The Inter-Agency Minimum Standards for Gender-based Violence in Emergencies Programming

MONITORING AND EVALUATION FRAMEWORK

Acknowledgements

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CONTACT INFORMATION FOR FEEDBACK:

This is a living document that should be updated as new M&E tools are developed and additional best practice emerges. Contact the project at **GBVMandE@gmail.com** with any feedback you may have.

Introduction

Gender-based violence (GBV) is "*any harmful act that is perpetrated against a person's will and that is based on socially ascribed (i.e., gender) differences between males and females. It includes acts that inflict physical, sexual or mental harm or suffering, threats of such acts, coercion and other deprivations of liberty*" (The Inter-Agency Minimum Standards for Gender-based Violence in Emergencies [GBViE MS]). The term GBV is used to "*underscore how systemic inequality between males and females, which exists in every society in the world, acts as a unifying and foundational characteristic of most forms of violence perpetrated against women and girls*" (GBViE MS).

In 2019, the GBV Area of Responsibility (AoR) developed **16 Minimum Standards** that aim to *"establish a common understanding of what constitutes* ***minimum*** *GBV prevention and response programming in emergencies"* (GBViE MS). The Minimum Standards seek to establish a common understanding of what programs should seek to achieve to be 1) reflective of good practice and 2) not cause harm. By achieving these minimums, humanitarian agencies will implement GBV programming that meets adequate quality, enhances accountability, and improves programme quality. Engagement of women and girls is critical to the implementation of the Minimum Standards, and women and girls should be key actors throughout the design, implementation, monitoring and evaluation of the standards.

The Minimum Standards lay out a number of principles that underlie their implementation. These principles can also be helpful to guide monitoring and evaluation (M&E) practices that help measure the progress of implementing the Minimum Standards.

The **GBV AoR** brings together non-governmental organisations, UN agencies, academics and others under the shared objective of ensuring life-saving, predictable, accountable and effective GBV prevention, risk mitigation and response in emergencies, both natural disaster and conflict-related humanitarian contexts.

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These Guiding Principles are:

- **Survivor-centred approach**: A survivor-centred approach creates a supportive environment in which survivors' rights and wishes are respected, their safety is ensured, and they are treated with dignity and respect. A survivor-centred approach is based on the following guiding principles:
  - **Safety**: The safety and security of survivors and their children are the primary considerations.
  - **Confidentiality**: Survivors have the right to choose to whom they will or will not tell their story, and any information about them should only be shared with their informed consent.Respect: All actions taken should be guided by respect for the choices, wishes, rights and dignity of the survivor. The role of helpers is to facilitate recovery and provide resources to aid the survivor.
  - **Respect**: All actions taken should be guided by respect for the choices, wishes, rights and dignity of the survivor. The role of helpers is to facilitate recovery and provide resources to aid the survivor. Non-discrimination: Survivors should receive equal and fair treatment regardless of their age, disability, gender identity, religion, nationality, ethnicity, sexual orientation, or any other characteristic.
  - **Non-discrimination**: Survivors should receive equal and fair treatment regardless of their age, disability, gender identity, religion, nationality, ethnicity, sexual orientation, or any other characteristic.
- **Rights-based approach**: A rights-based approach seeks to analyse and address the root causes of discrimination and inequality to ensure that everyone has the right to live with freedom and dignity, safe from violence, exploitation, and abuse, in accordance with principles of human rights law.

HOW WAS THIS DOCUMENT DEVELOPED?

This document was developed as part of a multi-step process that sought to bring in best practices from existing global guidance and programme implementation materials. To inform its development, the project team undertook a desk review to identify existing M&E materials that could relate to the Minimum Standards including potential additional indicators that could increase the scope and robustness of M&E around the standards and existing M&E tools. We held consultations with key global stakeholders including with members of the GBV AoR's Minimum Standard's Task Team. In addition, we learned from in-depth work with local organisations (TOCH and KMSS) in South Sudan and Myanmar who participated in a human-centred design process to create some of the M&E tools in this document and inputted into the new recommended indicators for the Standards.

- **Community-based approach**: A community-based approach ensures that affected populations are engaged actively as partners in developing strategies related to their protection and the provision of humanitarian assistance. This approach involves direct involvement of women, girls, and other at-risk groups at all stages in the humanitarian response, to identify protection risks and solutions, and build on existing community-based protection mechanisms.
- **Humanitarian principles**: The humanitarian principles of humanity, impartiality, independence and neutrality should underpin the implementation of the Minimum Standards and are essential to maintaining access to affected populations and ensuring an effective humanitarian response.
- **"Do no harm" approach**: A "do no harm" approach involves taking all measures necessary to avoid exposing people to further harm as a result of the actions of humanitarian actors.
- **Principles of Partnership**: The Principles of Partnership comprise a framework for all actors in the humanitarian space to follow principles of equality, transparency, a results-oriented approach, responsibility, and complementarity. The principles strive to highlight the role of local and national humanitarian response capacity and enhance the effectiveness of humanitarian action based on accountability to affected populations.
- **Best interests of the child**: Child and adolescent girl and boy survivors of sexual abuse have the right to have their best interests assessed and taken as a primary consideration in all decisions that affect them.

Purpose of this document

The main GBV Minimum Standards document provides details on the 16 Standards, key actions that should be taken to achieve each standard, the minimum indicators needed to measure each standard, guidance notes with further information and tools and resources to support the fulfilment of each standard.

This document acts as a complement to the main Minimum Standards guidance and explores potential avenues to monitor and evaluate the achievement of each standard. It is a compilation of current best practices and measurement tools that are available for humanitarian agencies and clusters to employ as they seek to rollout and measure their progress against each standard. Using the definitions and tools included in this document, actors and agencies implementing GBV-specialized programming[1] will be able to consistently measure core and recommended indicators related to the standards.

The document first details the core indicators that were laid out in the main resource, which are *"signals that show whether or not a Standard has been achieved and is of adequate quality"* (GBViE

1 GBV programme actors are personnel who have received GBV-specific training and/or have experience working on GBV programming; A GBV agency is one that implements targeted programmes for the prevention and response to GBV (GBViE MS).

MS). These indicators provide guidance for the minimum data that should be collected in emergencies. While not every indicator needs to be collected in each context, sub-clusters and individual organisations can select the most relevant indicators for their context to collect data for. In this document we give details on the definition of each indicator, key considerations for monitoring and evaluating the progress towards and achieving this indicator and links to any available M&E tools. We also provide targets that will help organisations and clusters to understand their progress in achieving each standard.

This document also seeks to present a more comprehensive M&E framework for GBV practitioners that describes how to measure and use both output and outcome-level indicators related to each Minimum Standard. Included in the **"CORE INDICATOR"** sections of each standard are the indicators that are listed in the main Minimum Standards. We have added additional **"RECOMMENDED INDICATORS"** for each standard that give guidance on indicators that "go beyond the minimum" and may help organisations employ more robust M&E of each standard. While we are not prescriptive as to the exact measurement tool that should be utilised to measure each standard, as variations in context and capacity may sometimes make different M&E tools more appropriate, wherever possible we include links to existing M&E tools that can be used to measure these standards. They can be adapted and contextualised as appropriate in each context.

This is a living document as the development of a full M&E system for the Minimum Standards is an iterative process. As new tools and analysis plans are developed or adapted in the future, this document will be updated. It is our hope that this will provide the basic information to support both GBV and M&E staff the needed background and tools to safely and ethically collect and utilise data to measure the implementation of the GBV Minimum Standards.

KEY TERMS

OBJECTIVE: The result expected to occur as a consequence, at least in part, of the project. Multiple activities may be necessary to achieve an objective. Example: Reducing risks of GBV.

OUTCOMES: The changes that occur as a consequence of a specific project's activities. Example: Improved survivor well-being.

OUTPUTS: The result of the activities implemented. Example: GBV staff are trained on the GBV Guiding Principles.

INDICATORS: A way to track if objectives, outcomes and outputs have been achieved. Primarily are quantitative (e.g., tracking percentages or numbers of people) but can also be qualitative (e.g., documenting perceptions, quality, etc.).

Theory of Change[2]

MS 1: Guiding Principles	GBV programmes are survivor centred and preserve/promote confidentiality, safety, non-discrimination and respect for choices, rights and dignity of women and girls, including GBV survivors
MS 2: Women's and Girls' Participation and Empowerment	Humanitarian programming is led by and meets the needs of women and girls affected by crisis
MS 3: Staff Care and Support	Trained and supported GBV staff are better equipped to support the needs of women and girls
MS 4: Health Care for GBV Survivors	Health needs of survivors are met
MS 5: Psychosocial Support	Psychosocial needs of survivors are met
MS 6: GBV Case Management	Survivors feel supported and are able to heal after an incident of violence
MS 7: Referral Systems	Survivors access needed support services, in accordance with their needs and preferences, after an incident of violence
MS 8: Women's and Girls' Safe Spaces	Women and girls are able to heal, improve their wellbeing and are empowered

GBV prevention and response programming in emergencies is of adequate quality, reflects good practice and do not cause harm.

2 More details for each standard can be found in the individual Minimum Standard sections below

MS 9: Safety and Risk Mitigation	GBV programmes are survivor centred and preserve/promote confidentiality, safety, non-discrimination and respect for choices, rights and dignity of women and girls, including GBV survivors
MS 10: Justice and Legal Aid	Survivors are able to seek safe and survivor centred legal redress if they so choose
MS 11: Dignity Kit, Cash and Voucher Assistance	Risks for GBV are reduced during and after distributions of dignity kits, cash, and voucher assistance
MS 12: Economic Empowerment and Livelihoods	Women and girls have increased economic security and decision-making power over income and assets
MS 13: Transforming Systems and Social Norms	Reduced harmful social norms and improved gender equality
MS 14: Collection and Use of GBV Survivor Data	Safe and ethical data collection, storage and use reduces the risk of confidentiality breaches and negative consequences for survivors
MS 15: GBV Coordination	Effective coordination improves action and accountability to prevent and respond to GBV at all levels of the response
MS 16: Assessment, Monitoring and Evaluation	Data on GBV is collected, shared, stored, and analysed safely and ethically in consultation with GBV and gender experts, and supports humanitarian planning, programming, and funding decisions.

GBV prevention and response programming in emergencies is of adequate quality, reflects good practice and does not cause harm.

GBV Minimum Standards within the M&E Cycle

Monitoring

Monitoring is the systematic and continuous process of collecting, analysing, and using information to track a programme's progress toward reaching its objectives and to guide management decisions. This process tracks changes in performance over the lifetime of a programme. Through these processes, information is collected on where and when activities occur, how many people are reached through an activity, and progress against programme indicators.

Evaluation

Evaluation is the investigation of how activities meet the objectives of the programme. It focuses on comparing the expected and achieved programme accomplishments.

Quantitative and qualitative data collection methods should be utilised. While quantitative methods (e.g., surveys, etc.) can be used to measure population-based indicators and track overall programme change, qualitative methods can provide contextual data that helps to interpret the experiences of women and girls. Both primary and secondary data can be helpful including routine programme M&E data as well as demographic and social and economic information, legal and judicial frameworks, academic and other reports, etc.

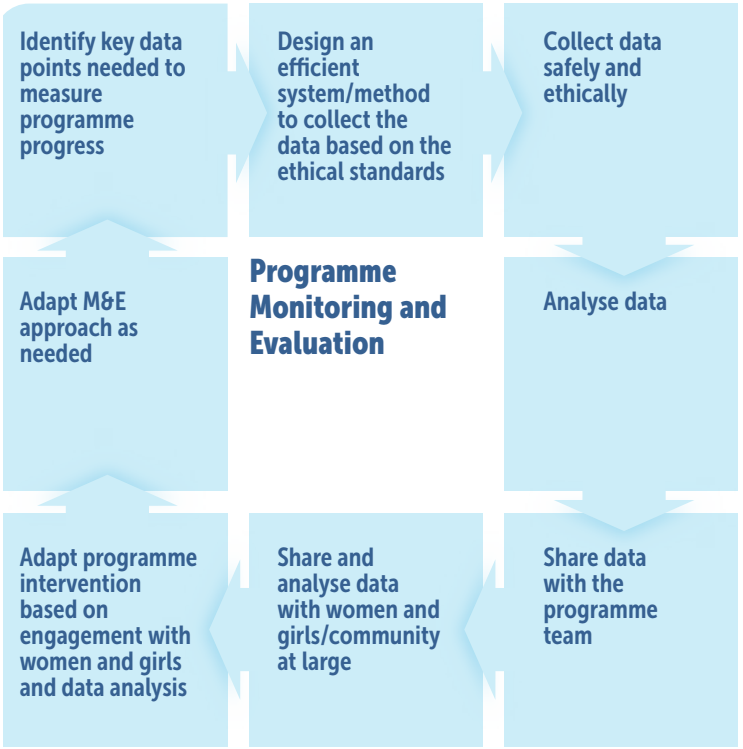

Figure 1: M&E Cycle for GBViE MS

Ethical and safety considerations for data collection on GBV

When collecting, storing, and using GBV data, the safety of women and girls is of paramount concern. Unlike M&E practices for many sectors, the act of collecting data on GBV can put women and girls at risk for further violence. In addition, key considerations around data security, safe data storage and sharing take on heightened importance when considering GBV data for M&E.

The Minimum Standards lay out some of the challenges and risks that may occur when collecting GBV data in humanitarian settings including:

- Potential to cause harm to beneficiaries, including in creating safety risks for survivors and other women and girls;
- Shortage of qualified, female enumerators/data collectors;
- Stigma faced by survivors who report GBV incidents;
- Insecurity, including the risk of retaliation by perpetrators and/or the community;
- Impunity of perpetrators;
- Lack of harmonised GBV-related data collection tools and data collection methods;
- Lack of or weak data-protection mechanisms to ensure the safety, security, confidentiality and anonymity of case information;
- Lack of service infrastructure;
- Lack of effective and quality case management services for GBV survivors;
- Limitations on the mobility of typically marginalised segments of the female population (e.g., older women and adolescent girls or women and girls with disabilities);
- Restricted humanitarian access to the affected population, especially women and girls;
- Limited time to establish trust and rapport with affected populations; and
- Difficulty in establishing adequate interview settings that ensure basic privacy.

The GBV Guiding Principles laid out in the Minimum Standards are also relevant for M&E practices, particularly the principles of respect, safety, confidentiality and do no harm. The key principles as related to M&E include:

- **RESPECT:** All data collection activities should be designed to ensure the dignity of respondents and respect their wishes. Key research principles that will help ensure respect include:
  - **VOLUNTARY NATURE*:*** Participation should always be voluntary and should not be tied to future provision of services. In particular when asking details about experiences of GBV, women and girls should be allowed to skip questions if they do not feel comfortable answering.
  - **INFORMED CONSENT***:* Obtaining informed consent requires explaining why you are collecting data and what you plan to do with it before asking permission to administer your questionnaire. It is essential to ensure informed consent (either written or verbal as relevant) is obtained before collecting any data. For data collection with children, you may also need the consent of a parent or guardian – though it is always important to consider if this will put a child more at risk of violence.
  - **TRAINED AND RESPECTFUL INFORMATION GATHERING TEAM*:*** Simply by asking questions on sensitive subjects such as GBV it is possible to retraumatize someone who has experienced violence. For this reason, it is often recommended that GBV staff themselves, rather than external data collectors or M&E staff, collect M&E with survivors.
- **SAFETY:** The safety of participants in data collection on GBV is of primary importance for GBV M&E. Data collection should take place in locations and times that are safe for respondents. It should never be made known to outsiders that the participants are discussing GBV.
- **CONFIDENTIALITY:** The confidentiality of individuals who provide information should be protected at all times. Where possible, data should be collected anonymously and if identifiers are needed a unique code should be assigned to all participants and stored separately from the respondent's name. All data needs to be secured during and after the completion of data collection, including ensuring that any tablet, phone or computer used for data collection or storage is password protected or in locked locations (for hard copies).
- **DO NO HARM:** Always consider the safety and security of respondents as the most important aspect of designing a GBV M&E system.

WHO Ethical and Safety Principles for Collecting GBV Data in Emergencies

The Guiding Principles are closely linked to the **WHO Ethical and Safety Guidelines for Researching, Documenting and Monitoring Sexual Violence in Emergencies**. The WHO guidelines are the key principles that guide all research, monitoring and evaluation activities in emergencies. Each should be assessed and considered when engaging in any data collection/analysis process:

1. **ANALYSE RISKS AND BENEFITS**: Before collecting any data, it is important to consider both: (1) potential risks that respondents and data collectors may experience, and (2) potential benefits to the affected community and the wider humanitarian community. It is critical that the benefits outweigh the risks.

2. **METHODOLOGY**: Data collection activities must be safe and survivor-centred, methodologically sound and not time intensive.

3. **REFERRAL SERVICES**: Basic care and support to survivors must be available locally before commencing any activity that may involve individuals disclosing information about their experiences of violence.

4. **SAFETY**: The safety and security of all those involved in information gathering is a primary concern and should be monitored continuously. Safety and security conditions should be regularly incorporated into the security protocol.

5. **CONFIDENTIALITY**: The confidentiality of individuals who participate in any data-collection activity must be protected at all times. Data should be collected anonymously where possible.

6. **INFORMED CONSENT**: Anyone participating in data gathering activities must give informed consent. Before collecting data, all participants need to be informed of the purpose of the exercise, the risks they may face, and the benefits (including any monetary or in-kind compensation) they can expect to receive due to their participation.

7. **INFORMATION GATHERING TEAM**: The data gathering team must include women. All members must be selected carefully and receive relevant and sufficient specialised training and ongoing support.

8. **CHILDREN**: Additional safeguards must be established if children or adolescents (i.e., those under 18 years old) participate in information-gathering.

See Minimum Standard 16 on Assessment, Monitoring and Evaluation for more details on the key considerations for collecting and using M&E data for GBV programmes in humanitarian settings.

Data Protection[3]

Related to these principles, but also specific to M&E data are the issue of data protection and safe data sharing. Data protection is the act of protecting personal or sensitive information and how it is collected, stored, used, and shared. It is important to consider data protection when developing an M&E system for the GBV Minimum Standards because we collect sensitive information about survivors. It is important to develop specific policies, protocols and practices to ensure that data is protected and the safety of women and girls, as well as staff and programming, is prioritised. Data should only be collected if we can realistically protect that data to ensure that survivor or beneficiary data is not abused.

Protecting the data of the survivors and beneficiaries we work with can be a challenge. Especially so when there is a lack of policies or guidance on data protection, when programmes are working in highly insecure environments, and when resources are limited.

Data is "protected" when:

- there is a clear purpose for collection;
- there are limits to what is being collected (safe, ethical, actionable, consented);
- the information is secure (reasonable safeguards are in place to protect from unauthorised access, use or sharing, destruction, or loss);
- survivors/beneficiaries are informed about their rights, and their rights are respected; and
- policies, protocols and/or practices are implemented and effective in regulating the collection and use of information.

M&E data is often collected via mobile data collection modalities (e.g. phones or tablets) or paper-based tools. Both of these options have benefits and challenges to consider when using for GBV M&E data.

WHAT IS SURVIVOR DATA?

- Personal or identifiable data about an individual survivor accessing a GBV response service.
- The details of the GBV incident such as: the type of violence, location of the incident, relationship of the survivor to the perpetrator, etc.
- Case management data such as information about the support provided to an individual survivor through the GBV case management process.
- Enhanced data security and clear data sharing protocols are needed for this data!

