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.
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.
  
  - **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.

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**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 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

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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

<table>
<thead>
<tr>
<th>MS 1: Guiding Principles</th>
<th>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</th>
</tr>
</thead>
<tbody>
<tr>
<td>MS 2: Women’s and Girls’ Participation and Empowerment</td>
<td>Humanitarian programming is led by and meets the needs of women and girls affected by crisis</td>
</tr>
<tr>
<td>MS 3: Staff Care and Support</td>
<td>Trained and supported GBV staff are better equipped to support the needs of women and girls</td>
</tr>
<tr>
<td>MS 4: Health Care for GBV Survivors</td>
<td>Health needs of survivors are met</td>
</tr>
<tr>
<td>MS 5: Psychosocial Support</td>
<td>Psychosocial needs of survivors are met</td>
</tr>
<tr>
<td>MS 6: GBV Case Management</td>
<td>Survivors feel supported and are able to heal after an incident of violence</td>
</tr>
<tr>
<td>MS 7: Referral Systems</td>
<td>Survivors access needed support services, in accordance with their needs and preferences, after an incident of violence</td>
</tr>
<tr>
<td>MS 8: Women’s and Girls’ Safe Spaces</td>
<td>Women and girls are able to heal, improve their wellbeing and are empowered</td>
</tr>
</tbody>
</table>

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

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

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The Inter-Agency Minimum Standards for Gender-based Violence in Emergencies Programming: Monitoring and Evaluation Framework
| 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](image-url)
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

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.

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3 Adapted from: gbvims.com/data-protection

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
**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**

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.

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

The Inter-Agency Minimum Standards for Gender-based Violence in Emergencies Programming: Monitoring and Evaluation Framework
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](image)

![cluster](image)

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

<table>
<thead>
<tr>
<th>NARRATIVE</th>
<th>COUNTS</th>
<th>PERCENTAGE</th>
<th>PERCENTAGE CHANGE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CALCULATION</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NONE</td>
<td>NUMERATOR</td>
<td>(NUMERATOR / DENOMINATOR) * 100</td>
<td>((PERCENTAGE AT ENDLINE – PERCENTAGE AT BASELINE) / PERCENTAGE AT BASELINE) * 100</td>
</tr>
</tbody>
</table>

**EXAMPLES**

<table>
<thead>
<tr>
<th>Organisation level</th>
<th>Cluster level</th>
<th>Both</th>
</tr>
</thead>
</table>

**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.

**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.

**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

**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

**HOWN 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
**STANDARD 1. GBV GUIDING PRINCIPLES**

**CORE INDICATORS**

### 1.3 Percentage of referrals that include documentation of survivors’ informed consent

**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.

**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.

**SUGGESTED M&E TOOLS**

GBVIMS Incident Recorder

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The Inter-Agency Minimum Standards for Gender-based Violence in Emergencies: Monitoring and Evaluation Framework

20
**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

**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

**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](#).

---

The Inter-Agency Minimum Standards for Gender-based Violence in Emergencies: Monitoring and Evaluation Framework
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).

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**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.

<table>
<thead>
<tr>
<th>OUTPUTS</th>
<th>OUTCOMES</th>
<th>OBJECTIVES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women and girls have spaces to meaningfully participate in humanitarian action</td>
<td>Women and girls from affected communities are involved in GBV programme design and implementation</td>
<td>Humanitarian programming is led by and meets the needs of women and girls affected by crisis</td>
</tr>
<tr>
<td>HNOs are based on gender analysis and sex- and age-disaggregated data</td>
<td>Women and girls from affected communities are in leadership positions within humanitarian programming</td>
<td></td>
</tr>
<tr>
<td>Inputs from local women’s organisations are integrated into HNOs &amp; HRPs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Women-led organisations are active members of GBV coordination mechanisms and receive direct funding from country-based pooled funds</td>
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</table>
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.

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

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

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

**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

**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)

**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

**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:

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<th># of Indicators MET (of 5)</th>
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<tr>
<th># of Indicators WORKING TOWARDS (of 5)</th>
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<th># of Indicators NOT MET (of 5)</th>
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**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.

