Guide for Integrating Gender into Health Programming Monitoring and Evaluation Plans

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## Abbreviations

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<td>acquired immunodeficiency syndrome</td>
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<td>BCC</td>
<td>behavior change communication</td>
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<td>CDC</td>
<td>U.S. Centers for Disease Control and Prevention</td>
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<td>DHS</td>
<td>Demographic Health Survey</td>
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<tr>
<td>FGM/C</td>
<td>female genital mutilation/cutting</td>
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<td>GEM</td>
<td>Gender-Equitable Men Scale</td>
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<td>GHI</td>
<td>Global Health Initiative</td>
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<td>GBV</td>
<td>gender-based violence</td>
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<td>HIV</td>
<td>human immunodeficiency virus</td>
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<td>HMIS</td>
<td>health management information systems</td>
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<td>IGWG</td>
<td>Interagency Gender Working Group</td>
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<td>IMAGES</td>
<td>International Men and Gender Equality Survey</td>
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<td>LGBT</td>
<td>lesbian, gay, bisexual, or transgender</td>
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<td>LSMS</td>
<td>Living Standards Measurement Survey</td>
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<td>M&amp;E</td>
<td>monitoring and evaluation</td>
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<td>MICS</td>
<td>Multiple Indicator Cluster Survey</td>
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<tr>
<td>MOH</td>
<td>ministry of health</td>
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<td>PEPFAR</td>
<td>U.S. President’s Emergency Plan for AIDS Relief</td>
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<td>PMI</td>
<td>President’s Malaria Initiative</td>
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<td>PMP</td>
<td>performance management plan</td>
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<td>PPT</td>
<td>Microsoft PowerPoint presentation</td>
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<td>QA</td>
<td>quality assurance</td>
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<td>RHA</td>
<td>Reproductive Health Assessment</td>
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<td>RHS</td>
<td>Reproductive Health Survey</td>
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<tr>
<td>SGBV</td>
<td>sexual and gender-based violence</td>
</tr>
<tr>
<td>SMART</td>
<td>specific, measurable, action-oriented, realistic and timed</td>
</tr>
<tr>
<td>STI</td>
<td>sexually transmitted infection</td>
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<tr>
<td>USAID</td>
<td>U.S. Agency for International Development</td>
</tr>
<tr>
<td>USG</td>
<td>U.S. government</td>
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<tr>
<td>VAW/G</td>
<td>Violence against women and girls</td>
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<tr>
<td>WGGE</td>
<td>Women, Girls, and Gender Equality principle of the Global Health Initiative</td>
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INTRODUCTION

Purpose

This guide is intended to help U.S. government (USG) country teams, including gender advisors, program officers, and monitoring and evaluation (M&E) officers of USG agencies, integrate a gender perspective into their M&E efforts and become better equipped to draw from multiple sectors, offices, USG initiatives (e.g., U.S. President’s Emergency Plan for AIDS Relief [PEPFAR], President’s Malaria Initiative [PMI], Feed the Future) and other initiatives (e.g., Family Planning 2020) as they assess the effectiveness of their efforts to integrate gender across the board. The goals of this guide are to:

- present self-directed steps and tools for integrating gender into a health program’s M&E;
- facilitate dialogue with key stakeholders about the importance of gender and M&E; and
- provide further resources on gender-integrated programming and M&E.

The value of gender-sensitive data

Underlying gender norms and inequalities often result in disparities in health care and health status between men and women, boys and girls, and lesbian, gay, bisexual, or transgender (LGBT) individuals. For example, tobacco use is rising more quickly among younger women than younger men; the AIDS epidemic in sub-Saharan Africa is increasingly female; and up to 71% of women have experienced intimate partner violence sometime in their lives.

Gender-sensitive data helps to identify:

- gender norms and inequalities affecting access to and use of health services;
- determinants of risk behaviors;
- who benefits from health programs; and,
- whether health program approaches contribute to gender equality or exacerbate gender disparities.

As a result, gender-sensitive data helps to improve health programs, and ultimately improve health.

Background

The term 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, as well as the relationships between and among women and men. Gender norms, or the
definition and expectations of what it means to be a man or a woman, as well as sanctions for not adhering to expectations, varies across cultures and over time and often intersects with other factors such as race, class, age, and sexuality. Transgender persons, whether they identify as women or men, are also subject to these gender expectations. While gender is about both men and women, most policies and initiatives currently focus on women because of existing disparities.

Global initiatives now encourage health programs to explicitly address gender-based violence (GBV), promote inclusion of LGBT individuals in development efforts, address harmful gender norms, and increase equality between men and women in order to achieve health outcomes that benefit women and girls, as well as their families and communities. Consistent with development principles and policies, these initiatives encourage gender-integrated programming with intermediate objectives around gender norms, equality and equity in access to health, economic, educational and political resources, as well as long-term objectives around health behaviors and health status.1,2,4,5,6

Assessing whether such programming achieves intermediate and long-term objectives requires gender-relevant information. Integrating gender into M&E is an important step towards collecting this information and understanding the effectiveness of gender-integrated programming and improving service delivery and health outcomes for women and men, girls and boys. The collection and use of high quality, sex and age-disaggregated data and gender-sensitive indicators can help identify program successes and gender barriers. Furthermore, gender-based analysis in M&E can provide persuasive support for gender-related advocacy, and help decision-makers develop and refine evidence-based policies and programs that address specific gender-related problems.7,8

Recognizing the importance of gender M&E, this guide will help you integrate gender into your existing M&E. A variety of U.S. and international agencies have developed specific policies promoting gender integration into M&E, as well as health programs. For example, 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 and, in turn, affect families and communities. The WGGE principle considers gender norms and compensates for gender-based inequalities, integrating gender throughout planning, implementation, and M&E.2 Likewise, a key component of PEPFAR is the integration of gender throughout HIV/AIDS prevention, care, and treatment efforts.4 The importance of this approach was reinforced by the 2013 Institute of Medicine Evaluation of PEPFAR which called for PEPFAR to develop M&E activities to assess implementation and outcomes of gender-related activities across its portfolio.9 Finally, the U.S. Agency for International Development (USAID) has a long history of addressing gender equality issues, and in 2012 the Agency adopted the Gender Equality and Female Empowerment Policy.10 Under this policy, USAID has reformed budgeting and reporting requirements to capture gender equality results. This policy holds staff accountable for tracking outputs and outcomes related to gender equality and female empowerment.10

GHI’s guidance under the WGGE principle described above includes 10 gender-related program elements intended to help improve the health of women and girls, promote norms that respect and promote women’s and girls’ empowerment and decision making, and increase gender equality in
access to resources, including health resources. The USG partner agencies (USAID and the Centers for Disease Control and Prevention [CDC]) convened a WGGE M&E working group, which developed a results framework (Tool #12), three global indicators, a number of illustrative indicators, and this guide to help USG country teams to integrate gender into their health programs’ M&E.

**Audience for the Guide**

This guide is designed for personnel responsible for integrating gender into M&E and reporting, such as health program officers, gender focal points, and M&E officers. Because USAID and U.S. State Department gender policies require the integration of gender into health programs, the guide has been designed with USG country offices (e.g., USAID, CDC) in mind, although it may be used by others implementing gender-integrated health programming. Use the rapid assessment below to assess whether or not your office is ready to implement this guide.

**Rapid Assessment: Are you ready to implement this guide?**

1. Are you implementing programs with some level of gender integration (e.g., by health area, by type of intervention, across the health portfolio)?
   a. Do you have documents related to your office’s gender integrated programming?
   b. Was gender integration guided by a gender assessment or analysis?
   c. Did your office identify gender and health outcomes expected from gender integrated programming?

2. Are you carrying out M&E activities of any kind?
   a. Does your office maintain an M&E plan or M&E framework?

If it is determined from the rapid assessment that your office is not ready to implement this guide, an important first step would be to develop a gender integration framework or policy to guide your programs and inform your M&E plan. The USAID gender policy is an example of a comprehensive policy designed to enhance women’s empowerment and reduce gender gaps. Other implementing partners, such as FHI 360 and Care International, also have examples of how they integrate gender in their work. The next step would be to develop an M&E plan or M&E framework, informed by the principles from your gender policy.

**How to Use This Guide**

This guide offers a series of modules directing the user through the different steps to integrate gender into a health program’s M&E. These modules can be used in sequence or independently of one another. Where you begin and how you use them will depend on the level of gender integration you hope to incorporate into your M&E and where you are in the development of your M&E activities. Ultimately, it is meant to be a self-directed process for a team made up of program and M&E officers, and gender points of contact, allowing you (the team) to work at your own pace and
without external technical assistance (although, as described later in the guide, we suggest you involve stakeholders in the process).

All of the modules include accompanying tools. These tools include handouts, spreadsheets, and sample Microsoft PowerPoint (PPT) presentations. The handouts are one to two pages in length and highlight important information for each module and can be easily distributed to your stakeholders or other interested parties that the team involves in the process. The spreadsheets can be helpful for organizing program and M&E information. The PPT presentations are meant to help guide your discussion, ensuring that key points of each topic are covered. You can modify these tools for your particular context or needs (e.g., simplify the spreadsheet to reflect your programming or M&E system).

As a first step, we suggest you form a team made up of at least one program officer, one M&E officer, and one gender point of contact (or gender advisor). Team members should be able to devote sustained time and effort to this activity. It will take several weeks to several months to complete, depending on your current M&E situation. The team should review the guide and decide which modules to use. Table 1 lists the modules, when they may be appropriate to use, and the tools that may be useful as your team works through a given module. Again, depending on your needs, you may choose to use all or only a select few of the materials and tools in each module.

Following is a list of concepts and their 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, as well as the relationships between and among women and men. The definition and expectations of what it means to be a man or a woman, as well as sanctions for not adhering to expectations, varies across cultures and over time, and often intersects with other factors such as race, class, age and sexuality. Transgender individuals, whether they identify as men or women, can be subject to the same set of expectations and sanctions.

**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 ultimate goal of gender-integrated programming is to achieve desired health outcomes while simultaneously transitioning to greater equality.

**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 must be taken to compensate for cumulative economic, social, and political disadvantages that prevent women and men from operating on a level playing field.

Women's Empowerment

Women's empowerment focuses on attention to women's degree of 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.

Gender Identity

Each person's internal and individual experience of gender, which may or may not correspond with the sex assigned at birth, including the person's deeply felt sense of their body (which may involve, if freely chosen, modification of bodily appearance or function by medical, surgical or other means). Because gender identity is internal and personally defined, it is not “visible” to others.

Sex and gender-disaggregated data

Sex and gender-disaggregated data are normal variables that are presented by sex and/or by gender identity. For example, the percent of women, men, transgender males-men, transgender females-women, who received HIV counseling and testing or the percent of men, women, boys and girls, transgender males-men, and transgender females-women sleeping under insecticide-treated bed nets.

Gender-sensitive indicators

Gender-sensitive indicators are those that directly address gender and go beyond disaggregated data (but should also be presented for men and women separately). For example, percent of women and men who express accepting attitudes towards wife-beating or percent of men and women who share in decision making (on health issues OR other issue) with spouse or sexual partner.

Gender-based violence (GBV)

In the broadest terms, GBV is violence that is directed at individuals based on their biological sex, gender identity, or perceived 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.
## Table 1: Material included in the Guide

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<td><strong>Activity C.3:</strong> Introducing gender-integrated M&amp;E</td>
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<td><strong>Activity C.4:</strong> Presenting the country’s gender, gender-related programming, and M&amp;E situation</td>
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<td><strong>MODULE D:</strong> Building a Gender-Integrated M&amp;E Plan</td>
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<td><strong>Activity D.1:</strong> Adapting program goals and objectives and reviewing the scope of the M&amp;E system</td>
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<td><strong>Activity D.2:</strong> Building your gender-integrated M&amp;E results framework</td>
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<td><strong>Activity D.3:</strong> Defining indicators to measure gender-related outputs and outcomes</td>
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<td><strong>Activity D.4:</strong> Creating your gender indicators to measure gender-related outputs and outcomes</td>
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<td>Determine methods for data collection, analysis, dissemination and interpretation</td>
<td><strong>Activity E.1:</strong> Determining methods for data collection</td>
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<td><strong>Activity E.2:</strong> Developing a plan for analyzing, disseminating and using your data</td>
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MODULE A: Developing a Rationale for Integrating Gender into M&E

To gain support for and begin the process of integrating gender into your M&E plan, your team first needs to identify gender-related M&E questions and objectives that are relevant to the success of your health programs. The first step is to assess current gender-integration programming efforts. Important questions include:

- Have you commissioned or conducted a gender analysis to identify, understand, and explain gaps between men and women in your country? Have you identified gender norms, power relations, and/or inequalities in access to resources relevant to health outcomes? Did the analysis identify gender-related goals and objectives for health programming (e.g., changes in specific gender norms)?
- Have you made plans to integrate gender into your health program(s) of interest? Have you started implementing your plans?
- Do you have an overall M&E system in place? Have you started modifying the system to better track gender integrated programming?

By the end of Module A you will have a better understanding of the existing or lack of, gender-integrated health programs and M&E efforts in your country, and you will have documented that information so that it is available for use throughout the steps in this guide and for future reference.