DATA PROTECTION CHECKLIST

3 Adapted from: **gbvims.com/data-protection**

Mobile Data Collection: Popular data collection tools such as KoboToolbox, Open Data Kit, etc. can greatly simplify the data collection process and improve data quality. For general M&E (e.g. collecting non-identifiable data on knowledge, attitudes and behaviours, etc.) these can be useful tools. Always ensure that all devices are password/pin protected and encrypted to prevent data from falling into the wrong hands if your phone or tablet is stolen. Always use a secure server to store your data. Create protocols to remove your data from individual devices to a secure server as soon as possible. Remove any identifiers (specific birth dates, addresses, phone numbers, names, etc.) before sharing any datasets. If you are collecting data that includes names or other identifiers of survivors for any reason **do not** use open source tools (e.g. Kobo, Open Data Kit, etc.) and instead utilise mobile data services with higher levels of security such as CommCare or PRIMERO.

Safe Data Sharing[4]

GBV information is extremely sensitive and can have dangerous consequences if misused. That is why it is essential that GBV data be shared confidentially and compiled and analysed in a format that ensures anonymity and the safety and security of all involved. This is true for both survivor data as well as any data you collect from affected communities. You should always consider the risks and benefits of sharing data outside your individual programme teams.

For general M&E data (e.g., results of survey or qualitative data collection exercises), you should always only communicate aggregated and de-identified data. For quantitative data (e.g., numbers), this usually means summarising information into percentages or averages. This allows you to communicate trends without disclosing individual responses. For qualitative data (e.g., stories or quotes), it is important that you ensure anything shared is sufficiently de-identified. This goes beyond just ensuring that names are not shared – as unique characteristics of an experience may also be identifiable. It is acceptable to edit quotes to remove or change specific details that may make this data identifiable (though you should include a note that details have been changed to protect the respondent).

For data that is collected with survivors, enhanced security is needed, and only de-identified data should be shared. The **GBVIMS** has developed information-sharing protocols that help organisations consider how to safely share de-identified data with other organisations. We recommend that any M&E data collected directly with survivors follows these same procedures and protocols if it is to be shared outside an organisation. GBV service providers adopt and adhere to information sharing protocols that outline the parameters for information sharing and ensure the security of the client and those involved.

See **Minimum Standard 14** for more details on the collection and use of survivor data.

4 Adapted from: **gbvims.com/gbvims-tools/isp/** and MS 14 : Collection and Use of Survivor Data

Standards

A Guide to the Standards:

The following tables provide an overview of key M&E considerations for each Minimum Standard.

For each Standard, indicators to measure progress are included.

CORE INDICATORS, IN BLUE, are from the Minimum Standards document.

RECOMMENDED INDICATORS, IN GREEN, are additional to the core indicators and can be utilised when more robust measurement is possible.

At the beginning of each section there is a theory of change for each Minimum Standard. Outputs or outcomes that connected to core indicators are in **blue**, while those associated with recommended indicators are in **green**.

Indicators may be at **organisation level** (e.g. to be collected by humanitarian agencies), at **cluster level** (e.g. to be collected by the GBV sub-cluster) or **both**. These are indicated by icons:

ORGANISATION

CLUSTER

Indicators in this guide are typically structured in four ways (narrative, counts, percentages, percentage change). To calculate each:

NARRATIVE	COUNTS	PERCENTAGE	PERCENTAGE CHANGE
CALCULATION			
NONE	**NUMERATOR**	**(NUMERATOR / DENOMINATOR) * 100**	**((PERCENTAGE AT ENDLINE – PERCENTAGE AT BASELINE) / PERCENTAGE AT BASELINE) * 100**
EXAMPLES			
Special fora established, in a safe and non-stigmatising manner, to ensure the meaningful participation of all women and girls who may face increased barriers to access **CALCULATION**: None – narrative summary.	Number of women and girls from the affected communities involved in leadership positions in humanitarian programming **CALCULATION**: Count the number	Percentage of referrals that include documentation of survivors' informed consent. **CALCULATION**: # of referrals with documentation / # of referrals	Percentage change from baseline in women's and girl's access to and control over financial resources following participation in economic empowerment or livelihood programmes **CALCULATION**: ((% of women and girls who report access to and control over financial resources at endline - % of women and girls who report access to and control over financial resources at baseline) / (% of women and girls who report access to and control over financial resources at baseline)) * 100

Standard 1: GBV Guiding Principles

All aspects of GBV programming are survivor-centred to preserve and promote the confidentiality, safety, non-discrimination and respect for the choices, rights and dignity of women and girls, including GBV survivors.

READ THE STANDARD

OUTPUTS

Staff have appropriate attitudes, knowledge and skills to appropriately support survivors

Confidentiality is maintained when working with survivors

All survivors consent to their data being shared with other service providers to whom they are referred

OUTCOMES

Women and girls who access GBV services feel respected, that their privacy and confidentiality are maintained and that they are able to make informed choices about what services to access

OBJECTIVES

GBV programmes are survivor centred and preserve/promote confidentiality, safety, non-discrimination and respect for choices, rights and dignity of women and girls, including GBV survivors

1.1 Percentage of GBV programme staff, including volunteers and community workers, who are trained on the GBV Guiding Principles, and who demonstrate improved survivor-centred attitudes, knowledge and skills after training.

INDICATOR LEVEL
ORGANISATION

DEFINITION

NUMERATOR:

# of GBV programme staff (including GBV prevention and response staff as well as volunteers and community/ incentive workers) who improve their score on post-training tests compared to their pre training scores

DENOMINATOR:

# of GBV programme staff/ volunteers/ community workers trained

HOW TO MEASURE

To measure this indicator, a questionnaire should be administered to all training participants both prior to and immediately after participating in a training. The number of participants who increase their score from prior to the training (at pre-test) to after the training (post-test) should be tracked and compared to all participants trained.

The GBV Guiding Principles that should be trained on are:

1. Safety
2. Confidentiality
3. Respect
4. Non-Discrimination

See Standard #1 for more details and Minimum Standards Facilitator's Guide for training support.

MEETING THE STANDARD?

MET	100% of staff, volunteers & community workers who take the pre- and post-test improve their score (or if received a perfect score at pre-test and maintained their score).
WORKING TOWARDS	80%-99% of staff, volunteers & community workers improve their score.
NOT MET	Below 80% of staff, volunteers & community workers improve their score.

SUGGESTED M&E TOOLS

Specific questions on attitudes, knowledge and skills in tools can be contextualised by organisation/context based on the training needs for each.

See a sample questionnaire with key questions based on Exercise 3 'Introducing the GBV Guiding Principles' from Minimum Standards Facilitator's Guide as a starting point.

To assess progress against the Standard, calculate the combined score on 1) knowledge and skills + 2) attitudes.

1.2 Percentage of GBV programme staff, and other staff working directly with GBV survivors, who sign confidentiality commitments

INDICATOR LEVEL
ORGANISATION

DEFINITION

NUMERATOR:

# of GBV and other staff working directly with GBV survivors who sign a document agreeing to the confidentiality commitments

DENOMINATOR:

# of GBV and other staff working directly with GBV survivors

HOW TO MEASURE

To measure this indicator, data should be tracked routinely to ensure all staff have signed confidentiality commitments after onboarding. The number of staff who have signed these documents should be compared to the total number of GBV programme staff (or other staff directly working with GBV survivors) working for an organisation.

MEETING THE STANDARD?

MET	100% of staff, volunteers & community workers who take the pre- and post-test improve their score (or if received a perfect score at pre-test and maintained their score).
WORKING TOWARDS	80%-99% of staff, volunteers & community workers improve their score.
NOT MET	Below 80% of staff, volunteers & community workers improve their score.

SUGGESTED M&E TOOLS

This indicator can be tracked using an excel sheet detailing all GBV programme staff and other staff working directly with GBV survivors and tracking who have signed confidentiality commitments on file. See for example: Confidentiality Commitments Tracking

1.3 Percentage of referrals that include documentation of survivors' informed consent

INDICATOR LEVEL
ORGANISATION

DEFINITION

NUMERATOR:

of referrals that include documentation of survivor's informed consent

DENOMINATOR:

of GBV and other staff working directly with GBV survivors

HOW TO MEASURE

To measure this indicator, review GBV case records to assess the number of referrals that include documentation (written or verbal as below) compared to the number of referrals provided.

Informed consent can be written or verbal depending on local procedures and safety procedures.

Documented means that either:

1. an informed consent document signed by the survivor is safely stored as part of the case management files OR
2. for verbal consent a form signed by the case manager that verbal consent has been received.

Data should be tracked on an ongoing basis, with monthly audits of a referral tracker to ensure informed consent has been achieved for all survivors. See the GBVIMS system for an example of safe data tracking/sharing.

Hard copies of informed consent statements should be maintained with other confidential files for case management.

SUGGESTED M&E TOOLS

GBVIMS Incident Recorder

MEETING THE STANDARD?

MET	100% of referrals have documented informed consent.
WORKING TOWARDS	80%-99% of referrals have documented informed consent.
NOT MET	Below 80% of referrals have documented informed consent.

R1.4 Percentage of women and girls who access GBV services who report that they felt respected, that privacy and confidentiality were maintained and that they were able to make informed choices about the actions they want to take in relation to their experiences of violence

INDICATOR LEVEL
ORGANISATION

DEFINITION

NUMERATOR:

# of women and girls who access GBV services who report that they felt respected, that privacy and confidentiality were maintained and that they were able to make informed choices about the actions they want to take after their experience of violence

DENOMINATOR:

# of women and girls who access GBV response services

HOW TO MEASURE

To measure this indicator, administer a survey questionnaire to clients after they participate in GBV services.

Typically given to a random sample of women and girls who interact with GBV services. All data collected for this indicator should remain anonymous and no identifiable information should be written on the form. The purpose of this indicator is to understand overall trends, rather than to audit a specific case for follow up.

AVAILABLE M&E TOOLS

Specific questions in tools can be contextualised by organisation/context.

An example tool can be found:

Interagency Case Management Guidelines Client Satisfaction Survey:

Responses to Qs 16 & 19 (Respect), Q12 & 14 (Privacy and Confidentiality) and Q10 (Informed Choices).

The questions included in this tool are only examples that can be expanded upon as part of your measurement strategy.

R1.5 Minimum standards of care for survivors met for health, case management and psychosocial care and support, law enforcement, and legal services/justice

INDICATOR LEVEL
CLUSTER

DEFINITION

NUMERATOR:

# of minimum standards for care for survivors achieved

DENOMINATOR:

# of minimum standards for care for survivors

HOW TO MEASURE

To measure this indicator, use an assessment tool – such as the Interagency Case Management Guideline's Service Gap Analysis tool - to compare current practice to the minimum standards for care. While there is no formal definition of "meeting the standard" here, we suggest aiming for at least 75% of activities completed in each section for this standard to be "on track." All four areas should be assessed to determine if the minimum standards for care are achieved as all are necessary for effective survivor support.

AVAILABLE M&E TOOLS

Interagency Case Management Guideline's Service Gap Analysis and Planning Tool.

Assessment: MS 1 Are we meeting the standard?

In order to assess your overall progress in meeting this standard, consider your progress on each core indicator. Organization and cluster level progress should be tracked separately. The overall goal is to increase the number of indicators met for each standard over time. Use the following guide to track your progress.

ORGANISATIONAL-LEVEL:

Assess progress on the **core indicators** – consider only indicators that apply to your level (organisation rather than cluster).

# of Indicators **MET** (of 3)	
# of Indicators **WORKING TOWARDS** (of 3)	
# of Indicators **NOT MET** (of 3)	

CLUSTER-LEVEL:

There are no cluster-level core indicators for MS 1

ACTION PLANNING:

For areas where your organisation/cluster is not meeting the standard, utilise the **MS Contextualization Tool** to assess your challenges and plan for improvements in order to meet the minimum standards.

Standard 2. Women's and Girls' Participation and Empowerment

Women and girls are engaged as active partners and leaders in influencing the humanitarian sector to prevent GBV and support survivors' access to quality services.

READ THE STANDARD

OUTPUTS

- Women and girls have spaces to meaningfully participate in humanitarian action
- HNOs are based on gender analysis and sex- and age-disaggregated data
- Inputs from local women's organisations are integrated into HNOs & HRPs
- Women-led organisations are active members of GBV coordination mechanisms and receive direct funding from country-based pooled funds

OUTCOMES

- Women and girls from affected communities are involved in GBV programme design and implementation
- Women and girls from affected communities are in leadership positions within humanitarian programming

OBJECTIVES

- Humanitarian programming is led by and meets the needs of women and girls affected by crisis

2.1 Special fora established, in a safe and non-stigmatising manner, to ensure the meaningful participation of all women and girls who may face increased barriers to access.

INDICATOR LEVEL CLUSTER

DEFINITION

Women and girls are consulted throughout the programme management cycle through special fora (for example, meetings, focus groups, etc.) where their views are taken into consideration (e.g., about timing, locations, safety of activities, risk mitigation strategies, etc.).

Barriers to participation include: timing of consultations, accommodations for people with disabilities, translation or specific language group consultations, etc.

Key principles of safe participation include: privacy, confidentiality, informed consent, female facilitators, etc.

HOW TO MEASURE

To measure this indicator, assess if women and girls are regularly (at least quarterly) being consulted, if barriers to participation are being mitigated and if participation is being held in a safe and non-stigmatising manner.

MEETING THE STANDARD?

MET	Regular (at least quarterly) consultations held with women and girls through special fora, barriers to participation identified and mitigated and participation held in a safe and non-stigmatising manner.
WORKING TOWARDS	Some consultations held but there are deficiencies in the approach (e.g., consultations not regularly occurring throughout the project cycle, barriers to participation not lowered, safety and chance of stigmatisation not prioritised).
NOT MET	No consultations held.

SUGGESTED M&E TOOLS

No specific M&E tool available

2.2 Humanitarian Needs Overview (HNO) is based on gender analysis and sex- and age-disaggregated data

INDICATOR LEVEL
CLUSTER

DEFINITION

HNO includes a gender analysis, and all included data is sex and age disaggregated.

A gender analysis is an assessment that examines the different needs, capacities and coping strategies of women, men, boys and girls in a crisis situation.

While various gender analysis tools can be used an example is CARE's Rapid Gender Analysis Toolkit.

Examples of how this tool has been used can be found on CARE's website.

HOW TO MEASURE

To measure this indicator, review each HNO after publication to see if a gender analysis was completed and if primary data included is sex and age disaggregated.

For example, does the HNO highlight the specific needs and preferences of women and girls within each section (summary, impact, risk analysis, and sectoral analysis) and include needs related to GBV prevention and response?

MEETING THE STANDARD?

MET	HNO includes results of a gender analysis, and all primary data is age and sex disaggregated.
WORKING TOWARDS	HNOs lack at least one of the following: sex disaggregated data; age disaggregated data; gender analysis.
NOT MET	HNOs lack all of the following: sex disaggregated data; age disaggregated data; gender analysis.

SUGGESTED M&E TOOLS

No specific M&E tool available

2.3 Direct consultations with local women's organisations have taken place and their inputs integrated into the Humanitarian Needs Overview / Humanitarian Response Plan

INDICATOR LEVEL
CLUSTER

DEFINITION

Interviews or focus groups with local women's organisations are held.

Recommendations are documented and are included in HNO/HRPs.

HOW TO MEASURE

To measure this indicator, interview staff who put the HNOs/HRP together to assess if consultations with local women's organisations were conducted and recommendations documented.

Recommendations made by local women's organisations should be cross checked against the final HNOs/HRPs to confirm they were incorporated.

In addition, interviews with women's organisations can inform the measurement of this indicator (e.g., were they consulted? Did their input make it into the final HNO/HRP)?

MEETING THE STANDARD?

MET	Consultations with local women's organisations took place and were documented. Most of recommendations from these consultations included in final HNO/HRP.
WORKING TOWARDS	Consultations with local women's organisations took place and were documented. Some of these recommendations were included in final HNO/HRP.
NOT MET	Consultations with local women's organisations either did not take place or few recommendations were integrated.

SUGGESTED M&E TOOLS

An example tracking tool can be used to help assess this indicator.

2.4 Percentage of women-led organisations and groups that are active members of the GBV coordination mechanism

INDICATOR LEVEL
CLUSTER

DEFINITION

NUMERATOR:

# of women-led organisations and groups that regularly (at least once a quarter) attend GBV coordination meetings

DENOMINATOR:

# of women-led organisations and groups in the operational area who work on women's and girls' rights

HOW TO MEASURE

To measure this indicator, track attendance at coordination meetings and compare this to a list of local women's organisations/groups.

A women-led organisation is an organisation with a humanitarian mandate and/or mission that is: (a) governed or directed by women; or (b) whose leadership is principally made up of women, demonstrated by 50 per cent or more occupying senior leadership positions.

It will be necessary to conduct a mapping exercise of women-led organisations and groups in the operational area, if this does not exist Indicators should be assessed at least once a year.

SUGGESTED M&E TOOLS

An example tracking tool can be used to help assess this indicator.

MEETING THE STANDARD?

MET	More than 25% of local women-led organisations and groups regularly attend meetings (at least once a quarter) of the GBV coordination mechanism.
WORKING TOWARDS	Few (25% of less) of local women-led organisations and groups regularly attend meetings of the GBV coordination mechanism.
NOT MET	Local women-led organisations and groups do not regularly attend meetings of the GBV coordination mechanism.

2.5 Percentage of women-led organisations and groups that receive direct funding from country-based pooled funds

INDICATOR LEVEL
CLUSTER

DEFINITION

NUMERATOR:

# of women-led organisations and groups that receive direct funding from country-based pooled funds

DENOMINATOR:

# of women-led organisations and groups in the operational area

HOW TO MEASURE

To measure this indicator, track funding distributed and compare it to a list of local women's organisations/ groups.

If it doesn't already exist, document all the women-led organisations or groups using the proposed process in the above indicator.

Indicators should be assessed at least once a year.

MEETING THE STANDARD?

MET	More than 30% of local women-led organisations and groups receive funding.
WORKING TOWARDS	15-30% of local women-led organisations and groups receive funding.
NOT MET	Less than 15% of local women-led organisations and groups receive funding.

SUGGESTED M&E TOOLS

An example tracking tool can be used to help assess this indicator.

R2.6 Percentage of recommendations of women and girls during assessments/ programme design that are adopted in programme implementation

INDICATOR LEVEL
ORGANISATION

DEFINITION

NUMERATOR:

Recommendations adopted

DENOMINATOR:

Recommendations documented during assessment activities

HOW TO MEASURE

To measure this indicator, review programme/ assessment documents to assess recommendations documented versus recommendations implemented.

AVAILABLE M&E TOOLS

No specific M&E tool available.

R2.7 Number of women and girls from the affected communities directly involved in the design and implementation of GBV programming (by type: risk mitigation, prevention, response)

INDICATOR LEVEL
ORGANISATION

DEFINITION

NUMERATOR:

# of women and girls who participate in sessions to design and/or support programme implementation of GBV programmes

HOW TO MEASURE

To measure this indicator, review programme documents summarising the total number of women and girls who were consulted/engaged during programme design and in programme implementation.

Final results should be disaggregated by type of GBV programming (risk mitigation, prevention, or response).

AVAILABLE M&E TOOLS

No specific M&E tool available.

R2.8 Number of women and girls from the affected communities involved in leadership positions in humanitarian programming

INDICATOR LEVEL
ORGANISATION/ CLUSTER

DEFINITION

NUMERATOR:

# of women and girls from the affected communities involved in leadership positions in humanitarian programming

HOW TO MEASURE

To measure this indicator, review programme/HR documents to count the number of women and girls involved in leadership positions in humanitarian programming. Leadership roles could include participation in steering or other community committees, managerial staff, participants in women's leadership groups, community leaders that help steer humanitarian programming, etc.

AVAILABLE M&E TOOLS

No specific M&E tool available.

Assessment: MS 2 Are we meeting the standard?

