudes** • # of health programmers and policy makers who recognize the ways gender affects health • % of staff who recognize gender barriers to service use • % of staff with gender-equitable attitudes • Staff practice and skill • % of staff who consider clients' preferences for service provision, treatment options, etc. **Organizational/program characteristics** • # of service sites/programs that maintain modified hours, fees, and locations to encourage use • # of service sites/programs that maintain integrated services and/or have robust referral system in place	**Health behaviors** • % of women who make decisions about own health • Increased protective behaviors, e.g., ◦ % of 18 to 24-year-olds who have first birth before age 18 (GHI) ◦ % of all birth intervals that are 36 months or longer (GHI) ◦ #people protected from malaria with a prevention measure (GHI) **Service use** • % change in service use, e.g., ◦ % of HIV-positive pregnant women who received antiretroviral prophylaxis for preventing mother-to-child transmission (GHI)

***Indicators in blue** are found in MEASURE Evaluation's Family Planning/Reproductive Health Indicators Database: https://www.measureevaluation.org/prh/rh_indicators.
***Indicators in red** are used by the USG, often by USAID. Many are found in PEPFAR documents. The abbreviations indicate which program uses that specific indicator.
If you would like more detailed information about indicators in blue or red, please contact Joan Kraft (jkraft@usaid.gov).

Source: Michal Avni, Joan Marie Kraft, Diana Santillan, Ana Djapovic Scholl, Amani Selim, & the M&E Technical Working Group. (2013). Results framework for the WGGE principle. Washington, DC, USA: The Global Health Initiative's Women, Girls, and Gender Equality Principle M&E Technical Working Group.

Elements and illustrative activities or programs	Immediate outputs	Reduced inequalities in access to and control over social and economic resources	Demand	Supply	Behavior and prevention, care and treatment use
Element 4: Empower adolescent and pre-adolescent girls by fostering and strengthening their social networks, educational opportunities, and economic assets • Support positive youth development through peer networks and mentorship in and out of schools; foster positive adult-child communication • Develop specific programming for out-of-school adolescents and pre-adolescents • Involve youth, parents, schools, communities, and religious leaders when designing programs • Link health activities to education and viable livelihoods programs	• # of multi-sectoral interventions addressing social, economic, legal, and/or cultural determinants of health (e.g., land rights, school voucher, economic strengthening) • % of schools that incorporate health and gender in life skills curriculum • % of females reached (e.g., % of female participants in program to increase access to productive economic resources (assets, income, credit, employment)	• ratio (boys to girls) in primary and secondary schools • school completion rates among girls • % of women who have completed at least 10 years of education • sex ratio at birth and at age 5 **Psychological empowerment** • % of females who report increased self-efficacy at conclusion of training/program (USAID & Department of State)	• % of women who believe that spouse, friends, relatives, and community approve (or disapprove) of the practice **Perceptions of services** • % of clients who believe services meet needs • % of clients who report receiving quality services and guarantees of confidentiality	• # of service sites/ programs that maintain free or reduced fees (e.g., on sliding scale) • # of linkages between facility and community-based health service alternatives (e.g., referral systems, health tracking/ monitoring systems) • # of linkages between facility or community-based health programs and livelihood (other economic) programs	• #adults/children with advanced HIV infection receiving antiretroviral therapy (GHI) • coverage of voluntary medical male circumcision (GHI) • coverage of diphtheria, pertussis, and tetanus vaccines • % who adhere to scheduled appointments • % who are satisfied with services • % who make/keep referral appointments made