**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 well-being prioritised when engaging in GBV service delivery

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

The Inter-Agency Minimum Standards for Gender-based Violence in Emergencies: Monitoring and Evaluation Framework
### STANDARD 3. STAFF CARE AND SUPPORT

#### CORE INDICATORS

**STANDARD 3. STAFF CARE AND SUPPORT**

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

**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.

**MEETING THE STANDARD?**

<table>
<thead>
<tr>
<th>MET</th>
<th>WORKING TOWARDS</th>
<th>NOT MET</th>
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<tbody>
<tr>
<td>All GBV programme job profiles are fully aligned with the GBV Core Competency framework.</td>
<td>Some (~ 50-99%) of GBV programme job profiles are fully aligned with the GBV Core Competency framework.</td>
<td>Few (~ less than 50%) of GBV programme job profiles are fully aligned with the GBV Core Competency framework.</td>
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**SUGGESTED M&E TOOLS**

- Competency Checklist
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

**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.

**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.

**SUGGESTED M&E TOOLS**

No specific M&E tool available.
**3.3.** All GBV programmes have an actionable plan in place and associated budget to protect and promote staff safety and well-being

**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.

**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.

**SUGGESTED M&E TOOLS**

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

**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.

**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.

**SUGGESTED M&E TOOLS**

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

**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

**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

**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).

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<th># of Indicators NOT MET (of 4)</th>
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**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.
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.

**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
### Standard 4. Health Care for GBV Survivors

#### 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 standard of care at health facilities. Items marked with an asterisk 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.

#### Meeting the Standard?

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<tr>
<th>MEETING THE STANDARD?</th>
<th>DEFINITION</th>
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<tbody>
<tr>
<td><strong>MET</strong></td>
<td>All health facilities met the minimum requirements (items marked with an asterisk) on the WHO checklist.</td>
</tr>
<tr>
<td><strong>Working Towards</strong></td>
<td>Most (50% or more) of health facilities met the minimum requirements (items marked with an asterisk) on the WHO checklist.</td>
</tr>
<tr>
<td><strong>Not Met</strong></td>
<td>Few (less than 50%) of health facilities met the minimum requirements (items marked with an asterisk) on the WHO checklist.</td>
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**Suggested M&E Tools**

WHO Checklist for Quality Clinical Care for Survivors of Rape and IPV
4.2 MISP implemented within 2 weeks of crisis onset

**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.

**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.

**SUGGESTED M&E TOOLS**

MISP Checklist - 3.1 to 3.5
4.3 Health care actors integrated in (emergency) GBV standard operating procedures and included in the referral pathway

**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.

**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.

**SUGGESTED M&E TOOLS**

No specific M&E tool available.
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

**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**

**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.

**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.

**Suggested M&E Tools**

No specific M&E tool available - review of medical records.
**STANDARD 4. HEALTH CARE FOR GBV SURVIVORS**

**ADDITIONAL RECOMMENDED INDICATORS**

**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

**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).

**CLUSTER-LEVEL:**
Assess progress on the **core indicators**:

**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.

**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
- Women and girls who access PSS services think these services were delivered in accordance with their needs and preferences

**OBJECTIVES**

- Psychosocial needs of survivors are met
Context-specific psychosocial support services focused on the needs of women and girls established within 2 weeks of the onset of a crisis.

**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.

**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.
STANDARD 5. PSYCHOSOCIAL SUPPORT

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

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.*
**Core Indicators**

**Standard 5. Psychosocial Support**

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

**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.

**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.

Suggested M&E Tools:

- PSS Satisfaction Survey
**CORE INDICATORS**

**STANDARD 5. PSYCHOSOCIAL SUPPORT**

**DEFINITION**

**NUMERATOR:**

# of women and girls who report the focused psychosocial support they received was delivered in accordance with their needs and preferences (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.