Activity A.1: Gathering Background Information

In order to answer the above questions, you will need to gather information on your country’s USG-sponsored or funded (or, if not USG, other relevant) gender-related health programs, as well as their measurement, analysis, and reporting. Keep in mind that resources should be selected on the basis of their usefulness and strategic importance. There are many possible sources of this information, including gender analysis or gender assessment reports, program logic models, program work plans, and performance-monitoring plans.

Consider TOOL #1

“Sources of information for M&E gender integration” can help you identify potential relevant materials
Activity A.2: Organizing Background Information

As you collect the relevant information, it will be helpful to consolidate key points into one document. This activity will ensure that you are considering various programmatic approaches in each of your health programs.

As you investigate the status of gender integration of your health programs you will have gender objectives and health objectives with activities that correspond to these objectives. Tool #2 provides a structure for organizing the key aspects of your program’s gender and health activities and their measurement. Tool #2 is an Excel spreadsheet that captures the following information:

- program name
- implementers
- timeline
- coverage/population target
- health-related program objectives
- gender-related program objectives
- health-based inputs, outputs, and outcomes, by activity
- gender-based inputs, outputs, and outcomes, by activity
- health-based indicators
- gender-based indicators
- data collection methods/sources
- frequency and schedule for data collection
- responsible parties for collection
- when data will be available
- plans for data analysis
- responsible parties for data analysis
- plan for information dissemination

Consider TOOL #2

“Organizing gender integration information” can help you identify/organize key program information in a spreadsheet
MODULE B: Identifying and Engaging Stakeholders

Information from gender-integrated M&E will only be valuable 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 health program decision making. For data ownership to be built, your USG team should identify a set of stakeholders and engage them in proposing, designing, implementing, and reporting on gender-integrated M&E.11,12

Activity B.1: Identifying Stakeholders

Stakeholders are people or organizations who are invested in your program, those who benefit from or are affected by your program, interested in the results of your evaluation, and/or who have a stake in what will be done with your evaluation results. This guide assumes your stakeholders may include those outside of the USG offices and missions in your country but that the process of stakeholder identification and other steps in working with stakeholders will be led by your team.

**Identifying stakeholders tends to be an iterative process.** Your team may begin by asking a key informant to identify key stakeholders. Those individuals will likely identify other stakeholders. Ideally, for USG offices, there should be representation from the following eight categories:

1. USG technical M&E specialists, such as an M&E officer
2. USG technical gender specialists, such as a gender focal point
3. USG program officers and staff, such as health officers or program managers responsible for making decisions about programming and/or ensuring programs are implemented
4. Local organizations/offices that need/request gender-sensitive data, such as women’s activist groups, LGBT groups, any local government Ministry of gender or of women, a division in the Ministry of Health (MoH) that addresses gender or women, etc.
5. Local organizations/offices who are empowered to implement any planned improvements in both M&E systems and in programming, such as a representative from the MoH or a donor partner
6. Persons representing program beneficiaries and others directly affected (positively or negatively) by the programs; do not consider just program beneficiaries, as there may be other groups that are somehow disadvantaged by the intervention that also should be included
7. Implementing partner technical M&E staff
8. Implementing partner technical gender specialists

Furthermore, stakeholders should be included from various levels — national, regional and local — and segments of the population — including from both sexes and multiple gender identities— as
appropriate to the activity. Stakeholders who have interest, expertise, resources, or influence should be considered with particular interest.

**Important questions to ask when identifying stakeholders include:**

- Who needs to use the data and/or will benefit from it and what questions do they want to answer?
- Who is actively seeking this data? Human rights groups, LGBT-focused groups, women’s rights groups, civil society groups, etc.?
- Who has influence and resources that can help integrate gender into the M&E plan?
- Who will be directly or indirectly, positively or negatively affected by the implementation of and/or outcome of the gender-integrated health programs?
- Who will support our gender-integrated M&E plan? Who will oppose it? Why? How do we deal with that?
- What does each of the stakeholders contribute to the M&E process?

**What not to do when choosing stakeholders:**

- **DO NOT** only invite stakeholders who are in agreement with the proposed work.
- **DO NOT** only select stakeholders who are directly involved in the projects.
- **DO NOT** only invite stakeholders to the preliminary briefing; include them thereafter in adapting the M&E plans and system, and using the data for program decision making.
- **DO NOT** only include the required bare minimum number of stakeholders to obtain formal approvals.
- **DO NOT** only invite USAID representatives and/or implementing partner representatives. You want representation from all actors who could benefit from this data.

**Consider TOOL #3**

“Stakeholder Analysis Matrix” can assist with choosing your stakeholders
Activity B.2: Engaging Stakeholders

It is important to engage stakeholders throughout the M&E gender-integration process. Often, stakeholders are not involved throughout the M&E cycle. Instead, they may be consulted at the beginning to endorse an already formulated plan, or later to disseminate information and/or receive feedback. To be most effective in your efforts, your USG team should attempt to engage stakeholders in the design, execution, and application of integrating gender into M&E efforts. It will not only raise awareness of ongoing gender-integrated activities and gender M&E activities, but it will also facilitate the use of data and information produced by those activities. Therefore, when deciding on who your stakeholders will be, also consider creating a “stakeholder engagement plan”:

- Consider the different ways each stakeholder can be involved in integrating gender into the M&E process and define the specifics of how you will engage them at different points in your M&E.
- Start by listing the steps in your plans and discussing whether/how each stakeholder can contribute to that step.

You might want to consider dividing your stakeholders into two groups:

<table>
<thead>
<tr>
<th>Group</th>
<th>Task</th>
<th>Example Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Steering Committee</td>
<td>✓ Make overarching decisions. &lt;br&gt; ✓ Represent the group at higher level meetings to communicate gender M&amp;E activities. &lt;br&gt; ✓ Oversee any actions that have budget implications. &lt;br&gt; ✓ Guide and maintain the process. &lt;br&gt; ✓ Ensure that gender is integrated into M&amp;E through review of plans from the working group. &lt;br&gt; * Meet two or three times.</td>
<td>✓ A representative from MOH, State Department, and/or civil society &lt;br&gt; ✓ MOH staff member &lt;br&gt; ✓ USAID health officer &lt;br&gt; ✓ CDC Director &lt;br&gt; ✓ Directors of USG implementing partners</td>
</tr>
<tr>
<td>Working Group</td>
<td>✓ Create indicator reference sheets for new indicators. &lt;br&gt; ✓ Adapt data collection tools to collect data for gender-sensitive indicators. &lt;br&gt; ✓ Analyze gender-integrated M&amp;E data. &lt;br&gt; ✓ Contribute specific skill sets to carry out gender integration into M&amp;E. &lt;br&gt; * Meet at benchmarks towards completion of your gender integration into M&amp;E work.</td>
<td>✓ Agreement Officer of a USAID project &lt;br&gt; ✓ CDC advisor &lt;br&gt; ✓ Gender focal point &lt;br&gt; ✓ MOH M&amp;E officer &lt;br&gt; ✓ Program officer &lt;br&gt; ✓ M&amp;E or gender staff at implementing partners</td>
</tr>
</tbody>
</table>
**Sources for information for identifying and engaging stakeholders:**

MODULE C: Setting the Stage for Integration of Gender into M&E Plans

Assuming you have your group of stakeholders, 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 into your M&E plan/system. Your team should prepare an agenda/outline of topics and issues you want to discuss. (Tool #4, Sample Stakeholder Meeting Agenda, can help with this.) You should allow time and flexibility to pursue unanticipated but relevant issues. To make sure that everyone understands key concepts, it might be useful to cover the following topics and activities.

Activity C.1: Reviewing Gender-Integrated Programming

What do we mean by 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 ultimate 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., recognize and work around gender inequalities and norms) and at best, they are “gender transformative” (i.e., seek to reduce gender inequality and modify norms). They should never be “gender exploitative”. (See Figure 1: Gender Continuum.)

Research suggests that integrating gender into health programs helps to reduce HIV transmission, violence against women, unmet need for contraception, and maternal and neonatal mortality (see, for example: Rottach, E. Schuler, SR, and Hardee, K. Gender Perspectives Improve Reproductive Health Outcomes: New Evidence, December 2009.) It does so by maximizing access to and quality of health information and services, and by facilitating individual decision-making among women and men about their own health and that of their families. Your stakeholders may not understand what it means to integrate gender into health programs. It is your role to explain gender integration and why it is important.

Lead your stakeholders through a discussion of:

- the definitions of gender & related terms
- why gender is important to health outcomes & programming
- criteria for and ways that gender is addressed in programs
- process used to develop gender-integrated programming (see Strategic Steps to a Gender-
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 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 key program strategies to address gender-based constraints and opportunities.

STEP 4: Monitor - Develop indicators that measure gender-specific outcomes; monitor implementation and effectiveness in addressing program objectives.

STEP 5: Evaluate - Measure impact of program on health and gender equity outcomes; adjust design accordingly to enhance successful strategies.

Consider TOOLS #4, #5, and #6

- Tool #4: “Sample Stakeholder Meeting Agenda” to help plan your meeting.
- Tool #5: PPT A - “Fundamentals of Gender-integrated Programming” to help guide the discussion, and
- Tool #6: “Gender-Integrated Programming Basics” as a handout

Sources for information on gender-integrated programming:

Figure 1: Gender Continuum

**GENDER EQUALITY CONTINUUM TOOL**

- **Gender Blind**
  - Ignores:
    - the set of economic/social/political roles, rights, entitlements, responsibilities, obligations and power relations associated with being female & male
    - dynamics between and among men & women, boys & girls
  - Examines and addresses these gender considerations and adopts an approach along the continuum

- **Gender Aware**
  - Fosters critical examination of gender norms* and dynamics
  - Strengthens or creates systems* that support gender equality
  - Strengthens or creates equitable gender norms and dynamics
  - Changes inequitable gender norms and dynamics

  * Norms encompass attitudes and practices
  * A system consists of a set of interacting structures, practices, and relations

- **Exploitative**
  - Reinforces or takes advantage of gender inequalities and stereotypes

- **Accommodating**
  - Works around existing gender differences and inequalities

- **Transformative**
  - Gender Equality and better development outcomes

**GOAL**
Activity C.2: Introducing Fundamentals of M&E

What is monitoring and evaluation? M&E is the process by which data are collected, analyzed and used to improve programs and inform decision-making. It should be incorporated at all stages of the program cycle: developed alongside the assessment of needs and program planning, continued through routine monitoring of program implementation, and finalized with a robust evaluation agenda. This ongoing feedback and analysis allows for necessary and timely program changes, making it more likely to reach program objectives and lead to improved health outcomes. It also helps identify evolving gender and health issues that may need to be incorporated into current programming or may require additional health programming.

Your stakeholders may have preconceived ideas about M&E, which can prevent them from moving forward. It is important to clarify M&E concepts and emphasize its role in providing a better understanding of how your programs are working.

Introduce the fundamentals of M&E and lead stakeholders through a discussion of:

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

Consider TOOLS #7 and #8

| Tool #7: | PPT B - “Fundamentals of Monitoring and Evaluation” can guide the stakeholder discussion, and |
| Tool #8: | “Monitoring and Evaluation Basics” as a handout |

Sources for information on M&E:

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

What does it mean to integrate gender into M&E? \(^{2,15,16}\)

Gender M&E considers the influence of the gender-integrated program on the target population, particularly on gender-related and health objectives. It ensures that gender is integrated throughout the program cycle in a tangible way and will be a measureable component of program inputs, outputs, and outcomes. Information gleaned from data that are analyzed and interpreted through a gender lens can provide evidence to raise awareness of gender imbalances, advocate for change, address gender dimensions of health, and demonstrate program progress and impact.

In gender M&E, we ask questions such as: 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 help answer these questions:

- **Multiple indicators** are used to measure progress over time, showing changes in intermediate gender outcomes, as well as greater equality in health outcomes.

- **Data are at a minimum collected, analyzed, and reported by sex and age.** This information highlights possible differences in program influence and health outcomes between the sexes, as data are presented for both men and women or boys and girls (e.g., the percentage of women and men who received HIV counseling and testing). Sex and age-disaggregated indicators are necessary to monitor whether gaps between men and women, and between boys and girls, are closing, such as those related to health behaviors, access and utilization of services, and health outcomes.

- **Gender-sensitive indicators should be used**, such as GBV or maternal mortality, as well as other more complex indicators like gender attitudes and norms, power differences, female autonomy, etc. (See WGGE illustrative indicators under Activity D4 of Module D for further examples.) These indicators go beyond sex disaggregation alone, to measure intermediate gender outputs and outcomes directly.

**Sample gender M&E questions:**

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

- **Example of data needed:** Percent of men present at health facility during the birth of last child.

*Has the program influenced norms around GBV?*

- **Example of data needed:** Proportion of people who agree that rape can take place between a man and woman who are married.
The role of qualitative data in gender M&E:

It is important that both quantitative and qualitative data be collected and analyzed in gender M&E. By disaggregating most indicators by sex or developing gender-sensitive indicators, we can help to illuminate gender differences in program implementation and impact. These quantitative indicators, however, do not explain why or how differential outcomes transpire. For example, sex-disaggregated data on the number of people using tuberculosis treatment services may show that more men than women are using services, but it will not tell you why this is the case. Qualitative research can be particularly helpful in uncovering the reasons for such differences.