Knowledge, Beliefs, Perceptions, and Practices

Elements and illustrative activities or programs	Immediate Outputs	Improved gender norms and increased capacity to make decisions free of coercion or threat of violence	Demand	Supply	Behavior and prevention, care and treatment use
Element 5: Engage men and boys as clients, supportive partners, and role models for gender equality • -Affirm the positive role men and boys can play to improve their own health and to support the health and rights of women, girls, and communities • Provide health services for men • Provide couples counseling • Mobilize community, and mobilize male religious/ other community leaders and role models to support gender equality, human rights, etc. **Element 8: Use multiple community-based programmatic approaches, such as behavior change communication (BCC), community mobilization, advocacy, and engagement of community leaders/role models to improve health for women and girls** • Incorporate BCC activities focused on gender in health programs (e.g., address knowledge; change harmful attitudes and behaviors; and influence social norms and policies) • Engage community leaders, role models, gatekeepers (e.g., teachers, religious/tribal leaders, mothers-in-law) to increase knowledge of health consequences of specific behaviors and advocate for community change • Work with local actors to identify and reinforce cultural norms and practices that support women's and girls' health and gender equality	**For elements 5 and 8*** • Availability of accessible, relevant, and accurate information about gender influences and health behaviors (# and types of sources)* • # of programs that use multiple community-based approaches • # of health programs that incorporate gender-focused BCC activities (e.g., # of programs implemented for men and boys that include examining gender and culture norms related to SGBV) • % of target population /audience who recall hearing/seeing specific message about gender • ratio of local community to external staff	**Familial/Interpersonal Empowerment** • # of community leaders who recognize gender effects on health • % of community members who recognize gender effects on health • % of men who hold gender-equitable attitudes (on the GEM Scale) • % of men and women who share in decision making (RH issue or other issues) with spouse or sexual partner • % of target population that views GBV as less acceptable after participating in or being exposed to USG programming • % of ever married or partnered women (ages 15-49) who experience physical or sexual violence from a male intimate partner in the past 12 months (MERG)	**Awareness/ knowledge** • % of target population/ audience that know of a product, practice (e.g. health behavior), or service • % of target population that understands links between gender and health issues • % of target population that can identify one way to overcome a gender-related barrier to practicing safer behavior or using a service • % of target population with self-efficacy to change behavior or use of a service	**Staffing knowledge/ awareness** • # of staff with increased awareness of GBV, in general, and role of GBV on other health issues (e.g., attitudes of health care providers toward SGBV survivors or services) **Staff practices/skill** • % of health units with at least one service provider trained to care for and refer SGBV survivors • # of staff who follow procedures/ protocol for GBV services **Organizational/ program characteristics** • % of health facilities with GBV and coercion services available (PEPFAR)	**Health behaviors** • Increased protective behaviors, e.g., ◦ % who used condoms at last sex with non-martial partner ◦ % of total condoms supported by PEPFAR (GHI) ◦ # of people protected from malaria with a prevention measure (GHI) ◦ modern contraceptive prevalence (GHI) ◦ mean number of food groups consumed by women of reproductive age

* Elements 5 and 8 may use similar intervention approaches (e.g., community outreach/mobilization, mass media, small group activities) to address underlying gender issues (e.g., harmful practices, women's familial and inter-personal empowerment) that influence many health behaviors and service use patterns. Those behaviors and service use patterns, in turn, influence health outcomes central to GHI, including maternal and child health, FP, HIV, TB, malaria, and neglected tropical diseases. Given the similarity of potential activities across health outcomes, "generic" indicators that can be adapted to fit local needs are provided.

Elements and illustrative activities or programs	Immediate Outputs	Improved gender norms and	Demand	Supply	Behavior and prevention, care and treatment use
• Employ community members in the provision of information and services (e.g., peer educators, community-based distributors, or caregivers) • Address resource and health needs of women/girls in the lowest economic quintiles. **Element 3: Monitor, prevent, and respond to GBV** • Advocate for laws and policies to monitor, prevent, and respond to GBV • Support community and mass media efforts around attitudes and behaviors • Facilitate discussion (families, community organizations, religious, traditional, and other leaders) about human rights, GBV, and addressing GBV • Support programs to improve women and girls' self-esteem and negotiation skills • Require RH and life skills programs for adolescent and pre-adolescent girls and boys to address healthy relationships, sexual coercion, and abuse • Build provider capacity to recognize and address GBV as a contributor to negative health status and adherence to regimens • Integrate GBV screening and response in health services (PEP, emergency contraception, psycho-social support, where feasible) • -Link with multi-sectoral programs to increase GBV prevention and response • -Promote research on the incidence and impact of GBV on men and boys.	• # of community leaders and role models engaged to increase knowledge of health consequences of behaviors, and promote safer behaviors and service use • # of people completing an intervention pertaining to gender norms that meets minimum criteria (PEPFAR) • completed mapping of GBV services (facility, community) • % of health units that have documented and adopted a protocol for the clinical management of SGBV services, includes referral • % of health facilities with HIV PEP available (PEPFAR) • # of community health worker/other community outreach programs that integrate GBV • # of service providers trained to identify, refer, and care for SGBV survivors	• % of 13 to 24-year-olds reporting that they experienced sexual, physical, or emotional violence before the age of 18 (Together for Girls) **Economic empowerment** • % of target population reporting increased agreement with the concept that males and females should have equal access to social, economic, and political opportunities	• % of men who accompany their partner to antenatal care (or other type) of visit • # of community members aware of GBV services **Perception of services** • % of clients who believe that GBV services (including screening) are confidential • % of clients who believe that GBV services are non-stigmatizing	• % of facilities that have adequate supplies for GBV services (e.g., rape kits, test kits, emergency contraception) • % of facilities that have support systems (e.g., human resource policies, support groups) in place for staff providing GBV services (e.g., # of service delivery points providing appropriate medical, psychological, and legal support to women and men who have been raped or experienced incest)	**Service use** • # of people screened for GBV • # of people receiving post-GBV care (PEPFAR) • # of people provided with PEP (PEPFAR)