---

The Inter-Agency Minimum Standards for Gender-based Violence in Emergencies: Monitoring and Evaluation Framework 53
STANDARD 5. PSYCHOSOCIAL SUPPORT

ADDITIONAL RECOMMENDED INDICATORS

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

**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

**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

**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).

<table>
<thead>
<tr>
<th># of Indicators</th>
<th>MET (of 3)</th>
<th>WORKING TOWARDS (of 3)</th>
<th>NOT MET (of 3)</th>
</tr>
</thead>
<tbody>
<tr>
<td># MET</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td># WORKING</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td># NOT MET</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

### CLUSTER-LEVEL:

Assess progress on the core indicators:

<table>
<thead>
<tr>
<th># of Indicators</th>
<th>MET (of 1)</th>
<th>WORKING TOWARDS (of 1)</th>
<th>NOT MET (of 1)</th>
</tr>
</thead>
<tbody>
<tr>
<td># MET</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td># WORKING</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td># NOT MET</td>
<td>[ ]</td>
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</tbody>
</table>

### 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.

<table>
<thead>
<tr>
<th>OUTPUTS</th>
<th>OUTCOMES</th>
<th>OBJECTIVES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff have appropriate attitudes, knowledge and skills to appropriately support survivors</td>
<td>Case management services meet expected quality</td>
<td>Survivors feel supported and are able to heal after an incident of violence</td>
</tr>
<tr>
<td>GBV case managers have a manageable number of active cases</td>
<td>Women and girl who access case management services have improved PS functioning, reduced felt stigma and maintain or improve their coping capacity</td>
<td></td>
</tr>
<tr>
<td>GBV supervisors have a manageable number of caseworkers to manage</td>
<td>Accessible case management services in place in all targeted locations</td>
<td></td>
</tr>
<tr>
<td>Women and girl who access case management services are satisfied with their quality</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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

**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

**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

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

**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.

**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.

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

### 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

### 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

**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*

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

**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

**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).

<table>
<thead>
<tr>
<th># of Indicators</th>
<th>MET (of 4)</th>
<th>WORKING TOWARDS (of 4)</th>
<th>NOT MET (of 4)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

**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.

<table>
<thead>
<tr>
<th>OUTPUTS</th>
<th>OUTCOMES</th>
<th>OBJECTIVES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referral pathways in place and regularly updated, and service mapping and standard operating procedures established</td>
<td>Survivors who report are referred to health, psychosocial, case management, legal or any other service based on their needs within the recommended timeframe</td>
<td>Survivors access needed support services, in accordance with their needs and preferences, after an incident of violence</td>
</tr>
<tr>
<td>Capacity of service providers is assessed to improve quality of service delivery and strengthen referral systems</td>
<td>All targeted locations have updated and functional referral pathways to support survivors needs</td>
<td></td>
</tr>
<tr>
<td>Standard GBV consent and intake forms are adapted and utilised by service providers within the GBV information management system, if available</td>
<td>Service providers in the referral pathway meet minimum quality standards and are able to provide quality support to survivors</td>
<td></td>
</tr>
<tr>
<td>Women and girl who access referral pathway services are satisfied with their quality</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-specialist GBV staff know who to refer cases to</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**STANDARD 7. REFERRAL SYSTEMS**

**CORE INDICATORS**

**STANDARD 7. REFERRAL SYSTEMS**

### REFERRAL PATHWAYS IN PLACE AND REGULARLY UPDATED, AND SERVICE MAPPING AND STANDARD OPERATING PROCEDURES ESTABLISHED

**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.

**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

**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 one 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
The Inter-Agency Minimum Standards for Gender-based Violence in Emergencies: Monitoring and Evaluation Framework

### STANDARD 7. REFERRAL SYSTEMS

#### CORE INDICATORS

#### STANDARD 7. REFERRAL SYSTEMS

**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](#)
Standard GBV consent and intake forms are adapted and utilised by service providers within the GBV information management system, if available.