When introducing gender M&E, bring the concepts of gender and M&E together and lead stakeholders through a discussion of:

- what it means to integrate gender into M&E;
- why you want to integrate gender into your USG M&E plans; and
- how you integrate gender into M&E, including data and indicator requirements (you may want to show the WGGE Results Framework, see activity D.3, as an example of a product of this integration).

Consider TOOLS #9 and #10

| Tool #9:     | PPT C - “Fundamentals of Gender-integrated Monitoring and Evaluation” to guide the discussion, and |
|             | Tool #10: “Gender and Health M&E Basics” as a handout |

Sources for information on gender and health M&E:

- MEASURE Evaluation gender website: www.measureevaluation.org/gender
- VAW/G compendium: https://www.cpc.unc.edu/measure/publications/ms-08-30
- Gender scales: http://www.c-changeprogram.org/content/gender-scales-compendium/index.html
- K4 Health IGWG Gender and Health Toolkit: http://www.k4health.org/toolkits/igwg-gender
Activity C.4: Presenting the Country’s Gender, Gender-Related Programming, and M&E Situation and USG Gender and M&E Policies

Once your stakeholders understand what it means to integrate gender into M&E, the next step is to review information on the prevailing gender norms and attitudes affecting health in your country, the existing and planned gender and health programming, and information on what the current M&E system involves. It may be helpful to develop presentations based on the material collected under the activities of MODULE A and/or invite stakeholders to present on their related expertise. In addition, depending on the composition of your stakeholder group and their familiarity with USG policies related to gender and M&E, you may need to provide some background on such policies.

The following questions should be addressed:

Regarding the gender reality in your country:

- What gender norms and power dynamics directly or indirectly influence relevant health behaviors and outcomes?
- What are the most prevalent health-related gender inequalities/inequities?
- Is there evidence of GBV?

Regarding gender-related programming in your country:

- What are the in-country gender-integrated programs?
- What are their goals and objectives, and how do they address gender?
- How do the goals and objectives relate to the “gender reality” in your country?

Regarding USG and local gender and M&E-related policies (if needed, considering stakeholder familiarity):

- What are USG policies related to gender and M&E?
- How are these policies being implemented?
- What are the local laws and policies on gender, and at what level(s) are they implemented and enforced?

Regarding information on your current M&E situation:

- What are the main objectives of the existing M&E plan/system?
- What inputs, outputs and outcomes are currently being measured?
- Is there a plan in place for using the collected data? How are the data supposed to be used?
- Is gender being integrated into the current M&E plan? If so, what gender related indicators exist? (See Activity D.3. if you need more information/examples related to indicators.) How are they being measured?
Consider (and update if needed) Tool #2

“Organizing Gender Integration Information” can be used to review relevant information already gathered

Sources for information on M&E plans:


MODULE D: Building a Gender-integrated M&E Plan

Assuming your stakeholders have a good understanding of the gender integrated programming in their country, 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 assistance. You should convene a meeting or workshop with the stakeholders in the working group to complete Module D, and possibly Module E as well. (Tool #11, Sample Meeting Agenda, Modules D and E, will be helpful for preparing the outline of topics you will want to discuss.)

There are typically six steps for developing an M&E plan, all of which apply when adapting an M&E plan to integrate gender. While these steps are iterative in nature, for the purposes of this guide, we present them as follows:

1. Define the program goals and objectives.
2. Define the purpose of monitoring and/or evaluation.
3. Build a results framework for the specific intervention(s). (Tool #12, the Results Framework for the WGGE Principle can be used as a reference.)
4. Identify the indicators. (Can refer to WGGE Global and Illustrative Indicators as a tool.)
5. Identify appropriate methodological approach and sources of data.
6. Develop an implementation, dissemination and use plan, which includes:
   - reporting and feedback requirements (format, frequency, distribution);
   - M&E schedule;
   - assignment of M&E responsibilities;
   - data use plan (see Module E) and
   - M&E budget.

This guide assumes that you already have some form of an M&E plan and/or system. This module, therefore, does not walk your team through the process of creating an M&E plan or system. Rather, it makes note of special considerations needed under each of the six steps to integrate gender into your existing M&E plan. For assistance with building an M&E plan, the M&E fundamentals course is useful, as is USAID’s Performance Management Plan (PMP) Toolkit, which helps to establish guidelines for the collection of specific information to be used to assess program progress.

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

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 adaptation of your M&E plan so that gender is integrated. In this activity, we begin by discussing more general goals, objectives, and
questions. Then, in Activity D.2, we will 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 they account for gender-related factors important to 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 may be:

**Young men and women engage in sexual behaviors that put them at risk to have an unintended pregnancy or acquire or transmit 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 using condom or other contraceptives
- low perceived risk for HIV acquisition and pregnancy
- lack of risk reduction knowledge and skills
- other determinants as applicable

The ultimate goal of your program(s) may only reflect desired health outcome changes, but the objectives (short-term aims) should always include gender-related items.

So for the above example, the program’s goals could be:

- reduction in risky sexual behaviors
- increase in condom or contraceptive use
- reduction of HIV unintended pregnancy or incidence or transmission

The ultimate goal here is a change in health outcomes, but to achieve these changes, short- and intermediate-term objectives focusing on both health and gender are required. For example, they could include:

- increased knowledge about condoms and contraception
- realistic perception of personal risk to become pregnant and/or acquire or transmit HIV enhanced
- HIV testing increased
- family planning service use increased
- increase in gender-equitable norms
- increased condom use for dual protection
✓ increase in women's ability to negotiate condom and contraceptive use
✓ increase in the age at first sex
✓ other objectives as applicable

Next, keeping in mind your adapted goals and objectives, you and your stakeholders should rethink what they want to measure. The following questions can 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?

Answering these questions will also determine the scope of your programs' M&E system. For example, if at the end of your program you want to know whether health status has changed (e.g., from the above example, HIV incidence), you will need population-based measures. 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 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 rigorousness 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:15,19

It is important to define your key gender-integrated M&E questions with your stakeholders. These questions should be focused on the short, intermediate, and long-term results of your program. Example M&E questions might be the following.*

Output-related questions:

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

NOTE: Many questions may be interesting, however, it is crucial to narrow the list to those that will be particularly helpful for monitoring, evaluating, and advancing your program and that can be answered given available program resources, including staff expertise, funding, and time.

* See Activity D.2 for definitions of input, output, outcome, and impact.
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 family planning, antenatal, delivery, and postnatal care?
- Have the instances of GBV among women decreased due to implemented programs?
- Have the instances of GBV among LGBT decreased due to implemented programs?

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

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

Impact-related questions regarding health status:

- Has there been a change over time in total fertility rate?
- Has there been a change in HIV incidence? How does it differ by sex? By gender identity?
- Has there been a change in nutrition status among teenage girls? Or teenage boys?

Since **resources for evaluation are always limited**, you should choose your evaluation questions 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 assisting in program improvement and success?
- **Feasibility**: How much time and resources are available for the evaluation? What questions are easier or more feasible to answer?

Furthermore, the right program evaluation depends on who is asking the questions and what will be done with the information.
Consider Tools #3, #11 and #12 and Activity B.2

<table>
<thead>
<tr>
<th>Tool #3:</th>
<th>“Stakeholder Analysis Matrix”</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tool #11:</td>
<td>“Sample Meeting Agenda, Modules D and E”</td>
</tr>
<tr>
<td>Tool #12:</td>
<td>“Checklist for Defining Evaluation Questions” to assist with developing an appropriate evaluation question</td>
</tr>
<tr>
<td>Activity B.2:</td>
<td>“Engaging stakeholders” can determine which steps to carry out with the full stakeholder group versus those to do with only a select group.</td>
</tr>
</tbody>
</table>
Activity D.2: Building your Gender-Integrated M&E Results Framework

In short, 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 key factors related to the implementation of a program, and it is the foundation for selecting appropriate and useful M&E indicators (a term that is discussed in detail in Activity D.3).\(^{12,15,21}\)

In this activity we describe:

- steps for integrating gender into your results framework; and
- the WGGE principle results framework, as a tool you can use in building your gender and health framework (figure 2).

Keep in mind that the WGGE principle results framework is only one way of thinking about outputs and outcomes. It may be too detailed — or not detailed enough — for your specific program.

**Steps for building a gender-integrated results framework\(^{12,15,21}\)**

Based on previous work (e.g., Activity D.1 of this guide), 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 vision of the future, by describing what you expect to achieve both in the short, intermediate and long-term. It is an iterative process, so as you work on your results framework you might note gaps, and thus decide to modify your program objectives and activities. The WGGE results framework set out later in this section is designed to help you as a tool or reference as you work through this process.

**STEP 1:** Describe the gender-related results you are aiming to generate from your program. These results should be **Specific**, **Measurable**, **Action-oriented**, **Realistic** and **Timed** (**SMART**).

A results framework may include all or some of the following components. Different organizations and agencies follow different conventions.

**Key Activities:** The activities carried out to achieve the program’s objectives.

**Output:** The direct product of the program’s activities. For example, the number of women trained in small business skills by community-based programs or the number of messages related to gender and malaria that are broadcasted by local radio stations.

**Outcome:** The short-term and intermediate results of a program. Gender-related examples include joint-decision-making in couples, gender equitable attitudes of health facility staff, or community attitudes towards GBV. Health behavior examples include reduction in disparities in HIV testing by sex, and increased use of FP services by males, both as beneficiaries and as supportive partners.
**Impact:** The long-term health status outcome of the program. For example, reduced sexually transmitted infection (STI) incidence among teenage boys in your community or reductions in unintended pregnancies.

**STEP 2:** Link available resources and planned activities to the results (i.e. particular outputs and outcomes) you expect to achieve.

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

In addition, if you are building your gender-integrated results framework based off of a preexisting results framework, much of your work is already done. You already have some number of the elements noted above (activities, outputs, outcomes, etc.) and have already linked available resources and planned activities to the results. Your task now is to review this framework to ensure that it incorporates the desired gender-related results.

**The WGGE principle results framework**

The GHI WGGE M&E results framework describes pathways by which addressing gender in programs may affect health outcomes. The framework groups the 10 WGGE program elements of implementation (see WGGE Principle Program Elements, next page) 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 family planning/reproductive health, etc.). This tool can be adopted in whole or part or just used as an example on which to base your own results framework.

It is important to note the following:

- Programs produce multiple gender-related results; however arrows on the framework show which results are most likely from programs in a particular domain.
- The framework is not intended to be a full causal model.
- Actual results may not be as “linear” as they are depicted to be 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.

**Consider Tool #13**

“Results Framework for the WGGE Principle: An Example” to use as a reference
WGGE PRINCIPLE PROGRAM ELEMENTS

To improve the health of women and girls and increase gender equality, the GHI WGGE principle suggests that programs and policies aim to address 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 monitoring and evaluation 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. Utilize 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 health care providers, caregivers, and decision makers throughout the health systems, 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.
You likely already have a results framework to accompany your program(s) and/or M&E plan. However, if you do not, there are a number of helpful resources to get you started on creating one:


MATCHING TERMS IN EVALUATION

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

- conceptual frameworks
- logic models
- results frameworks

Though these design frameworks sometimes include different 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 results framework. TO CLARIFY: Programs begin with abstract/conceptual goals that are built on theory and are sometimes pictorially depicted in conceptual models. On the other hand, 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 key activities all the way up to the overall objective or goal; and measures the effectiveness of the projects related activities every step of the way.
Activity D.3. Defining Indicators to Measure Gender-Related Outputs and Outcomes

Once you have your gender-related M&E questions and framework, you need a way to measure the results. Performance indicators measure a particular characteristic or dimension of your program results (outputs or outcomes). In this activity we review the “what”, “why”, and “how” of M&E indicators.15,19

What is an indicator?

- A **variable** whose value is expected to change between the beginning and end of a program, due to the impact of program activities.
- A **measurement** of change that is expressed in meaningful units, such as a percentage or a number that can be compared to past and future units.
- A tool to measure 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 and as precise as possible.

What are gender M&E indicators, specifically?

There are many different indicators that can be used to look at potential gender differences in health and at the effect of gender-integrated programs on health and gender outcomes. These can be categorized in one of two ways:

- **Sex-disaggregated indicators** — that is, regular health indicators that are presented for both men and women or boys and girls. For example, the percent of women and men who received HIV counseling and testing or the percent of women vs. men sleeping under insecticide-treated bed nets.

- **Gender-sensitive indicators** — indicators that address gender directly and go beyond sex disaggregation alone. For example gender-based violence, as well as other more complex indicators like gender attitudes and norms, power differences, female autonomy, access to educational and economic opportunities etc. (For further examples, see the WGGE illustrative indicators section below).

Why are indicators important for your results framework?

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

- Indicators of **outputs** measure the immediate results obtained by the program. (For example, number of participants in a women's small business training program or number of workshops with health providers on GBV screening and referral given in X community.)

Indicators of **outcomes** measure whether the outcome changed in the desired direction and whether this change signifies program "success". (For example, *gender/age mix for each service provided at clinic* or % of men (age 15-49) who hold gender-equitable beliefs).
How do you design a “good indicator”?

Like the gender-related results you have identified, gender indicators, like all other indicators, should be **SMART** (Specific, Measurable, Achievable, Relevant and Time-bound). More specifically, they should do the following:

- Capture information needed for decision-making
- Produce same results when used repeatedly to measure the same condition or event.
- Measure only the condition or event it is intended to measure.
- Accurately represents 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.
- 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 non-directional and can vary in any direction. For instance, an indicator should measure the number of clients receiving counseling rather than an increase in the number of clients receiving counseling.