In order to assess your overall progress in meeting this standard, consider your progress on each core indicator. Organization and cluster level progress should be tracked separately. The overall goal is to increase the number of indicators met for each standard over time. Use the following guide to track your progress.

ORGANISATIONAL-LEVEL:

There are no organisation-level core indicators for this standard.

CLUSTER-LEVEL:

Assess progress on the **core indicators**:

# of Indicators **MET** (of 5)	
# of Indicators **WORKING TOWARDS** (of 5)	
# of Indicators **NOT MET** (of 5)	

ACTION PLANNING:

For areas where your organisation/cluster is not meeting the standard, utilise the **MS Contextualization Tool** to assess your challenges and plan for improvements in order to meet the minimum standards.

Standard 3: Staff Care and Support

GBV staff are recruited and trained to meet core competencies, and their safety and well-being are promoted.

READ THE STANDARD

OUTPUTS

- GBV programme job profiles are aligned with the GBV Core Competency framework
- GBV programme staff have required support and supervision
- GBV programmes have plans and budget to promote staff safety and well-being
- GBV staff members have limits on the number of hours they work directly with survivors

OUTCOMES

Staff and volunteers' are safe and have their wellbeing prioritised when engaging in GBV service delivery

OBJECTIVES

Trained and supported GBV staff are better equipped to support the needs of women and girls

3.1 All GBV programme job profiles are aligned with the GBV Core Competency framework

INDICATOR LEVEL
ORGANISATION

DEFINITION

NUMERATOR:

# of GBV programme job descriptions that are aligned with GBV Core Competency framework

DENOMINATOR:

# of GBV programme job descriptions

HOW TO MEASURE

The GBV AoR developed Core Competencies for GBV Programme Managers and Coordinators in Humanitarian Settings.

To measure this indicator, job descriptions should be compared with the GBV Core Competencies to assess if all listed competencies are included in the job profiles.

This indicator should be assessed for each newly recruited staff.

SUGGESTED M&E TOOLS

Competency Checklist

MEETING THE STANDARD?

MET	All GBV programme job profiles are fully aligned with the GBV Core Competency framework.
WORKING TOWARDS	Some (~ 50-99%) of GBV programme job profiles are fully aligned with the GBV Core Competency framework.
NOT MET	Few (~ less than 50%) of GBV programme job profiles are fully aligned with the GBV Core Competency framework.

3.2 All frontline GBV programme staff have access to monthly support and supervision sessions with a GBV specialist to ensure staff safety and service quality

INDICATOR LEVEL
ORGANISATION

DEFINITION

Monthly support and supervision sessions are available to all frontline GBV staff. Available means: the services exist, are accessible (e.g., available in the location staff work or available via phone/internet) and are known to frontline GBV staff.

HOW TO MEASURE

To measure this indicator, organisations should self-assess if: 1) monthly support and supervision sessions are held with frontline GBV staff; 2) these services are accessible to all staff and 3) frontline GBV staff know about the services.

This indicator should be assessed on a yearly basis.

See supervision tools (starting on page 193 of the Interagency GBV Case Management Guidelines for tools to support supervision of GBV programme staff) for materials to support supervisory activities.

SUGGESTED M&E TOOLS

No specific M&E tool available.

MEETING THE STANDARD?

MET	Services exist, are accessible and known by staff.
WORKING TOWARDS	Services exist but there are weaknesses in accessibility (e.g. not available at each worksite either virtually or in person) or knowledge (e.g., not all staff know about existing support).
NOT MET	Regular sessions are not held.

3.3 All GBV programmes have an actionable plan in place and associated budget to protect and promote staff safety and well-being

INDICATOR LEVEL
ORGANISATION

DEFINITION

NUMERATOR:

# of GBV programmes with staff safety and well-being plans/policies and budgets

DENOMINATOR:

# of GBV programmes

HOW TO MEASURE

To measure this indicator, examine GBV programme documents and talk to implementing staff. Assess if there are policies and plans to promote safety and wellbeing including: 1) staff well-being plans, 2) staff safety plans, and 3) budget for staff well-being. If all exist, then this standard is achieved.

This indicator should be assessed on a yearly basis.

SUGGESTED M&E TOOLS

Sample assessment tool

MEETING THE STANDARD?

MET	Plans for staff safety and well-being exist with associated funding
WORKING TOWARDS	Plans and policies exist but there are weaknesses in availability of funds, some missing plans or other challenges that prevent full implementation.
NOT MET	No plans or policies exist.

3.4 Limits in contact hours per week are established and maintained for all frontline staff

INDICATOR LEVEL
ORGANISATION

DEFINITION

NUMERATOR:

# of frontline staff who have 16 contact hours or less per week

DENOMINATOR:

# of frontline staff

HOW TO MEASURE

Contact hours are hours that staff are directly working with GBV survivors.

To measure this indicator, an excel sheet (or other staff management tool) can be used to track each staff member and the # of contract hours they have each week.

This indicator should be assessed monthly.

SUGGESTED M&E TOOLS

Staff Contact Tracking

MEETING THE STANDARD?

MET	All frontline staff have 16 contact hours or less every week.
WORKING TOWARDS	Most (more than 50%) of frontline staff have 16 contact hours or less every week.
NOT MET	Few (less than 50%) of frontline staff have 16 contact hours or less every week.

R3.5 Percentage of GBV staff and volunteers who report that they feel safe while engaging in GBV service delivery

INDICATOR LEVEL
ORGANISATION

DEFINITION

NUMERATOR:

# of GBV staff and volunteers who report that they feel safe while engaging in GBV service delivery

DENOMINATOR:

# of GBV staff and volunteers

HOW TO MEASURE

To measure this indicator, administer a survey to GBV staff and volunteers asking how safe staff and volunteers feel during GBV service delivery. This can be a challenging indicator to collect internally. Consider using anonymised methods or external consultants to collect and analyse this data to promote honest disclosure. For example, online survey tools (e.g., SurveyMonkey, Google Forms etc.) can be set to collect data anonymously.

AVAILABLE M&E TOOLS

No specific M&E tool available.

R3.6 Percentage of GBV staff and volunteers who believe that their organisation cares about their well-being

INDICATOR LEVEL
ORGANISATION

DEFINITION

NUMERATOR:

# of GBV staff and volunteers who agree that their organisation cares about their well-being

DENOMINATOR:

# of GBV staff and volunteers

HOW TO MEASURE

To measure this indicator, administer a survey to GBV staff and volunteers asking if respondents believe their organisations care about their well-being. This can be a challenging indicator to collect internally. Consider using anonymised methods or external consultants to collect and analyse this data to promote honest disclosure. For example, online survey tools (e.g. SurveyMonkey, Google Forms etc.) can be set to collect data anonymously.

AVAILABLE M&E TOOLS

No specific M&E tool available.

R3.7 Percentage of member organisations in the GBV coordination mechanism (cluster/sector/working group) that have an actionable plan in place and associated budget to protect and promote staff safety and well-being

INDICATOR LEVEL
CLUSTER

DEFINITION

NUMERATOR:

# of member organisations in the GBV coordination mechanism (cluster/sector/working group) that have an actionable plan in place and associated budget to protect and promote staff safety and well-being

DENOMINATOR:

# of member organisations in the GBV coordination mechanism (cluster/sector/working group)

HOW TO MEASURE

To measure this indicator, collect data via a cluster/sector/working group survey to participating member organisations.

AVAILABLE M&E TOOLS

No specific M&E tool available.

Assessment: MS 3 Are we meeting the standard?

In order to assess your overall progress in meeting this standard, consider your progress on each core indicator. Organization and cluster level progress should be tracked separately. The overall goal is to increase the number of indicators met for each standard over time. Use the following guide to track your progress.

ORGANISATIONAL-LEVEL:

Assess progress on the **core indicators** – consider only indicators that apply to your level (organisation rather than cluster).

# of Indicators **MET** (of 4)	
# of Indicators **WORKING TOWARDS** (of 4)	
# of Indicators **NOT MET** (of 4)	

CLUSTER-LEVEL:

No cluster level core indicators for MS 3

ACTION PLANNING:

For areas where your organisation/cluster is not meeting the standard, utilise the **MS Contextualization Tool** to assess your challenges and plan for improvements in order to meet the minimum standards.

Standard 4: Health Care for GBV Survivors

GBV survivors access quality, survivor-centred health care, including health services for sexual and IPV and other forms of GBV, and referrals to prevent and/or reduce the effects of violence.

READ THE STANDARD

OUTPUTS

- Health facilities have trained & supportive staff and sufficient supplies and equipment to provide CMR
- MISP implemented within 2 weeks of crisis onset
- Health actors are included in emergency GBV SOPs and referral pathways
- Eligible survivors of rape receive post-exposure prophylaxis within 72 hours of an incident or from exposure, and/or emergency contraception within 120 hours of an incident or from exposure

OUTCOMES

- GBV survivors access health care in a way that is safe and respectful of their dignity in a survivor-centred manner
- All targeted locations have at least one health facility providing CMR and health care for survivors of IPV

OBJECTIVES

- Health needs of survivors are met

4.1 All health facilities have trained staff, sufficient supplies and equipment for clinical management of rape survivor services based on national or international protocols

INDICATOR LEVEL
ORGANISATION/ CLUSTER

DEFINITION

NUMERATOR:

# of health facilities that meet all criteria laid out in the WHO Checklist for Quality Clinical Care for Survivors of Rape and IPV

DENOMINATOR:

# of health facilities in operational area where CMR services should be offered

HOW TO MEASURE

To measure this indicator, use the WHO Checklist for Quality Clinical Care for Survivors of Rape and IPV to assess the stand of care at health facilities. Items marked with asterisks are the minimum required for care.

Depending on the context only certain levels of health providers may be expected to provide CMR. Consider local health protocols and guidance in your calculation of the denominator.

This indicator should be assessed at least yearly.

SUGGESTED M&E TOOLS

WHO Checklist for Quality Clinical Care for Survivors of Rape and IPV

MEETING THE STANDARD?

MET	All health facilities met the minimum requirements (items marked with an asterisks) on the WHO checklist.
WORKING TOWARDS	Most (50% or more) of health facilities met the minimum requirements (items marked with an asterisks) on the WHO checklist.
NOT MET	Few (less than 50%) of health facilities met the minimum requirements (items marked with an asterisks) on the WHO checklist.

4.2 MISP implemented within 2 weeks of crisis onset

INDICATOR LEVEL
CLUSTER

DEFINITION

All items on the MISP SRH Monitoring Checklist's Section 3 implemented within 2 weeks of crisis onset.

*Note the entire MISP should be implemented within 2 weeks but only Objective 3 is relevant for GBV M&E.

HOW TO MEASURE

To measure this indicator, assess the achievement of the activities/milestones under Section 3 of the MISP Checklist.

It should initially be measured 2 weeks after the onset of the crisis. The date of "the onset of the crisis" needs to be collaboratively decided by Health Cluster and GBV Sub-Cluster.

SUGGESTED M&E TOOLS

MISP Checklist - 3.1 to 3.5

MEETING THE STANDARD?

MET	MISP's objective on sexual violence is fully implemented within 2 weeks of crisis onset – e.g., every area in section 3 of the MISP checklist completed.
WORKING TOWARDS	MISP's objective on sexual violence is fully implemented but takes longer than 2 weeks after the onset of the crisis.
NOT MET	MISP's objective on sexual violence is not fully implemented.

4.3 Health care actors integrated in (emergency) GBV standard operating procedures and included in the referral pathway

INDICATOR LEVEL
CLUSTER

DEFINITION

All standard operating procedures (SOPs) and referral pathways have health actors included and referral information is available at health facilities.

HOW TO MEASURE

To measure this indicator, review the emergency GBV SOPs and referral pathways and assess if the names of local health clinics and contact information are included. To ensure they are integrated into the referral pathway, visit local health facilities to see if referral information (for survivors and health staff) is available at the sites.

SUGGESTED M&E TOOLS

No specific M&E tool available.

MEETING THE STANDARD?

MET	Health actors are included in both the emergency GBV SOPs and referral pathways and referral materials available at health facilities.
WORKING TOWARDS	Health actors are included in either the GBV SOPs or referral pathways in most locations.
NOT MET	Health actors are not included in SOPs or referral pathways in most locations.

4.4 All GBV survivors state they accessed health care in a way that felt safe and respectful of their dignity in a survivor-centred manner

INDICATOR LEVEL
ORGANISATION

DEFINITION

NUMERATOR:

# of respondents who state they accessed health care in a way that felt safe and respectful of their dignity in a survivor-centred manner

DENOMINATOR:

# of respondents interviewed

HOW TO MEASURE

To measure this indicator, administer a client satisfaction survey to GBV survivors who have accessed health services.

While the indicator refers to "all survivors", in order to measure this a random sample can be utilised. Furthermore, survivors can decline to complete the interview and provide this information if they so choose.

If it is not possible to directly assess this information with survivors, a proxy indicator can be used by working with health staff to see if they employ the LIVES approach (from WHO's Clinical management of rape and IPV survivors) which is the basis for a safe and respectful interaction.

MEETING THE STANDARD?

MET	All survivors surveyed report that the health care they accessed was delivered in a safe and respectful way.
WORKING TOWARDS	A majority (50% of more) of survivors surveyed report that the health care they accessed was delivered in a safe and respectful way.
NOT MET	Few (less than 50%) survivors surveyed report that the health care they accessed was delivered in a safe and respectful way.

SUGGESTED M&E TOOLS

Example Satisfaction Questionnaire

While this questionnaire is specific to case management it could be adapted to health services.

Consider:

Questions on respectful interactions: 4-5; 15-19

Questions on safety/ confidentiality: 12-14

4.5 All eligible survivors of rape receive post-exposure prophylaxis within 72 hours of an incident or from exposure, and emergency contraception within 120 hours of an incident or from exposure

INDICATOR LEVEL
ORGANISATION

DEFINITION

This indicator should be tracked in 2 parts:

PART 1

NUMERATOR:

# of service users who receive post-exposure prophylaxis within 72 hours of an incident or from exposure

DENOMINATOR:

# of service users for whom PEP was indicated at health facilities that offer clinical management of rape (CMR)

PART 2

NUMERATOR:

# of service users who receive emergency contraception within 120 hours of an incident or from exposure

DENOMINATOR:

# of service users for whom emergency contraception was indicated at health facilities that offer CMR

HOW TO MEASURE

To measure this indicator, review the records of survivors to assess if all survivors of sexual violence who seek services, for whom PEP and/or ECP are indicated and receive prophylaxis within 72 hours and ECP within 120 hours. Report each indicator separately.

Close coordination with the health sector and administration of health clinics will be needed to collect this data.

SUGGESTED M&E TOOLS

No specific M&E tool available - review of medical records.

MEETING THE STANDARD?

MET	All (100%) of survivors of rape who seek services receive post-exposure prophylaxis within 72 hours of an incident or from exposure, and/or emergency contraception within 120 hours of an incident or from exposure, where indicated.
WORKING TOWARDS	Most (50% or more) of survivors of rape who seek services receive post-exposure prophylaxis within 72 hours of an incident or from exposure, and/or emergency contraception within 120 hours of an incident or from exposure, where indicated.
NOT MET	Few (less than 50%) of survivors of rape who seek services receive post-exposure prophylaxis within 72 hours of an incident or from exposure, and/or emergency contraception within 120 hours of an incident or from exposure, where indicated.

R4.6 Percentage of targeted locations with health facilities that have trained staff, sufficient supplies and equipment for clinical management of rape and IPV survivor services

INDICATOR LEVEL
ORGANISATION/
CLUSTER

DEFINITION

NUMERATOR:

# of targeted locations with health facilities that have trained staff, sufficient supplies and equipment for clinical management of rape and IPV survivor services

DENOMINATOR:

# of targeted locations

HOW TO MEASURE

To measure this indicator, use the WHO Checklist for Quality Clinical Care for Survivors of Rape and IPV to assess the standard of care at health facilities. All items marked with a star at the minimum requirements necessary to provide care.

Compare the health facilities that met the minimum requirements in the WHO checklist to the targeted locations in your context. All locations should have access to at least one facility where there is sufficient care for rape and IPV.

AVAILABLE M&E TOOLS

No specific M&E tool available.

Assessment: MS 4 Are we meeting the standard?

In order to assess your overall progress in meeting this standard, consider your progress on each core indicator. Organization and cluster level progress should be tracked separately. The overall goal is to increase the number of indicators met for each standard over time. Use the following guide to track your progress.

ORGANISATIONAL-LEVEL: Assess progress on the **core indicators** – consider only indicators that apply to your level (organisation rather than cluster).	# of Indicators **MET** (of 3) ☐
	# of Indicators **WORKING TOWARDS** (of 3) ☐
	# of Indicators **NOT MET** (of 3) ☐

CLUSTER-LEVEL: Assess progress on the **core indicators**:	# of Indicators **MET** (of 3) ☐
	# of Indicators **WORKING TOWARDS** (of 3) ☐
	# of Indicators **NOT MET** (of 3) ☐

ACTION PLANNING:

For areas where your organisation/cluster is not meeting the standard, utilise the **MS Contextualization Tool** to assess your challenges and plan for improvements in order to meet the minimum standards.

Standard 5: Psychosocial Support

Women and girls safely access quality, survivor-centred psychosocial support focused on healing, empowerment and recovery.

READ THE STANDARD

OUTPUTS

- Context-specific psychosocial support services focused on the needs of women and girls established within 2 weeks of the onset of a crisis
- GBV programme staff trained to provide quality, age-appropriate, focused PSS
- Women and girl who access PSS services are satisfied with the quality
- Women and girls who access PSS services think these services were delivered in accordance with their needs and preferences

OUTCOMES

- Women and girls who access PSS services have improved PS functioning, reduced felt stigma and/or improved coping capacity

OBJECTIVES

- Psychosocial needs of survivors are met

5.1 Context-specific psychosocial support services focused on the needs of women and girls established within 2 weeks of the onset of a crisis

INDICATOR LEVEL
CLUSTER

DEFINITION

Group or individual psychosocial support activities established within 2 weeks of the onset of the crisis.

Psychosocial care and support are services to assist with healing and recovery from emotional, psychological and social effects of violence, including but not limited to crisis care, longer term emotional and practical support, and information and advocacy.

See IRC's Women Rise Toolkit for more details on psychosocial support programming.

HOW TO MEASURE

To measure this indicator, assess if services are available within 2 weeks of crisis by examining programming/funding documents/cluster minutes and speaking to service providers about when the services were established.

The date of "the onset of the crisis" needs to be determined by the GBV Sub-Cluster. It may be different in different sub-national locations.

SUGGESTED M&E TOOLS

Sample Assessment Tool

MEETING THE STANDARD?

MET	Group or individual activities are available for psychosocial support focused on the needs of women and girls within 2 weeks of the onset of a crisis.
WORKING TOWARDS	Group or individual psychosocial support services for women and girls not yet fully implemented in all locations or first established more than 2 weeks after the onset of a crisis.
NOT MET	Psychosocial support services focused on the needs of women and girls not implemented.

5.2 Percentage of GBV staff trained to provide quality, age-appropriate, focused psychosocial support services to women and girls

INDICATOR LEVEL
ORGANISATION

DEFINITION

NUMERATOR:

# of GBV staff trained to provide quality, age-appropriate, focused psychosocial support services to women and girls

DENOMINATOR:

# of GBV staff

HOW TO MEASURE

To measure this indicator, examine training logs of GBV staff trained.

See IRC's Women Rise Toolkit for more details on psychosocial support programming and potential training topics to ensure quality care.

This information can be bolstered by utilising pre and post training tests to ensure that GBV staff who have been trained meet a minimum level of quality.

MEETING THE STANDARD?

MET	100% of GBV staff trained to provide quality, age-appropriate, focused psychosocial services to women and girls.
WORKING TOWARDS	Most (75% or more) of GBV staff have been trained to provide quality, age-appropriate, focused psychosocial services to women and girls.
NOT MET	Less than 75% of GBV staff have been trained to provide quality, age-appropriate, focused psychosocial services to women and girls.

SUGGESTED M&E TOOLS

Sample Training Log

See the additional M&E resources from the Women Rise Toolkit for further materials and support.

*Note: registration is required for access.

5.3 Percentage of women and girls (disaggregated by age) who accessed focused psychosocial supported services indicating satisfaction with services

INDICATOR LEVEL
ORGANISATION

DEFINITION

NUMERATOR:

# of women and girls who accessed focused psychosocial support who report they are satisfied with services

DENOMINATOR:

# of women and girls accessing focused psychosocial support interviewed

HOW TO MEASURE

To measure this indicator, conduct client satisfaction surveys with a random selection of clients.

Additional information can be collected by conducting focus groups with clients to understand what components of essential PSS services are being provided.

In general age disaggregation should include:

- Adolescents (10-19)
- Adult women (20-49)
- Older and elderly women (50 +)

Though additional breakdowns can also be informative.

SUGGESTED M&E TOOLS

PSS Satisfaction Survey

MEETING THE STANDARD?

MET	Most (more than 80% of women and girls) report they are very or mostly satisfied with the psychosocial support services they accessed.
WORKING TOWARDS	Some (60 to 80% of women and girls) report they are very or mostly satisfied with the psychosocial support services they accessed.
NOT MET	Few (less than 60% of women and girls) report they are very or mostly satisfied with the psychosocial support services they accessed.

5.4 Percentage of women and girls who report that the focused psychosocial support services they accessed were delivered in accordance with their needs and preferences (disaggregated by individual and group-based support, gender, and age)

INDICATOR LEVEL
ORGANISATION

DEFINITION

NUMERATOR:

# of women and girls who report the focused psychosocial support they received was delivered in accordance with their needs (e.g., was helpful to them) and preferences

DENOMINATOR:

# of women and girls interviewed who were accessing focused psychosocial support.

HOW TO MEASURE

To measure this indicator, conduct client satisfaction surveys with a random selection of clients who accessed focused psychosocial support.

Additional information can be collected by conducting focus groups with clients to understand what components of essential PSS services are being provided.

Data should be disaggregated between participants who access psychosocial support via individual versus group support.

In general disaggregation should include:

- Adolescents (10-19)
- Adult women (20-49)
- Older and elderly women (50 +)

Though additional breakdowns can also be informative.

SUGGESTED M&E TOOLS

PSS Satisfaction Survey

Assessment Tool to understand what core components of PSS support are being provided.

MEETING THE STANDARD?

MET	More than 80% of women and girls report that the PSS they received was delivered in accordance with their needs and preferences.
WORKING TOWARDS	Some (60 to 80% of women and girls) report that the PSS they received was delivered in accordance with their needs and preferences.
NOT MET	Less than 60% of women and girls report that the PSS they received was delivered in accordance with their needs and preferences.

R5.5 Percentage of women and girls who demonstrate an improvement in their psychosocial functioning after 3 or more GBV case management sessions

INDICATOR LEVEL: ORGANISATION

DEFINITION

NUMERATOR:

women and girls who improve their score on the Psychosocial Functionality Scale after 3 or more case management sessions

DENOMINATOR:

female survivors interviewed who attend 3 or more case management sessions

HOW TO MEASURE

To measure this indicator, utilise pre and post-test assessments of psychosocial functionality with a PSS functionality scale.

Administered during the first case management session and then again after 3 or more sessions of case management.

AVAILABLE M&E TOOLS

The Women Rise Toolkit's psychosocial functioning outcome survey.

*Note: registration is required for access.

R5.6 Percentage of women and girls participating in psychosocial support who are able to maintain or improve their coping capacity

INDICATOR LEVEL: ORGANISATION

DEFINITION

NUMERATOR:

# of women and girls who report improved or maintained coping capacity after participation in psychosocial support sessions

DENOMINATOR:

# of women and girls interviewed who have completed their expected psychosocial support sessions

HOW TO MEASURE

To measure this indicator, conduct pre and post-test assessments of coping capacity before and after participating in psychosocial support services.

Administered during the first session (or as early as possible) and then again after the expected psychosocial support sessions have been completed.

May be collected with a random sample of survivors.

AVAILABLE M&E TOOLS

Trócaire's Coping Capacity Assessment tool

R5.7 Percentage of women and girls who have a reduced felt stigma score after participating in psychosocial support sessions

INDICATOR LEVEL
ORGANISATION

DEFINITION

NUMERATOR:

# of women and girls who have reduced felt stigma score

DENOMINATOR:

# of women and girls interviewed after participating in psychosocial support services

HOW TO MEASURE

To measure this indicator, conduct pre and post-test assessments of felt stigma before and after participating in psychosocial support services.

Administered during the first session (or as early as possible) and then again after the expected psychosocial support sessions have been completed.

May be collected with a random sample of survivors.

AVAILABLE M&E TOOLS

The Women Rise Toolkit's Felt Stigma outcome survey.

*Note: registration is required for access.

Assessment: MS 5 Are we meeting the standard?

In order to assess your overall progress in meeting this standard, consider your progress on each core indicator. Organization and cluster level progress should be tracked separately. The overall goal is to increase the number of indicators met for each standard over time. Use the following guide to track your progress.

ORGANISATIONAL-LEVEL: Assess progress on the **core indicators** – consider only indicators that apply to your level (organisation rather than cluster).	# of Indicators **MET** (of 3) ☐
	# of Indicators **WORKING TOWARDS** (of 3) ☐
	# of Indicators **NOT MET** (of 3) ☐

CLUSTER-LEVEL: Assess progress on the **core indicators**:	# of Indicators **MET** (of 1) ☐
	# of Indicators **WORKING TOWARDS** (of 1) ☐
	# of Indicators **NOT MET** (of 1) ☐

ACTION PLANNING:

For areas where your organisation/cluster is not meeting the standard, utilise the **MS Contextualization Tool** to assess your challenges and plan for improvements in order to meet the minimum standards.

Standard 6: GBV Case Management

GBV survivors access appropriate, quality care management services including coordinated care and support to navigate available services.

READ THE STANDARD

OUTPUTS

- Staff have appropriate attitudes, knowledge and skills to appropriately support survivors
- GBV case managers have a manageable number of active cases
- GBV supervisors have a manageable number of caseworkers to manage
- Women and girl who access case management services are satisfied with their quality

OUTCOMES

- Case management services meet expected quality
- Women and girl who access case management services have improved PS functioning, reduced felt stigma and maintain or improve their coping capacity
- Accessible case management services in place in all targeted locations

OBJECTIVES

- Survivors feel supported and are able to heal after an incident of violence

6.1 Percentage of GBV caseworkers who, after training, meet 80% of supervision criteria for attitudes, knowledge and skills required to provide quality GBV case management services

INDICATOR LEVEL
ORGANISATION

DEFINITION

NUMERATOR:

# of GBV caseworkers who met 80% of the supervision criteria for attitudes, knowledge and skills required to provide quality GBV case management services

DENOMINATOR:

GBV caseworkers trained.

HOW TO MEASURE

To measure this indicator, administer a questionnaire with caseworkers after a training on caseworker skills has been administered. Example tools are provided, but specific questions can be contextualised as needed.

MEETING THE STANDARD?

MET	More than 80% of GBV caseworkers assessed met the knowledge/skills and attitudes assessment.
WORKING TOWARDS	60-80% of GBV caseworkers assessed met the knowledge/skills (21 or more points) and attitudes (28 or more points) assessment.
NOT MET	Less than 60% of GBV caseworkers assessed met the knowledge/skills (21 or more points) and attitudes (28 or more points) assessment.

SUGGESTED M&E TOOLS

Knowledge and Skills Assessment

Attitudes Assessment

6.2 Percentage of GBV caseworkers with active cases at or below the 1 to 20 maximum ratio

INDICATOR LEVEL
ORGANISATION

DEFINITION

NUMERATOR:

# of GBV caseworkers with active case at or below the 1 (caseworker) to 20 (clients) ratio

DENOMINATOR:

GBV caseworkers

HOW TO MEASURE

To measure this indicator, examine caseloads of GBV caseworkers using case management records to determine how many active cases each caseworker has. Assess this indicator on a monthly basis.

MEETING THE STANDARD?

MET	More than 80% of GBV caseworkers with active cases at or below the 1 to 20 maximum ratio.
WORKING TOWARDS	60-80% of GBV caseworkers with active cases at or below the 1 to 20 maximum ratio.
NOT MET	Less than 60% of GBV caseworkers with active cases at or below the 1 to 20 maximum ratio.

SUGGESTED M&E TOOLS

No specific M&E tool available.

6.3 Percentage of GBV supervisors supporting caseworkers at or below the 1 to 8 maximum ratio

INDICATOR LEVEL
ORGANISATION

DEFINITION

NUMERATOR:

# of GBV supervisors supporting caseworkers at or below the 1 to 8 maximum ratio

DENOMINATOR:

GBV supervisors

HOW TO MEASURE

To measure this indicator, examine caseloads of GBV caseworkers using case management records to determine how many active cases each caseworker has. Assess this indicator on a monthly basis.

MEETING THE STANDARD?

MET	More than 80% of GBV supervisors supporting caseworkers at or below the 1 to 8 maximum ratio.
WORKING TOWARDS	60-80% of GBV supervisors supporting caseworkers at or below the 1 to 8 maximum ratio.
NOT MET	Less than 60% of GBV supervisors supporting caseworkers at or below the 1 to 8 maximum ratio.

SUGGESTED M&E TOOLS

No specific M&E tool available

6.4 Percentage of survivors (disaggregated by sex and age) who completed a feedback survey who are satisfied with the case management services

INDICATOR LEVEL
ORGANISATION

DEFINITION

NUMERATOR:

survivors who report they are satisfied with the case management services they have engaged with

DENOMINATOR:

survivors interviewed

HOW TO MEASURE

To measure this indicator, conduct client satisfaction surveys with survivors who participate in case management activities. May be collected with a random sample of survivors.

In general, age disaggregation should include:

- Children (under 10)
- Adolescents (10-19)
- Adults (20-49)
- Older and elderly (50 +)

Additional disaggregation can also be helpful.

SUGGESTED M&E TOOLS

Trócaire's Case Management Satisfaction Questionnaire

For more details on the quality of case management the use of the GBV Case Management Toolkit: Client Feedback Form can also be employed.

MEETING THE STANDARD?

MET	More than 80% of survivors who complete a feedback survey are satisfied with the case management services.
WORKING TOWARDS	60-80% of survivors who complete a feedback survey are satisfied with the case management services.
NOT MET	Less than 60% of survivors who complete a feedback survey are satisfied with the case management services.

R6.5 Percentage of GBV caseworkers who meet quality criteria of 80% or higher during supervision visits

INDICATOR LEVEL
ORGANISATION

DEFINITION

NUMERATOR:

# of GBV caseworkers who meet quality criteria of 80% of higher during supervision visits

DENOMINATOR:

# of GBV caseworkers assessed

HOW TO MEASURE

To measure this indicator, have supervisors observe GBV caseworkers and assess their work against a case management quality checklist.

AVAILABLE M&E TOOLS

GBV Case Management: Survivor-centred case management quality checklist

R6.6 Percentage of survivors (disaggregated by sex and age) reporting improvement in their psychosocial functioning after 3 or more case management sessions

INDICATOR LEVEL
ORGANISATION

DEFINITION

NUMERATOR:

survivors who improve their score on the Psychosocial Functionality Scale after 3 or more case management sessions

DENOMINATOR:

survivors interviewed who attend 3 or more case management sessions

HOW TO MEASURE

To measure this indicator, utilise pre and post-test assessments of psychosocial functionality with survivors who participate in case management sessions. Administered during the first session and then again after 3 or more sessions of case management.

AVAILABLE M&E TOOLS

The Women Rise Toolkit's psychosocial functioning outcome survey.

*Note: registration is required for access.

R6.7 Percentage of survivors (disaggregated by sex and age) participating in case management who are able to maintain or improve their coping capacity

INDICATOR LEVEL: ORGANISATION

DEFINITION

NUMERATOR:

# of survivors who report improved or maintained coping capacity after at least 3 case management services

DENOMINATOR:

# of survivors interviewed who have completed at least 3 case management services

HOW TO MEASURE

To measure this indicator, utilise pre and post-test assessments of coping capacity with survivors who participate in case management sessions.

Administered during the first session (or as early as possible) and then again after the expected psychosocial support sessions have been completed.

May be collected with a random sample of survivors.

AVAILABLE M&E TOOLS

Trócaire's Coping Capacity Assessment tool

R6.8 Percentage of survivors (disaggregated by sex and age) who have a reduced felt stigma score

INDICATOR LEVEL: ORGANISATION

DEFINITION

NUMERATOR:

# of survivors who have reduced felt stigma scores

DENOMINATOR:

# of survivors interviewed after 3 case management sessions

HOW TO MEASURE

To measure this indicator, conduct pre and post-test assessments of felt stigma with survivors who participate in case management sessions.

Administered during the first session (or as early as possible) and then again after 3 case management sessions have been completed.

May be collected with a random sample of survivors.

AVAILABLE M&E TOOLS

The Women Rise Toolkit's Felt Stigma outcome survey.

*Note: registration is required for access.

R6.9 Percentage of targeted locations with case management services accessible to GBV survivors, and with case management trainings and supervision for case workers in place

INDICATOR LEVEL
CLUSTER

DEFINITION

NUMERATOR:

# of targeted locations with case management services accessible to GBV survivors, and with case management trainings and supervision for case workers in place

DENOMINATOR:

# of total targeted locations (by the HRP/JRP/other response plans)

HOW TO MEASURE

To measure this indicator, acquire data from service mapping & training registers kept by the cluster.

AVAILABLE M&E TOOLS

No specific M&E tool available.

Assessment: MS 6 Are we meeting the standard?

In order to assess your overall progress in meeting this standard, consider your progress on each core indicator. Organization and cluster level progress should be tracked separately. The overall goal is to increase the number of indicators met for each standard over time. Use the following guide to track your progress.

ORGANISATIONAL-LEVEL:

Assess progress on the **core indicators** – consider only indicators that apply to your level (organisation rather than cluster).

# of Indicators **MET** (of 4)	
# of Indicators **WORKING TOWARDS** (of 4)	
# of Indicators **NOT MET** (of 4)	

CLUSTER-LEVEL:

No cluster-level core indicators for MS 6

ACTION PLANNING:

For areas where your organisation/cluster is not meeting the standard, utilise the **MS Contextualization Tool** to assess your challenges and plan for improvements in order to meet the minimum standards.

Standard 7: Referral Systems

Referral services in place to connect GBV survivors to appropriate, quality, multisectoral services in a timely, safe and confidential manner.

READ THE STANDARD

OUTPUTS

- Referral pathways in place and regularly updated, and service mapping and standard operating procedures established
- Capacity of service providers is assessed to improve quality of service delivery and strengthen referral systems
- Standard GBV consent and intake forms are adapted and utilised by service providers within the GBV information management system, if available
- Women and girl who access referral pathway services are satisfied with their quality
- Non-specialist GBV staff know who to refer cases to

OUTCOMES

- Survivors who report are referred to health, psychosocial, case management, legal or any other service based on their needs within the recommended timeframe
- All targeted locations have updated and functional referral pathways to support survivors needs
- Service providers in the referral pathway meet minimum quality standards and are able to provide quality support to survivors

OBJECTIVES

- Survivors access needed support services, in accordance with their needs and preferences, after an incident of violence

7.1 Referral pathway in place and regularly updated, and service mapping and standard operating procedures established

INDICATOR LEVEL
CLUSTER

DEFINITION

Referral pathways, including psychosocial support, health, legal and protection services, exist and are updated at least once a year.

Updated lists of available services and locations/contact details exist.

See the Interagency Case Management Guideline's Service Gap Analysis and Planning Tool and other service mapping and 3/4/5W templates.

Standard operating procedures are specific procedures and agreements among organisations that reflect the plan of action and individual organisations' roles and responsibilities.

HOW TO MEASURE

To measure this indicator, first consider the relevant geographic levels referral pathways are needed in each context. For many contexts, sub-national referral pathways are required as the distance for referrals would be too large for national-level only referral pathways. In other contexts, national referral pathways are appropriate.

Once you have determined the relevant geographic areas, assess if a referral pathway exists and is updated at least twice a year. This should include updated 'Who does What Where (When and for Whom – 3/4/5Ws) documents and lists of available services with physical locations and contact details.

In addition, assess if SOPs have been developed and agreed upon by relevant stakeholders.

SUGGESTED M&E TOOLS

Sample assessment

MEETING THE STANDARD?

MET	Referral pathways at relevant levels for the context (e.g., national, sub-national, both) exist and are updated at least twice a year. SOPs and 3/4/5Ws are established and updated.
WORKING TOWARDS	Referral pathways, SOPs and/or service mapping exist but are not updated/ current.
NOT MET	Referral pathway, SOPs or service mapping not completed.

7.2 Capacity of service providers is assessed to improve quality of service delivery and strengthen the referral system

INDICATOR LEVEL
CLUSTER

DEFINITION

A quality assurance checklist/ service gap analysis tool is utilised with all service providers in a referral pathway.

HOW TO MEASURE

To measure this indicator, utilise a quality assurance checklist with service providers on the referral pathway.

Capacity should be assessed at least once a year. In areas where there are multiple services providers (e.g multiple health providers), efforts should be made to assess all. If this is not possible, a random sample of locations should be drawn (e.g., out of hat) as a proxy to understand capacity.

MEETING THE STANDARD?

MET	Capacity of all service providers is assessed at least once a year.
WORKING TOWARDS	Capacity of some service providers is assessed irregularly.
NOT MET	Capacity is not assessed.

SUGGESTED M&E TOOLS

Interagency Case Management Guideline's Service Gap Analysis and Planning Tool

7.3 Percentage of clients who report satisfaction with service providers to which they are referred

INDICATOR LEVEL
ORGANISATION

DEFINITION

NUMERATOR:

# of clients who report they are satisfied

DENOMINATOR:

# of clients who access each service provider and are interviewed.

HOW TO MEASURE

To measure this indicator, administer client satisfaction surveys to a random selection of clients engaging with services in the referral pathway.

Break down by type of service each client is referred to.

MEETING THE STANDARD?

MET	More than 80% of clients report satisfaction with service providers to which they are referred.
WORKING TOWARDS	60%-80% of clients report satisfaction with service providers to which they are referred.
NOT MET	Less than 60% of clients report satisfaction with service providers to which they are referred.

SUGGESTED M&E TOOLS

Trócaire's Satisfaction Questionnaire

7.4 Standard GBV consent and intake forms are adapted and utilised by service providers within the GBV information management system, if available

INDICATOR LEVEL
CLUSTER

DEFINITION

GBV consent and intake forms are edited to be relevant for the local context. Service providers who utilised the GBVIMS use these forms 100% of the time when intaking a client.

HOW TO MEASURE

To measure this indicator, conduct a self-assessment to determine if the standard forms have been adapted as needed and review records to ensure all service providers are using the standard tools.

GBVIMS consent and intake forms can be found on the gbvims.com website.

MEETING THE STANDARD?

MET	Tools exist and are always/almost always (more than 90% of the time) utilised by service providers to intake clients.
WORKING TOWARDS	Tools exist and are sometimes (50-90% of the time) utilised by service providers.
NOT MET	Tools exist but are rarely (less than 50% of the time) utilised by service providers.