**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 GBVIMS website for forms and support.
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

**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.

**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.

**SUGGESTED M&E TOOLS**

See the [GBV IMS](https://www.gbvims.org/) website for forms and support.
### 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

**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

**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

**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).

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<th># of Indicators MET (of 2)</th>
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<th># of Indicators WORKING TOWARDS (of 2)</th>
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<th># of Indicators NOT MET (of 2)</th>
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</table>

**CLUSTER-LEVEL:**
Assess progress on the core indicators:

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<tr>
<th># of Indicators MET (of 3)</th>
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<th># of Indicators NOT MET (of 3)</th>
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</table>

**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.

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

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

READ THE STANDARD
### STANDARD 8. WOMEN’S AND GIRLS’ SAFE SPACES

#### CORE INDICATORS

<table>
<thead>
<tr>
<th>8.1</th>
<th>Number and percentage of women and girls consulted to inform WGSS development, disaggregated by age, disability, etc.</th>
</tr>
</thead>
</table>

#### DEFINITION

**NUMERATOR:**

# of women and girls consulted to inform WGSS development

**DENOMINATOR:**

# women and girls in the community

#### 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.

#### MEETING THE STANDARD?

<table>
<thead>
<tr>
<th>MET</th>
<th>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.</th>
</tr>
</thead>
<tbody>
<tr>
<td>WORKING TOWARDS</td>
<td>Women and girls were consulted when developing WGSS, but they were not from diverse backgrounds.</td>
</tr>
<tr>
<td>NOT MET</td>
<td>Women and girls were not consulted when developing WGSS.</td>
</tr>
</tbody>
</table>

#### SUGGESTED M&E TOOLS

No specific M&E tool available.
**Standard 8. Women’s and Girls’ Safe Spaces**

**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

**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.
### STANDARD 8. WOMEN’S AND GIRLS’ SAFE SPACES

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

#### 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

**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

**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)
Women and girls report feeling safe while at WGSS

**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.

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<tr>
<th>CLUSTER-LEVEL:</th>
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<tr>
<td>No cluster level indicators for MS 8.</td>
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<tr>
<th>ACTION PLANNING:</th>
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<td>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.</td>
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</table>
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.

<table>
<thead>
<tr>
<th>OUTPUTS</th>
<th>OUTCOMES</th>
<th>OBJECTIVES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Active clusters / sectors have a GBV focal point</td>
<td>Community members have increased knowledge of how to seek services / support</td>
<td>Women and girls are safer and less likely to experience GBV</td>
</tr>
<tr>
<td>Humanitarian response plans and refugee response plans include GBV risk mitigation interventions</td>
<td>Humanitarian staff have increased knowledge of GBV risks and how to mitigate them</td>
<td></td>
</tr>
<tr>
<td>Safety audits conducted and tracked</td>
<td>Risks identified in safety audits addressed</td>
<td></td>
</tr>
<tr>
<td>Humanitarian organisations and service providers have in place community-based feedback and complaint mechanisms</td>
<td>Women and girls report feeling safe in their communities, in their homes and when accessing goods and services</td>
<td></td>
</tr>
<tr>
<td>Clusters/sectors receive technical support on GBV prevention and risk mitigation from the GBV coordination mechanism</td>
<td>Women and girls participating in programmes report increased ability to make decisions about their safety</td>
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</tr>
<tr>
<td></td>
<td>Women and girls participating in programmes report increased ability to make decisions about their safety</td>
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</tbody>
</table>
Standard 9. Safety and Risk Mitigation

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

**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) a GBV specialist who attends other sectoral meetings as a focal person.

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

**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.

**Suggested M&E Tools**

No specific M&E tool available.
**STANDARD 9. SAFETY AND RISK MITIGATION**

**CORE INDICATORS**

**STANDARD 9. SAFETY AND RISK MITIGATION**

**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.
**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.
**CORE INDICATORS**

**STANDARD 9. SAFETY AND RISK MITIGATION**

**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.

---

**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.

---

**MEETING THE STANDARD?**

**MET**

More than 80% of community members increase their knowledge on 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 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 how to seek services/support and less than 60% of humanitarian staff increase their knowledge about GBV risks and how to mitigate them.

---

The Inter-Agency Minimum Standards for Gender-based Violence in Emergencies: Monitoring and Evaluation Framework
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.