Consider Tool #14

“Indicators” can facilitate the discussion
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. In this activity we cover 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?
2. What are the systems/data from which your indicators are derived?
   - routine data (i.e., health information systems data, program data, etc.)
   - 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 can be adapted for gender-integrated programs (e.g., can collect sex-disaggregated data, can add gender indicators such as gender norms)?

**STEP 2:** Carry out a “Gap Analysis” (See Tool #15): Determine what indicators you have versus priority gender-related outputs and outcomes (per 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?
4. What other indicators are needed?

**STEP 3:** Select indicators based on existing indicators and gap analysis. Select sex-disaggregated (e.g., health outcomes for women and men) and gender indicators (e.g., norms) to measure the gender-related outputs and outcomes identified in your gender M&E results framework. You may not need to create your own indicators, as there are a number of good gender-related indicators available to you, such as those outlined by the WGGE global and illustrative indicators at the end of this section, and those in sources identified in the box at the end of this section.

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

- Select indicators that can be measured with data from available resources as much as possible.
Select at least 1 or 2 indicators (ideally, from different data sources) per key activity and key outcome.

Select no more than 8-10 indicators per area of significant program focus.

Use a mix of data collection sources whenever possible.

Formulate measures that demonstrate removal of gender–related barriers.

For example, if a barrier to men accessing health services is the perception that men who go to health clinics are weak, and your program is trying to counter this by promoting the idea that being a “real man” includes taking care of your health, you could measure success of your program through indicators such as:

- percent of women and men who agree that men who take care of their health are “real men”; and
- number of men accessing health services.

Your indicators should capture both quality and quantity.

For example, not just attendance at a training but true participation and knowledge gained; or quality of jobs held by women or men rather than just numbers employed. For instance:

- “number/percent of trainees who have mastered relevant knowledge”; or
- “percent of management positions held by women”.

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:

- “percent of farmer association members who are women”; or
- “women in leadership positions”.

Consider selecting indicators based on the four domains of the WGGE results framework (see tables below).

**STEP 4:** Develop indicator reference sheets, as needed. (See Tool #16.)

Reference sheets are tools for describing your indicators in more depth.

Suggested concepts/topics to include in 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.
The WGGE Principle Global and Illustrative Indicators

Global indicators — There are seven USAID/State Department indicators on gender equality, female empowerment, and gender-based violence, as follows:

1. Number of laws, policies, or procedures drafted, proposed or adopted to promote gender equality at the regional, national or local level
2. Proportion of female participants in USG-assisted programs designed to increase access to productive economic resources (assets, credit, income or employment)
3. Proportion of females who report increased self-efficacy at the conclusion of USG-supported training/programming
4. Proportion of target population reporting increased agreement with the concept that males and females should have equal access to social, economic, and political opportunities
5. Number of laws, policies or procedures drafted, proposed, or adopted with USG assistance designed to improve prevention of or response to SGBV at the regional, national or local level
6. Number of people reached by a USG-funded intervention providing GBV services (e.g., health, legal, psycho-social counseling, shelters, hotlines, other)
7. Percentage of target population that views GBV as less acceptable after participating in or being exposed to USG programming

Operating units and USAID missions that have funding attributed to gender equality and women’s empowerment are required, as applicable, to report on indicators 2, 4, and 6 (noted in bold above). These are the same three indicators that have been adopted as global GHI WGGE indicators.

Illustrative Indicators — In addition to the global indicators, for each of the four domains of program activities described above in the GHI WGGE results framework, the GHI WGGE M&E working group identified illustrative indicators for select outputs (not included on results framework), gender results and health outcomes. To the extent possible, the working group drew on existing indicators (e.g., UN indicators documents, PEPFAR indicators, Food for Security indicators, MEASURE Evaluation Family Planning and Reproductive Health Indicators Database). When existing indicators were not available, the working group created new ones to fill important gaps. These tables of indicators (one table for each domain of program activities) may be useful to your stakeholders when trying to fill in indicator gaps. Please note that the indicators are not always in
SMART format. The workgroup used “short-hand” versions of indicators to save space in the table. None-the-less, the indicators give you a sense of the range of outputs and outcomes you might measure.

The illustrative indicators provide examples of the range of results (outputs and outcomes) associated with program activities within each domain. The M&E working group included this range of indicators to illustrate what a more comprehensive M&E plan might include. Various 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 indicators are SMART, specify when to collect sex disaggregated data, etc.) output and outcome indicators, and develop your M&E plan.

See tables D1-D4 of indicators below for each WGGE domain.

### Consider Tools #15 and #16

<table>
<thead>
<tr>
<th>Tool #15</th>
<th>“Gap Analysis” can help conduct an indicator gap analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tool #16</td>
<td>“Indicator Reference Sheets” provides an example of an</td>
</tr>
<tr>
<td></td>
<td>indicator reference sheet</td>
</tr>
</tbody>
</table>

### Sources of examples of gender-related indicators:

- VAW/G compendium. Available at: [https://www.cpc.unc.edu/measure/publications/ms-08-30](https://www.cpc.unc.edu/measure/publications/ms-08-30)
- Compendium of Gender Equality and HIV Indicators. Available at: [http://www.cpc.unc.edu/measure/publications/ms-13-82](http://www.cpc.unc.edu/measure/publications/ms-13-82)
- MEASURE Evaluation PRH Family Planning and Reproductive Indicators Database, Service Delivery - Gender Equity/Sensitivity. Available at: [http://www.cpc.unc.edu/measure/prh/rh_indicators/crosscutting/service-delivery-ii.h.4](http://www.cpc.unc.edu/measure/prh/rh_indicators/crosscutting/service-delivery-ii.h.4)
- HIV indicator Registry (UNAIDS). Available at: [http://www.indicatorregistry.org/](http://www.indicatorregistry.org/)
Table D2: Illustrative Indicators — Social and Economic Resources

<table>
<thead>
<tr>
<th>Elements and illustrative activities or programs</th>
<th>Immediate Outputs</th>
<th>Reduced inequalities in access to and control over social and economic resources</th>
<th>Demand</th>
<th>Supply</th>
<th>Behavior and prevention, care &amp; treatment use</th>
</tr>
</thead>
</table>
| **Element 1: Ensure equitable access to essential health services at facility and community levels**<br>- Reduce barriers to access (e.g., hours, transportation, financial, language, confidentiality, etc.)<br>- Provide alternatives for clients unable to reach facilities<br>- Train providers on respectful care & preferences (e.g., type of provider, style of decision making)<br>- Integrate service, build robust referral<br>- Develop accountability mechanisms, solicit clients’ perspectives on services<br>- Mobilize communities to support essential health services for all | # of trainings by topic (e.g., gender & health.)<br>- # women trained<br>- % women among trainees<br>- # changes to improve access (e.g., hours, confidentiality, referral/integration insurance)<br>- # referrals made<br>- # new community service provision alternatives (e.g., community health worker, health fair)<br>- # facilities establish quality assurance (QA) systems<br>- # QA systems seek feedback<br>- # community-based programs addressing gender equitable access (e.g., women’s health, awareness of services)<br>- # multi-sectoral interventions addressing social, economic, legal and/or cultural determinants of health<br>- Address harmful traditional practices, (e.g., child/forced marriage, abduction, FGM/C, “honor” crimes) & support traditional practices that promote gender equality<br>- Address resource and health needs of women & girls in lowest economic quintiles. | Economic empowerment<br>- % who earn cash*<br>- % women who mainly decide how their own income will be used<br>- % target population agree with concept that males & females should have equal access to social economic & political opportunities (USAID & Department of State)

Reproductive empowerment<br>- # communities leaders disavow harmful traditions such as early marriage, FGM/C, etc<br>- % target population disavow harmful traditions<br>- % males & females marry aged 18 or older

Socio-cultural empowerment<br>- % of families provide adequate nutrition, education, care & protection to children (including girls) is increased (Children in Adversity)<br>- # schools that incorporate health & gender into life skills curriculum<br>- % females reached (e.g., % female) | Awareness/knowledge<br>- % target population aware of services (e.g., # aware youth-friendly services)<br>- % target population report fewer barriers to service use<br>- # women/girls receive support from support group/social network for safer behaviors &/or service use (e.g., % who are supportive of their partners’ reproductive health practices/service use)<br>- % women who believe that spouse, friends, relatives, and community approve (or disapprove) of the practice, | Knowledge & attitudes<br>- # health programmers and policy makers who recognize the ways gender affects health<br>- % staff recognize gender barriers to service use<br>- % staff with gender-equitable attitudes | Health behaviors<br>- % women make decisions about own health<br>- Increased protective behaviors, e.g.,<br>  o % 18-24 year olds who have first birth before age 18 (GHI)<br>  o % of all birth intervals that are 36 months or longer (GHI)<br>  o #people protected from malaria with a prevention measure (GHI)<br>- Service use<br>  o # change in service use, e.g.,<br>  o % HIV pregnant women received antiretroviral prophylaxis for preventing mother-to-child transmission (GHI)<br>- Organizational/program characteristics<br>  o # service sites/programs maintain modified hours, fees, locations to encourage use<br>  o # service sites/programs maintain integrated services and/or have robust referral system in place<br>- Perceptions of services<br>  o % clients who believe services meet needs<br>  o % clients who report receiving quality services and guarantees of confidentiality | # of trainings by topic (e.g., gender & health.)<br>- # women trained<br>- % women among trainees<br>- # changes to improve access (e.g., hours, confidentiality, referral/integration insurance)<br>- # referrals made<br>- # new community service provision alternatives (e.g., community health worker, health fair)<br>- # facilities establish quality assurance (QA) systems<br>- # QA systems seek feedback<br>- # community-based programs addressing gender equitable access (e.g., women’s health, awareness of services)<br>- # 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References<br>- Guide for Integrating Gender into Health Programming Monitoring and Evaluation Plans

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<table>
<thead>
<tr>
<th>Elements and illustrative activities or programs</th>
<th>Immediate Outputs</th>
<th>Reduced inequalities in access to and control over social and economic resources</th>
<th>Demand</th>
<th>Supply</th>
<th>Behavior and prevention, care &amp; treatment use</th>
</tr>
</thead>
</table>
| - Support positive youth development through peer networks and mentorship in & out of schools, foster positive adult-child communication | **participants in program to increase access to productive economic resources (assets, income, credit, employment)** | among girls  
• % women who have completed at least 10 years of education  
• sex ratio at birth and at age 5  
**Psychological empowerment**  
• % females who report increased self-efficacy at conclusion of training/program (USAID & Department of State) | community based health service alternatives (e.g., referral systems, health tracking/monitoring systems)  
• # linkages between facility or community based health programs and livelihood (other economic) programs | vaccines  
• % adhere to scheduled appointments  
• % satisfied with services  
• % make/keep referrals made |
| - Develop specific programming for out-of-school adolescent and pre-adolescents  
- Involve youth, parents, schools, communities and religious leaders when designing programs  
- Link health activities to education and viable livelihoods programs | | | | | |

*Indicators in blue are found in MEASURE Evaluation PRH’s Family Planning/Reproductive Health Indicators Database: [http://www.cpc.unc.edu/measure/index.html/prh/rh_indicators](http://www.cpc.unc.edu/measure/index.html/prh/rh_indicators).*

*Indicators in red are used by the USG, often by USAID. Many are found in FACTS or PEPFAR documents. The initials indicate which program uses that particular indicator.*