Participation and Leadership

Elements and illustrative activities or programs	Immediate Outputs	More equal participation of women with men as decision makers in shaping sustainable development of society	Demand	Supply	Behavior and prevention, care and treatment use

Element 2: Increase participation in planning, implementation, and M&E of programs
• Grants to community-based organizations to enhance girls and women's communication, advocacy, networking, and leadership
• Orientation on program design, implementation, and M&E ("programming")
• Participation in and feedback on design, implementation, and M&E
• Feedback mechanisms for evaluation
Element 9: Build capacity (emphasis on women) as caregivers, providers, and decision makers
• Promote role models, conduct outreach, and otherwise support women for pre- and in-service training
• Implement adult education curricula/ training that addresses gender equity and health topics
• Implement systems for equitable recruitment, retention, and promotion
	• # of awards directly to local organizations*
	• # of trainees by sex, type of personnel, and topic*
	• # who participate in health programming; % female
	• Quick investigation of quality (particularly an exit interview)
	• # of new mechanisms for client reporting
	• # of new/revised pre- and in-service courses that integrate gender
	• # of new/revised policies on equality/ discrimination
	• # of new entrants in community health work, pre-service training
	• # of in-service advancement trainings; % female
		Political and socio-cultural empowerment
		• # of girls/women in leadership roles
		• # of women role models in schools, health service, and community-based organizations
		• # of coalitions formed around gender equity
		• % of community members who value efforts to address gender equity in health services
		• % of health programs that actively seek input from community organizations
		• # of new networks for sharing information, mentoring, etc.
		Economic empowerment
		• # of females in paid health positions (government or private; facility or community)
		• % of paid health positions occupied by females
		• # of women promoted in health occupations
			Perceptions of services
			• % of community members who cite smaller number of staff or organizational barriers to service use
			• % of clients who believe service providers are responsive to articulated concerns or needs
			• % of clients who believe that services met their needs
			• % of clients who provide feedback on services through established quality assurance feedback mechanisms
				Staffing levels
				• Gender equity in organizational context (e.g., % of women and men in "non-traditional" cadres)
				Staff knowledge and attitudes
				• % of staff who recognize barriers to service use
				• % of staff with gender-equitable attitudes
				Staff practice and skill
				• % of staff/trainees who are competent to provide specific services
				• % of registered/licensed staff
				Organizational/program characteristics
				• # of incentivized community health jobs
				• # of health workers employed by government
				• # of complaints about discrimination/sexual harassment responded to according to policy
				• # of facilities/communities with task shifting
					Health behaviors
					• % of women making decisions about their own health
					• # of women receiving support from support group/ social network for safer behaviors and/or service use
					• Service use
					  ◦ Modern contraceptive prevalence (GHI)
					  ◦ # of eligible adults/ children provided with a minimum of one (HIV) care service (GHI)
					• % change in service use year to year
					• % who adhere to scheduled appointments
					• % who are satisfied with services

Institutional and Policy Environment

Elements and illustrative activities or programs	Immediate Outputs	Reduced gender-based disparities in rights and status	Demand	Supply	Behavior and prevention, care and treatment use