**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 (CBCMs) 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.
R9.6 Percentage of safety audit/sectoral actions points achieved

**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

**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

**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

**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

**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

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The Inter-Agency Minimum Standards for Gender-based Violence in Emergencies: Monitoring and Evaluation Framework
### 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.

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<tr>
<th>ORGANISATIONAL-LEVEL:</th>
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<th># of Indicators WORKING TOWARDS (of 3)</th>
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<tbody>
<tr>
<td>Assess progress on the <strong>core indicators</strong> – consider only indicators that apply to your level (organisation rather than cluster).</td>
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<th># of Indicators NOT MET (of 3)</th>
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</thead>
<tbody>
<tr>
<td>Assess progress on the <strong>core indicators</strong>:</td>
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</table>

#### 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.

**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 girls 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

**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
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.

**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.”)

**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

**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

**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).

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**CLUSTER-LEVEL:**
Assess progress on the **core indicators**:

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**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.

**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.
### STANDARD 11. DIGNITY KIT, CASH AND VOUCHER ASSISTANCE

#### CORE INDICATORS

**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

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

**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)

### 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.

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The Inter-Agency Minimum Standards for Gender-based Violence in Emergencies: Monitoring and Evaluation Framework
**STANDARD 11. DIGNITY KIT, CASH AND VOUCHER ASSISTANCE**

**CORE INDICATORS**

**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**

### STANDARD 11. DIGNITY KIT, CASH AND VOUCHER ASSISTANCE

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

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<th><strong>DEFINITION</strong></th>
<th><strong>HOW TO MEASURE</strong></th>
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<tr>
<td><strong>NUMERATOR:</strong></td>
<td>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.).</td>
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See [CalP website](http://example.com), [IRC’s Safer Cash Toolkit](http://example.com), [Cash & Voucher Assistance and Gender-Based Violence Compendium: Practical Guidance for Humanitarian Practitioners](http://example.com) for support conducting needs assessment and considering CVA and GBV.

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<tr>
<th><strong>MET</strong></th>
<th>Assessment of women and girls’ specific needs conducted to inform CVA.</th>
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<td><strong>WORKING TOWARDS</strong></td>
<td>Assessment of women and girls’ specific needs ongoing to inform CVA.</td>
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<tr>
<td><strong>NOT MET</strong></td>
<td>Assessment of women and girls’ specific needs not undertaken to inform CVA.</td>
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<th><strong>SUGGESTED M&amp;E TOOLS</strong></th>
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STANDARD 11. DIGNITY KIT, CASH AND VOUCHER ASSISTANCE

CORE INDICATORS

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

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

**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+)

**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.

**SUGGESTED M&E TOOLS**
No specific M&E tool available.
**R11.6** Assessment of women’s and girls’ specific needs conducted to inform DK distributions

**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

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

**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

**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

**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

**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: \(
\frac{\text{# of women and girls who received CVA who report improved ability to provide for HH needs after receiving CVA}}{\text{# of women and girls who received CVA}} \times 100
\)

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).

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**CLUSTER-LEVEL:**
Assess progress on the core indicators:

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**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.

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

**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.
**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 of 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.

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The Inter-Agency Minimum Standards for Gender-based Violence in Emergencies: Monitoring and Evaluation Framework

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### 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

#### 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.

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

**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.

The Inter-Agency Minimum Standards for Gender-based Violence in Emergencies: Monitoring and Evaluation Framework
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

**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

**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

**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:**

# of 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).

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**CLUSTER-LEVEL:**
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**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.

<table>
<thead>
<tr>
<th><strong>OUTPUTS</strong></th>
<th><strong>OUTCOMES</strong></th>
<th><strong>OBJECTIVES</strong></th>
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<tbody>
<tr>
<td>Programmes focused on male engagement include explicit mechanisms for accountability to women and girls</td>
<td>Increasing women, men, girls and boys who disagree or strongly disagree with locally relevant harmful social norms</td>
<td>Reduced harmful social norms and improved gender equality</td>
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<td>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</td>
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<tr>
<td>Culturally and locally appropriate key messages, and information, education and communication materials developed to accompany information on GBV services and social norms</td>
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The Inter-Agency Minimum Standards for Gender-based Violence in Emergencies: Monitoring and Evaluation Framework
Programmes focused on male engagement include explicit mechanisms for accountability to women and girls

**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.

**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.

Suggested M&E Tools

No specific M&E tool available.
**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.