If you would like more detailed information about indicators in blue or red, please contact Joan Kraft ([jkraft@usaid.gov](mailto:jkraft@usaid.gov)).
<table>
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<tr>
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<th>Immediate Outputs</th>
<th>Improved gender norms &amp; Increased capacity to make decisions free of coercion or threat of violence</th>
<th>Demand</th>
<th>Supply</th>
<th>Behavior and prevention, care &amp; treatment use</th>
</tr>
</thead>
</table>
| **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 own health and to support 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. | For elements 5&8*  
- Availability of accessible, relevant and accurate information about gender influences & health behaviors ([# & types of sources]*  
- # programs that use multiple community-based approaches  
- # of health programs that incorporate gender focused BCC activities (e.g., # programs implemented for men and boys that include examining gender and culture norms related to SGBV  
- % target population /audience recall hearing/seeing specific message about gender  
- ratio of local community to external staff  
- # of community leaders & role models engaged to increase knowledge of health consequences of behaviors, and promote safer behaviors & service use  
- # people completing an intervention pertaining to gender | Familial/Interpersonal Empowerment  
- # community leaders recognize gender effects on health  
- % community members recognize gender effects on health  
- % men hold gender equitable attitudes (on Gender-Equitable Men (GEM) scale)  
- % of men and women who share in decision making (reproductive health issues OR other issue) with spouse or sexual partner  
- % target population that views GBV as less acceptable after participating in or being exposed to USG programming  
- % ever married or partnered women (aged 15-49) who experience physical or sexual violence from a male intimate partner in the past 12 months (MERG)  
- % 13-24 year olds reporting experiencing sexual, physical or emotional violence before the age of 18 (Together for Girls) | Awareness/knowledge  
- % target population/audience that know of a product, practice (e.g. health behavior) or service  
- % target population understands links between gender and health issue  
- % target population can identify one way to overcome gender related barrier to practicing safer behavior or using service  
- % target population with self-efficacy to change behavior or use service  
- % men who accompany their partner to antenatal care (or type) visit  
- % community members aware of GBV services | Staffing knowledge/awareness  
- # staff with increased awareness of GBV in general, and role of GBV on other health issues (e.g., attitudes of health care providers towards SGBV survivors or services,  
Staff practices/skill  
- % health units with at least one service provider trained to care for and refer SGBV survivors  
# staff follow procedures/ protocol for GBV services | **Health behaviors**  
- Increased protective behaviors, e.g.,  
- % used condoms at last sex with non-martial partner  
- % total condoms supported by PEPFAR (GHI)  
- % people protected from malaria with a prevention measure (GHI)  
- modern contraceptive prevalence (GHI)  
- Mean number of food groups consumed by women of reproductive age | **Service use**  
- # people screened for GBV  
- # people receiving post-GBV care (PEPFAR)  
- # persons provided with post exposure prophylaxis (PEPFAR) |
<table>
<thead>
<tr>
<th>Elements and illustrative activities or programs</th>
<th>Immediate Outputs</th>
<th>Improved gender norms &amp; increased capacity to make decisions free of coercion or threat of violence</th>
<th>Demand</th>
<th>Supply</th>
<th>Behavior and prevention, care &amp; treatment use</th>
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</thead>
<tbody>
<tr>
<td>- Address resource &amp; health needs of women/girls in the lowest economic quintiles.</td>
<td>norms, that meets minimum criteria (PEPFAR)</td>
<td>concept that males &amp; females should have equal access to social, economic, and political opportunities</td>
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<td></td>
<td>raped or experienced incest,</td>
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<tr>
<td>• Element 3: Monitor, prevent and respond to gender-based violence</td>
<td>• completed mapping of GBV services (facility, community)</td>
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<tr>
<td>- Advocate for laws and policies to monitor, prevent &amp; respond to GBV</td>
<td>• % health units that have documented and adopted protocol for the clinical management of SGBV services, includes referral</td>
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<tr>
<td>- Support community &amp; mass media efforts around attitudes &amp; behaviors</td>
<td>• % of health facilities with HIV post-exposure prophylaxis available (PEPFAR)</td>
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<tr>
<td>- Facilitate discussion (families, community organizations, religious, traditional &amp; other leaders) about human rights, GBV &amp; addressing GBV</td>
<td>• #community health worker/other community outreach programs integrate GBV</td>
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<tr>
<td>- Support programs to improve women &amp; girls’ self-esteem &amp; negotiation skills</td>
<td>• #service providers trained to identify, refer and care for SGBV survivors,</td>
<td></td>
<td></td>
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<tr>
<td>- Require RH &amp; life skills programs for adolescent and pre-adolescent girls and boys to address healthy relationships, sexual coercion &amp; abuse</td>
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<tr>
<td>- Build provider capacity to recognize &amp; address GBV as contributor to negative health status &amp; adherence to regimens.</td>
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<tr>
<td>- Integrate GBV screening &amp; response into health services (post-exposure prophylaxis, emergency contraception, psycho-social support where feasible)</td>
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<tr>
<td>- Link with multi-sectoral programs to increase GBV prevention and response</td>
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<tr>
<td>- Promote research on the incidence and impact of GBV on men and boys.</td>
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</table>

* Elements 5 & 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 a number of 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, family planning, HIV, TB, malaria and neglected tropical diseases. Given the similarity of potential activities across health outcomes, we’ve provided “generic” indicators that can be adapted to fit local needs.


*Indicators in red* are used by the USG, often by USAID. Many are found in FACTS or PEPFAR documents. The initials indicate which program uses that particular indicator.

If you would like more detailed information about indicators in blue or red, please contact Joan Kraft (jkraft@usaid.gov).
Table D4: Illustrative Indicators — Participation and Leadership

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


*Indicators in red are used by the USG, often by USAID. Many are found in FACTS or PEPFAR documents. The initials indicate which program uses that particular indicator.

If you would like more detailed information about indicators in blue or red, please contact Joan Kraft ([jkraft@usaid.gov](mailto:jkraft@usaid.gov)).
Table D5: Illustrative Indicators — Institutional and Policy Environment

<table>
<thead>
<tr>
<th>Elements and illustrative activities or programs</th>
<th>Immediate Outputs</th>
<th>Reduced gender-based disparities in rights and status</th>
<th>Demand</th>
<th>Supply</th>
<th>Behavior and prevention, care &amp; treatment use</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Element 10: Strengthen institutions which set policies, guidelines, standards and norms standards that impact access to &amp; quality of health-related outreach/services to improve health &amp; promote gender equality -Training &amp; mentoring on gender equality &amp; health needs of women/youth -Address harassment, violence and discrimination. -Support civil society organizations participation -Capacity to collect &amp; use data</td>
<td>• # trainees by sex, type of personnel &amp; topic* • gender analysis/ assessment done by MOH (or other org) • policies harmonized • accountability system established • # advocacy trainings - # organizations &amp; # people trained - % female trainees • # &amp; type of advocacy activities (e.g., awareness-raising) • #policies on select topics (including for health care facilities) (e.g., # laws, policies, or procedures drafted, proposed or adopted to promote gender equality at the regional, national or local level; # laws, policies or procedures...to improve prevention of or response to S/GBV (USAID &amp; Department of State))* • (e.g., existence of national laws, regulations or policies that limit access to effective FP for unmarried and/or young people)</td>
<td>Political empowerment • % government officials &amp; other policy makers who hold gender equitable attitudes • % community members participate in advocacy events (e.g., awareness raising, meetings) • % target population reporting increased agreement with the concept that males &amp; females should have equal access to social, economic, and political opportunities (SPG) • % program participants know legal rights of children, women and men</td>
<td>Awareness/knowledge • % target population who believe women and men should have equal access to health care services, at facility and community level • % of non-use of services related to gender (or psycho-social) barriers • % target population who know relevant policy, law, regulation regarding health &amp; access to services</td>
<td>Access</td>
<td>Gender sensitivity in service delivery environment (e.g., gender sensitive services), select from menu or indicators • % of health care facilities that provide full range (TBD) 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 &amp; health)</td>
</tr>
<tr>
<td>• 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, other policies and standards to increase gender equality and empowerment (e.g., discrimination, child marriage, gender-based violence, trafficking in persons, inheritance) -Champions promote gender equality &amp; safeguard women’s and girls’ health</td>
<td>• # &amp; type of advocacy activities (e.g., awareness-raising) • #policies on select topics (including for health care facilities) (e.g., # laws, policies, or procedures drafted, proposed or adopted to promote gender equality at the regional, national or local level; # laws, policies or procedures...to improve prevention of or response to S/GBV (USAID &amp; Department of State))* • (e.g., existence of national laws, regulations or policies that limit access to effective FP for unmarried and/or young people)</td>
<td></td>
<td>Quality</td>
<td>% health care facilities that follow new/revised policies, regulations, standard procedures (e.g., percent of facilities w/non-medical restrictive eligibility criteria for contraception) • % facilities/decision making bodies use data on implementation and outcomes to revise policies, procedures, etc.</td>
<td></td>
</tr>
</tbody>
</table>


*Indicators in red are used by the USG, often by USAID. Many are found in FACTS or PEPFAR documents. The initials indicate which program uses that particular indicator.

If you would like more detailed information about indicators in blue or red, please contact Joan Kraft (jkraft@usaid.gov).
Activity D.5. Identifying Data Sources

Once you have decided on and created your list of indicators, you need to determine the source of the data for these indicators.\(^{15,22}\) Consider these three questions:

1. **How frequently or at what intervals do you need this information?**

Data can come from either routine or non-routine sources: Routine data sources provide data that are collected on a continuous basis, such as information that hospitals collect on the patients who use their services. Non-routine 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, etc.), such as Demographic and Health Surveys (DHS), other population-based survey, or a census.

2. **Do the data already exist and are they readily available?**

When possible it is important to use data that already exist to answer your gender-related M&E questions. (The member of your team who is a strategic information or M&E officer should be able to help you determine available data sources.) Many gender-sensitive indicators are not routinely collected and may require special studies or surveys. Examples of data sources include:

- health management information systems (HMIS)
- sentinel surveillance systems
- project information systems/records
- hospital patient records
- health facility registers
- DHS — the following types of information are often available: educational and employment status, control over earnings, freedom of movement, control over finances, attitudes towards gender roles, spousal communication, attitudes towards 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).
- other nationally representative surveys (e.g., AIDS Indicator Survey)
- UNICEF’s Multiple Indicator Cluster Survey (MICS)
- World Bank Living Standards Measurement Study (LSMS)
- population census
- police records (GBV data)
- court records (GBV data)
- government budget (for data on funding for gender-related programs)
- special studies/research
  - secondary analysis
If the existing data do not provide the data needed for your indicators so as to answer to your question(s), ask:

- Can our indicator be refined to so that existing data provides needed insight? For example, can you disaggregate the indicator by sex with existing data?
- Can items or questions on existing data collection forms be refined to provide 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 needed data or where can the necessary information be found?
  - What is the most efficient method of collecting this information? Consider whether it can be collected by adding a module onto existing data collections efforts so as to minimize new effort.

3. **Are the data of sufficient quality?**

When determining the existing data sources, **data quality** should also be considered. The better the quality of the data, the more trustworthy these data will be, and the more likely it is that stakeholders will use the data. There are several dimensions of data quality dimensions as noted below. There are many tools for assessing these dimensions of data quality and for then strengthening them.
### Table D5: Data Quality Dimensions

<table>
<thead>
<tr>
<th>Dimension of Data Quality</th>
<th>Operational Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Accuracy</strong></td>
<td>Also known as validity. Accurate data are considered correct: the data measure what they are intended to measure. Accurate data minimize errors (e.g., recording or interviewer bias, transcription error, sampling error) to a point of being negligible.</td>
</tr>
<tr>
<td><strong>Reliability</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Precision</strong></td>
<td>This means that the data have sufficient detail. For example, an indicator requires the number of individuals who received HIV counseling &amp; 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.</td>
</tr>
<tr>
<td><strong>Completeness</strong></td>
<td>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 and not just a fraction of the list.</td>
</tr>
<tr>
<td><strong>Timeliness</strong></td>
<td>Data are timely when they are up-to-date (current), 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 actually used or required.</td>
</tr>
<tr>
<td><strong>Integrity</strong></td>
<td>Data have integrity when the system used to generate them is protected from deliberate bias or manipulation for political or personal reasons.</td>
</tr>
<tr>
<td><strong>Confidentiality</strong></td>
<td>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).</td>
</tr>
</tbody>
</table>


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**Sources for information for strengthening quality of data:**

MODULE E: Developing an Implementation and Dissemination Plan

Now that you have refined your M&E results framework, defined the indicators needed to answer your gender M&E questions, and identified the sources for your data, it is time to revise (as needed) the implementation and dissemination component of your M&E plan to reflect the changes you have made during gender-integration.\textsuperscript{15,23} This can be done as a separate workshop or meeting with your working group, or in conjunction with the meeting covering Module D. (For help with preparing a meeting outline, see Tool #11, Sample Meeting Agenda, Modules D and E.) Steps in the revision process include:

1. determining methods for any new data collection
   - develop data collection tools & describe data collection procedures and plans
   - determine M&E responsibilities;

2. developing a plan for analyzing, disseminating and using your data;
   - determine the types of data aggregation or summary products you will produce to communicate information back to the programs, regions, districts, or facilities that collected the data
   - complete a Framework for Linking Data with Action to identify the specific actions you will take or decisions you will make with the data you collected;

3. planning for mid-course adjustments to the program (or to the data collection); and

4. finalizing a timeline for launching your plan.

Activity E.1. Determining Methods for Data Collection

If you have determined that new data collection is required, you must decide the "what", "who", and "how" of your new data collection. (Note: To facilitate this activity, you may want to break your stakeholder team into smaller groups and answer these questions.)

The "WHAT" of data collection:

- What data collection system should be used? Does it 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 (staff, office supplies, computers, transportation, etc.) will be needed at each stage of implementation?

The "WHO" of data collection:

- Who will be responsible for data collection and its supervision?
✓ Who will be responsible for ensuring data quality at each stage?

A critical part of “WHO” is training data collection and analysis staff on gender M&E. If staff does not understand the importance of sex and age-disaggregated data collection and analysis, they are more likely to aggregate at various points in the process. In addition, if you are adding gender-sensitive indicators, staff will need training on how to collect and calculate the indicators and the importance of their measurement. Also, if data on GBV is to be collected, there are special ethical considerations surrounding data collection so as to maintain the safety and security of respondents and staff. (See Researching Violence Against Women: A Practical Guide for Researchers and Activists [Ellsberg & Heise, 2005].) You should note in your plan that staff will be trained on these topics as applicable. Finally, the gender of the data collector/interviewer may be exceptionally important for getting valid, reliable and accurate data and thus should be an important consideration during the process of determining the “WHO” of data collection.

The “HOW” of data collection:

✓ How often will the data be collected, compiled, and sent? Be sure to note that sex and age disaggregation must be maintained throughout.

✓ How will data quality be checked at every stage?