SUGGESTED M&E TOOLS

See the GBV IMS website for forms and support

7.5 Survivors who report are referred to health, psychosocial, case management, legal or any other service based on their needs and informed consent within the recommended time frame

INDICATOR LEVEL
ORGANISATION

DEFINITION

Appropriate referrals are made based on the needs of the survivor within the recommended time frame. Informed consent is received and documented.

HOW TO MEASURE

To measure this indicator, conduct a record review of case management documents.

Ensure informed consent was documented and consider when each referral was made.

Recommended time frames include:

- All eligible survivors of rape receive post-exposure prophylaxis within 72 hours of an incident or from exposure
- All eligible survivors of rape receive emergency contraception within 120 hours of an incident or from exposure
- Relevant first-line support for survivors who seek services later than the 72/120 hour windows for preventive care. See MS 4, Guidance Note 1.

SUGGESTED M&E TOOLS

See the GBV IMS website for forms and support

MEETING THE STANDARD?

MET	All/almost all (more than ~90%) survivors are referred to appropriate services as necessary. And all/almost all (more than 90%) of referrals are done within appropriate timelines and informed consent is received for all survivors.
WORKING TOWARDS	Most survivors (50-90%) are referred to appropriate services as necessary. Most referrals are done within appropriate timelines and informed consent is received for all survivors.
NOT MET	Few survivors (less than 50%) are referred as appropriate. Recommended timelines are generally not followed. Informed consent is not always documented.

R7.6 Number of non-GBV specialist staff trained on providing immediate support after spontaneous disclosures of GBV and know who the relevant referral providers are

INDICATOR LEVEL
CLUSTER

DEFINITION

NUMERATOR:

# of non-GBV specialist staff trained on providing immediate support after spontaneous disclosures of GBV and know who the relevant referral providers are

HOW TO MEASURE

To measure this indicator, acquire data from service mapping & training registers kept by the cluster.

AVAILABLE M&E TOOLS

No specific M&E tool available.

R7.7 Percentage of service providers in the referral pathway assessed that meet minimum quality standards

INDICATOR LEVEL
CLUSTER

DEFINITION

NUMERATOR:

# of service providers in the referral pathway meeting the minimum quality standards

DENOMINATOR:

service providers assessed

HOW TO MEASURE

Utilize the Interagency Case Management to Guideline's Service Gap Analysis and Planning Tool to assess if each aspect of the referral pathway., meets the minimum standards.

AVAILABLE M&E TOOLS

Interagency Case Management Guideline's Service Gap Analysis and Planning Tool.

R7.8 Percentage of targeted locations with a functional referral pathway that is updated at least twice a year

INDICATOR LEVEL
CLUSTER

DEFINITION

NUMERATOR:

# of targeted locations with functional referral pathways that is updated each year

DENOMINATOR:

# of targeted locations

HOW TO MEASURE

Utilize the Interagency Case Management to Guideline's Service Gap Analysis and Planning Tool to assess if each aspect of the referral pathway is functional (e.g., meets the minimum standards). Ensure the referral pathway was updated at least twice a year. Compare this data to the targeted locations for humanitarian assistance (from the HRP, etc.) to see if all locations are covered by an updated, functional referral pathway.

AVAILABLE M&E TOOLS

Interagency Case Management Guideline's Service Gap Analysis and Planning Tool.

Assessment: MS 7 Are we meeting the standard?

In order to assess your overall progress in meeting this standard, consider your progress on each core indicator. Organization and cluster level progress should be tracked separately. The overall goal is to increase the number of indicators met for each standard over time. Use the following guide to track your progress.

ORGANISATIONAL-LEVEL: Assess progress on the **core indicators** – consider only indicators that apply to your level (organisation rather than cluster).	# of Indicators **MET** (of 2) ☐
	# of Indicators **WORKING TOWARDS** (of 2) ☐
	# of Indicators **NOT MET** (of 2) ☐

CLUSTER-LEVEL: Assess progress on the **core indicators**:	# of Indicators **MET** (of 3) ☐
	# of Indicators **WORKING TOWARDS** (of 3) ☐
	# of Indicators **NOT MET** (of 3) ☐

ACTION PLANNING:

For areas where your organisation/cluster is not meeting the standard, utilise the **MS Contextualization Tool** to assess your challenges and plan for improvements in order to meet the minimum standards.

Standard 8: Women's and Girls' Safe Spaces

Women and girls only safe spaces (WGSS) are available, accessible and provide quality services, information and activities that promote healing, well-being and empowerment.

READ THE STANDARD

OUTPUTS

- Women and girls consulted to inform WGSS development
- Women and girls use WGSS to meet their needs
- WGSS personnel trained on the GBV guiding principles and WGSS guidelines

OUTCOMES

- Targeted locations have functional WGSS
- Women and girls participating in WGSS increase their knowledge and skills
- Women and girls participating in WGSS improve their decision-making
- Women and girls participating in WGSS feel safe at the space

OBJECTIVES

- Women and girls are able to heal, improve their well-being and are empowered

8.1 Number and percentage of women and girls consulted to inform WGSS development, disaggregated by age, disability, etc.

INDICATOR LEVEL
ORGANISATION

DEFINITION

NUMERATOR:

# of women and girls consulted to inform WGSS development

DENOMINATOR:

women and girls in the community.

MEETING THE STANDARD?

MET	Women and girls of varied backgrounds are consulted to inform WGSS development. Of those consulted, at least 50% of women and girls are of non-majority race/ethnicity, living with a disability, or outside the ages of 15-34.
WORKING TOWARDS	Women and girls were consulted when developing WGSS, but they were not from diverse backgrounds.
NOT MET	Women and girls were not consulted when developing WGSS.

HOW TO MEASURE

To measure this indicator, agencies should track who/when consultations with women and girls occur including noting age and disability status of each person consulted to inform WGSS development.

A WGSS is a safe space for women and girls is a place where women and girls can go to at any time to feel safer and empowered and have access to information, education, recreational activities, support and services. These spaces support women and girls to recover from violence, form networks and access support, safety and opportunities. (See "Safe Spaces for Women and Girls (SSWG) Standardization and Technical Guidance")

Age disaggregation should include:

- Children and younger adolescents (14 and younger)
- Older adolescents (15-19)
- Young women (20-34)
- Adult women (35-49)
- Older and elderly women (50 or older)

Additional disaggregation may be helpful.

The Washington Group Tool can also assist in determining disability status.

SUGGESTED M&E TOOLS

No specific M&E tool available.

8.2 Number of women and girls using WGSS to meet their needs (e.g., attending one cycle of recreational / psychosocial sessions)

INDICATOR LEVEL
ORGANISATION

DEFINITION

NUMERATOR:

# of women and girls attending at least one cycle of recreational / psychosocial sessions

HOW TO MEASURE

To measure this indicator, utilise attendance sheets at WGSS.

One cycle refers to one complete cycle of expected sessions that a woman or girl who participates in recreational or psychosocial support sessions. For example, if there are 7 planned sessions in psychosocial curriculum.

MEETING THE STANDARD?

MET	WGSS in targeted locations are routinely open and women and girls regularly attend sessions with no major drop offs in attendance rates detected (20% or more).
WORKING TOWARDS	WGSS in targeted locations are routinely open and women and girls regularly attend sessions but attendance rates are low or decreasing considerably (by 20% or more).
NOT MET	WGSS do not exist and/or very few women and girls access these services.

SUGGESTED M&E TOOLS

WGSS tracking

Additional tools can be found in IRC and IMC's WGSS Toolkit.

8.3 Percentage of trained WGSS personnel who exhibit sufficient knowledge and skills in implementing the GBV Guiding principles and WGSS guidelines

INDICATOR LEVEL
ORGANISATION

DEFINITION

NUMERATOR:

# of trained WGSS personnel who exhibit sufficient knowledge and skills

DENOMINATOR:

# of trained WGSS personnel

HOW TO MEASURE

To measure this indicator, utilise observation and post training assessments including WGSS's capacity and skills assessment and observation tools. "Sufficient" knowledge and skills in general means a passing score (at least 60%) is achieved on any knowledge or skills assessment.

Calculation = (# of trained WGSS personnel who exhibit sufficient knowledge and skills / # of trained WGSS personnel) * 100.

MEETING THE STANDARD?

MET	80% or more of trained WGSS personnel exhibit sufficient knowledge and skills in implementing the GBV Guiding principles and WGSS guidelines.
WORKING TOWARDS	60%-80% of trained WGSS personnel exhibit sufficient knowledge and skills in implementing the GBV Guiding principles and WGSS guidelines.
NOT MET	Less than 60% of trained WGSS personnel who exhibit sufficient knowledge and skills in implementing the GBV Guiding principles and WGSS guidelines.

SUGGESTED M&E TOOLS

WGSS's Individual Capacity Assessment and Teamwork Skills Assessment Questionnaire

Additional questions about specific WGSS guidelines can be added.

WGSS Toolkit's Observation Checklist can also provide information on the staff's facilitation skills.

8.4 Percentage of targeted locations with WGSS to provide quality services, information and activities that promote healing, well-being and empowerment

INDICATOR LEVEL
CLUSTER

DEFINITION

NUMERATOR:

HRP targeted locations with at least one WGSS

DENOMINATOR:

# of HRP targeted locations

HOW TO MEASURE

To measure this indicator, compare the locations of the WGSS against the target locations from the HRP (or other guiding document) using the 3-4-5W template as reported by partners under the GBV sub-cluster/sector/WG.

MEETING THE STANDARD?

MET	80% or more of the HRP-targeted locations have at least one WGSS.
WORKING TOWARDS	60%-80% of the HRP-targeted locations have at least one WGSS.
NOT MET	Less than 60% of the HRP-targeted locations have at least one WGSS.

SUGGESTED M&E TOOLS

Service mapping and 3/4/5W templates

R8.5 Percentage of surveyed women and girls gain knowledge and skills in the WGSS

INDICATOR LEVEL
ORGANISATION

DEFINITION

NUMERATOR:

women and girls increasing knowledge and skills in WGSS from pre to post test

DENOMINATOR:

# of women and girls participating in WGSS curriculum

HOW TO MEASURE

To measure this indicator, conduct a survey with participants from the WGSS. Tools will need to be adapted to the relevant topics each WGSS is exploring.

The same questionnaire should be administered prior to engaging with the curriculum and then after.

A random sample of women and girls participating in the WGSS programming should be surveyed.

AVAILABLE M&E TOOLS

Tools from WGSS Toolkit - Knowledge and/or skills assessment which accompanies the curriculum being used.

Specific tools employed should be tailored to the WGSS curriculum.

R8.6 Percentage of surveyed WGSS members whose report improved decision making after 3 months of attendance in WGSS

INDICATOR LEVEL
ORGANISATION

DEFINITION

NUMERATOR:

women and girls with increasing scores on decision-making subscale

DENOMINATOR:

# of women and girls participating in WGSS curriculum

HOW TO MEASURE

To measure this indicator, conduct a survey with participants from the WGSS. The questionnaire should be administered before beginning the WGSS curriculum and then after 3 sessions.

A random sample of women participating in the WGSS programming should be surveyed.

AVAILABLE M&E TOOLS

Tools from WGSS Toolkit -

Tool: WGSS Member Survey - Baseline (30a) and Follow Up (30b)

R8.7 Women and girls report feeling safe while at WGSS

INDICATOR LEVEL
ORGANISATION

DEFINITION

NUMERATOR:

# of women and girls who report they feel safe while at the WGSS

HOW TO MEASURE

To measure this indicator, conduct a visual assessment of the WGSS space (noting aspects such as doors, fences, etc.) and then facilitate a group discussion with attendees at the WGSS.

AVAILABLE M&E TOOLS

WGSS Safe Space Assessment

Assessment: MS 8 Are we meeting the standard?

In order to assess your overall progress in meeting this standard, consider your progress on each core indicator. Organization and cluster level progress should be tracked separately. The overall goal is to increase the number of indicators met for each standard over time. Use the following guide to track your progress.

ORGANISATIONAL-LEVEL:

Assess progress on the **core indicators** – consider only indicators that apply to your level (organisation rather than cluster).

# of Indicators **MET** (of 3)	
# of Indicators **WORKING TOWARDS** (of 3)	
# of Indicators **NOT MET** (of 3)	

CLUSTER-LEVEL:

Assess progress on the core indicators:

# of Indicators **MET** (of 1)	
# of Indicators **WORKING TOWARDS** (of 1)	
# of Indicators **NOT MET** (of 1)	

ACTION PLANNING:

For areas where your organisation/cluster is not meeting the standard, utilise the **MS Contextualization Tool** to assess your challenges and plan for improvements in order to meet the minimum standards.

Standard 9: Safety and Risk Mitigation

GBV actors advocate for and support the integration of GBV risk mitigation and survivor support across all humanitarian sectors.

READ THE STANDARD

OUTPUTS

- Active clusters / sectors have a GBV focal point
- Humanitarian response plans and refugee response plans include GBV risk mitigation interventions
- Safety audits conducted and tracked
- Humanitarian organisations and service providers have in place community-based feedback and complaint mechanisms
- Clusters/sectors receive technical support on GBV prevention and risk mitigation from the GBV coordination mechanism

OUTCOMES

- Community members have increased knowledge of how to seek services / support
- Humanitarian staff have increased knowledge of GBV risks and how to mitigate them
- Risks identified in safety audits addressed
- Women and girls report feeling safe in their communities, in their homes and when accessing goods and services
- Women and girls participating in programmes report increased ability to make decisions about their safety
- Women and girls participating in programmes report increased ability to make decisions about their safety

OBJECTIVES

- Women and girls are safer and less likely to experience GBV

9.1 Percentage of active clusters/ sectors with a GBV focal point

INDICATOR LEVEL
CLUSTER

DEFINITION

NUMERATOR:

# of active clusters/sectors that have identified a GBV focal point

DENOMINATOR:

# of active clusters/sectors

HOW TO MEASURE

To measure this indicator, assess if each active cluster/sector in your operational area has a GBV focal point (organisation, name, contact information).

Track both (and disaggregate by) if this focal person is 1) a technical staff from another sector attending GBV sub-cluster meetings or 2) is a GBV specialist who attends other sectoral meetings as a focal person.

Data should be collected routinely (at least once a year) due to turn over in staffing.

SUGGESTED M&E TOOLS

No specific M&E tool available.

MEETING THE STANDARD?

MET	All (100%) active clusters/sectors have a GBV focal point.
WORKING TOWARDS	Most (50% or more) of active clusters/sectors have a GBV focal point
NOT MET	Less than half (50%) of active clusters/sectors have a GBV focal point

9.2 All humanitarian response plans and refugee response plans include GBV risk mitigation interventions

INDICATOR LEVEL
CLUSTER

DEFINITION

All humanitarian response plans and refugee response plans describe how they are going to mitigate GBV risks

HOW TO MEASURE

To measure this indicator, examine HRPs and RRPs to assess if: 1) they include actions that clearly address specific GBV risks outlined in assessments and do not cause or increase the likelihood of GBV; 2) they seek to reduce GBV-related barriers that prevent vulnerable populations from accessing services; 3) include actions that address responsiveness to GBV risks identified in the environment; and, 4) include at least one objective focused on ensuring safety/improving safe access to/use of sector-specific services/goods and at least one indicator supporting measurement of improvements in safety/well-being among vulnerable groups.

MEETING THE STANDARD?

MET	Humanitarian response and refugee response plans are assessed to fully meet or meet the assessment criteria.
WORKING TOWARDS	Humanitarian response and refugee response plans are assessed to partially meet the assessment criteria.
NOT MET	Humanitarian response and refugee response plans are assessed to not meet the assessment criteria.

SUGGESTED M&E TOOLS

Assessment Rubric.

9.3 Number of safety audits conducted and tracked

INDICATOR LEVEL
ORGANISATION

DEFINITION

Safety Audits are undertaken to assess and mitigate GBV risks within humanitarian programming (see an example from the Whole of Syria M&E Toolkit). A safety audit can be part of a situational assessment and analysis. It is an observational tool that helps to identify observable risks and gaps in the camp or site environment.

Safety audits must be undertaken, documented and a tracking document created that tracks risks, mitigation activities and progress achieved.

HOW TO MEASURE

To measure this indicator, assess if safety audits have been undertaken and if the items uncovered as part of the audit have been tracked to ensure they are addressed.

MEETING THE STANDARD?

MET	Safety audits that cover all relevant sectors (e.g. WASH, Health, CCCM, Food Security/Nutrition, etc.) undertaken at least once a year. Tracking of mitigation actions and progress undertaken for each plan documented.
WORKING TOWARDS	Safety audits that cover some relevant sectors (e.g. WASH, Health, CCCM, Food Security/Nutrition, etc.) undertaken at least once a year. Or tracking of action items not fully completed.
NOT MET	No or outdated (more than a year since undertaken) safety audits.

SUGGESTED M&E TOOLS

Example tracking sheet

9.4 Percentage of community members surveyed who report increased knowledge of GBV risks and how to seek services / support

INDICATOR LEVEL
ORGANISATION

DEFINITION

Consider this indicator in two parts:

PART 1:

NUMERATOR:

# of community members surveyed who have increased knowledge of how to seek services/support

DENOMINATOR:

# of community members surveyed

PART 2:

The community members referenced for part two are members of the humanitarian community (e.g. humanitarian staff).

NUMERATOR:

# of humanitarian staff surveyed who have increased knowledge of GBV risks and how to mitigate them

DENOMINATOR:

# of humanitarian staff surveyed

HOW TO MEASURE

To measure part 1 of this indicator, conduct a survey with community members to see if they know what GBV services exist and how to access them.

For GBV risks, women and girls should be engaged in identification of these risks/ development of mitigation strategies through participatory methods (see Empowered Aid M&E tools for examples). Humanitarian staff should be surveyed about their knowledge of GBV risks and mitigation strategies.

The data for each part of this the numerator should be collected at least 2 time points to document the # of community members with increased knowledge.

MEETING THE STANDARD?

MET	More than 80% of community members increase their knowledge on know how to seek services/support and more than 80% of humanitarian staff increase their knowledge about GBV risks and how to mitigate them.
WORKING TOWARDS	60-80% of community members increase their knowledge on know how to seek services/support and more than 60-80% of humanitarian staff increase their knowledge about GBV risks and how to mitigate them.
NOT MET	Less than 60% of community members increase their knowledge on know how to seek services/support and less than 60% of humanitarian staff increase their knowledge about GBV risks and how to mitigate them.

SUGGESTED M&E TOOLS

How to seek services support:

WGSS Toolkit - Tool: WGSS Member Survey - Follow Up (30b)

Database: WGSS Member Survey Database (G)

No specific M&E tool for GBV risks.

9.5 Humanitarian organisations and service providers have in place community-based feedback and complaint mechanisms that can respond to sexual exploitation and abuse, including complaint referral forms

INDICATOR LEVEL ORGANISATION/ CLUSTER

DEFINITION

Community-based feedback and complaint mechanisms are in place in the community. These mechanisms "aim to facilitate SEA reporting and referral of allegations, and help known and potential SEA survivors to access assistance and services. Community-based complaints mechanisms (CBCM) are jointly developed with a community of concern, preferably in an interagency framework if applicable, and make use of the community's resources and structures. CBCMs should therefore be culturally and gender sensitive and remove barriers that hinder members of the communities from reporting SEA incidents to appropriate stakeholders for follow up." (see "Interagency Collaboration on Setting up Community Based Complaints Mechanisms."

HOW TO MEASURE

To measure this indicator, each organisation should self-assess if they have feedback and complaints mechanisms in place including complaint referral forms.

MEETING THE STANDARD?

MET	Community-based feedback and complaints mechanisms, including complaint referral forms, established in all operational locations.
WORKING TOWARDS	Community-based feedback and complaints mechanisms, including complaint referral forms, established but not yet rolled out in all operational locations. Or gaps in process (e.g. lack of complaint referral forms) but general feedback mechanisms are in place.
NOT MET	Community-based feedback and complaints mechanisms, including complaint referral forms, not established.

SUGGESTED M&E TOOLS

No specific M&E tool available.

R9.6 Percentage of safety audit/ sectoral actions points achieved

INDICATOR LEVEL
ORGANISATION/ CLUSTER

DEFINITION

NUMERATOR:

# of safety audit planned risk mitigation actions achieved

DENOMINATOR:

# of safety audit actions planned for

HOW TO MEASURE

To measure this indicator, compare what safety audits/ sectoral action points that were planned versus those that have been undertaken.

AVAILABLE M&E TOOLS

Example tracking sheet

R9.7 Percentage of women and girls who report feeling safe in their communities, in their homes and when accessing goods and services

INDICATOR LEVEL
ORGANISATION

DEFINITION

NUMERATOR:

# of women and girls who report feeling safe in their communities, in their homes, and when accessing goods and services

DENOMINATOR:

# of women and girls surveyed

HOW TO MEASURE

To measure this indicator, conduct surveys with women and girls asking if they 1) feel safe within their home and 2) feel safe moving around their communities (both during the day and a night) and 3) when accessing goods and services.

AVAILABLE M&E TOOLS

Empowered Aid M&E tools

Example safety questions

R9.8 Reductions in service barriers (availability, accessibility, acceptability, quality) that prevent access to aid

INDICATOR LEVEL
ORGANISATION

DEFINITION

Qualitative indicator that documents improvements in indicators associated with use of goods, services, etc. (privacy/safety/dignity; cultural appropriateness, etc.)

HOW TO MEASURE

Utilise the Availability, Accessibility, Acceptability and Quality Framework to assess service barriers for goods and services and document reductions in these barriers.

AVAILABLE M&E TOOLS

AAQ Framework

R9.9 Percentage of women and girls participating in programmes who report increased ability to make decisions about their safety

INDICATOR LEVEL
ORGANISATION

DEFINITION

NUMERATOR:

# of women and girls participating in programmes who report increased ability to make decisions about their safety

DENOMINATOR:

# of women and girls surveyed

HOW TO MEASURE

To measure this indicator, conduct surveys with women and girls who report that their ability to make decisions about their safety has increased. This should be measured both at baseline (assessing initial ability to make decisions) and after participation in programmes.

AVAILABLE M&E TOOLS

WGSS Decision Making Tool
- Tool: WGSS Member Survey
- Baseline (30a) and Follow Up (30b)

R9.10 Number and percentage of clusters/sectors that have received technical support on GBV prevention and risk mitigation from the GBV coordination mechanism

INDICATOR LEVEL
ORGANISATION

DEFINITION

NUMERATOR:

# of clusters/sectors that have received technical support on GBV prevention and risk mitigation from the GBV coordination mechanism

DENOMINATOR:

# of activated clusters in the context

HOW TO MEASURE

To measure this indicator, count the number of clusters/sectors that have received technical assistance by examining programme documents/interviewing key stakeholders.

AVAILABLE M&E TOOLS

No specific M&E tool available

Assessment: MS 9 Are we meeting the standard?

In order to assess your overall progress in meeting this standard, consider your progress on each core indicator. Organization and cluster level progress should be tracked separately. The overall goal is to increase the number of indicators met for each standard over time. Use the following guide to track your progress.

ORGANISATIONAL-LEVEL:

Assess progress on the **core indicators** – consider only indicators that apply to your level (organisation rather than cluster).

# of Indicators **MET** (of 3)	☐
# of Indicators **WORKING TOWARDS** (of 3)	☐
# of Indicators **NOT MET** (of 3)	☐

CLUSTER-LEVEL:

Assess progress on the **core indicators**:

# of Indicators **MET** (of 3)	☐
# of Indicators **WORKING TOWARDS** (of 3)	☐
# of Indicators **NOT MET** (of 3)	☐

ACTION PLANNING:

For areas where your organisation/cluster is not meeting the standard, utilise the **MS Contextualization Tool** to assess your challenges and plan for improvements in order to meet the minimum standards.

Standard 10: Justice and Legal Aid

Legal and justice sectors support GBV survivors to access safe and survivor-centred legal services that protect their rights and promote their access to justice.

READ THE STANDARD

OUTPUTS

Security personnel trained on how to safely respond to incidents of GBV according to established protocols

Judicial institutions and law enforcement bodies supported to reduce barriers to women's access to justice

Women and girl who access legal services think these services were delivered in accordance with their needs and preferences

OUTCOMES

Women and girls who sought legal redress for their cases through the formal justice are satisfied with the outcome of the case

OBJECTIVES

Survivors are able to seek safe and survivor centred legal redress if they so choose

10.1 Proportion of GBV programme participants who report that the legal support they accessed was delivered in accordance with their needs and preferences

INDICATOR LEVEL
ORGANISATION

DEFINITION

NUMERATOR:

# of GBV programme participants who report that the legal support they accessed was delivered in accordance with their needs and preferences

DENOMINATOR:

# of GBV programme participants who accessed legal support services

HOW TO MEASURE

To measure this indicator, administer client satisfaction surveys with a random selection of clients who access legal support.

Legal services are services that can promote or help survivors to claim their legal rights and protections. This includes prosecution, legal aid services and court support.

If, overall, the client was mostly or very satisfied with support received, they received enough information to make a decision on how to move forward and the services were viewed as age appropriate by assessor, the services were delivered in accordance with their needs and preferences.

MEETING THE STANDARD?

MET	More than 80% of women and girls report that the legal support they received was delivered in accordance with their needs and preferences.
WORKING TOWARDS	60-80% of women and girls report that the legal support they received was delivered in accordance with their needs and preferences.
NOT MET	Less than 60% of women and girls report that the legal support they received was delivered in accordance with their needs and preferences.

SUGGESTED M&E TOOLS

Satisfaction survey example

10.2 Number of security personnel, disaggregated by sex, trained on how to safely respond to incidents of GBV according to established protocols that adhere to GBV guiding principles

INDICATOR LEVEL
ORGANISATION/ CLUSTER

DEFINITION

NUMERATOR:

# of security personnel trained on how to safely respond to incidents of GBV according to established protocols that adhere to GBV guiding principles.

HOW TO MEASURE

To measure this indicator, keep a training log tracking the number of security personnel trained, disaggregated by sex.

Security personnel include state actors such as police, armed forces, border control, reserve security units, intelligence services, and justice services and non-state actors such as non-statutory security forced or armed groups, and traditional authorities Security personnel should be tracked by a unique data (e.g. ID number) to reduce double counting. Each person should be tracked once, no matter the number of trainings they attend.

Training should be based on the relevant local SOPs.

Further robust M&E systems should include pre- and post-tests for all training to consider knowledge retention and the impact of training.

(See "Working with the Security Sector to End Violence against Women and Girls. SD Direct and UN Women.")

SUGGESTED M&E TOOLS

For example: Sample Training Log

MEETING THE STANDARD?

MET	An increasing number of security personnel in an operational area is being trained.
WORKING TOWARDS	Security personnel have been trained in the past but new trainings are not ongoing. Trainings do not fully encompass local GBV protocols and the GBV guiding principles.
NOT MET	No security personnel trained.

10.3 Number of judicial institutions and law enforcement bodies supported to reduce barriers to women's access to justice

INDICATOR LEVEL
ORGANISATION/ CLUSTER

DEFINITION

NUMERATOR:

# of judicial institutions and law enforcement bodies receiving funding, training and/or material support to promote women's access to justice

HOW TO MEASURE

To measure this indicator, utilise cluster-led survey/ report on work plan progress. Count the number of judicial institutions and law enforcement bodies in the target area who have received support.

Judicial institutions and law enforcement bodies may be formal or informal courts, police, paralegal, legal aid and/or investigation services.

Support can be trainings, mentorship, funding, and/or material support.

MEETING THE STANDARD?

MET	An increasing number of judicial institutions and law enforcement bodies in an operational area are being supported.
WORKING TOWARDS	Judicial institutions and law enforcement bodies have been supported in the past, but support is not ongoing. Support given is not sufficient to fully reduce barriers to women's access to justice.
NOT MET	No judicial institutions and law enforcement bodies supported.

SUGGESTED M&E TOOLS

No specific M&E tool available.

R10.4 Percentage of women and girls who sought legal redress for their cases through the formal justice who are satisfied with the outcome of the case

INDICATOR LEVEL
ORGANISATION/
CLUSTER

DEFINITION

NUMERATOR:

# of GBV programme participants who report that they were satisfied with the outcome of the case

DENOMINATOR:

# of GBV programme participants who accessed legal support services

HOW TO MEASURE

To measure this indicator, conduct client satisfaction surveys with women who have pursued formal legal justice and are interviewed at the end of their case.

AVAILABLE M&E TOOLS

Satisfaction survey example

Assessment: MS 10 Are we meeting the standard?

In order to assess your overall progress in meeting this standard, consider your progress on each core indicator. Organization and cluster level progress should be tracked separately. The overall goal is to increase the number of indicators met for each standard over time. Use the following guide to track your progress.

ORGANISATIONAL-LEVEL:

Assess progress on the **core indicators** – consider only indicators that apply to your level (organisation rather than cluster).

# of Indicators **MET** (of 3)	☐
# of Indicators **WORKING TOWARDS** (of 3)	☐
# of Indicators **NOT MET** (of 3)	☐

CLUSTER-LEVEL:

Assess progress on the **core indicators**:

# of Indicators **MET** (of 2)	☐
# of Indicators **WORKING TOWARDS** (of 2)	☐
# of Indicators **NOT MET** (of 2)	☐

ACTION PLANNING:

For areas where your organisation/cluster is not meeting the standard, utilise the **MS Contextualization Tool** to assess your challenges and plan for improvements in order to meet the minimum standards.

Standard 11. Dignity Kit, Cash and Voucher Assistance

Women and girls receive dignity kits, and/or cash and voucher assistance to reduce GBV risk and promote safety and dignity.

READ THE STANDARD

OUTPUTS

- Vulnerable women and adolescent girls receive dignity kits and/or cash/voucher assistance
- Women and girl who are satisfied with the items provided in the dignity kits they received
- Assessments of women's and girls' specific needs conducted to inform CVA and DK construction/distribution
- Inter-agency, inter-departmental protocol and/or information sharing for CVA developed and operationalized

OUTCOMES

- Populations in targeted locations have access to DK and CVA
- Risk to the safety of women and girls as a result of receiving CVA tracked and minimised
- Women and girls receiving CVA have improved ability to provide for HH needs and experience less household tension/violence

OBJECTIVES

- Risks of GBV are reduced during and after distributions of dignity kits, cash and voucher assistance

11.1 DIGNITY KITS: Percentage of women and adolescent girls who received dignity kits, disaggregated by age

INDICATOR LEVEL
ORGANISATION

DEFINITION

NUMERATOR:

# of women and adolescent girls of reproductive age who received dignity kits

DENOMINATOR:

women and adolescent girls in the catchment area who meet the criteria prioritised for dignity kit distribution

HOW TO MEASURE

To measure this indicator, track the # of women and adolescent girls who receive a kit through programme records/tracking sheets.

See MS 11 for details on dignity kit contents. To calculate the denominator for this indicator, consider the MS guidance on identifying target groups to receive dignity kits:

- Those with immediate/acute needs, paying particular attention to underserved communities and women and adolescent girls at increased risk of GBV due to barriers to participation and access.
- Programmatic opportunities to provide sexual and reproductive health and GBV information, referrals and services.
- Geographical location: identify a specific area, taking into account the number of affected people and presence of partners to help with distribution.
- Specific individual criteria such as age, reproductive health status or other criteria as needed in the local context.

Age disaggregation should include:

- Adolescents (10-19)
- Adult women (20-49)

SUGGESTED M&E TOOLS

No specific M&E tool available.

MEETING THE STANDARD?

MET	Most (more than 80%) prioritised women and adolescent girls receive a dignity kit.
WORKING TOWARDS	Some (40-80%) prioritised women and adolescent girls receive a dignity kit.
NOT MET	Few (Less than 40%) prioritised women and adolescent girls receive a dignity kit.

11.2 DIGNITY KITS: Percentage of women and adolescent girls who indicate they are satisfied with the items provided in the dignity kits they received, disaggregated by age

INDICATOR LEVEL
ORGANISATION

DEFINITION

NUMERATOR:

# of women and adolescent girls who say they are satisfied with the items provided in the dignity kits they received

DENOMINATOR:

women and adolescent girls who received dignity kits

HOW TO MEASURE

To measure this indicator, administer a post-distribution monitoring questionnaire with women and girls reporting their level of satisfaction with the items provided in the dignity kits. Any woman or girl who reports she is satisfied (very, strongly, somewhat, etc.) should be counted towards the numerator. A random sample of women and adolescent girls can be interviewed.

In general, age disaggregation should include:

- Adolescents (10-19)
- Adult women (20-49)

MEETING THE STANDARD?

MET	Most (more than 75%) of women and adolescent girls who received a dignity kit report that they are strongly or somewhat satisfied.
WORKING TOWARDS	Some (40-75%) of women and adolescent girls who received a dignity kit report that they are strongly or somewhat satisfied.
NOT MET	Few (Less than 40% of women and adolescent girls who received a dignity kit report that they are strongly or somewhat satisfied.

SUGGESTED M&E TOOLS

GBV Sub-Cluster M&E Toolkit: Post-Distribution Monitoring (PDM) Survey Questionnaire – Dignity Kits.

11.3 CASH AND VOUCHER ASSISTANCE: Assessment of women's and girls' specific needs conducted to inform CVA

INDICATOR LEVEL
ORGANISATION

DEFINITION

NUMERATOR:

Assessment conducted

HOW TO MEASURE

To measure this indicator, consider if an assessment has been conducted that specifically looks at the needs of women and girls to inform CVA programming. This includes data collection undertaken with women and girls (data disaggregated by age; inclusive of vulnerable groups such as people with disabilities, elderly, etc.).

See CaLP website, IRC's Safer Cash Toolkit, Cash & Voucher Assistance and Gender-Based Violence Compendium: Practical Guidance for Humanitarian Practitioners for support conducting needs assessment and considering CVA and GBV.

MEETING THE STANDARD?

MET	Assessment of women and girls' specific needs conducted to inform CVA.
WORKING TOWARDS	Assessment of women and girls' specific needs ongoing to inform CVA.
NOT MET	Assessment of women and girls' specific needs not undertaken to inform CVA.

SUGGESTED M&E TOOLS

No specific M&E tool available.

11.4 Inter-agency, inter departmental protocol and / or information-sharing protocol for CVA developed and operationalized

INDICATOR LEVEL
CLUSTER

DEFINITION

Internal or inter-agency protocols, which outline the roles and responsibilities of cash and GBV programme actors to ensure the availability of quality services and timely, confidential and accessible care for survivors, are developed.

They are operationalized undertaking activities such as assigning focal persons, budgets, needed supplies procured, etc. to implement the protocol.

HOW TO MEASURE

To measure this indicator, assess if written protocols are available and operationalized by reviewing programme documents, budgets and interviewing key staff.

MEETING THE STANDARD?

MET	Protocols for CVA developed and operationalized.
WORKING TOWARDS	Protocols for CVA being developed or operationalized.
NOT MET	Protocols for CVA not developed or operationalized.

SUGGESTED M&E TOOLS

No specific M&E tool available.

11.5 Number of women and girls who receive cash and / or voucher assistance

INDICATOR LEVEL
ORGANISATION

DEFINITION

NUMERATOR:

Number of women and girls who receive cash and / or a voucher.

HOW TO MEASURE

To measure this indicator, count the number of women and girls who receive CVA. Unique IDs should be used so that women and girls are only counted once and not double counted if they receive more than one payment/voucher.

Disaggregate by age and disability status. In general age disaggregation should include:

- Adolescents (10-19)
- Adult women (20-49)
- Older and elderly women (50 +)

SUGGESTED M&E TOOLS

No specific M&E tool available.

MEETING THE STANDARD?

MET	Increasing numbers of women and girls in greatest need (e.g., most impoverished, female or child headed households, disabled, etc.) are receiving CVA.
WORKING TOWARDS	The number of women and girls in greatest need (e.g., most impoverished, female or child headed households, disabled, etc.) who are receiving CVA is maintained.
NOT MET	The number of women and girls in greatest need (e.g., most impoverished, female or child headed households, disabled, etc.) who are receiving CVA is declining, or no women and girls are receiving CVA.

R11.6 Assessment of women's and girls' specific needs conducted to inform DK distributions

INDICATOR LEVEL
CLUSTER

DEFINITION

NUMERATOR:

Assessment conducted

HOW TO MEASURE

To measure this indicator, consider if an assessment has been conducted that specifically looks at the needs of women and girls to inform DK programming.

AVAILABLE M&E TOOLS

No specific M&E tool available

R11.7 Percentage of targeted locations with access to DK and CVA

INDICATOR LEVEL
CLUSTER

DEFINITION

NUMERATOR:

# of targeted locations with DK and CVA distribution programmes

DENOMINATOR:

# of targeted locations in HRP/RRP

HOW TO MEASURE

To measure this indicator, compare the # of targeted locations with DK distributions and CVA programming compared to all targeted locations in the HRP/RRP.

AVAILABLE M&E TOOLS

No specific M&E tool available

R11.8 Percentage of women and girls who report experiencing risks to their safety as a result of receiving CVA

INDICATOR LEVEL ORGANISATION

DEFINITION

NUMERATOR:

# of women and girls who received CVA who report experiencing a risk to their safety as a result of receiving CVA

DENOMINATOR:

# of women and girls who received CVA

HOW TO MEASURE

To measure this indicator, collect as part of a PDM with a random sample of women and girls cash recipients. Women and girls should be asked if they experienced any risks to their safety as a result of receiving cash. The specific risks they report should be noted.

AVAILABLE M&E TOOLS

PDM Tool for CVA: What to keep in mind in regards to GBV risk and mitigation measures?

Safer Cash Toolkit's Tool 3.1- Question PDM 61

Empowered Aid's PDM Toolkit

R11.9 Percentage of women and girls who received CVA who report less household tension/fighting/violence

INDICATOR LEVEL ORGANISATION

DEFINITION

NUMERATOR:

# of women and girls who received CVA who report less household tension/fighting after receiving CVA

DENOMINATOR:

# of women and girls who received CVA

HOW TO MEASURE

To measure this indicator, collect as part of PDM. For example, the Whole of Syria's PDM question 8.1 (less abuse or threat of abuse) or the Safer Cash Toolkit's questions on HH tensions.

Collected with a random sample of cash recipients.

Enumerators should have training on GBV core concepts and data collection on sensitive issues and/or this question to be asked by those with specialist training only (i.e. case managers, GBV and/or protection specialists). If it is not possible to ask this question in a safe and ethical manner consider R11.8 as a proxy.

AVAILABLE M&E TOOLS

GBV Whole of Syria Sub-Cluster's PDM – Question 8 and 8.1

Safer Cash Toolkit's Tool 3.1 – Questions PRM 84- 96

R11.10 Percentage of women and girls who received CVA who report improved ability to provide for household (HH) needs

INDICATOR LEVEL
ORGANISATION

DEFINITION

NUMERATOR:

# of women and girls who received CVA who report improved ability to provide for HH needs after receiving CVA

DENOMINATOR:

women and adolescent girls who received CVA

HOW TO MEASURE

To measure this indicator, collect as part of a post distribution monitoring (PDM) with a random sample of women and girls who received CVA.

Women and girls should be asked if receiving the cash or voucher helped them provide for their household needs (see HESPER for some example needs such as having a serious problem getting food).

Calculation: (# of women and girls who received CVA who report improved ability to provide for HH needs after receiving CVA / # of women and girls who received CVA) * 100

As CVA and particularly vouchers may be provided for specific purposes, the measurement tool should include standard questions such as who actually received the cash or voucher and its intended purpose.

AVAILABLE M&E TOOLS

Select relevant HH needs from the Humanitarian Emergency Settings Perceived Needs Scale (HESPER)

Assessment: MS 11 Are we meeting the standard?

In order to assess your overall progress in meeting this standard, consider your progress on each core indicator. Organization and cluster level progress should be tracked separately. The overall goal is to increase the number of indicators met for each standard over time. Use the following guide to track your progress.

ORGANISATIONAL-LEVEL: Assess progress on the **core indicators** – consider only indicators that apply to your level (organisation rather than cluster).	# of Indicators **MET** (of 4) ☐
	# of Indicators **WORKING TOWARDS** (of 4) ☐
	# of Indicators **NOT MET** (of 4) ☐

CLUSTER-LEVEL: Assess progress on the **core indicators**:	# of Indicators **MET** (of 1) ☐
	# of Indicators **WORKING TOWARDS** (of 1) ☐
	# of Indicators **NOT MET** (of 1) ☐

ACTION PLANNING:

For areas where your organisation/cluster is not meeting the standard, utilise the **MS Contextualization Tool** to assess your challenges and plan for improvements in order to meet the minimum standards.

Standard 12. Economic Empowerment and Livelihoods

Women and adolescent girls access economic support as part of a multisectoral response.

READ THE STANDARD

OUTPUTS

- Economic empowerment and livelihood programmes are integrated into GBV standard operating procedures, and included in the referral system and service mapping
- Economic empowerment of women and older adolescent girls through targeted livelihood and employment interventions are funded in humanitarian response plans

OUTCOMES

- Increasing percentage of women and girls who report sole or joint involvement in household decision-making
- Increasing percentage of women and girls who have access to and control over financial resource
- Increased net income of the female participants of livelihood programmes
- Women and girls experience less HH tension/fighting
- Women and girls have improved ability to provide for HH needs

OBJECTIVES

- Women and girls have increased economic security and decision making power over income and assets

12.1 Economic empowerment and livelihood programmes are integrated into GBV standard operating procedures, and included in the referral system and service mapping

INDICATOR LEVEL
CLUSTER

DEFINITION

Economic empowerment and livelihood programmes that target women and older adolescent girls are included as part of GBV standard operating procedures and in referral system and service mapping.

Common economic empowerment and livelihoods programming in emergencies include: cash grants, cash for work, asset restoration (livestock, tools, equipment), agrarian interventions, training and placement programmes, market interventions, enterprise development, village savings and loans association, and microfinance (see "A Double-edged Sword: Livelihoods in Emergencies."

HOW TO MEASURE

To measure this indicator, review the GBV SOPs, referral pathways and service mapping to see if economic empowerment and livelihoods programmes are included. See the list of common interventions in the definition.

MEETING THE STANDARD?

MET	SOPs and referral pathways/service mapping includes economic empowerment and/or livelihoods programmes that specifically target women and older adolescent girls.
WORKING TOWARDS	SOPs and referral pathways/service mapping includes economic empowerment and/or livelihoods programmes, however these programmes are not targeted to women or older adolescent girls. Or either the SOPs or referral system do not include economic empowerment and/or livelihoods programming targeted to women or older adolescent girls.
NOT MET	Neither SOPs or referral pathways/service mapping include any economic empowerment or livelihoods programmes.

SUGGESTED M&E TOOLS

No specific M&E tool available.

12.2 Percentage of women and older adolescent girls who report sole or joint involvement in household decision-making

INDICATOR LEVEL
ORGANISATION

DEFINITION

NUMERATOR:

# of partnered women and older adolescent girls who report sole or joint involvement in at least 1 of the major household decision-making criteria in the past month

DENOMINATOR:

partnered women and adolescent girls surveyed

HOW TO MEASURE

To measure this indicator, conduct surveys with partnered women and adolescents aged 15 and older in each target area and assess decision making in each the following four key areas:

1. Household purchases
2. Schooling
3. Healthcare
4. Visits to family or relatives

Decisions should be solely or jointly made with partner.

MEETING THE STANDARD?

MET	Most (more than 80%) of partnered women and older adolescent girls report sole or joint involvement in household decisions over the past month.
WORKING TOWARDS	Some (60%-80%) of partnered women and older adolescent girls report sole or joint involvement in household decisions over the past month.
NOT MET	Few (less than 60%) of partnered women and older adolescent girls report sole or joint involvement in household decisions over the past month.

SUGGESTED M&E TOOLS

Decision Making Questions

12.3 Percentage change from baseline in women's and girl's access to and control over financial resources following participation in economic empowerment or livelihood programmes

INDICATOR LEVEL
ORGANISATION

DEFINITION

NUMERATOR:

# of women and girls who report an increase in their individual or joint decision-making around money that they earn

DENOMINATOR:

# of women and girls who participate in economic empowerment or livelihood programmes

HOW TO MEASURE

To measure this indicator, conduct a survey with a random sample of participants in economic empowerment or livelihood programmes. Data should be collected at baseline and endline (after participation in a programme). Assess their ability to decide how her earnings should be used.

MEETING THE STANDARD?

MET	After participating in an economic empowerment or livelihood programme more women and adolescent girls report access to and control over financial resources.
WORKING TOWARDS	After participating in an economic empowerment or livelihood programmes, women and adolescent girls report no increased access to and control over financial resources.
NOT MET	No survey data collected with women and girls participating in economic empowerment or livelihoods programmes.

SUGGESTED M&E TOOLS

Decision Making Questions

12.4 Percentage change in net income of the female participants of livelihood programmes

INDICATOR LEVEL
ORGANISATION

DEFINITION

NUMERATOR:

Net income of the female participants of livelihood programmes

DENOMINATOR:

# of women and girls who participate in livelihood programmes

HOW TO MEASURE

To measure this indicator, conduct a survey with participants in economic empowerment or livelihood programme. Revenue – production cost = net income.

Data should be collected at baseline and endline (after participation in a programme).

MEETING THE STANDARD?

MET	Women and adolescent girls are increasing their net income after participating in livelihoods programmes.
WORKING TOWARDS	Women and girls are not increasing their net income after participating in livelihoods programmes.
NOT MET	No survey data collected with women and girls participating in livelihoods programmes.

SUGGESTED M&E TOOLS

Any tool that calculates total income and expenditures – For example ICRC's Cash in Emergencies Baseline Questionnaire tool. This would need to be adapted to track income and costs for female participants specifically rather than the whole of household

12.5 Number of projects to support the economic empowerment of women and older adolescent girls through targeted livelihood and employment interventions funded in humanitarian response plans

INDICATOR LEVEL
CLUSTER

DEFINITION

NUMERATOR:

# of projects to support the economic empowerment of women and older adolescent girls through targeted livelihood and employment interventions funded in humanitarian response plans

HOW TO MEASURE

To measure this indicator, review funding mechanisms to assess the number of economic empowerment projects where women and girls are included as a specific target group for the intervention.

If data on projects specifically funded through the HRP are not available, a proxy measure for this indicator can be to examine projects in the humanitarian financial tracking system.

Compare the locations of the funded programmes to targeted locations in the HRP.

SUGGESTED M&E TOOLS

No specific M&E tool available.

MEETING THE STANDARD?

MET	Economic empowerment and livelihood projects targeted to women and older adolescent girls are funded as part of the HRP (or alternatively included in the humanitarian tracking system) and cover the majority of targeted locations for humanitarian response.
WORKING TOWARDS	Economic empowerment and livelihood projects targeted to women and older adolescent girls are funded as part of the HRP (or alternatively included in the humanitarian tracking system) but do not cover the majority of targeted locations for humanitarian response.
NOT MET	Livelihoods and economic empowerment projects that target the general community (not specifically women and adolescent girls) are funded as part of the HRP (or alternatively included in the humanitarian tracking system.

R12.6 Percentage of women and girls who participated in economic empowerment or livelihoods programmes who report less household tension/fighting

INDICATOR LEVEL ORGANISATION

DEFINITION

NUMERATOR:

# of women and girls who participated in economic empowerment or livelihoods programmes who report less household tension/fighting after participation

DENOMINATOR:

# of women and girls who participated in economic empowerment or livelihoods programmes

HOW TO MEASURE

To measure this indicator, collect as part of a survey with participants in economic empowerment or livelihoods programmes.

Collect with a random sample of programme participants at baseline and endline.

Enumerators should have training on GBV core concepts and data collection on sensitive issues and/or this question to be asked by those with specialist training only (i.e. case managers, GBV and/or protection specialists.

AVAILABLE M&E TOOLS

GBV Whole of Syria Sub-Cluster's PDM – Question 8 and 8.1

Safer Cash Toolkit's Tool 3.1 – Questions PRM 84–96

R12.7 Percentage of women and girls who participated in an economic empowerment or livelihoods programme who report improved ability to provide for HH needs

INDICATOR LEVEL ORGANISATION

DEFINITION

NUMERATOR:

# of women and girls who participated in economic empowerment or livelihoods programmes report improved ability to provide for HH needs after participation

DENOMINATOR:

women and adolescent girls who participated in economic empowerment or livelihoods programmes

HOW TO MEASURE

To measure this indicator, conduct a survey with participants in economic empowerment or livelihood programmes.

Collect with a random sample of programme participants at baseline and endline.

Women and girls should be asked if participating in and economic empowerment or livelihoods programme helped them provide for their household needs (see HESPER for some example needs such as having a serious problem getting food).

AVAILABLE M&E TOOLS

Select relevant HH needs from the Humanitarian Emergency Settings Perceived Needs Scale (HESPER)

Assessment: MS 12 Are we meeting the standard?

In order to assess your overall progress in meeting this standard, consider your progress on each core indicator. Organization and cluster level progress should be tracked separately. The overall goal is to increase the number of indicators met for each standard over time. Use the following guide to track your progress.

ORGANISATIONAL-LEVEL: Assess progress on the **core indicators** – consider only indicators that apply to your level (organisation rather than cluster).	# of Indicators **MET** (of 3) ☐
	# of Indicators **WORKING TOWARDS** (of 3) ☐
	# of Indicators **NOT MET** (of 3) ☐

CLUSTER-LEVEL: Assess progress on the **core indicators**:	# of Indicators **MET** (of 2) ☐
	# of Indicators **WORKING TOWARDS** (of 2) ☐
	# of Indicators **NOT MET** (of 2) ☐

ACTION PLANNING:

For areas where your organisation/cluster is not meeting the standard, utilise the **MS Contextualization Tool** to assess your challenges and plan for improvements in order to meet the minimum standards.

Standard 13. Transforming Systems and Social Norms

GBV programming addresses harmful social norms and systematic gender inequality in a manner that is accountable to women and girls.

READ THE STANDARD

OUTPUTS

Programmes focused on male engagement include explicit mechanisms for accountability to women and girls

Programmes focused on male engagement include commitment to the principle of perpetrator accountability, and clear protocols and mechanisms for responding to disclosures of perpetration of GBV by programme participants

Culturally and locally appropriate key messages, and information, education and communication materials developed to accompany information on GBV services and social norms

OUTCOMES

Increasing women, men, girls and boys who disagree or strongly disagree with locally relevant harmful social norms

Women, men, girls and boys with increasing knowledge of GBV and harmful traditional practices

OBJECTIVES

Reduced harmful social norms and improved gender equality

13.1 Programmes focused on male engagement include explicit mechanisms for accountability to women and girls

INDICATOR LEVEL
ORGANISATION

DEFINITION

Male engagement programmes are programmes that specifically seek to work with men and boys to change gender attitudes and reduce use of violence.

These programmes should include accountability to women and girls including:

- Promoting and ensuring women's and girls' leadership in work on GBV;
- Listening to the demands and advice of diverse women and girls when undertaking male engagement efforts;
- Recognizing the existing gender hierarchy, and striving to transform a system of inequality from which men benefit;
- Working at both individual and structural levels to change personal behaviour while transforming patriarchal systems;
- Ensuring that male involvement efforts demonstrably empower women and girls and honour women's leadership; and
- Examining funding decisions to ensure that gender hierarchies are not inadvertently reproduced

HOW TO MEASURE

To measure this indicator, review programme design documents to determine if the following are included:

- Women's and girls' in leadership positions for GBV programming;
- Regular listening sessions with women and girls from the community to seek feedback on the harmful and helpful effects of GBV prevention programmes;
- Recognition of the existing gender hierarchy, and activities that seek to transform a system of inequality;
- Activities that seek to change men's behaviours while transforming patriarchal systems;
- Male involvement efforts demonstrably empower women and girls and honour women's leadership

SUGGESTED M&E TOOLS

No specific M&E tool available

MEETING THE STANDARD?

MET	All male engagement programmes have explicit mechanisms for accountability to women and girls.
WORKING TOWARDS	More than half of male engagement programmes have explicit mechanisms for accountability to women and girls.
NOT MET	Less than half of male engagement programmes have explicit mechanisms for accountability to women and girls.

13.2 All programmes focused on male engagement include commitment to the principle of perpetrator accountability, and clear protocols and mechanisms for responding to disclosures of perpetration of GBV by programme participants

INDICATOR LEVEL
ORGANISATION

DEFINITION

Male engagement programmes should include commitments to holding perpetrators accountable (e.g., through legal action, etc.) for violent actions and clear protocols and mechanisms for responding to disclosures of perpetration of GBV by programme participants.

HOW TO MEASURE

To measure this indicator, examine programme documents to see if there are procedures to ensure perpetrator accountability and protocols/ mechanisms for responding to disclosures of perpetration of GBV by programme participants.

See IRC's Engaging Men through Accountable Practice programme for examples and support.

SUGGESTED M&E TOOLS

No specific M&E tool available

MEETING THE STANDARD?

MET	All programmes focused on male engagement include a commitment to the principle of perpetrator accountability, and clear protocols and mechanisms for responding to disclosures of perpetration of GBV by programme participants.
WORKING TOWARDS	More than half of programmes focused on male engagement include a commitment to the principle of perpetrator accountability, and clear protocols and mechanisms for responding to disclosures of perpetration of GBV by programme participants.
NOT MET	Less than half of programmes focused on male engagement include a commitment to the principle of perpetrator accountability, and clear protocols and mechanisms for responding to disclosures of perpetration of GBV by programme participants.

13.3 Percentage of women, men, girls and boys who report that they disagree or strongly disagree with locally relevant harmful social norms (e.g., victim-blaming attitudes, discriminatory attitudes towards survivors)

INDICATOR LEVEL
ORGANISATION

DEFINITION

NUMERATOR:

# of women, men, girls and boys who report that they disagree or strongly disagree with locally relevant harmful social norms (e.g., victim-blaming attitudes, discriminatory attitudes towards survivors)

DENOMINATOR:

# of women, men, girls and boys surveyed

HOW TO MEASURE

To measure this indicator, conduct survey with a random sample of community members.

Exact tools should be adapted to local contexts and include locally relevant harmful social norms and attitudes. See questionnaire tools for examples.

MEETING THE STANDARD?

MET	Most (more than 80%) of women, men, girls and boys report that they disagree or strongly disagree with locally relevant harmful social norms (e.g., victim-blaming attitudes, discriminatory attitudes towards survivors).
WORKING TOWARDS	Some (40- 80%) of women, men, girls and boys report that they disagree or strongly disagree with locally relevant harmful social norms (e.g., victim-blaming attitudes, discriminatory attitudes towards survivors).
NOT MET	Few (less than 40%) of women, men, girls and boys report that they disagree or strongly disagree with locally relevant harmful social norms (e.g., victim-blaming attitudes, discriminatory attitudes towards survivors).

SUGGESTED M&E TOOLS

Example questionnaires that can be adapted:

Communities care beliefs questionnaire

DHS Domestic Violence Attitude Questions

Whole of Syria M&E Toolkit – Information Session Tool

13.4 Percentage of community members targeted (disaggregated by sex and age) with social and behavioural change communication (BCC) strategies that demonstrate increased knowledge of GBV and harmful traditional practices

INDICATOR LEVEL
ORGANISATION

DEFINITION

NUMERATOR:

# of community members targeted (disaggregated by sex and age) with social and behavioural change communication strategies that demonstrate increased knowledge of GBV and harmful traditional practices

DENOMINATOR:

# of women, men, girls and boys surveyed

HOW TO MEASURE

To measure this indicator, collect at least two rounds of surveys with a random sample of community members who were targeted for BCC messages.

Social and behaviour change communication uses media messaging, community mobilisation and interpersonal communication to influence the knowledge, attitudes and practices of individuals, families and communities.

Exact tools should be adapted to local contexts and local BCC programming messages.

In general age disaggregation should include:

- Adolescents (10-19)
- Adult women (20-49)
- Older and elderly women (50 +)

SUGGESTED M&E TOOLS

Example questionnaires that can be adapted:

DHS Domestic Violence Knowledge Questions

Community Cares

Whole of Syria M&E Toolkit – Information Session Tool

MEETING THE STANDARD?

MET	Most (more than 70%) of community members targeted with social and behavioural change communication strategies demonstrate increased knowledge of GBV and harmful traditional practices.
WORKING TOWARDS	Some (30- 70%) of community members targeted with social and behavioural change communication strategies demonstrate increased knowledge of GBV and harmful traditional practices. Or anecdotal data suggests that this is improving but no follow-on survey has yet been conducted to document increased knowledge.
NOT MET	Few (less than 30%) of community members targeted with social and behavioural change communication strategies that demonstrate increased knowledge of GBV and harmful traditional practices. Or no surveys have been conducted.

13.5 Culturally and locally appropriate key messages, and information, education and communication materials developed to accompany information on GBV services and social norms

INDICATOR LEVEL
ORGANISATION/
CLUSTER

DEFINITION

Culturally and locally appropriate key messages, and information, education and communication materials (e.g., posters, dramas, radio/tv programmes, WhatsApp messages, etc.) developed to accompany information on GBV services and social norms.

HOW TO MEASURE

To measure this indicator, review programme materials/interview local staff/women and girls to understand the appropriateness of messaging.

MEETING THE STANDARD?

MET	Culturally and locally appropriate key messages, and information, education and communication materials developed to accompany information on GBV services and social norms.
WORKING TOWARDS	Key messages, and information, education and communication materials developed to accompany information on GBV services and social norms but not adapted for the local culture.
NOT MET	No key messages or information, education and communication materials developed.

SUGGESTED M&E TOOLS

No specific M&E tool available

Assessment: MS 13 Are we meeting the standard?

In order to assess your overall progress in meeting this standard, consider your progress on each core indicator. Organization and cluster level progress should be tracked separately. The overall goal is to increase the number of indicators met for each standard over time. Use the following guide to track your progress.

ORGANISATIONAL-LEVEL:

Assess progress on the **core indicators** – consider only indicators that apply to your level (organisation rather than cluster).

# of Indicators **MET** (of 5)	☐
# of Indicators **WORKING TOWARDS** (of 5)	☐
# of Indicators **NOT MET** (of 5)	☐

CLUSTER-LEVEL:

Assess progress on the **core indicators**:

# of Indicators **MET** (of 1)	☐
# of Indicators **WORKING TOWARDS** (of 1)	☐
# of Indicators **NOT MET** (of 1)	☐

ACTION PLANNING:

For areas where your organisation/cluster is not meeting the standard, utilise the **MS Contextualization Tool** to assess your challenges and plan for improvements in order to meet the minimum standards.

Standard 14. Collection and Use of GBV Survivor Data

All survivor data are managed with survivor's full informed consent for the purpose of improving service delivery, and are collected, stored, analysed and shared safely and ethically.