**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.

**SUGGESTED M&E TOOLS**

No specific M&E tool available.
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)

**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
### Standard 13. Transforming Systems and Social Norms

#### Core Indicators

**Standard 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

**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.
**STANDARD 13. TRANSFORMING SYSTEMS AND SOCIAL NORMS**

**CORE INDICATORS**

**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.

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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.

**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
**STANDARD 14. COLLECTION AND USE OF GBV SURVIVOR DATA**

**CORE INDICATORS**

**STANDARD 14. COLLECTION AND USE OF GBV SURVIVOR DATA**

**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](https://gbvims.org) for more details.

**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.

**SUGGESTED M&E TOOLS**

Whole of Syria Sub-Cluster’s [GBV Case Management Core Competencies Assessment Tool](https://www.unwomen.org/en/capacity-development/assessment-tools/)
- Knowledge and Skills Test questions I, J, K, M
14.2 Percentage of data gathering organisations (DGOs) that adhere to the GBVIMS Data Protection Checklist

**DEFINITION**

**NUMERATOR:**
Number of DGOs that adhere to the GBVIMS Data Protection Checklist

**DENOMINATOR:**
Number 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.

**SUGGESTED M&E TOOLS**
GBVIMS Data Protection Checklist

**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.
The Inter-Agency Minimum Standards for Gender-based Violence in Emergencies: Monitoring and Evaluation Framework

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.

**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

**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](http://gbvims.org) for more details.

**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.

**SUGGESTED M&E TOOLS**

No specific M&E tool available.
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.

**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

**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
**STANDARD 15. GBV COORDINATION**

**CORE INDICATORS**

15.1

**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 or prevalence.

**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.

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

**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
**STANDARD 15. GBV COORDINATION**

**CORE INDICATORS**

### 15.2 GBV subcluster/ sector strategy developed and workplan in place

**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

**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**:

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<tr>
<td># of Indicators WORKING TOWARDS (of 4)</td>
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<tr>
<td># of Indicators NOT MET (of 4)</td>
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**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.
All GBV data is collected in a manner that meets all ethical and safety recommendations and, where possible, is based on participatory approaches.

### Standard 16. Assessment, Monitoring and Evaluation

**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.
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.

**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.

**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)

**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.

**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.).
The Inter-Agency Minimum Standards for Gender-based Violence in Emergencies: Monitoring and Evaluation Framework

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

**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
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.

**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 organization-level) and can modify their reporting accordingly.

**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

The Inter-Agency Minimum Standards for Gender-based Violence in Emergencies: Monitoring and Evaluation Framework
### ADDITIONAL RECOMMENDED INDICATORS

#### STANDARD 16. ASSESSMENT, MONITORING AND EVALUATION

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

**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

**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.

<table>
<thead>
<tr>
<th>ORGANISATIONAL-LEVEL:</th>
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<tbody>
<tr>
<td>Assess progress on the <strong>core indicators</strong> – consider only indicators that apply to your level (organisation rather than cluster).</td>
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<table>
<thead>
<tr>
<th></th>
<th># of Indicators MET (of 4)</th>
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<tbody>
<tr>
<td></td>
<td># of Indicators WORKING TOWARDS (of 4)</td>
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<tr>
<td></td>
<td># of Indicators NOT MET (of 4)</td>
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<tr>
<th>CLUSTER-LEVEL:</th>
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<table>
<thead>
<tr>
<th></th>
<th># of Indicators MET (of 2)</th>
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<th>ACTION PLANNING:</th>
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<tr>
<td>For areas where your organisation/cluster is not meeting the standard, utilise the <strong>MS Contextualization Tool</strong> to assess your challenges and plan for improvements in order to meet the minimum standards.</td>
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