✓ How will the data be sent (raw, summary)?

The “WHEN” of data collection:

✓ What time of day? Month? Year?

✓ If applicable, what is the most appropriate time of day to interview women? Men?

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, in monitoring, 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.
Consider Tools #17 and #18

Tool #17: “Example Data Collection Tools” are tools that may be useful to new data collection efforts

Tool #18: “What, Who and How of Data Collection” can help facilitate the process of new data collection

Sources for information for gender M&E training materials and information on conducting research:


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

After determining your methods for data collection, you must decide how you will analyze, disseminate and use the information. Consider the following steps:

**STEP 1: Set plans for data analysis**

The *key questions* to answer under 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 into reports?

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 within your results framework.

For example, to determine the utilization of an education program that is teaching the risk factors for HIV to teenage girls, you would look at the number of teenage girls educated during a specific time period compared to the program’s goal. If by X date the program had educated 300 girls and the goal for Y date was 900, you would divide the goal by the number of people reached (or 300/900). This equals 0.33. You multiply this by 100 to get a percentage. You reached 33% of your target group with HIV education.

Indicators are often measured as a number or a percentage. For example,

- number of new family planning users, disaggregated by sex and age
- percentage of female HIV positive clients currently on antiretroviral therapy

In gender-integrated M&E your data should be analyzed by sex and age. Even gender-sensitive indicators should be analyzed by sex and age, as applicable. While it is important to note in your analysis plan that data will be analyzed by sex and age, this is not the same as a “gender analysis.” To gather more meaningful information you will need to examine quantitative sex and age-disaggregated data to identify patterns, potential issues in program implementation and program outcomes, and ask questions such as the following:

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

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**NOTE:** One of the goals of integrating gender into your M&E plan is to show the influence of your program on gender-related outcomes. Thus, clearly report your data by sex and age, report on any gender-sensitive data collected, and report on any gender analyses you carried out in your dissemination activities.
STEP 2: Set plans for dissemination and use of your data

The key questions to answer under this step are:

- Who will use our M&E findings to advocate 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 them? 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 the following:

- Annual report and data review meetings
- Database(s) to manage data and facilitate access and use
- Data synthesis products that are tailored to specific stakeholders and decision makers with the authority to advocate for new services, allocate funds, develop new programs and improve those that already exist.

Disseminating your data and key findings, while a precursor to the data use process, it is not use and is not sufficient to achieve data informed decision making. You will need to consider additional activities to actively engage with your key stakeholders and decision makers to give them the opportunity to discuss the data and ask questions about the findings, such as the following:

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

Lastly, it’s important to follow-up with key decision makers to determine if they’ve 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 absence of outcomes indicated in future data. This will be important for you to improve your efforts and advocate for addition funds and resources to continue to support gender-sensitive M&E.
Consider Tool #19 and update as needed, Tool #2

Tool #19: “What to do with your data” can facilitate how to analyze, disseminate, and use your data

Tool #2: “Organizing Gender Integration Information” can be used to note plans for analysis, dissemination, and data use

Additional information on gender analysis:

- Gender Analysis and Integration for HIV and Sexuality, IGWG. Available at: http://www.igwg.org/training/GenderAnalysisIntegration/GenderAnalysisIntegrHIV-Sexuality.aspx

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

GENDER M&E TOOL #1: Sources of Information for M&E Gender Integration

In the beginning of the M&E gender integration process, you will need to seek out information on your country’s gender reality, gender-related programs and their measurement. The following are possible sources of this information:

- strategic plans
- operational plans
- performance monitoring plans
- evaluation plans
- list of evaluation indicators
- data collection plans
- plans for use and dissemination of data
- M&E system self-assessments
- gender assessment/analysis reports
- gender mapping exercises
- baseline and/or endline survey reports
- funding frameworks
- key policy documents
- annual reports
- donor progress reports
- reports from population-based surveys, such as the Demographic Health Survey (DHS) or Reproductive Health Survey (RHS)
- results frameworks/logic models
- project/activity proposals (from implementing partners)
- activity documents/plans
GENDER M&E TOOL #2: Organizing Gender Integration Information

Although you may have one health program, when it is gender-integrated, it will have gender objectives and health objectives with activities that correspond to these objectives. Tool #2 is an Excel spreadsheet that provides a structure for organizing the key aspects of your program's gender and health activities and their measurement.

The tool is designed so that information for one health program will be entered into two worksheets: one worksheet for the health-related aspects of the program, and the other worksheet for the gender-related aspects of the program. Both worksheets will include the same background information:

- program name
- implementers
- timeline
- coverage/population target

Each worksheet will then include the following information:

- program objectives
- inputs, outputs, and outcomes, by activity
- indicators
- data collection methods/sources
- frequency and schedule for data collection
- responsible parties for collection
- when data will be available
- plans for data analysis
- responsible parties for data analysis
- plan for information dissemination
- plan for data use

Although the column and row headings for both of the worksheets are nearly identical, the objectives, activities, indicators, etc. that you enter will correspond to whether it is a health-related program aspect or a gender-related program aspect.

This is a program management tool, therefore, it should be tailored to your needs. If you require additional rows or columns, you are encouraged to modify the tables accordingly. Likewise, if you have more than two programs (which is what the document currently includes space for), include additional worksheets to capture your other programs.

To use the spreadsheet, see the Microsoft Excel document entitled “Tool 2-Organizing Gender Integration Information” posted with this manual at MEASURE Evaluation.
## GENDER M&E TOOL #3: Stakeholder Analysis Matrix

<table>
<thead>
<tr>
<th>Name of stakeholder (National, regional, or local?)</th>
<th>Stakeholder description (Primary purpose, affiliation, funding)</th>
<th>Potential role in the activity (Vested interest in the activity)</th>
<th>Knowledge level re: the issue (Specific areas of expertise)</th>
<th>Level of commitment (Support or oppose the activity, to what extent and why?)</th>
<th>Available resources (Staff, volunteers, money, technology, information, influence)</th>
<th>Constraints (Limitations: needs funds to participate, lack of personnel, political or other barriers)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Government sector</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Commercial Sector</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Implementing Partners</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Representatives of persons affected – positively or negatively -- by the program (disaggregated by sex and gender)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>International donor and advocacy groups</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

### Practical considerations for using this tool

This tool represents a guide to asking the right questions, but there is no one way or specific protocol for gathering the necessary information. Useful information to add to the matrix and plan can surface in any encounter, not just in meetings specifically designed for this tool.

GENDER M&E TOOL #4: Sample Stakeholder Meeting for Module C

Name of Meeting

Date

Place and address were meeting is being held

Meeting Objectives:
1)
2)
3)

Agenda:
I. Welcome, introductions, and review of meeting objectives

II. Review of gender-integrated programming
   • Definitions of gender and related terms
   • Why considering gender is important to health outcomes and programming
   • Criteria for and ways that gender is addressed in programs
   • The process used for developing gender-integrated programming

III. Introduction of fundamentals of monitoring and evaluation (M&E)
   • The definitions of M&E
   • The purpose of M&E
   • How M&E fits into the program life cycle
   • The importance of an M&E plan and its different components

IV. Introduce gender-integrated M&E
   • What it means to integrate gender into M&E
   • Why you want to integrate gender into your M&E plans
   • How you integrate gender into M&E, including data and indicator requirements

V. Presentation of your specific gender-integrated program(s) and existing M&E plan(s)

VI. Facilitated discussion with stakeholders on how existing M&E plans do/do not address gender

VII. Discussion with stakeholders on how they can be involved with improving gender integration into M&E plans

VIII. Next steps (continuation next day? Or future additional meeting? Etc.) and closing
GENDER M&E TOOL #5: PPT Presentation A – Fundamentals of Gender-Integrated Programming

Learning Objectives

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

Key Definitions

**SEX**

- Biological difference between males & females
- Universal for all human beings
- Unchanging
- Determined at birth

**GENDER**

- 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

*Source: WHO 2009: Integrating gender into HRH/MDG programmes in the health sector*

Possible Activity: Vote with your feet

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

Source: USAID: Training of Trainers: Gender and Reproductive Health 101

Key Definitions Continued

**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, boys and girls. To ensure fairness, measures must be taken to compensate for cumulative economic, social, and political disadvantages that prevent women and men, boys and girls from operating on a level playing field.

*Source: IAMS training/resources

What is gender integration?

Strategies applied in organizational and programmatic design, implementation, monitoring and evaluation to take gender considerations into account and to compensate for gender-based inequalities.
**Why do we integrate gender into programming efforts?**

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

**Why do we think about gender & health?**

Gender equality is associated with positive health outcomes:
- Low child mortality, low rates of stunting and wasting
- Higher rates of health care utilization for maternal, child, and reproductive health services (including STI/HIV)
- Lower rates of maternal mortality
- Lower rates of gender-based violence

Gender inequality is associated with lower health outcomes.

---

**Gender Equality Continuum Tool**

- **Gender Blind:**
  - View of gender norms and expectations
  - Non-critical examination of gender norms and dynamics
  - Assumptions on rights and roles
  - Assumptions on social and cultural norms and roles
  - Assumptions on social and cultural norms and roles
  - Assumptions on social and cultural norms and roles

- **Gender Aware:**
  - Examine and challenge these gender assumptions and stereotypes

- **Gender Exploitative:**
  - Examine critical examination of gender norms and dynamics
  - Assumptions on rights and roles
  - Assumptions on social and cultural norms and roles

- **Gender Accommodative:**
  - Work to understand gender difference and inequalities

- **Gender Transformative:**
  - Examine critical examination of gender norms and dynamics
  - Change social and cultural norms and roles

**Goal:**

- Gender equality and gender development.

---

**Activity**

How would you categorize the following projects? Exploitative? Accommodating? or Transformative?

---

**Example Project 1: How would you categorize it?**

**Condom Social Marketing in Columbia**

The goal of a social marketing campaign in Columbia 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 sexual partners. The intended message was that he used condoms whenever he had sex.

*Source: Adapted from UN Women training resources*

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**Answer: Exploitative**

**Condom Social Marketing in Columbia**

**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.

*Source: Adapted from UN Women training resources*
Example Project 2: How would you categorize it?

Youth Roles in Care and Support for Persons 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.

*Source: Adapted from IGWS training resources

Answer: Accomodating

Youth Roles in Care and Support for Persons 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.

*Source: Adapted from IGWS training resources

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.

*Source: Adapted from IGWS training resources

Answer: 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.

*Source: Adapted from IGWS training resources
GENDER M&E TOOL #6: Gender-Integrated Programming Basics

What is gender integration?
✓ Strategies applied in organizational and programmatic design, implementation, monitoring and evaluation to take gender considerations, including gender norms, into account and to compensate for gender-based inequalities.

What is the objective of gender-integrated programming?
✓ To gradually challenge existing gender inequities and promote positive changes in gender roles, norms, and power dynamics.
✓ To maximize access to and quality of health services (for both men and women), support individual and couple (family) decision-making about health, improve health behaviors and health outcomes, and increase sustainability of programs and policies.

Why is gender-integrated programming important?
Gender equity contributes to gender and health outcomes, including:
✓ reduced unmet need for contraception
✓ improved access to care and treatment
✓ reduced violence against women
✓ 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 joint decision making between wives and husbands

The Gender Integration Continuum is a tool for planners and implementers to use in planning how to integrate gender into their programs/policies. It categorizes approaches by how to treat gender norms and inequities in the design, implementation, and evaluation of program/policy.
GENDER CONTINUUM CONCEPTS

**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, boys and girls. The project ignores gender considerations altogether.

**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, boys and girls.

**Gender Exploitative** policies and programs intentionally or unintentionally reinforce or take advantage of gender inequalities and stereotypes in pursuit of 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 realization 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, 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.

<table>
<thead>
<tr>
<th>COMMON DEFINITIONS RELATED TO GENDER</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
</tr>
<tr>
<td>A culturally-defined set of economic, social, and political roles, responsibilities, rights, entitlements obligations, and power relations associated with being female and male, as well as the relationships between and among women and men. The definition and expectations of what it means to be a man or a woman, as well as sanctions for not adhering to expectations, varies across cultures and over time, and often intersects with other factors such as race, class, age and sexuality. Transgender individuals, whether they identify as men or women, can be subject to the same set of expectations and sanctions.</td>
</tr>
<tr>
<td><strong>Gender Equality</strong></td>
</tr>
<tr>
<td>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.</td>
</tr>
<tr>
<td><strong>Gender Equity</strong></td>
</tr>
<tr>
<td>The process of being fair to women and men. To ensure fairness, measures must be taken to compensate for cumulative economic, social, and political disadvantages that prevent women and men from operating on a level playing field.</td>
</tr>
<tr>
<td><strong>Gender-based Violence (GBV)</strong></td>
</tr>
<tr>
<td>In the broadest terms, GBV is violence that is directed at individuals based on their biological sex, gender identity, or perceived 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.</td>
</tr>
<tr>
<td><strong>Gender-integrated Programming</strong></td>
</tr>
<tr>
<td>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 ultimate goal of gender-integrated programming is to achieve desired health outcomes while simultaneously transitioning to greater equality.</td>
</tr>
</tbody>
</table>


GENDER M&E TOOL #7: PPT Presentation B – Fundamentals of Monitoring and Evaluation

Fundamentals of Monitoring and Evaluation

PPT for Module C
Activity C.2.