Element 10: Strengthen institutions that set policies, guidelines, standards, and norms, which impact access to and quality of health-related outreach/ services to improve health and promote gender equality
• Training and mentoring on gender equality and health needs of women/youth
• Address harassment, violence, and discrimination
• Support civil society organizations' participation
• Capacity to collect and use data
Element 6: Promote policies and laws that will improve gender equality and health status, and/or increase access to health and social services
• Advocacy activities
• Develop and enforce laws, guidelines, norms, operational policies, and other policies and standards to increase gender equality and empowerment (e.g., discrimination, child marriage, GBV, trafficking in persons, inheritance)
• Champions promote gender equality and safeguard women's and girls' health
	• # of trainees by sex, type of personnel and topic*
	• gender analysis/ assessment done by the MOH (or another organization)
	• policies harmonized
	• accountability system established
	• # of advocacy trainings
	  ◦ # of organizations and # of people trained
	  ◦ % female trainees
	• # and type of advocacy activities (e.g., awareness raising meeting)
	• # of policies on selected topics (including for healthcare facilities) (e.g., # of laws, policies, or procedures drafted, proposed, or adopted to promote gender equality at the regional, national, or local level; # of laws, policies, or procedures to improve prevention of or response to SGBV (USAID & Department of State)*
	• (e.g., existence of national laws, regulations, or policies that limit access to effective FP for unmarried and/or young people)
		Political empowerment
		• % of government officials and other policy makers who have gender-equitable attitudes
		• % of community members who participate in advocacy events (e.g., awareness raising, meetings)
		• % of target population reporting increased agreement with the concept that males and females should have equal access to social, economic, and political opportunities
		• % of program participants who know the legal rights of children, women, and men
			Awareness/ knowledge
			• % of target population who believe women and men should have equal access to healthcare services, at facility and community levels
			• % of non-use of services related to gender (or psycho-social) barriers
			• % of target population who know relevant policy, laws, and regulations regarding health and access to services
				Access
				• Gender sensitivity in service delivery environment (e.g., gender-sensitive services), select from menu or indicators
				• % of healthcare facilities that provide full range of health services for women, girls, men, and boys in one place or through robust referral (e.g., % of facilities where x% of clients receive service that meets the expected standards for gender sensitivity and health)
				Quality
				• % of healthcare facilities that follow new/revised policies, regulations, and standard procedures (e.g., % of facilities w/non-medical restrictive eligibility criteria for contraception)
				• % of facilities/decision-making bodies that use data on implementation and outcomes to revise policies, procedures, etc.	

APPENDIX C. Illustrative Indicator Reference Sheets

Indicator Reference Sheet: illustrative (Output Indicator)

INDICATOR

Number of service providers trained to identify, refer, and care for sexual and gender-based violence (SGBV) survivors

DEFINITION

- "Training" can include SGBV courses in nonacademic settings or nonacademic seminars, workshops, webinars, or conferences. On-the-job training is instruction in SGBV awareness through mentoring provided by a practitioner using explanations, demonstration, practice, and feedback.
- "Health service provider" is defined as any clinician providing direct clinical services to clients seeking primary care at a public health facility.

TARGET

To identify possible inequities, service providers will be surveyed in both poor and nonpoor service areas. It is planned to provide trainings in Years 2, 3, 4, and 5. In total, we assume that "X" number of providers will be trained over the life of the project, for a total of "Y" providers. These assumptions will be revised in Year 2 when training needs will have been assessed.

RATIONALE

Health service delivery programs are essential to the prevention of and response to SGBV. Every clinic visit made by a SGBV survivor presents an opportunity to address and ameliorate the effects of violence and help prevent future incidents. To take advantage of these opportunities, providers need to be prepared to deliver appropriate services, including the identification of survivors, necessary health services, counseling, and referrals to community-based resources, such as legal aid, safe shelter, and social services. This indicator will provide a measure of coverage for trained personnel per geographic area of interest, and will help monitor whether the program is attaining its target number of providers trained.

UNIT	DISAGGREGATE BY
Number of service providers	Type of provider trained; sex; area in which they work (urban or rural); type of area served (poor/nonpoor)
TYPE	**DIRECTION OF CHANGE**
Output	Higher number is better

DATA SOURCE

Records of the training program that reflect program participants among staff, what type of provider the participant was, and where they practice.

MEASUREMENT NOTES

This indicator will provide a count of providers trained, but not indicate how well they integrate the information disseminated or how well they use it later in their own practice. Presumably, if they participate in the training program, there is a level of support at the health unit in which they practice for service provision to SGBV survivors. This is one among several factors that may influence overall care provided in any place by any one provider.

DATA USE

The data will be used to press for funding to train providers, to compare with data from clients reporting that they were screened for SGBV, to determine program effectiveness, and to provide an initial benchmark as to how knowledgeable and responsive service providers are to SGBV.

Indicator Reference Sheet: Illustrative (Outcome indicator)

INDICATOR

Percent of women who own property or resources to produce goods, services, and/or income in their own name

DEFINITION

This indicator is calculated as:

- (Number of women ages 15 to 49 who report that they own property or productive resources in their own name / Total number of women respondents ages 15 to 49) x 100
- Property and productive resources are defined as land, house, company or business, livestock, produce, crops, or durable goods

TARGET

Women ages 15 to 49 living in "X" community

RATIONALE

Even in countries where laws exist to protect women's ownership rights, women may not know about or feel able to assert these rights. Women's ownership of property and resources is vital to their livelihood, economic and social independence, access to healthcare, including RH services and FP, and their overall well-being. Also, women's economic empowerment is considered necessary for equitable and sustainable economic growth and development at regional, national, district, and local levels.

UNIT	DISAGGREGATE BY
Percentage of women	Whether the woman owns property and resources alone or jointly with her husband of family member(s), by age group and urban/rural location.
TYPE	**DIRECTION OF CHANGE**
Outcome	Higher percentage is better

DATA SOURCE

Population-based surveys such as the DHS and the WHO multicountry survey on women's health and life events women's questionnaire

MEASUREMENT NOTES

The questions in the DHS and related surveys allow for responses that the woman owns the property alone, jointly with someone else, or not at all. Responses may be subject to bias when the woman does own the property alone, but feels it is more socially acceptable to say that it is jointly owned with a spouse or partner. Moreover, a woman may report that she owns property, but technically does not have or feels that she does not have the right to use or dispose of the property as she sees fit. The DHS follow-up question about whether the woman reports that she can sell the asset without anyone else's permission can help clarify these responses.

DATA USE

The data will be used to work for laws or policies that protect women's ownership rights. A positive change in this indicator can signify greater autonomy and economic independence among the women surveyed.

APPENDIX D. Illustrative Data Collection Tools

Title	Purpose	Available URL
Demographic and Health Survey	To collect gender-sensitive health data	www.measuredhs.com/What-We-Do/Survey-Types/DHS.cfm
How to Conduct a Situation Analysis of Health Services for Survivors of Sexual Assault	To provide tools to conduct a national situational analysis of sexual assault services	http://www.svri.org/sites/default/files/attachments/2016-04-13/SituationalAna.pdf
International Men and Gender Equality Survey Questionnaire	To collect household data on men's attitudes and practices, and women's opinions and reports of men's practices on topics related to gender equality	www.icrw.org/publications/international-men-and-gender-equality-survey-images
Reproductive Health Assessment Toolkit for Conflict-Affected Women	To provide tools for collecting data on safe motherhood, FP, sexual history, sexually transmitted infections, HIV/AIDS, GBV, and FGC/M	https://www.cdc.gov/reproductivehealth/global/tools/docs/pdf/rha-toolkit-cover_tag508.pdf
Researching Violence Against Women: A Practical Guide for Researchers and Activists	To suggest innovative techniques that have been used to address methodological and ethical challenges of conducting research on violence against women	http://www.who.int/reproductivehealth/publications/violence/9241546476/en/
Women's Empowerment in Agriculture Index	To measure the empowerment, agency, and inclusion of women in the agriculture sector and identify ways to overcome obstacles and constraints	www.ifpri.org/publication/womens-empowerment-agriculture-index
The Gender Equitable Men Scale	To measure attitudes toward "gender-equitable" norms, and the effectiveness of any program that hopes to influence those norms	https://www.c-changeprogram.org/content/gender-scales-compendium/gem.html
Compendium of Gender Scales	To provide tools to assess gender-related attitudes and beliefs and evaluate their interventions	www.c-changeprogram.org/content/gender-scales-compendium/about.html

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