READ THE STANDARD

OUTPUTS

GBV staff have the knowledge and skills to implement safe and ethical practices related to survivor data and internal procedures on data sharing

Data gathering organisations adhere to the GBVIMS Data Protection Checklist

Service provider organizations have internal procedures to regulate how individual-level identifiable data (for referrals) and non-identifiable aggregate-level data can be shared safely and confidentiality

OUTCOMES

GBV information management systems are in place, including an inter-agency information-sharing protocols

OBJECTIVES

Safe and ethical data collection, storage and use reduces the risk of confidentiality breaches and negative consequences for survivors

14.1 Percentage of GBV staff with the knowledge and skills to implement safe and ethical practices related to survivor data and internal procedures on data sharing

INDICATOR LEVEL
ORGANISATION

DEFINITION

NUMERATOR:

# of GBV staff with the knowledge and skills to implement safe and ethical practices related to survivor data and internal procedures on data sharing

DENOMINATOR:

# of GBV staff

HOW TO MEASURE

To measure this indicator, conduct surveys with all GBV staff.

Assessing satisfactory knowledge and skills should include questions on:

- Privacy
- Informed Consent
- Confidentiality
- Data protection (paper and electronic)
- Safe collection and storage of identifiable data
- Safe data sharing

See the GBVIMS website for more details.

SUGGESTED M&E TOOLS

Whole of Syria Sub-Cluster's GBV Case Management Core Competencies Assessment Tool - Knowledge and Skills Test questions I, J, K, M

MEETING THE STANDARD?

MET	All GBV staff have satisfactory knowledge and skills to implement safe and ethical practices related to survivor data and internal procedures on data sharing.
WORKING TOWARDS	Some GBV staff (60-99%) have satisfactory knowledge and skills to implement safe and ethical practices related to survivor data and internal procedures on data sharing.
NOT MET	Few GBV staff (less than 60%) have satisfactory knowledge and skills to implement safe and ethical practices related to survivor data and internal procedures on data sharing.

14.2 Percentage of data gathering organisations (DGOs) that adhere to the GBVIMS Data Protection Checklist

INDICATOR LEVEL
CLUSTER

DEFINITION

NUMERATOR:

# of DGOs that adhere to the GBVIMS Data Protection Checklist

DENOMINATOR:

# of organisations providing GBV response services

HOW TO MEASURE

To measure this indicator, compare practices of organisations using GBVIMS system against GBVIMS Data Protection Checklist. Organisations can self-assess their progress against the checklist. If all are adhered to, then the standard is met.

MEETING THE STANDARD?

MET	All GBV response organisations using GBVIMS adhere to the GBVIMS Data Protection Checklist.
WORKING TOWARDS	Most (75% or more) GBV response organisations using GBVIMS adhere to the GBVIMS Data Protection Checklist.
NOT MET	Few (less than 75%) GBV response organisations using GBVIMS adhere to the GBVIMS Data Protection Checklist.

SUGGESTED M&E TOOLS

GBVIMS Data Protection Checklist

14.3 Percentage of service provider organisations with internal procedures to regulate how individual-level identifiable data (for referrals) and non-identifiable aggregate-level data can be shared safely and confidentiality

INDICATOR LEVEL
CLUSTER

DEFINITION

NUMERATOR:

# of organisations providing GBV response services with internal procedures to regulate how individual-level identifiable data (for referrals) and non-identifiable aggregate-level data can be shared safely and confidentiality

DENOMINATOR:

# of organisations providing GBV response services.

HOW TO MEASURE

To measure this indicator, assess service provider organisations' internal procedures to see if they have internal procedures that regulate how they share individual-level identifiable and non-identifiable aggregate data.

Review documents such as information sharing protocols, operational data guidance, Annex C for UNHCR projects, etc.

Partners should never share identifiable, individualised data outside of the context of referrals and without informed consent, or any data that could compromise the survivor's confidentiality or create safety risks for their communities. GBV programme actors should not be pressured to share data outside of the information-sharing protocol or other interagency protocols, as these protocols are in place to protect survivors' safety and confidentiality and promote survivors' and the wider community's trust in service.

See the GBVIMS website for more details.

SUGGESTED M&E TOOLS

No specific M&E tool available

MEETING THE STANDARD?

MET	All GBV response organisations have internal procedures to regulate how individual-level identifiable data (for referrals) and non-identifiable aggregate-level data can be shared safely and confidentiality.
WORKING TOWARDS	Most (75% or more) GBV response organisations have internal procedures to regulate how individual-level identifiable data (for referrals) and non-identifiable aggregate-level data can be shared safely and confidentiality.
NOT MET	Few (less than 75%) of GBV response organisations have internal procedures to regulate how individual-level identifiable data (for referrals) and non-identifiable aggregate-level data can be shared safely and confidentiality.

14.4 GBV information management systems (GBVIMS) in place, including an inter-agency information-sharing protocol

INDICATOR LEVEL
CLUSTER

DEFINITION

A harmonized GBV case management information system (e.g., GBVIMS) is set up and in use by GBV response agencies.

Interagency information sharing protocols are in place and being utilised by all actors.

HOW TO MEASURE

To measure this indicator, assess if the GBVIMS (or another harmonized GBV case management information system with ethical and safety standards) is in place and being utilised by all GBV response agencies that have the capacity to employ the system and inter-agency information sharing protocols are agreed to by all participants in the system.

See the GBVIMS website for more details

SUGGESTED M&E TOOLS

No specific M&E tool available

MEETING THE STANDARD?

MET	A harmonized GBV case management information management system is in place, including inter-agency information-sharing protocols, and being utilised by all relevant GBV response agencies.
WORKING TOWARDS	A harmonized GBV case management information management system, including inter-agency information-sharing protocols, is in place and being utilised by some (50% or more) relevant GBV response agencies.
NOT MET	A harmonized GBV case management information management system, including inter-agency information-sharing protocols, is in place and being utilised by a few (less than 50%) relevant GBV response agencies. Or no system is in place.

Assessment: MS 14 Are we meeting the standard?

In order to assess your overall progress in meeting this standard, consider your progress on each core indicator. Organization and cluster level progress should be tracked separately. The overall goal is to increase the number of indicators met for each standard over time. Use the following guide to track your progress.

ORGANISATIONAL-LEVEL:

Assess progress on the **core indicators** – consider only indicators that apply to your level (organisation rather than cluster).

# of Indicators **MET** (of 1)	☐
# of Indicators **WORKING TOWARDS** (of 1)	☐
# of Indicators **NOT MET** (of 1)	☐

CLUSTER-LEVEL:

Assess progress on the **core indicators**:

# of Indicators **MET** (of 3)	☐
# of Indicators **WORKING TOWARDS** (of 3)	☐
# of Indicators **NOT MET** (of 3)	☐

ACTION PLANNING:

For areas where your organisation/cluster is not meeting the standard, utilise the **MS Contextualization Tool** to assess your challenges and plan for improvements in order to meet the minimum standards.

Standard 15: GBV Coordination

Coordination results in timely, concrete action to mitigate risks, and prevent and respond to GBV.

READ THE STANDARD

OUTPUTS

Multisectoral assessments include questions relevant to GBV service provision, while avoiding questions regarding GBV incidents or prevalence

GBV sub-cluster / sector strategy developed and workplan in place

OUTCOMES

Humanitarian Response Plans and Refugee Response Plans include: (1) GBV risk mitigation, (2) GBV-specialised programming, including response services, and (3) protection from sexual exploitation and abuse

Referral system in place and regularly updated, and service mapping and GBV SOPs established

OBJECTIVES

Effective coordination improves action and accountability to prevent and respond to GBV at all levels of the response

15.1 All multisectoral assessments include questions relevant to GBV service provision (e.g., understanding existing community resources and capacities, gaps in service provision, preferences of women and girls for locations and types of services), while avoiding questions regarding GBV incidents or prevalence

INDICATOR LEVEL
CLUSTER

DEFINITION

All multisectoral assessments include questions relevant to GBV service provision (e.g., understanding existing community resources and capacities, gaps in service provision, preferences of women and girls for locations and types of services), while avoiding questions regarding GBV incidents (where survivors report about individual cases) or prevalence (the rate and frequency of GBV in a given population).

HOW TO MEASURE

To measure this indicator, review the assessment tools to see if they include questions relevant to GBV service provision and do not include questions regarding GBV incidents or prevalence.

MEETING THE STANDARD?

MET	All multisectoral assessments include questions relevant to GBV service provision while avoiding questions regarding GBV incidents or prevalence.
WORKING TOWARDS	Some multisector assessments do not include questions relevant to GBV service provision or ask questions about incidence or prevalence.
NOT MET	Some multisector assessments do not include questions relevant to GBV service provision and ask questions about incidence or prevalence.

SUGGESTED M&E TOOLS

No specific M&E tool available

15.2 Referral system in place and regularly updated, and service mapping and GBV SOPs established

INDICATOR LEVEL
CLUSTER

DEFINITION

Referral pathways at relevant geographical levels (e.g., national, sub-national, etc.) including psychosocial support, health, legal and protection exist and are updated every 6 months. Updated lists of available services and locations/contact details exist. Standard operating procedures established.

HOW TO MEASURE

To measure this indicator, review the assessment tools to see if they include questions relevant to GBV service provision and do not include questions regarding GBV incidents or prevalence.

MEETING THE STANDARD?

MET	Referral pathway exists and is updated at least every 6 months. SOPs and service mapping are established.
WORKING TOWARDS	Referral pathways, SOPS and/or service mapping exists but is not updated/current.
NOT MET	Referral pathway, SOPs or service mapping not completed.

SUGGESTED M&E TOOLS

Interagency Case Management Guideline's Service Gap Analysis and Planning Tool

15.2 GBV subcluster/ sector strategy developed and workplan in place

INDICATOR LEVEL
CLUSTER

DEFINITION

GBV subcluster/ sector strategy has been developed and a workplan in place.

HOW TO MEASURE

To measure this indicator, assess if the strategy and workplan have been developed.

MEETING THE STANDARD?

MET	GBV subcluster/ sector strategy developed and workplan in place.
WORKING TOWARDS	GBV subcluster/ sector strategy and workplan under development.
NOT MET	GBV subcluster/ sector strategy and workplan not developed.

SUGGESTED M&E TOOLS

No specific M&E tool available

15.2 All Humanitarian Response Plans and Refugee Response Plans include: (1) GBV risk mitigation, (2) GBV-specialised programming, including response services, and (3) protection from sexual exploitation and abuse

INDICATOR LEVEL
CLUSTER

DEFINITION

All Humanitarian Response Plans and Refugee Response Plans include details on:

- GBV risk mitigation
- GBV-specialised programming, including response services, and
- protection from sexual exploitation and abuse

HOW TO MEASURE

To measure this indicator, examine HRPs and RRPs to see if there are objectives/activities/sections that cover each aspect (mitigation, specialised programming and protection from sexual exploitation and abuse).

MEETING THE STANDARD?

MET	Plans include objectives, activities and/ or sections that cover each aspect (risk mitigation, specialised programming and protection from sexual exploitation and abuse) of the standard.
WORKING TOWARDS	Plans include objectives, activities and/ or sections that cover some aspects (risk mitigation, specialised programming and protection from sexual exploitation and abuse) but not all of the standard.
NOT MET	None of these aspects (risk mitigation, specialised programming and protection from sexual exploitation and abuse) of the standard are included in HRPs or RRPs.

SUGGESTED M&E TOOLS

To assess the inclusion of risk mitigation see MS 9.2 and the associated Assessment Rubric.

Assessment: MS 15 Are we meeting the standard?

In order to assess your overall progress in meeting this standard, consider your progress on each core indicator. Organization and cluster level progress should be tracked separately. The overall goal is to increase the number of indicators met for each standard over time. Use the following guide to track your progress.

CLUSTER-LEVEL:

Assess progress on the **core indicators**:

# of Indicators **MET** (of 4)	
# of Indicators **WORKING TOWARDS** (of 4)	
# of Indicators **NOT MET** (of 4)	

ACTION PLANNING:

For areas where your organisation/cluster is not meeting the standard, utilise the **MS Contextualization Tool** to assess your challenges and plan for improvements in order to meet the minimum standards.

Standard 16. Assessment, Monitoring and Evaluation

All GBV data is collected in a manner that meets all ethical and safety recommendations and, where possible, is based on participatory approaches.

READ THE STANDARD

OUTPUTS

Staff involved in data collection are trained on the Ethical and Safety Recommendations for Researching, Documenting and Monitoring Sexual Violence in Emergencies and on participatory approaches

Women make up 70% of GBV-related assessment teams

At least one post-assessment participatory consultation is held with women and girls

OUTCOMES

WHO ethical and safety recommendations are met in all routine data collection (as measured against an agreed checklist)

GBV programmes are based on evidence-based theory and/or data informs programming in the programme design

GBV programmes hold regular M&E meetings to review data and make programming decisions based on collected information

Relevant M&E data is shared back with community stakeholders

OBJECTIVES

Data on GBV is collected, shared, stored, and analysed safely and ethically in consultation with GBV and gender experts, and supports humanitarian planning, programming, and funding decisions.

16.1 All staff involved in data collection are trained on the Ethical and Safety Recommendations for Researching, Documenting and Monitoring Sexual Violence in Emergencies and on participatory approaches

INDICATOR LEVEL
ORGANISATION

DEFINITION

NUMERATOR:

# of staff trained on the Ethical and Safety Recommendations for Researching, Documenting and Monitoring Sexual Violence in Emergencies and on participatory approaches

DENOMINATOR:

# of staff involved in data collection

HOW TO MEASURE

To measure this indicator, use a training log to track the number of staff trained compared to the staff participating in data collection.

This information can be bolstered by administering pre and post training tests to ensure that GBV staff who have been trained meet a minimum level of quality.

SUGGESTED M&E TOOLS

Sample Training Log

MEETING THE STANDARD?

MET	All staff involved in data collection are trained on the Ethical and Safety Recommendations for Researching, Documenting and Monitoring Sexual Violence in Emergencies and on participatory approaches.
WORKING TOWARDS	Some (60-99%) staff involved in data collection are trained on the Ethical and Safety Recommendations for Researching, Documenting and Monitoring Sexual Violence in Emergencies and on participatory approaches. Or all staff have been trained either on the ethical standards or participatory approaches but not both.
NOT MET	Few (less than 60%) staff involved in data collection are trained on the Ethical and Safety Recommendations for Researching, Documenting and Monitoring Sexual Violence in Emergencies and on participatory approaches.

16.2 WHO ethical and safety recommendations are met in all routine data collection (as measured against an agreed checklist)

INDICATOR LEVEL
ORGANISATION

DEFINITION

NUMERATOR:

# of recommendations adhered to

DENOMINATOR:

8 recommendations

HOW TO MEASURE

To measure this indicator, compare the WHO Ethical and Safety Recommendations for Researching, Documenting and Monitoring Sexual Violence in Emergencies to the research practices employed to determine if all are met.

SUGGESTED M&E TOOLS

Checklist of WHO recommendations

MEETING THE STANDARD?

MET	All recommendations from the Ethical and Safety Recommendations for Researching, Documenting and Monitoring Sexual Violence in Emergencies adhered to.
WORKING TOWARDS	Some recommendations were adhered to but there were some deficiencies in implementation (e.g., lost documents, minor breaches of privacy that are being rectified, etc.).
NOT MET	Major deficiencies in the application of the recommendations (e.g., women are asked about experiences of GBV but not referred to services, major breaches of confidentiality, poor methods that don't answer the research question, risks outweigh the benefits of data collection, etc.).

16.3 Women make up 70 per cent of GBV-related assessment teams

INDICATOR LEVEL
INDICATOR LEVEL ORGANISATION/ CLUSTER

DEFINITION

NUMERATOR:

# of women on GBV-related assessment teams

DENOMINATOR:

# of people on GBV-related assessment teams

HOW TO MEASURE

To measure this indicator, use a tracking sheet to document the members of the assessment teams and their sex.

MEETING THE STANDARD?

MET	Women make up 70% or more of GBV-related assessment teams.
WORKING TOWARDS	Women make up 50- 69% of GBV-related assessment teams
NOT MET	Women make up less than 50% of GBV-related assessment teams

SUGGESTED M&E TOOLS

Sample Tracking Sheet

16.4 At least one post-assessment participatory consultation with women and girls to share results and strategize on improvements to interventions is included in every assessment plan and budget

INDICATOR LEVEL
ORGANISATION/
CLUSTER

DEFINITION

After an assessment is completed, at least one consultation with women and girls to share results and strategize planned, budgeted and conducted.

HOW TO MEASURE

To measure this indicator, examine the assessment planning documents to see if at least one post- assessment participatory consultation is scheduled, budgeted and conducted.

This indicator measures how assessment findings are shared back with women and girls, and whether they are included in decision-making based on those findings. To avoid meeting/ assessment fatigue, in a context with many assessments it is not necessary to schedule a consultation or debriefing for each: the results of several assessments can be shared back at once and women and girls can be involved in making connections between them.

While this is an important accountability practice for all actors, in more established contexts, the GBV sub-cluster or working group may decide to focus this indicator only at cluster-level (rather than individual organisation-level) and can modify their reporting accordingly.

SUGGESTED M&E TOOLS

No specific M&E tool available.

MEETING THE STANDARD?

MET	At least one post-assessment participatory consultation with women and girls to share results and strategize on improvements to interventions is planned, budgeted for and conducted as relevant
WORKING TOWARDS	Some kind of debrief with women and girls is held but not a formal consultation due to lack of time, budget, etc.
NOT MET	No attempt of post-assessment consultation with women and girls is made

R16.5 Percentage of GBV programmes that cite evidence-based theory and/or data that informs programme design

INDICATOR LEVEL
ORGANISATION

DEFINITION

NUMERATOR:

# of GBV programmes that cite evidence-based theory and/or data in the programme design

DENOMINATOR:

# of GBV programmes implemented

HOW TO MEASURE

To measure this indicator, examine programme documents and see if there are citations of theory (e.g., behaviour change theory) or data (e.g., results of previous evaluations) that informs programming design.

AVAILABLE M&E TOOLS

No specific M&E tool available.

R16.6 Percentage of GBV programmes that hold regular M&E meetings to review data, regularly share data back with community stakeholders and make programming decisions based on collected information

INDICATOR LEVEL
ORGANISATION

DEFINITION

NUMERATOR:

# of GBV programmes that hold regular M&E meetings to review M&E data, share data back with community stakeholders and whose staff report that programme decisions are made based on collected information

DENOMINATOR:

# of GBV programmes

HOW TO MEASURE

To measure this indicator, review notes or minutes/ discussions with staff to know if monthly M&E meetings are held and if data is shared back with community stakeholders. Conduct interviews with staff to determine how data are utilised to inform programming.

AVAILABLE M&E TOOLS

No specific M&E tool available.

Assessment: MS 16 Are we meeting the standard?

In order to assess your overall progress in meeting this standard, consider your progress on each core indicator. Organization and cluster level progress should be tracked separately. The overall goal is to increase the number of indicators met for each standard over time. Use the following guide to track your progress.

ORGANISATIONAL-LEVEL: Assess progress on the **core indicators** – consider only indicators that apply to your level (organisation rather than cluster).	# of Indicators **MET** (of 4) ☐
	# of Indicators **WORKING TOWARDS** (of 4) ☐
	# of Indicators **NOT MET** (of 4) ☐

CLUSTER-LEVEL: Assess progress on the **core indicators**:	# of Indicators **MET** (of 2) ☐
	# of Indicators **WORKING TOWARDS** (of 2) ☐
	# of Indicators **NOT MET** (of 2) ☐

ACTION PLANNING:

For areas where your organisation/cluster is not meeting the standard, utilise the **MS Contextualization Tool** to assess your challenges and plan for improvements in order to meet the minimum standards.