Learning Objectives

- The definitions of monitoring and evaluation (M&E)
- The purpose of M&E
- How M&E fits into the program life cycle
- The different components of M&E plans

Possible Brainstorming Activity:

- What is Monitoring?
- What is Evaluation?
- Next:
  - How are they different?
  - How do they fit together?

Key Points (Brainstorming Activity Continued)

<table>
<thead>
<tr>
<th>Monitoring</th>
<th>Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ongoing</td>
<td>Is not continuous</td>
</tr>
<tr>
<td>Continuous Process</td>
<td>Data collection at the start and end of program</td>
</tr>
<tr>
<td>Data collection at multiple points throughout program</td>
<td>Measures program impact</td>
</tr>
<tr>
<td>Tracking changes over time</td>
<td>Well-planned study design</td>
</tr>
</tbody>
</table>

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.

- Can be used to determine if activities need adjustment during the intervention to improve use of resources, as well as desired outcomes
- Requires the collection of data at multiple points throughout the program cycle, including at the beginning to provide a baseline

Definition: Evaluation

**Performance Evaluation** focus on descriptive and normative questions: what a particular project or program has achieved; how it 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.
- Involves collection of data at the start of a program (to provide a baseline) and again at the end
Why is M&E Important?

- It provides objective evidence to inform decision-making
- It ensures the most effective and efficient use of resources
- It objectively assesses 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
- It produces information that can help convince donors that their investments have been worthwhile or that alternative approaches should be considered

*Source: M&E Fundamentals — A Self-Guided Mini-course, MEASURE Evaluation

When should M&E take place?

- M&E is a continuous process that occurs 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 for at the start because baseline data is important for end-of-program comparisons

*Source: M&E Fundamentals — A Self-Guided Mini-course, MEASURE Evaluation

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 these data will be collected, analyzed and used
- the resources required to conduct the plan; and
- 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. Typically, the plan includes:

- Underlying assumptions
- Anticipated relationships
- Measures and definitions
- Monitoring schedule
- Data sources
- Cost estimates
- List of partnerships and collaborations
- A plan for dissemination and utilization information
GENDER M&E TOOL #8: Monitoring and Evaluation Basics

**PURPOSE:** Monitoring and evaluation (M&E) is the process 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.

- Can be used to determine if activities need adjustment during the intervention to improve use of resources, as well as desired outcomes.
- 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 particular project or program has achieved; how it 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.
- Involves collection of data at the start of a program (to provide a baseline) and again at the end.

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**M&E helps program implementers:**

- Make informed decisions regarding 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.

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* There are different definitions for M&E. For performance monitoring, some measure the process of program implementation (e.g. is the program doing what is expected re: activities and outputs?) and some focus on outcome monitoring (e.g. has the program done what was expected re: 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).
DEVELOPMENT PROCESS:

✓ 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 is 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 basis.

✓ Evaluations are usually conducted at the end of programs. However, they should be planned for 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 approach and sources of data
6. Develop an implementation and dissemination plan

* Note that this is an iterative process.

M&E plans can be organized in a variety of ways. Typically, the components include:

✓ introduction
✓ program description and framework
✓ detailed description of the plan indicators
✓ data collection plan
✓ plan for monitoring
✓ plan for evaluation
✓ plan for the utilization of the information gained
✓ mechanism for updating the plan

GENDER M&E TOOL #9: PPT Presentation C – Fundamentals of Gender-Integrated Monitoring and Evaluation

Learning Objectives

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

What is gender-integrated M&E

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

What is gender-integrated monitoring, specifically?

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

What is gender-integrated evaluation, specifically?

- 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 into M&E efforts?

- To ensure gender is addressed in programs in a measurable way
- To provide evidence to:
  - Raise awareness about gender inequity
  - Advocate for change
  - Address gender dimensions of health
  - To demonstrate program progress and impact
Gender M&E & Health Policies

- New international push led by USG, UN and others to address gender in programmatic streams
- Donor requirements
  - Now: gender should be part of M&E Plan, reflecting how gender is addressed in all aspects of the program cycle
  - Who is demanding this?
    - USG Global Health Initiative, gender strategies of USAID, WHO, World Bank
    - HIV/AIDS: PEPFAR, UNAIDS, GFATM,

How is gender integrated into 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
      - Complex measures (e.g., attitudes, norms, power)
  - Data reporting
    - Including gender-related results in reports, tools, and publications

Sample gender-integrated M&E questions using routine data

- Are there gender differences in use/access to services/treatment? For example:
  - Use of ART? Adherence?
  - Detection of TB? Referral for treatment?
  - Malaria testing and treatment?
- Data needed: sex and age disaggregated data from Health Information Systems

Sample M&E question for a gender-integrated program

- Another Example: National Reproductive Health Strategy on Empowerment of Men and Women, Boys and Girls to Increase Utilization of RH Services
  - Question: Has there been an increase in male involvement in reproductive health programs?
  - Data needed: % of male clients receiving RH services (data collected at multiple time points):

Sample gender-sensitive indicators

- Gender Equality Measures: Percent 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 for production of 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 M&E Resources and Tools

- MEASURE Evaluation gender website:
  - http://www.measureevaluation.org/gender
- UNFPA compendium
  - http://www.unfpa.org/measurepublications/ne06-30
- Key indicator Registry (KIR) Gender
  - http://kiriunesources.wits.ac.za/Gender
- Gender scales
  - http://www.measureevaluation.org/content/gender-scaling-content.html
- Kit Health/WHO Gender and Health Tools:
  - http://www.who.int/hiv/topics/gender
  - http://www.who.int/hiv/topics/gender/toolkit/gender-assessments
- Questions about Gender M&E? Ask the expert:
GENDER M&E TOOL #10: 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 (ideally by gender rather than sex); and
- 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; and
- uses data to demonstrate progress and impact, influences demand for richer data.

Sample gender and health M&E questions:

Monitoring:

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

Evaluation:

- Has the program reduced power differences in relations between men and women? (For instance, is decision-making more equitable? Do men and women have more equal opportunities? Has women's mobility outside the home increased?)
- Has stigma and discrimination against people who do not follow traditional gender norms and behaviors been reduced?
- Has the removal of gender-based constraints contributed to improved health outcomes?

Issues to consider when selecting gender and health indicators:

- Are indicators disaggregated by gender, ethnic group, age, and socioeconomic status?
- Are baseline data collected on women and men of different demographics? Of MSM? Of transgender persons?
- Are there specific indicators to measure changes in gender norms, gender relations, access
to services and resources, and power and other inequalities?

- Does the project have a systematized way for collecting and analyzing the 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 health?

**SAMPLE INDICATORS**

- **Gender Equality Measures**: Percent 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 for production of goods, services and/or income in their own name.

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

- **GBV**: 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.

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### Gender and Health M&E Resources and Tools

- **MEASURE Evaluation gender Web site**: 
  [https://www.measureevaluation.org/gender](https://www.measureevaluation.org/gender)

- **VAW/G Compendium**: 
  [https://www.cpc.unc.edu/measure/publications/ms-08-30](https://www.cpc.unc.edu/measure/publications/ms-08-30)

- **Gender scales**: 
  [https://www.c-changeprogram.org/content/gender-scales-compendium/index.html](https://www.c-changeprogram.org/content/gender-scales-compendium/index.html)

- **K4 Health IGWG Gender and Health Toolkit**: 
  [http://www.k4health.org/toolkits/igwg-gender](http://www.k4health.org/toolkits/igwg-gender)

  [https://www.cpc.unc.edu/measure/publications/ms-12-52](https://www.cpc.unc.edu/measure/publications/ms-12-52)

- **Questions about Gender M&E? Ask the expert!** 

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GENDER M&E TOOL #11: Sample Stakeholder Meeting for Modules D and E

Name of Meeting

Date

Place and address were meeting is being held

Meeting Objectives:
1) 
2) 
3) 

Agenda for Day One (Module D):
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 the 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 are aiming to generate from the program
   • Link available resources and planned activities to the results
   • Review the Women, Girls, & Gender Equality (WGGE) Principle Results Framework
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 you’ve gathered and determine what indicators already exist
   • Carry out a gap analysis to decide what indicators you have versus what are needed
V. Select indicators
   • Develop indicator reference sheets to define the indicators, determine data sources, identify frequency of data collection, how the data will be used, etc.
Agenda for Day Two (Module E):

I. Decide the “who”, “what”, and “how” of your new data collection

II. Develop a plan for analyzing, disseminating, and using your data
   - Set plans for data analysis
   - Set plans for dissemination of your data; consider different products for different stakeholders
   - Discuss how the data will be used and who will have the most interest in your findings
GENDER M&E TOOL #12: Checklist for Defining Evaluation Questions

The development of good evaluation questions is essential because they 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. Evaluation questions should answer:

- 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 tool is designed to assist in developing a list of evaluation questions and refining them for a given 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 a number of available sources from which to draw from – including those listed below.

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

**PRIORITIZATION**

Evaluations cannot aim to answer all possible questions, especially given time and resource restraints. As such, prioritizing questions is crucial. The below list includes questions you should ask yourself to determine which questions are most important to incorporate into the evaluation.

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who would use the information? Who would be upset if the evaluation question were dropped? What’s the level of interest in this information to key stakeholders?</td>
<td></td>
</tr>
<tr>
<td>Would the information change or impact the course of events in your current program?</td>
<td></td>
</tr>
<tr>
<td>Is the question of passing interest, or does it meet a current information need?</td>
<td></td>
</tr>
<tr>
<td>Would the evaluation be compromised if this question were dropped?</td>
<td></td>
</tr>
<tr>
<td>Is it feasible to answer the question? (note: for research on sensitive topics such as GBV or with vulnerable populations such as MSM, consider whether you have the resources to answer the question using required ethical and safety protocols)</td>
<td></td>
</tr>
<tr>
<td>Can those interested in this evaluation envision how they would actually use the evidence in response to each question?</td>
<td></td>
</tr>
<tr>
<td>The personal factor--do the key users really care about the evaluation questions and are they really committed to acting on the changes recommended by the evaluation?</td>
<td></td>
</tr>
</tbody>
</table>

**TIPS FOR WRITING GOOD EVALUATION QUESTIONS**

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

<table>
<thead>
<tr>
<th>Tip</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Each link to the evaluation purpose.</td>
<td></td>
</tr>
<tr>
<td>Avoid asking two questions in one.</td>
<td></td>
</tr>
<tr>
<td>Avoid yes/no questions.</td>
<td></td>
</tr>
<tr>
<td>Include relevant sub-questions, when applicable. These could be particularly relevant in looking at differences between men and women.</td>
<td></td>
</tr>
<tr>
<td>Are feasible to answer given the stage of the program/policy cycle.</td>
<td></td>
</tr>
<tr>
<td>Are answerable with empirical evidence.</td>
<td></td>
</tr>
<tr>
<td>Take into account gender considerations per the program gender analysis.</td>
<td></td>
</tr>
<tr>
<td>Are realistic given the time and budget constraints for the evaluation.</td>
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</tbody>
</table>

GENDER M&E TOOL #13: Results Framework for the WGGE Principle

USG GHI WGGE INPUTS
(Element from WGGE guidance)

SOCIAL AND ECONOMIC RESOURCES
- Ensure equitable access to essential health services at facility and community levels (1)
- Address social, economic, legal & cultural determinants of health through a multi-sectoral approach (7)
- Empower adolescent and pre-adolescent girls by fostering and strengthening their social networks, educational opportunities and economic assets (4)

KNOWLEDGE, BELIEFS, PERCEPTIONS, PRACTICES
- Engage men and boys as clients, partners & role models for gender equality (5)
- Utilize multiple community-based programmatic approaches, such as behavior change communication, community mobilization, advocacy and engagement of community leaders/role models to improve health for women and girls (8)
- Monitor, prevent and respond to gender-based violence (3)

PARTICIPATION AND LEADERSHIP
- Increase the meaningful participation of women and girls in the planning, design, implementation, monitoring and evaluation of health programs (2)
- Build the capacity of individuals, with a deliberate emphasis on women, as health care providers, caregivers, and decision-makers throughout the health systems, from the community to national level (9)

INSTITUTIONAL AND POLICY ENVIRONMENT
- Strengthen the capacity of institutions which set policies, guidelines, norms and standards that impact access to, and quality of, health-related outreach and services (10)
- Promote policies and laws that will improve gender equality, and health status, and/or increase access to health and social services (6)

Results Framework for the WGGE Principle

Intermediate Gender Results
- Reduced inequalities between men and women in access to and control over social and economic resources (incl. health resources & health decision making)

Intermediate Health Results
- Increased capacity to make decisions free of coercion or the threat of violence
- Improved gender norms around valuing men and women equally
- More equal participation of women with men as decision-makers in shaping the sustainable development of their societies

DEMAND:
- Improved health knowledge, attitudes, norms at individual, family, peer and community levels

SUSTAIN:
- Sustained and gender equitable improvements in health behavior and prevention, care and treatment utilization

SUPPLY:
- Expanded coordinated & integrated gender-equitable services
  - Access (availability, affordability, acceptability)
  - Utilization
  - Quality services and providers

HEALTH STATUS OUTCOMES
- Improved FP/RH
- Improved MCH
- Improved Nutrition
- Reduced HIV/AIDS
- Reduced Malaria
- Reduced TB
- Reduced NTDS

Reduced gender-based disparities in rights and status
GENDER M&E TOOL #14: Indicators

One of the most critical steps in designing a monitoring & evaluation system is selecting appropriate indicators. The M&E plan should include descriptions of the indicators that will be used to monitor program implementation and achievement of the 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 the program began 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.
- Secondly, 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.
- Finally, 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 10-15 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, amount of funds allocated to gender-based violence prevention programs).
- Indicators of outputs measure the immediate results obtained by the program (for example, number of program participants or number of workshops given in X community).
- Indicators of outcomes measure whether the outcome changed in the desired direction and whether this change signifies program “success” (for example, % ever married or partnered women (aged 15-49) who have experienced physical violence from a male intimate partner in the past 2 months).
Question 3: How are indicators measured?

Indicators can either be quantitative or qualitative.

- **Quantitative** indicators are numeric and are presented as numbers or percentages.
- **Qualitative** indicators are descriptive observations and can be used to supplement the numbers and percentages provided by quantitative indicators. They complement quantitative indicators by adding a richness of information about the context in which the program has been operating. Examples include “availability of a clear, strategic organizational mission statement” and “existence of a multi-year procurement plan for each product offered.”

Question 4: What are characteristics of a “good indicator”?

A good indicator should be **SMART** (specific, measurable, achievable, relevant and time-bound). More specifically, it should:

- produce same results when used repeatedly to measure the same condition or event;
- measure only the condition or event it is intended to measure;
- accurately represent the desired outcome;
- reflect changes in the state or condition over time;
- represent reasonable measurement costs;
- rely on available data;
- be defined in clear and unambiguous terms (see Indicators Need to Be Clear and Unambiguous, below);
- be comparable across relevant populations, geography, and other program factors;
- be consistent with international standards and other reporting requirements*; and
- be **independent**, meaning that they are non-directional and can vary in any direction (for instance, an indicator should measure the number of clients receiving counseling rather than an increase in the number of clients receiving counseling; similarly, the contraceptive prevalence rate should be measured, rather than the decrease in contraceptive prevalence).

---

Question 5: What are guidelines for selecting indicators?

- Select indicators requiring data that can realistically be collected with the resources available.
- Select at least one or two indicators (ideally, from different data sources) per key activity or result.
- Select at least one indicator for each core activity (e.g., training event, social marketing message, etc.).
- Select no more than 8-10 indicators per area of significant program focus.
- Use a mix of data collection sources whenever possible.

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

- Are indicators disaggregated by sex, ethnic group, age, and socioeconomic status?
- 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 access to services and resources, and power?
- Does the project have a systematized way for collecting and analyzing the information on a regular basis?
- Does the project have policies about what to do when monitoring and evaluation data reveal gender inequities?
- How do gender-specific objectives link to impact on reproductive health?

GENDER M&E TOOL #15: Gap Analysis

To determine what, if any, extra indicators are needed to measure the gender-related outputs and outcomes of your M&E framework, break your core group of stakeholders into small groups and answer the following questions:

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

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

(Use back of sheet for more room)

<table>
<thead>
<tr>
<th>Existing Indicators</th>
<th>Type of indicator (output or outcome)</th>
<th>Can data be separated by sex or gender?</th>
<th>Is indicator gender sensitive?*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

*Indicators that address gender beyond sex disaggregation and are related to health, determinants of health, the health system, or the community*
Q3. Do your existing 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 below table (use back of sheet for more room):

<table>
<thead>
<tr>
<th>Potentially new/needed gender-sensitive indicators</th>
<th>Type of indicator (output or outcome)</th>
<th>Potential source for data collection?</th>
</tr>
</thead>
</table>

* Refer to Activities D.3. and D.4 in the Guide or Tool #12 for more information on the "what", "why" and "how" of indicators, as well as how to create your own.
GENDER M&E TOOL #16: Indicator Reference Sheets

<table>
<thead>
<tr>
<th>Indicator Reference Sheet: What Should Be Included?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>INDICATOR:</strong></td>
</tr>
<tr>
<td>➢ What is the indicator being measured?</td>
</tr>
<tr>
<td>➢ Remember: A good indicator should be <strong>SMART</strong> (Specific, Measurable, Achievable, Relevant and Time-bound)</td>
</tr>
<tr>
<td><strong>DEFINITION:</strong></td>
</tr>
<tr>
<td>➢ Indicators need to be defined clearly and unambiguously.</td>
</tr>
<tr>
<td>➢ In many cases, the terms used to define the indicator must be accompanied by clarifications.</td>
</tr>
<tr>
<td><strong>TARGET:</strong></td>
</tr>
<tr>
<td>➢ What is the population of interest?</td>
</tr>
<tr>
<td>➢ What is the desired sample size?</td>
</tr>
<tr>
<td><strong>RATIONALE:</strong></td>
</tr>
<tr>
<td>➢ Why should this indicator be included in the M&amp;E plan?</td>
</tr>
<tr>
<td>➢ Why is this indicator important for program implementation decision-making?</td>
</tr>
<tr>
<td><strong>UNIT:</strong></td>
</tr>
<tr>
<td>➢ Unit of measurement</td>
</tr>
<tr>
<td>➢ Usually expressed as a number or percentage</td>
</tr>
<tr>
<td><strong>DISAGGREGATE BY:</strong></td>
</tr>
<tr>
<td>➢ How will the data be disaggregated?</td>
</tr>
<tr>
<td>➢ For example: sex, age, socioeconomic status, etc.</td>
</tr>
<tr>
<td><strong>TYPE:</strong></td>
</tr>
<tr>
<td>➢ Is the indicator measuring a program input, output or outcome?</td>
</tr>
<tr>
<td><strong>DIRECTION OF CHANGE:</strong></td>
</tr>
<tr>
<td>➢ Should the desired units of measurement be higher or lower than baseline?</td>
</tr>
<tr>
<td><strong>DATA SOURCE:</strong></td>
</tr>
<tr>
<td>➢ Where can one attain the information needed to measure the indicator?</td>
</tr>
<tr>
<td><strong>MEASUREMENT NOTES:</strong></td>
</tr>
<tr>
<td>Might include-</td>
</tr>
<tr>
<td>➢ Level of collection</td>
</tr>
<tr>
<td>➢ Who collects data for this indicator</td>
</tr>
<tr>
<td>➢ How should it be collected</td>
</tr>
<tr>
<td>➢ Frequency of collection</td>
</tr>
<tr>
<td>➢ Important assumptions</td>
</tr>
<tr>
<td><strong>DATA USE:</strong></td>
</tr>
<tr>
<td>➢ How will the data be communicated to decision makers?</td>
</tr>
<tr>
<td>➢ How will the data be used to make programmatic changes/adjustments?</td>
</tr>
</tbody>
</table>
**Indicator Reference Sheet: SAMPLE (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 non-academic settings or non-academic seminars, workshops, webinars, or conferences. On-the-job training is instruction in SGBV awareness via mentoring by a practitioner using explanations, demonstration, practice, and feedback.
- “Health service provider” can be defined as any clinician providing direct clinical services to clients seeking primary care at a public health facilities

**TARGET:**
- To identify possible inequities, service providers will be surveyed in both poor and not poor service areas. It is currently 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” individuals. These assumptions will be revised in Year 2, when training needs will have been assessed.

**RATIONALE:**
Health service delivery programs are key in the prevention and response to SGBV. Every clinic visit made by a SGBV survivor presents an opportunity to address and ameliorate the effects of violence as well as help prevent future incidents. To take advantage of these opportunities, providers need to be prepared to deliver appropriate services, including 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 of trained personnel per geographic area of interest, and will help monitor whether or not the program is attaining its target number of providers trained.

**UNIT:**
- Number of service providers

**DISAGGREGATE BY:**
- Type of provider trained; sex; area in which they work (urban or rural); type of area served (poor/not-poor)

**TYPE:**
- Output

**DIRECTION OF CHANGE:**
- Higher number is better

**DATA SOURCE:**
Records of the training program that reflect program participants among current 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 how well they integrate the information disseminated or how well they use it later in their own practice. Presumably, if they are allowed to participate in the training program, there is a level of support in 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 advocate 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: SAMPLE (Outcome indicator)**

<table>
<thead>
<tr>
<th><strong>INDICATOR:</strong></th>
<th>Percentage of women who own property or resources for production of goods, services and/or income in their own name</th>
</tr>
</thead>
</table>
| **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 reproductive health services and family planning, 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:** | ➢ Percentage of Women |
| **DISAGGREGATE BY:** | ➢ 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:** | ➢ Outcome |
| **DIRECTION OF CHANGE:** | ➢ Higher percentage is better |
| **DATA SOURCE:** | ➢ Population-based surveys such as the Demographic Health Survey (DHS) and the WHO multi-country 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 actually does own the property alone, but feels it is more socially acceptable to say that it is jointly owned with a spouse or partner. Additionally, 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 advocate 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. |
### GENDER M&E TOOL #17: Example Data Collection Tools

<table>
<thead>
<tr>
<th>Title</th>
<th>Purpose</th>
<th>Available URL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demographic Health Survey (DHS)</td>
<td>To collect gender-sensitive health data</td>
<td><a href="http://www.measuredhs.com/What-We-Do/Survey-Types/DHS.cfm">www.measuredhs.com/What-We-Do/Survey-Types/DHS.cfm</a></td>
</tr>
<tr>
<td>Gender Equality Indexes</td>
<td>To provide a set of tools and methodological instruments that facilitate capacity building and skills development in gender issues and mainstreaming</td>
<td><a href="http://www.sdc-gender-development.net/en/Home/Instruments_Methods">http://www.sdc-gender-development.net/en/Home/Instruments_Methods</a></td>
</tr>
<tr>
<td>How to Conduct a Situation Analysis of Health Services for Survivors of Sexual Assault: A Guide</td>
<td>To provide tools to conduct a national situational analysis of sexual assault services</td>
<td><a href="http://www.svri.org/analysis.htm">www.svri.org/analysis.htm</a></td>
</tr>
<tr>
<td>International Men and Gender Equality Survey (IMAGES) Questionnaire</td>
<td>To collect household data on men's attitudes and practices, as well as women's opinions and reports of men's practices, on topics related to gender equality</td>
<td><a href="http://www.icrw.org/publications/international-men-and-gender-equality-survey-images">www.icrw.org/publications/international-men-and-gender-equality-survey-images</a></td>
</tr>
<tr>
<td>Reproductive Health Assessment (RHA) Toolkit for Conflict-Affected Women</td>
<td>To provide tools for collecting data on safe motherhood, family planning, sexual history, sexually transmitted infections, HIV/AIDS, gender-based violence, and female genital cutting</td>
<td><a href="http://www.iawg.net/resources/rhatoolkit.html">www.iawg.net/resources/rhatoolkit.html</a></td>
</tr>
<tr>
<td>Researching Violence Against Women: A Practical Guide for Researchers and Activists</td>
<td>To suggest innovative techniques that have been used to address methodological and ethical challenges of conducting research on violence against women</td>
<td><a href="http://www.who.int/gender/documents/women_and_girls/9241546476/en/index.html">www.who.int/gender/documents/women_and_girls/9241546476/en/index.html</a></td>
</tr>
<tr>
<td>Women's Empowerment in Agriculture Index</td>
<td>To measure the empowerment, agency, and inclusion of women in the agriculture sector and identify ways to overcome obstacles and constraints</td>
<td><a href="http://www.ifpri.org/publication/womens-empowerment-agriculture-index">www.ifpri.org/publication/womens-empowerment-agriculture-index</a></td>
</tr>
<tr>
<td>The Gender-Equitable Men (GEM) Scale</td>
<td>To measure attitudes toward “gender-equitable” norms, as well as the effectiveness of any program that hopes to influence those norms</td>
<td><a href="http://www.popcouncil.org/Horizons/ORToolkit/toolkit/gem1.htm">www.popcouncil.org/Horizons/ORToolkit/toolkit/gem1.htm</a></td>
</tr>
<tr>
<td>Compendium of Gender Scales</td>
<td>To provide tools to assess gender-related attitudes and beliefs and evaluate their interventions</td>
<td><a href="http://www.c-changeprogram.org/content/gender-scales-compendium/about.html">www.c-changeprogram.org/content/gender-scales-compendium/about.html</a></td>
</tr>
</tbody>
</table>
GENDER M&E TOOL #18: What, Who and How of Data Collection

When collecting new data, you must decide the “what”, “who”, “how” and “when” 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 proposed new indicators.

➢ **STEP 1: Describe the new data that you are wanting to collect**

➢ **STEP 2: Describe the “WHAT” of data collection.** (Answer the following questions to guide the discussion:)
  
  - What data collection system should be used? 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., staff, office supplies, computers, transportation, etc.) 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?

➢ **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 must be maintained throughout.
  - How will data quality be checked at every stage?
  - How will the data be sent (raw, summary)?

➢ **STEP 4: Describe the “WHEN” of data collection.** (Answer the following question to guide the discussion:)
  
  - What time of day? Month? Year? Be sure to consider times in which men vs. women are available if your data collection involves work in the community.
## GENDER M&E TOOL #19: What to do with your data

After determining your methods for data collection, you must 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 into reports? | What reports will be shared back with those that 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 specific 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 action on recommendations? |
REFERENCES:


