



A TOOLKIT FOR

# Monitoring and Evaluation of Gender-Based Violence

PROGRAMMING IN RESTRICTED ENVIRONMENTS



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# Acronyms

<b>CFM</b>	Community Feedback Mechanism
<b>CBPM</b>	Community-Based Protection Mechanism
<b>CPAN</b>	Child Protection Action Network
<b>CSO</b>	Civil Society Organization
<b>FGD</b>	Focus Group Discussions
<b>GAM</b>	Gender with Age Marker
<b>GBV</b>	Gender-Based Violence
<b>GBVIMS</b>	Gender-based Violence Information Management System
<b>IASC</b>	Inter-Agency Standing Committee
<b>ICRC</b>	International Committee of the Red Cross
<b>IFRC</b>	International Federation of the Red Cross
<b>IRC</b>	International Rescue Committee
<b>KII</b>	Key Informant Interviews
<b>M&amp;E</b>	Monitoring and Evaluation
<b>MDC</b>	Mobile Data Collection
<b>NGO</b>	Non-Governmental Organization
<b>PPR</b>	Project Progress Report
<b>PTSD</b>	Post-Traumatic Stress Disorder
<b>SMART</b>	Specific, Measurable, Achievable, Relevant, Time-bound
<b>ToR</b>	Terms of Reference
<b>UN</b>	United Nations
<b>UNFPA</b>	United Nations Population Fund
<b>USAID</b>	United States Agency for International Development
<b>WHO</b>	World Health Organization











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# Purpose and How to Use This Toolkit

The United Nations Population Fund (UNFPA) estimates that one in three women worldwide will experience physical or sexual violence at some point in their lifetimes. The scale at which gender-based violence (GBV) is occurring continues to increase as women and children face compounded vulnerabilities due to the complex and recurring conflicts and shocks experienced worldwide at an increasing frequency.<sup>1</sup> Protracted and violent conflict has increased dramatically since 2010.<sup>2</sup> An estimated one in five refugees or displaced women in complex humanitarian settings have experienced sexual violence; however, it is often unreported.<sup>3</sup> As a result, there is growing interest in these contexts in learning about GBV prevention and response programming and their effectiveness.

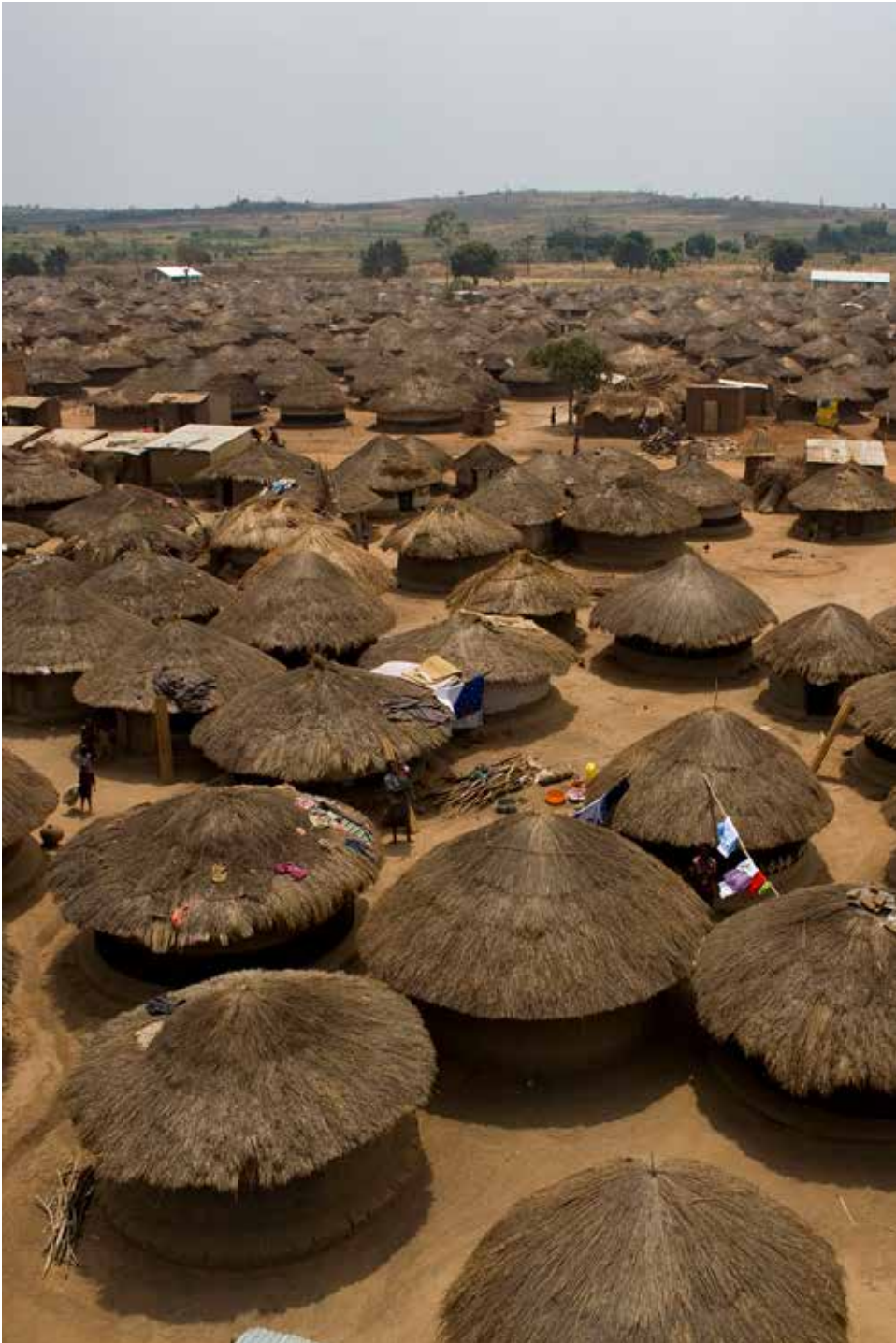
Depending on the context, organizational mission, capacity and resources, approaches that address GBV can vary significantly. They may focus on GBV prevention, response, or both. They can include justice, health or livelihoods programming or - programs that aim to change social norms for both women and men. Because GBV programming can be expansive and encompass multiple sectors, understanding the direct impact and effectiveness of these programs on individuals, families and communities is a complex process that requires careful planning.

It is critical for organizations using this toolkit to adapt all tools, examples and templates provided in the guide and annexes to the context in which they operate and to the specific program being implemented. This is especially true for organizations working in contexts where languages and terms related to GBV and violence against women and girls may be considered exceptionally sensitive.

1. UNFPA, 2019 - <https://www.unfpa.org/swop-2019>

2. World Bank, 2019 - <https://www.worldbank.org/en/topic/fragilityconflictviolence/overview>

3. UNFPA, 2019 - <https://www.unfpa.org/swop-2019>



Careful consideration must be given to select the appropriate terms and piloting the data collection tools before using them with communities is crucial.

This toolkit is by no means a comprehensive approach to monitoring and evaluation (M&E) for GBV programming. It provides practical steps and guidance on how to plan for and implement the basics of M&E, no matter where you are in the project cycle. The guidance in this toolkit will help you get started or improve in M&E and includes further resources to build upon as you gain confidence.

### **Why in Restricted Environments?**

An assessment was conducted prior to the development of this toolkit to learn about current practices in monitoring and evaluating GBV interventions among local and national civil society organizations (CSOs) responding to GBV in conflict-affected communities where international organizations have little to no access due to safety and security concerns. The assessment also approached several international organizations, UN and donor agencies to understand current best practices in M&E. Based on the findings, as well through a six-month toolkit piloting process with sixteen local CSOs in Afghanistan and South Sudan, we learned that the most critical need among organizations in these contexts is building a foundation in M&E concepts, together with basic techniques and strategies to measure progress and success at the output and outcome levels, and simple tools that CSOs can adapt to a range of programs and contexts.

Working in restricted environment also means that effective remote management of programming, including remotely managing some of the M&E activities, is critical in ensuring the continuity of activities and safety of staff and community members. Other important factors to consider in these contexts are reliance on community feedback mechanisms and entrusting trained community members to collect information about an intervention's progress and results. This is particularly true in the current context that is shaped by restrictions on travel and movement due to pandemics, such as COVID-19. Remote management and community-based systems or contacts for data collection emphasize the increased need for establishing strong ethical standards and protocols when implementing M&E activities, for everyone involved at every step. On these grounds, this toolkit was created to address the considerations specific to restricted settings, as a guide to help organizations working in conflict- and crisis-affected contexts to increase the quality of M&E practice for GBV programming. It also aims to support organizations better understand the needs of those they serve, using the highest standard of ethical approaches to reach individuals

and groups that are often overlooked.

### **Who is this toolkit for?**

This toolkit is primarily designed for program and M&E staff, but it can be useful for anyone who works with communities affected by GBV, on projects that prevent and respond to GBV. It can be used at any stage of the intervention but ideally should be used during the project design phase to inform the overall approach and ensure it includes a robust M&E strategy before any activities have started.

### **What is included in this toolkit?**

This toolkit is a guide on how to set up a monitoring and evaluation framework and conduct monitoring and evaluation activities for GBV projects.

**Section 1** provides foundational concepts of M&E, and overview of GBV, and the importance of M&E in GBV interventions. The section highlights important considerations for restricted environments, including how to establish remote management of M&E and mobile data collection systems, as well as how to integrate ethical approaches to conducting M&E.

**Section 2** outlines steps on how to develop an M&E framework with processes for defining key output- and outcome-level indicators that make up an M&E plan.

**Section 3** contains the steps to implement first, the monitoring, then evaluation activities, and describes common methods and tools that can be applied under each activity. Each section also includes further reading and resources that can help organizations deepen their M&E capacity.





## Section 1.

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# Monitoring and Evaluation Overview and Preparation

## 1.1 What Is Monitoring and Evaluation?

Monitoring and evaluation (M&E) is a key component of the project management cycle. Monitoring is composed of a continuous series of activities to collect and analyse information to measure the progress of project actions, their quality, and their progress towards targets. Evaluation is composed of activities to assess the project as a whole and is done at key points of project implementation (start – to determine a baseline, middle, and end). The key difference between monitoring and evaluation is timing: monitoring is ongoing and evaluation occurs at key points in the project. M&E is concerned with measurement and learning; it measures progress towards targets and achievement of targets (based on qualitative or quantitative indicators), and the collection of information, ideally, should be fed into future project planning.

**M&E is not *separate* from projects, it is *in service* to projects.**

The project cycle encompasses the full project process from inception to implementation to close out. The process feeds into itself, making it a cycle where the learning from the end of one project feeds into the development of new projects and the organization's knowledge of their programming and best practices. Monitoring and evaluation practices occur throughout the project cycle as shown in Figure 1.

M&E is focused on measuring results for short- medium- and long-term effects. Short-term results, often referred to as outputs, are the direct results of project activities. Outcomes, or medium-term results, are any project results that outputs contribute to, but for which the project is not solely responsible. Goals are the overarching change the project seeks to achieve or contribute to; they are project

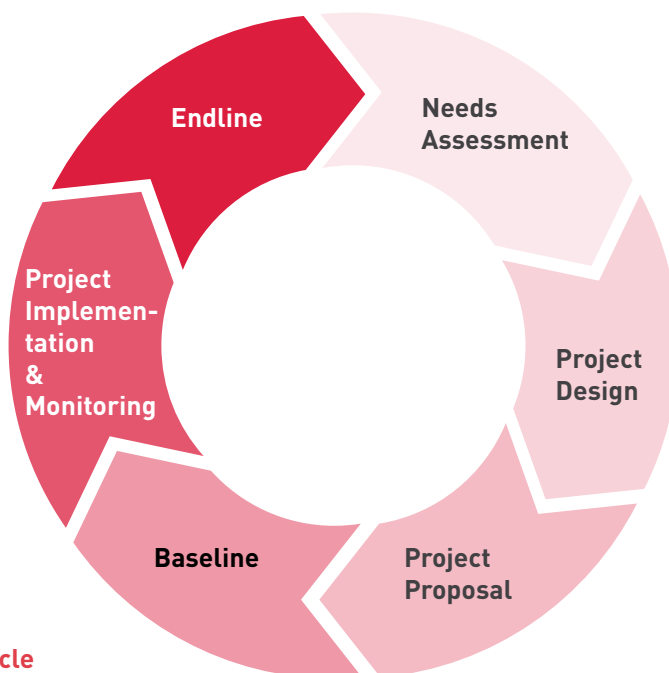


Figure 1.  
**Project Cycle**

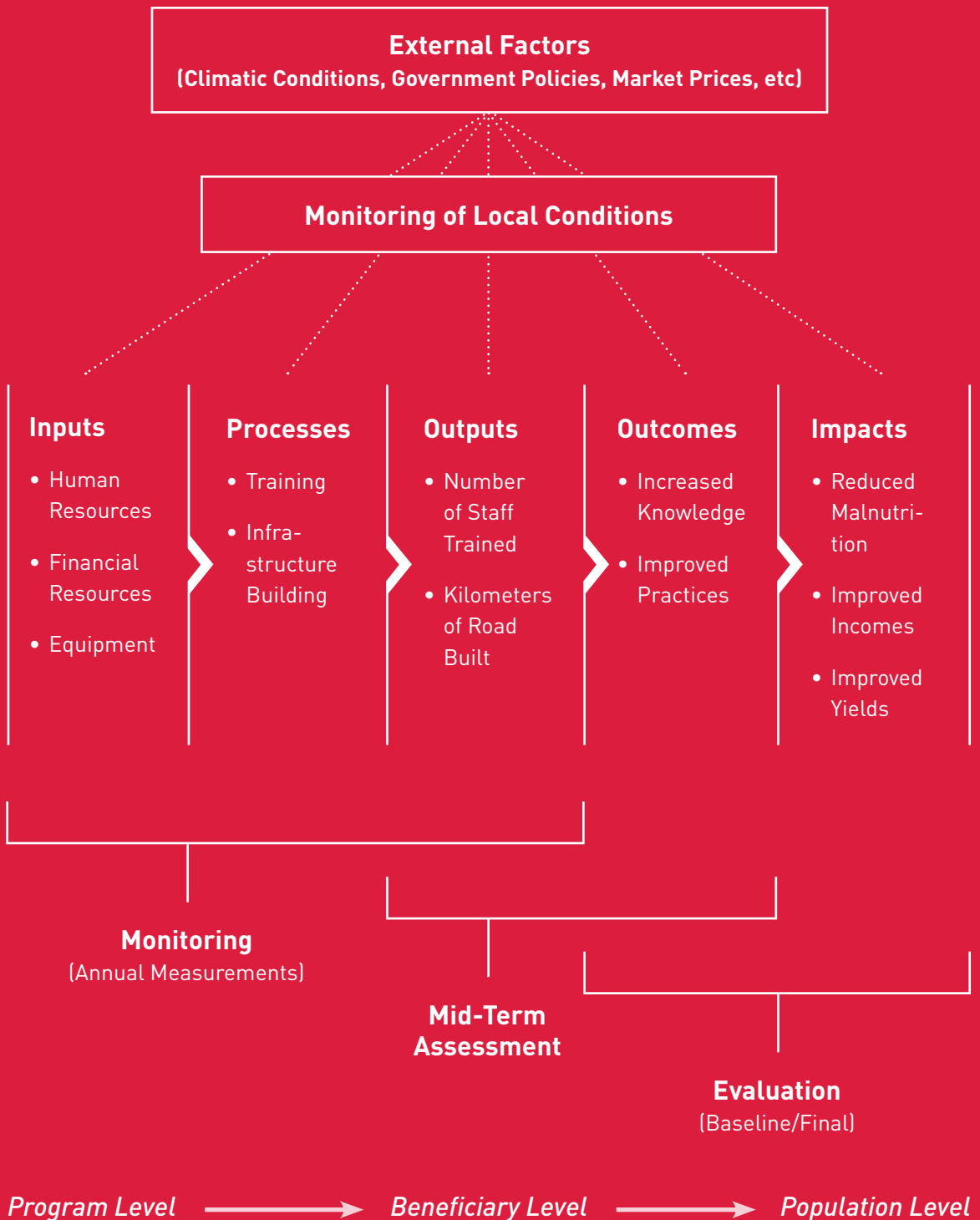
results which project staff and organizations have little control over, but to which their activities contribute. There are key activities and tools that are used for monitoring and evaluation of project results: logical frameworks (also called logframes, logical matrix, etc.), M&E plans/project management frameworks, and data collection tools (questionnaires, key informant interviews (KII), focus group discussions (FGDs), observation, etc.).

**Monitoring can help answer the following key questions about your project:**

- Are the activities being carried out as planned?
- Is the quality of the activities adequate?
- Is the target population being reached?
- Who is participating in the project and who is not? If not, why and how can the project include them?
- Are there any unforeseen consequences that arise as a result of these activities?

**Evaluation can help answer the following key questions about your project:**

- Did the project achieve what it set out to do?
- Was the observed change (outcome(s)) among participants due to the project?
- Were there any unintended consequences of the project?
- How do we know if a project made a difference?





## 1.2 What is Gender-based Violence?

Gender-based violence is any harmful act perpetrated against a person based on an individual's sex or gender identity. It includes physical, sexual, or psychological abuse, threats, coercion, and denial of resources or access to services, whether occurring in public or private life. It affects anyone, regardless of class, race, age, or religion. While women and girls are the most at risk and the most affected by GBV, boys, men, and sexual and gender minorities also experience GBV. It is a violation of human rights, rooted in unjust power relations and discriminatory cultural norms that perpetuate inequality. Poverty, lack of education and economic opportunities, lack of the rule of law and impunity for perpetrators contribute to and reinforce the cycle of violence and discrimination. These factors are aggravated in conflict, disasters, and resulting displacement, as community protection mechanisms erode and social fabric tears apart. In these settings, GBV often increases in scale and is underreported. It is also critical to note that certain at-risk groups, such as adolescent girls, elderly women, ethnic and religious minorities, sexual and gender minorities, persons with disabilities, etc., may face intersecting vulnerabilities that increase their exposure to GBV and other forms of violence.

There are many types of GBV, including: sexual violence, including rape, sexual exploitation and abuse; forced prostitution; domestic violence; forced and early marriage; harmful traditional practices such as female genital mutilation; honor crimes; widow inheritance; and, trafficking.

**GBV can have serious long-term and life-threatening consequences for survivors. These consequences can include but are not limited to:**

- **Physical:** such as minor to severe injuries leading to death or permanent disabilities; unintended pregnancies; unsafe abortion; sexually transmitted infections, including HIV.
- **Psychological:** such as anxiety disorders, including post-traumatic stress disorder (PTSD); depression; inability to trust; fear; substance use and abuse; sleep disorders; sexual dysfunction; suicide.
- **Socio-economic:** such as stigma, isolation and rejection (including by husbands and families); losses of income potential; interrupted education of adolescents; and homicide (e.g. honor killings or female infanticide).

All humanitarian actors have a responsibility to prevent and respond to GBV. Ensuring an effective response to GBV requires a multi-sectoral and coordinated effort by a variety of local, national and international actors. These include:

- At the **local and national level**: crisis-affected and displaced communities; ministries for justice, health, education, and social services; health care providers; police, security and legal authorities; traditional and religious institutions; local NGOs and civil society, particularly women's and youth organizations.
- At the **international level**: international organizations, such as UN agencies and the International Committee of the Red Cross (ICRC), the Global Protection Cluster, and many international NGOs.

GBV prevention and response programming can look very different based on the context. Effective GBV prevention and response requires an understanding of its causes and contributing factors or barriers. Programs are often cross-sectoral, addressing multiple dimensions of GBV, such as:

- **Physical factors**, including security due to the break-down of law enforcement or destruction of homes and other infrastructure, such as access to water. Women and girls may be particularly vulnerable when they leave their homes in search of food, water, firewood or work. Programs that address physical risk factors may include efforts to improve shelters and lighting in the community, increasing accessibility features in buildings and structures for persons with disabilities, provision of food and non-food items, and increasing water points. Programs that address these factors may include health-based interventions to support survivors, including clinical care and psychosocial support, capacity building and training of healthcare providers in GBV case management, increasing access to GBV services, improving referral mechanisms, and engaging men and boys to combat violence and promote gender equality.
- **Poverty and economic barriers**, including lack of education and livelihood opportunities, and access to income generation activities that can increase exposure to GBV, such as forced prostitution or survival sex. Programs that address these factors can be a wide range of women and girls' empowerment interventions, including business development and vocational training efforts, cash transfers and savings clubs.

- **Judicial barriers**, including the lack of access to due process, lack of adequate legal services and survivor protections mechanisms, or inadequate legal frameworks, including national and traditional law that may discriminate against women and girls or in some cases punish or criminalize the survivor (for example, rape defined as adultery). Programs that address these barriers could range from provision of free legal aid to training of law enforcement on GBV and other protection issues, awareness raising of legal rights, and advocacy campaigns on legislation and legal reforms.
- **Social, cultural, and political factors**, including at the community level: discriminatory social, cultural or religious norms and practices that marginalize certain groups and individuals (such as persons with disabilities or ethnic minorities), collapse of family and community structures that result in disrupted gender roles and risky coping mechanisms; at the individual level: threat or fear of stigma, isolation and social exclusion, lack of knowledge and information about human rights, including sexual and reproductive health (SRH). Programs that address these factors may include community awareness-raising activities, safe space programming for adolescent girls, increasing women and girls' access to healthcare services, including SRH services, increasing women's political participation and voice in decision-making processes, efforts that ensure inclusion and participation of persons with disabilities, and increasing women's participation in peacebuilding processes.

## **GBV and Protection from Sexual Exploitation and Abuse (PSEA)**

Sexual exploitation and abuse (SEA) is a form of GBV that constitutes an abuse of power by humanitarian staff against the affected population. It is based in gender inequality, power imbalance and disrespect of human rights. SEA can happen in any settings against anyone but can increase in emergencies settings. Staff always have more power over those they serve. PSEA is a term which refers to measures taken to protect community members from SEA by their staff, including any affiliated contractors and volunteers, and to ensure adequate response when abuses occur. These measures should include prevention, effective follow-up on allegations, and efforts to ensure survivors receive appropriate response services. It is ALL humanitarian actors' responsibility to protect affected people from SEA and take action when they have knowledge or suspicion of an incident.

Some recommended standards to address SEA in your agencies work include:

1. Develop and implement PSEA policy and procedures.
2. Implement PSEA requirements with partners, suppliers and contractors.
3. Committing and supporting a focal point to PSEA.
4. Provide clear guidance from HQ to field offices on engaging communities and the affected population to raise awareness on PSEA.
5. Develop and implement effective joint community-based complaints mechanisms (CBCM), including victim assistance.
6. Develop and implement effective recruitment and performance management.
7. Establish effective and comprehensive mechanisms to ensure awareness-raising on SEA amongst personnel.
8. Establish internal complaints and investigation procedures.

### **Resources:**

- Inter-Agency Standing Committee Minimum Standards for Gender-Based Violence in Emergencies Programming - <https://bit.ly/2CELSst1>
- Inter-Agency Standing Committee Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action - <https://bit.ly/2UedrZ>
- Inter-Agency Standing Committee Minimum Operating Standards: Protection from Sexual Exploitation and Abuse by Own Personnel - <https://bit.ly/20wzf2a>





## 1.3 M&E of GBV Projects in Restricted Environments

**GBV is happening everywhere. It is vastly underreported** due to fears of stigma or retaliation, limited availability of trusted service providers, impunity for perpetrators, and lack of awareness of the benefits of seeking service.<sup>4</sup> Rates of GBV are frequently higher in areas that are affected by conflict, natural disasters, and other crises. International organizations that focus on GBV prevention and response are often challenged by restrictions in accessing conflict- and crisis-affected areas. One way to better address the needs of GBV survivors that exist and to support prevention in such restricted environments is to partner with locally based NGOs and CSOs who are trusted by communities and are accepted to work there. For more information on conducting M&E for GBV projects see resource section for the link to IASC Minimum Standards for GBV in Emergencies Programming.

**Organizations working in these contexts face numerous challenges. These challenges include:**

- Limited access to communities due to issues related to safety, security, or disease outbreak
- Limited acceptance and established relationships in targeted community
- Sensitivity discussing GBV issues, compounded by increased vulnerability among GBV survivors
- Gross under-reporting of GBV incidents due to stigma and disruption of services for survivors
- Lack of reliable and up-to-date information on incident rates and needs in target communities

**Recognizing these unique challenges, implementation of M&E plans can still be done by following some of the below adaptations and considerations:**

- Use smaller sample sizes
- Use mixed methods to balance available data sources and information needs
- Conduct rolling baseline assessments as locations and beneficiary groups become accessible

4. 2015 IASC GBV Guidelines Pg. 2

- Accept that primary data collection may not be feasible due to safety concerns for beneficiaries and data collection staff
- Focus on qualitative data collection for primary data collection and use secondary sources (reports from UN agencies, clusters, working groups, other NGOs, etc.) for quantitative data as much as possible
- Coordinate with other implementing organizations in the area to organize joint data collection and sharing to avoid interview fatigue among target groups and reduce trauma for survivors
- If your organization does not have access in the targeted area, partner with a local actors, such as women's networks, youth organizations, indigenous groups, faith-based organizations, etc., that is accepted by the target community to conduct data collection (consider mobile data collection)

#### **Resources:**

- USAID Toolkit For Monitoring and Evaluating Gender-Based Violence Interventions Along the Relief to Development Continuum: <https://bit.ly/37l89Hx>
- Catholic Relief Services Monitoring, Evaluation, Accountability and Learning in emergencies: <https://bit.ly/2YiVmRT>
- World Health Organization (WHO) ethics guide: <https://bit.ly/2MKL1J8>
- Inter-Agency Standing Committee Minimum Standards for Gender-Based Violence in Emergencies Programming - <https://bit.ly/2CELSt1>

## **1.4 Why Conduct M&E?**

Humanitarian actors in restricted environments are often under-resourced and overburdened and M&E sometimes seems administratively cumbersome and intimidating. But when carried out effectively, M&E can become a powerful tool for social change within the communities where you operate and can help strengthen programming.

**There are many purposes and uses of M&E; but we highlight three:**

- Management tool to drive change
- Accountability tool (to affected communities, partners/supporters, and donors)
- Lessons learned tool

M&E can assess and demonstrate your project's effectiveness. It can improve your learning about what is working and not working well to help make better decisions about your programming. Lastly, if done in a participatory manner, M&E can empower and motivate project participants and the wider community to take on collective action to strategize for solutions to prevent and respond to GBV.

## 1.5 Who Should Be Involved in the Different Stages of M&E?

M&E should begin by engaging all parties who have a vested interest in your GBV project and may be interested in the M&E findings. To the extent it is safe for project participants and feasible to engage, they may include:

- Project participants
- Families of project participants
- Community leaders and community members
- Other community stakeholders, including self-help groups and local committees representing women, youth, persons with disabilities, etc.
- Project staff and senior management
- Project partners
- Government ministries or departments including Ministries of Health, Ministries of Women's Affairs, Ministries of Human Rights, etc.
- Donors

It is important to engage stakeholders (especially beneficiaries) because their involvement can be critical to the success of your project and the M&E of the project. Stakeholders can be involved in some or all of the broad stages of M&E:

- Design (project planning, including M&E approach)
- Implementation (project activities and monitoring)
- Evaluation
- Analysis
- Utilization of M&E learning



The following questions can help shape who should be included in the evaluation planning:

- Who is impacted by the project or by the evaluation?
- Who makes decisions about or can impact how the project or the evaluation is implemented?
- Whose voices are most in need of amplification during the process of evaluation planning?
- To whom will the evaluation need to speak? To whom do you need or want to tell the story of your work?
- What areas of expertise do you need to plan the evaluation? Who can you draw on for that expertise?
- What is the timeframe for planning the evaluation?
- What resources are available for planning (e.g., can you offer payment or any sort of stipend for participation in evaluation planning)?
- What is the level of buy-in for evaluation among the various groups and people named above?

How much involvement is right?

- Depends on the M&E goals, stakeholder interest/capacity, and available resources.
- Common roles may include:
  - › **Planning/Design committee** that meets with the project team to help develop overall approach to project implementation, including M&E
  - › **Advisory committee** that meets with evaluation team regularly to share input
  - › **Participant in data collection** to share their story or knowledge
  - › **Monitoring team member** who will monitor project activities. For example, a project stakeholder may be assigned to regularly collect specific monitoring data (pending safety/feasibility)
  - › **Evaluation team member**, in full or in part. For example, a young

woman with a training in interview techniques may be more effective in collecting information from her peers


- › **Reporter of evaluation findings** to share the M&E learning with broader community

Some strategies to build a culture of internal learning and reflection include:

- Acquire buy-in from internal and external stakeholders, including board members, key partner organizations, and donors
- Ensure project kick-off meetings include management participation and include detailed discussions about M&E and learning
- Support to raise core funding (as opposed to project-only funding) to allow the organization to pursue its own M&E approaches, rather than donor-driven M&E approaches
- Allocate funding for learning and justify on the basis of improved performance for the organization and for the communities it supports
- Seek peer accountability mechanisms within the staff teams and translate individual staff learning into organizational learning
- Carry out organizational self-evaluations or assessment of its strengths and weaknesses
- Commission external reviews (by peer organizations and donors) of the organization's performance

## 1.6 Supporting Project Staff on Beneficiary Selection and Targeting

M&E staff should be brought in to support program staff in beneficiary selection as early in the project as possible. It is important as an organization to establish the project's objectives and subsequently the criteria for targeting and selecting individuals from a population. There are two layers of selection and verification to be carried out: project-specific criteria; and vulnerability criteria for prioritizing certain persons. Project-specific criteria would be criteria that are part of the project design if the activities are focused on a particular demographic or type of beneficiary population. Vulnerability criteria can narrow down the selected beneficiaries of the project further to prioritize those with additional criteria that makes them more



Donors are increasingly requiring data that demonstrate the success and effectiveness of GBV programs. Organizations may also come under increasing pressure to justify funding by providing quantitative measurement of change beyond output level. One of the critical factors in an organization's ability to prioritize M&E is its senior management's internal commitment to M&E, learning, and accountability.

Senior management is responsible for an organization's overall policy and direction, including performance measurement and accountability to donors and affected populations. They are also responsible for allocating the required resources of staff time and funding.



vulnerable than others. This is only necessary when resources do not allow for full coverage of a population. It is best to engage with communities to agree on beneficiary criteria so that a transparent process of selection is conducted to reduce risk to selected beneficiaries and increase buy-in of communities to the project design.

Examples of GBV-Specific Targeting Criteria	Additional Vulnerability Targeting Criteria
<ul style="list-style-type: none"> <li>• Target individuals engaged or highly susceptible to engaging in high-risk income generation activities (sex work, etc.)</li> <li>• At-risk and/or survivors of SGBV or individuals who have suffered from other protection-related risks</li> <li>• At-risk Adolescent Youth</li> <li>• Forced or early marriage cases</li> </ul>	<ul style="list-style-type: none"> <li>• Dependency ratio (Working vs. dependent persons per household)</li> <li>• Presence of mental, physical disabilities or chronic illnesses in at least one household member</li> <li>• Households with at least one pregnant/lactating woman</li> <li>• Poor food security/nutrition or other relevant indicators to the context</li> <li>• Single-headed households (prioritizing female)</li> </ul>

## 1.7 Establishing Remote Monitoring and Management

Remote management is the temporary or partial delegation of responsibility and decision-making to national staff, national organizations, or communities themselves, with financial oversight retained remotely, often by head/field office staff. Remote monitoring is the use of methods to review project progress data from locations separate from the area of direct project implementation.

Remote management places the responsibility for project management and monitoring in the hands of those individuals and organizations that are most familiar with and accepted by target communities to continue monitoring project activities while ensuring the safety of staff and project participants.

Rather than being a “last resort” or temporary measure, remote monitoring and management is increasingly being used due to security issues, disease outbreaks such as COVID-19 and other challenges in accessing communities in conflict- or crisis-affected contexts. In a pandemic context, even local organizations that are embedded in the communities they serve may not be expected to resume standard

operations. Humanitarian actors, including local and national organizations, therefore, should consider adopting remote monitoring and management strategies as a permanent measure, not only for security or disease outbreak reasons, but as a broader aim to build local capacities among partner staff and community members as well as to strengthen accountability to communities themselves.

When instituting a system of remote management or monitoring, organizations must create a comprehensive plan for regular communications and information sharing. Remote monitoring practices should be reflected in the M&E plan (Section 2.4), detailing the responsibilities between different offices and the use of relevant technology for data collection, if applicable.

### **Benefits and challenges of remote monitoring and management**

There are many benefits to collecting and managing monitoring data remotely:

- Project staff and participants' safety may be increased as a result of not physically meeting to collect information, especially if the information they share is sensitive
- Geographic reach may be larger, particularly in restricted security contexts
- Costs and time taken to collect data may be reduced
- Fewer time delays between sampling and results
- Some data collection methods could encourage more participation and/or honesty in responses (if submitted anonymously)

Nonetheless, the lack of face-to-face communication can pose challenges as well. These may include:

- Upfront time investment, training and costs in rolling out remote monitoring and management
- Data security may be a concern as information is transmitted between the data collection point to technology platforms to the users
- Data accuracy may be compromised if remote monitoring systems are flawed in any way, or if project participants do not trust devices
- Cost of data collection devices



## Methods for remote monitoring and management

Methods to collect monitoring data remotely may include, but are not limited to:

- Key informant interviews
- Individual interviews
- Surveys and polls
- Feedback and complaints mechanisms
- Remote observations (or sensing) using GPS data, for example

## Tools for remote monitoring and management

Monitoring information can be collected applying some of the above methods through the use of technologies. Technologies can contribute to an increase in the quality of remote monitoring and management. Tools may include, but are not limited to:

- Cellular and smart phones with appropriate apps
- Internet conference technologies (such as Skype, GoToMeeting, Zoom, WebEx, etc.)
- Survey tools (such as Survey Monkey, Google Forms, Typeform, etc.)

See **Annex 1.7.A** on ‘Benefits and Challenges of Technology for Remote Monitoring’ for more detailed options available.

**NOTE:** Technology allows organizations and partners to coordinate and maintain connection across distances, but its use may also come with added risks in these contexts, for example, high-visibility tech equipment could be subject to theft or GPS locations may pose threats if used against the populations. When warranted, use only low-visibility devices (e.g., low-cost smartphones) to reduce risks.

## Integrating community-based approaches in remote monitoring and management

Using existing community structures, such as community health workers and various committees, is an effective way to remotely monitor projects that do not include GBV case management. Organizations should never have community members manage cases of GBV or collect information from survivors directly

unless properly trained and accredited (e.g., social workers, health workers living within the community). In cases where staff cannot reach or are not allowed to visit specific project sites (women's shelters for survivors, etc.) embedded staff from the community working at or managing the centers can provide monitoring data and a link for establishing remote management protocols. For project activities that are community based and do not directly target survivors, such as improvements to WASH or education infrastructure for GBV prevention, existing WASH committees or parent-teacher committees can help monitor the quality of implementation and project progress when staff are unable to regularly visit sites.





GBV Prevention/Response Programming	Examples of Remote Monitoring Strategies
<p><b>Case management services that are managed by local partners or supported community institutions:</b> A structured method for providing help to a GBV survivor, based on social work case management. It involves one organization, usually a psychosocial support or social services actor, ensuring that survivors are informed of all options available to them, identifying issues and problems facing a survivor and her/ his family, setting goals and care planning, following up in a coordinated way (making referrals as appropriate), and providing the survivor with emotional support and coping skills throughout the process. Case management includes ensuring access to available services through referrals. For example, health services for sexual assault survivors may be provided through referrals to other service providers or by the mobile teams directly.</p>	<p><b>Conducted by program staff:</b> Provide community-based social workers or other focal points the tools to extract up-to-date assessment information from beneficiaries. Subjects can include:</p> <ul style="list-style-type: none"> <li>• Safety perceptions</li> <li>• Life skills, psychosocial, or other activity feedback</li> <li>• Perceptions of changes around risk reductions in the community due to project interventions</li> <li>• Awareness of service provision details by community members and how they feel about looking for help.</li> </ul> <p><b>Conducted by other stakeholders:</b> If your organization does not want implementers to manage the data collection, this can be done jointly with government or other relevant stakeholders intermittently during visits to the remote field locations where possible. Otherwise it can be done by community focal points and reported directly to M&amp;E/Management staff to reduce the risk of bias in results from implementing staff collecting data on their own projects.</p>
<p><b>Non-case management individual sessions and outreach by social workers or other local staff:</b> One-on-one support for non-GBV issues, often used as a strategy to reduce potential stigma by making it appear common for case workers to talk to individual beneficiaries</p>	

GBV Prevention/Response Programming	Examples of Remote Monitoring Strategies
<p><b>Psychosocial support group activities:</b> Group recreation or life skills activities for women and girls, including activities for positive coping skills, community safety, and risk reduction.</p>	
<p><b>Outreach and information/awareness-raising activities:</b> Activities to raise awareness about GBV and service availability and to empower and build community capacity to address GBV, including:</p> <ul style="list-style-type: none"> <li>• Stand-alone sessions or sessions associated with existing community mobilization initiatives designed to educate community members about women’s rights and GBV basic concepts, to reduce stigma against GBV survivors, and to inform about service availability and encourage help-seeking.</li> <li>• Sessions designed to engage community leaders and service providers, focused on topics above as well as means of supporting survivors with quality services, risk mitigation for GBV, ongoing service mapping, and strengthening referral pathways.</li> </ul>	<p><b>See Annex 1.7.B for ‘Example Question Topics for Remote Monitoring Tools’ and Resource section below for guidance tools.</b></p>

GBV Prevention/Response Programming	Examples of Remote Monitoring Strategies
<p><b>Support call/hotline activities:</b> Hotlines can support mobile service delivery interventions when a mobile team is not on site. The functions of a hotline as part of a mobile intervention are:</p> <ol style="list-style-type: none"> <li>1. For caseworkers to speak directly with survivors and offer crisis intervention, safety planning, and information about resources and referrals;</li> <li>2. For caseworkers to provide remote technical support and supervision by speaking with community focal points and other service providers in mobile sites.</li> </ol> <p>A tertiary function of a hotline can be gathering feedback about project implementation for non-case workers.</p>	<p><b>Conducted by beneficiaries and program staff:</b></p> <p>Self-reporting can be used to gauge program quality. A suggested approach is to ask callers who call in to the hotline or report feedback directly to M&amp;E staff through a set of questions about the program interventions themselves, such as “Do you know where to receive legal aid?” or “Have you seen staff providing outreach in the community?”</p> <p><b>Some examples:</b></p> <ol style="list-style-type: none"> <li>1. Program Officers ask users of a women’s center how they find the services and location safety (non-sensitive questions);</li> <li>2. Program Officers ask community members who call in questions on activities they have seen in the community.</li> </ol>
<p><b>GBV Prevention &amp; Response – Sectoral Interventions:</b> Activities intentionally tailored towards preventing the causes of GBV by reducing threats/vulnerabilities of at-risk groups and by responding to the needs of survivors to reduce further vulnerability. Project Examples: WASH safety activities for reducing the threats and vulnerabilities in a community around latrine use or water collection; or livelihoods programs for at-risk women; or shelter programs in emergency settings.</p>	<p><b>Conducted by local partners:</b></p> <p>Data collection can be used to understand how specific sectoral interventions are contributing to reducing threats and vulnerabilities that exist in the community or supporting survivors of GBV.</p> <p>For guidance on a specific sector, organizations should refer to the IASC Guidelines for Integrating Gender Based Violence Interventions in Humanitarian Action (see link in resource section) and create questions from the chapter that are related to the project.</p>





## **Best practices for establishing community focal points:**

Conduct a community scan of existing community groups and focal points. There are often groups and individuals already collaborating with various organizations, so it is best to map out what structures already exist and leverage those, rather than creating parallel systems in a community.

Develop Memorandums of Understanding (MOU) and job or task descriptions for the role of the focal points, including clear boundaries of their roles if they participate in providing direct services. See **Annex 1.7.E**.

Have multiple contacts per location to ensure you can triangulate information easily.

Provide training to community focal points in protection from sexual exploitation and abuse (PSEA), legal rights and basic legal frameworks, ethical approaches, concepts of M&E, and other topics relevant to the GBV programming to create awareness within the communities on their roles and responsibilities and in responding to protection concerns. If it is not possible to provide in-person training due to disease outbreak, remote discussion on the topics can be done with key takeaways communicated to the focal points.

Ensure that the community focal points' MOUs, training and collaboration with staff includes confidentiality and safety standards related to engaging with community members.

Consider the focal points' gender, age and, if possible, disability, language, religion, ethnicity, and other social markers. It is best to have a diverse set of focal points to ensure equal opportunity for different voices to be heard. If a group is selected as a focal point, encourage the group composition to reflect the community as closely as possible, recognizing the need to protect individuals from being stigmatized if part of a minority group.

Discuss the types of activities you will support the community with so that the community monitoring focal points know what type of information is of interest and feasible to monitor.

Ensure that the community monitoring focal points participate in community mobilization and awareness activities so that they are visible in the community in their roles.





When carrying out physical site visits is appropriate, conduct both scheduled and unannounced visits to communities. Scheduled visits can be useful when community mobilization is needed; however, unannounced visits can help staff gain a natural understanding of project progress and reduce the possibility for false reporting and presentation.

### **Example of Community Focal Point Responsibilities:**

Manage complaints and feedback on project activities

Collect information on activities (numbers, quality)

Collect new assessment data from communities on their needs

Provide initial suggested input on project design and locations to ensure effectiveness

Identify programming gaps and capacities for improvement

### **Management of Risk Indicators**

Within every project, a plan to manage risks should be part of your organization's original work plan and M&E plan. As an organization working on the front lines of humanitarian response, risks exist and can create challenges to conducting your work. It is important then to consider including an agreement with the community members who will support your M&E activities on some risks that they will report to you during your regular follow up. Some of these may be:

Natural disasters or disease outbreaks occurring nearby or within project areas

Armed conflict or tension nearby

Economic shocks (heavy inflation, shortages of goods in markets)

Political shocks (elections, protests)

Disagreements within communities that may disrupt project activities

Identifying potential risks with the community focal points provides two benefits. They will report and identify early warning signs that can be managed; and it will help communities understand your capabilities and limitations as an organization to support them when unforeseen events occur.

### Case examples of remotely collected data within GBV prevention and response interventions:

A pilot organization working with War Child Canada conducts regular interviews by phone with women's center managers to collect information from locations inaccessible to some project staff and to maintain privacy of the center locations.

Utilize Community-based Protection Mechanisms (CBPMs)<sup>5</sup> to identify and report incidents to police or through other safe means for survivors. CBPMs are groups of community members trained on topics such as trafficking, child abuse, PSEA and legal rights in a community. CBPMs coordinate over the phone with the project team through bi-weekly coordination meetings, sharing the protection issues in the community. They also identify and refer GBV and child abuse survivors' cases to the project team and other service providers to provide free/pro bono legal aid and psychosocial services if the case is not settled within the community through alternative dispute resolution. CBPMs are supportive mechanisms for the remote implementation of activities and are a very strong link between the project team and the community. CBPMs carry out active surveillance of child protection and GBV issues and address them at the community level as well as in cooperation with larger organizational networks. They are active mediators and play a key role in the resolution of non-criminal cases using the informal justice system at the community level and provide reports to the project staff. Meanwhile, they coordinate with police to receive their support for investigating any criminal cases.

Community Mobilizers conduct assessments over the phone with CBPMs in order to obtain the most urgent needs related to COVID-19, including community members' awareness and understanding of the disease, the effects it has had on their livelihoods and what organizations can do to help them in the short term.

5. CBPMs are trained community groups who conduct outreach awareness raising and identifying protection violations while working with their local authorities where necessary. The end result are community-led initiatives to create a supportive environment and more security in the communities for marginalized populations.

## Principles of remote monitoring management

The safety and security of GBV survivors and survivor data is of the highest concern in monitoring GBV interventions. Data security risks can exist in mobile data collection, just as in paper-based data collection. Organizations should establish a data protection plan for their mobile data collection devices [see example in **Annex 1.7.C**]. In addition, the following are key principles in remote management and monitoring of GBV programming:

- Invest in training to enable staff and community focal points to fulfill their remote monitoring and management responsibilities, including in how to use technologies and how to gather and report on the data ethically.
- Develop a clear framework detailing monitoring, reporting, and communications modalities and frequencies for the project – regular communications are essential for remote monitoring and management and should be added to the project M&E plan [see example in **Annex 2.4.A**].
- Integrate qualitative methods in data collection. This will provide space for GBV survivors to tell their own stories, and will provide space for program staff to describe the project implementation process (successes and areas for improvement).
- Maintain the safety and confidentiality of survivors – photos and video should NOT be used for monitoring of GBV interventions unless it is for non-personal project activities such as infrastructure construction monitoring.
- Share findings from remote monitoring activities with the communities, while carefully mitigating any risks that sharing these findings may pose among survivors. All information must be handled in a way that is driven by the affected populations.

## Resources:

- International Rescue Committee. Mobile and Remote GBV Service Delivery. <https://bit.ly/2YiLDjj>
- Tearfund. Monitoring and accountability practices for remotely managed projects implemented in volatile operating environments. 2012. <https://bit.ly/2MMhQp6>
- UNICEF. Inter-Agency Guide to the Evaluation of Psychosocial Programming in Emergencies. 2011. <https://bit.ly/30vqbFF>



- UNFPA. Minimum Standards for Prevention and Response to Gender-Based Violence in Emergencies. <https://bit.ly/3hfP0eD>
- Inter-Agency Standing Committee. Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action: Reducing risk, promoting resilience and aiding recovery. 2015. <https://bit.ly/3hcGxZW>



## Mobile Data Collection for Project Monitoring & Evaluation

Mobile Data Collection (MDC) is the use of tablets, smartphones, or other devices to collect monitoring data which might otherwise be collected via paper-based data collection tools. In restricted and remote environments, it is not always possible to use mobile data collection for various reasons (capacity, culture and acceptance, resources) and therefore it is best to consider whether using MDC is sustainable over the course of a project or portfolio of projects before investing in the equipment and human resources.

Some of the advantages of MDC are:

- Improved data quality through reduced human error and improved quality control methods
- Sustainable and safe storage on cloud-based platforms
- Improved data safeguarding through reduced potential data leaks (particularly with SGBV data)
- Efficient and real-time data analysis
- Improved capacity-building opportunities for field-based staff
- Allows for remote monitoring of projects

All relevant platforms are online-offline capable, meaning one can download the survey form on a phone while on Wi-Fi, and capture a vast number of finished surveys on the phone in remote and offline locations and subsequently upload all of the data when back in the vicinity of Wi-Fi. No constant network is required. Android smartphones (v4.0+) are the industry standard as most open source platforms require Android devices for compatibility reasons.

If your organization is collecting data frequently for monitoring, site visits, observational assessments, and other initiatives, on a monthly basis there is simply not enough time to collect via paper-based tools and perform analysis. Population-based surveys such as household surveys or exhaustive screening can and should be done by MDC if the resources are available. MDC is only possible if the resources are available, as it requires several Android smartphones and staff oversight to manage this system. Mobile data collection reduces the time and cost for data entry and should be implemented using the below service options.

See **Annex 1.7.D** for an organizational self-assessment to decide if mobile data collection should be used.

There is a multitude of both open source and commercial options for MDC platforms. The following list are some established options that have little to no expense:

**KoBo Humanitarian Toolbox** – Created by the Harvard Humanitarian Initiative and supported and hosted on Amazon Web Services by UN OCHA this is free to use for all humanitarian organizations. Widely used as a community standard and fully integrated with Open Data Kit (ODK) and XLSFORM survey coding (the method for coding surveys in Excel). The app can be found on Google Play.

- Main support site for any questions you may have - <http://help.kobotoolbox.org/>
- XLSFORM Coding Support - <http://xlsform.org/>
- A strong community based around Open Data Kit and XLSFORM - <https://forum.opendatakit.org/>

**Open Data Kit Aggregate** – The original open source platform for MDC. It requires installation to a cloud-based service such as Amazon Web Service or Google Cloud. More difficult to use than KoBo and less supported with updates currently. The application can also be found on Google Play and resembles KoBo.

**Ona** – A commercial solution with a monthly service fee from US\$0 to US\$200. The MDC service falls under a larger umbrella of services available by Ona, some of which might be very relevant and useful for SGBV prevention and response programming such as Facebook Messenger and SMS integration, OpenSRP for Frontline Healthcare workers, and Canopy for a larger data management platform. Similar types of applications and features as KoBo or ODK but if you are looking for other M&E services to complement the MDC, Ona may be an option.

**Commcare** – A multi-purpose case management MDC platform, it has been used for mHealth, SGBV, distributions, agriculture, livelihoods, and a large set of other case management purposes. It has a cost to use through Dimagi and therefore should only be used if your purposes for MDC go beyond one-way data collection that open source platforms can provide.

### Data Safeguarding for Mobile Data Collection

As with paper-based collection of monitoring data, MDC requires specific security measures to be put in place to avoid sensitive information from being leaked, misused, or misrepresented.

When setting up smartphones for collection of monitoring data, ensure the following are completed:

1. Use Surelock or other applications to prevent data collectors from downloading apps and using the devices for personal use, which can lead to viruses and other damage to the device.
2. When connected to the online platform, ensure a username/password is required for uploading any completed surveys to the platform from the phone.
3. Turn on the feature to remove data once uploaded in the MDC application to prevent sensitive information remaining on phones.
4. Develop a set of logistical guidelines for the management, transport, storage, and maintenance of smartphone devices (locked at night, transported in NGO vehicles only, signed in-out each day by staff).
5. Develop routine maintenance plans and updating to be done by a designated M&E, IT, or administrative staff, as most applications and devices require regular updates.
6. Establish a set of rules on password protection and management of the online platform account (ensure one person is in charge of the administrator account).

#### **Resources:**

- IASC 2017 Revised AAP Commitments - <https://bit.ly/3hcYUOb>
- IASC Gender with Age Marker (GAM) - <https://bit.ly/3f7GCfp>
- “I See that It Is Possible”: Disability Inclusion in Gender-Based Violence Programming Toolkit - <https://bit.ly/37jfabL>
- Gender-based Violence Against Children and Youth with Disabilities Toolkit - <https://bit.ly/3cRD9A2>
- IASC Guidelines, Inclusion of Persons with Disabilities in Humanitarian Action - <https://bit.ly/2YqLJWi>

#### **Annexes:**

- **Annex 1.7.A:** Benefits and challenges of technology for remote monitoring
- **Annex 1.7.B:** Example question topics
- **Annex 1.7.C:** Physical Device Protection Policy
- **Annex 1.7.D:** Organizational self-assessment for mobile data collection
- **Annex 1.7.E:** MoU for communal focal points







## 1.8 Participatory, Gender-Sensitive, and Inclusive Approaches to M&E

Involving women, girls, men and boys affected by GBV in the design, monitoring and evaluation of projects is not only good practice, it leads to more effective humanitarian response. Participation and partnership with the affected population in all phases of programming is also ingrained in the *Accountability to Affected Population*.<sup>6</sup>

In a participatory M&E process, women, girls, men and boys become active planners and decision-makers. Instead of 'beneficiaries' they become 'agents of change'. Participatory practices should be used wherever possible for M&E activities. Participatory approaches refer to M&E activities that involve and empower project participants and local communities, working to have the results of the activities used by the community itself. In the case of GBV programming, it is integral to maintain the safety of survivors in your project's target area, therefore the information being shared with stakeholders about M&E activities, the presence of enumerators, and the data collected must all be planned and used in a way that protects the confidentiality and safety of survivors that choose to participate in M&E activities.

**As women and girls are disproportionately affected by GBV, projects and M&E design must take the following factors into account for M&E approaches to be gender-sensitive:**

- Gender roles and power relations between your organization and the communities you seek to assist, including between your M&E staff (male and female data collectors) and the women participating in your project
- Equal opportunities to participate in all M&E process by:
  - Finding suitable time and place for women
  - Making sure the space is accessible and providing reasonable accommodations so everyone invited can participate
  - Using local language

6. IASC Accountability to Affected Populations, The Operational Framework”): <https://bit.ly/3heFnNx>

Integrating gender perspectives into projects and M&E processes is often associated with supporting only women GBV survivors. However, gender and its link to other factors, including disability, age, ethnicity, socio-economic class, gender identity, and sexual orientation, and how these links play out in the community can increase marginalization of certain groups. These dynamics prevent marginalized groups from accessing power, resources, participation and decision-making. When GBV projects integrate gender perspectives and recognize the diversity amongst marginalized groups, they can contribute to equitable access as well as better use of financial resources.

**One way to ensure project and M&E design is gender-sensitive and inclusive is to collect sex- and age-disaggregated data in data collection.** There are helpful methods that can assist organizations to diagnose whether or not they are designing and implementing projects that are gender- and age-sensitive. The IASC Gender with Age Marker (GAM) can serve as an easy-to-use, automated tool to increase gender and age responsive programming throughout the project cycle. It is based on 12 codable measures (called “GEMs” – gender equality measures) that look at a project’s ability to reflect the needs, activities, participation and benefits for different genders and age groups. Donors are increasingly requiring the application of GAM in all the projects they fund.

While gender- and age-responsive programming is important, humanitarian response is increasingly moving towards understanding how disabilities can intersect with gender and age. It is important to recognize that persons with disabilities are at greater risk of GBV, as well as at greater risk than the general population of being excluded from participating in projects, including in M&E of those projects. For women with disabilities, the intersection of gender inequality and disability makes them especially vulnerable to GBV, while girls with disabilities, due to the same intersections as women with disabilities, are even more marginalized by the additional factor of age. Therefore, identifying the population of disabilities in project areas and intentionally targeting women and girls with disabilities is key to ensuring GBV projects are responsive to those most at risk. **See Annex 1.8.A for the Washington Group’s Short Set of Questions, designed to help identify people with a disability in your project communities.**

Along with the *GAM overview (Annex 1.8.B)*, see **Annex 1.8.C** for a tip sheet that offers interventions, guiding questions and an example of how to support gender, age and disability analysis in GBV interventions to design and monitor projects that are more responsive to the needs of the most vulnerable groups in the communities you serve.

### **Who are persons with disabilities?**

“Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.” (Convention on the Rights of Persons with Disabilities, 2006)

The World Health Organization estimates that 15 percent of the world’s population has some form of disability,<sup>7</sup> with potentially higher proportions in communities that have fled conflict or natural disasters.<sup>8</sup>

### **What about caregivers of persons with disabilities?**

In humanitarian contexts, the majority of caregivers of persons with disabilities are **women and girls. Persons with disabilities** are also caregivers – they are fathers, mothers, siblings, and so forth. As caregivers, they face stigma and discrimination including gender-based violence, in relation to their role (e.g. assumptions that they are not capable and/or should not become parents). Recognizing the rights of both individuals with disabilities and the rights of caregivers as being inextricably linked is important from a programming perspective.

### **Resources:**

- WHO’s Ethical and Safety Recommendations for Researching, Documenting and Monitoring Sexual Violence in Emergencies - <https://bit.ly/3h6SeBj>
- The Core Humanitarian Standards - <https://bit.ly/2Uthloh>
- IRC’s Caring for Child Survivors of Sexual Abuse - <https://uni.cf/2MLCuG0>
- Save the Children’s Toolkit for Monitoring and Evaluating Children’s Participation - <https://bit.ly/37iSys7>
- Handbook on Data Protection in Humanitarian Action - <https://bit.ly/37laFgX>
- IASC Accountability to Affected Populations, The Operational Framework”): <https://bit.ly/3heFnNx>

### **Annexes:**

- **Annex 1.8.A:** for the Washing Group’s Short Set of Questions
- **Annex 1.8.B:** IASC Gender with Age Marker (GAM) Overview
- **Annex 1.8.C:** Tip sheet to support gender, age and disability analysis in GBV interventions

7. WHO and the World Bank, World report on Disability (Geneva: WHO, 2011).

8. Handicap International and HelpAge, Hidden victims of the Syrian crisis: Disabled, injured and older refugees (2014).





## 1.9 Ethical Concerns to Consider Throughout the M&E Process<sup>9</sup>

Ethical guidelines are critical when carrying out monitoring and evaluations of GBV programming to minimize the risk of harm during the M&E process for everyone involved: the project participants, data collection teams, and others (such as family, caregivers, and community members of participants). The principles outlined below take a survivor-centered approach, prioritizing the M&E participants' rights, needs, and preferences, seeking to empower them. The principles help ensure that M&E processes respect the participants' autonomy, right and capacity to make their own decisions about participating and about what they share.

- 1. Ensure safety and security for all people involved in the M&E** – from project participants to data collection teams to the wider community. This should guide all decisions related to implementing the M&E activities and should be continuously monitored. Identities of participants who provided sensitive information must always be protected, and participants' safety should be considered in any reporting, disseminating, storing and moving of M&E data. Consider ways to address safety concerns and develop data security plans in advance of starting data collection. For further information read the ICRC Handbook on Data Protection in Humanitarian Action in the resources section below for further practical steps to ensuring safety and security of individuals.
- 2. Minimize risk and harm** – the M&E team must take care to ensure that the M&E activities will do no harm<sup>10</sup> to those participating, due to their vulnerabilities and power dynamics between the M&E team and them. Make efforts to analyze risk and develop strategies to reduce it: for example, M&E data collection is done while project participants are gathered at their usual weekly project activity and family members are informed about what will happen. In this way participants are not singled out during door-to-door data collection, reducing harm and likelihood of their stigmatization and identification. Other options to reduce risk in this case include the availability of hotlines staffed by counsellors or having open office hours for counsellors in a publicly accessible space in the community. Types of risks can be physical, psychological, social, economic, legal, and loss

9. This section is derived from WHO's Ethical and Safety Recommendations for Researching, Documenting and Monitoring Sexual Violence in Emergencies

10. [https://www.alnap.org/system/files/content/resource/files/main/donoharm\\_pe07\\_synthesis.pdf](https://www.alnap.org/system/files/content/resource/files/main/donoharm_pe07_synthesis.pdf)





of confidentiality. It is also critical to identify risks as a result of implementing GBV projects, including psychological abuse or intimate partner violence when women take on new roles or gain knowledge, re-traumatizing participants from disclosures of violence, and threats to personal safety of project staff.

#### Type of risks to consider:

- **Physical:** may include physical discomfort or bodily harm of participants or M&E staff.
- **Psychological:** may include anxiety, depression, guilt, shock and loss of self-esteem and altered negative behavior.
- **Social:** changes in relationships with others that are to participant's disadvantage, including embarrassment, loss of respect, stigma or in any way diminishing opportunities or powers the participant may have in relationships with others.
- **Economic:** may include loss of wages or other income, or any other financial costs, such as damage to participant's employability.
- **Legal:** consider if any methods used in the M&E data collection could cause participants to violate any existing laws or if the methods themselves might violate any laws.
- **Loss of confidentiality:** any identifiable information about the participants is kept confidential throughout the data collection process and thereafter (including in dissemination of learning), unless the M&E staff obtains express permission from participants.

This also means anyone implementing GBV projects, including M&E data collection teams, have an ethical responsibility to ensure that they are managing any potential risks for participants, in accordance with the humanitarian principle of ‘do no harm.’ M&E data collection methods and tools must follow good practice for working with survivors of GBV. This includes carefully framing the activity to ensure participants’ safety, reviewing questionnaires to ensure sensitivity, and making plans for how data will be analyzed, moved, and reported on before any M&E activity begins.

Avoid asking participants questions:

- That place a person in physical danger
- That expose a person to humiliation
- That reactivate a person’s pain and grief from traumatic events
- That cannot be addressed, especially beyond the scope of the M&E].



**Maximize benefits** – the M&E process should aim to empower all the stakeholders participating in the process at all stages by giving voice to their views. When M&E activities are done ethically, the act of sharing of experiences and reflecting on project outcomes (positive, negative, or no change) on participants' life, individually or as group, can have positive effects. For example, it can allow participants to learn from each others' experiences, build on their knowledge/skills, increase their sense of control over project decision-making (including taking or identifying corrective actions), and enhance their ownership of the project.

- 3. Ensure privacy and confidentiality of M&E participants at all times.** All persons have a right to privacy. M&E activities can involve entering into individual lives and exploring aspects of their participation (or non-participation) in the GBV project. Maintaining privacy and confidentiality allows the participants to express their opinions and share experiences freely and safely and helps to increase the credibility of the M&E process. Failure to maintain privacy and confidentiality of participants can lead to harm for participants and for the community; therefore, M&E teams have a responsibility to safeguard the data.

M&E activities should ideally be conducted in a private, quiet space (not in public) where disruptions are limited. Data collectors must be trained on the concepts of privacy and confidentiality. Safety issues related to privacy and confidentiality must be highlighted further if data collectors come from the target communities. Careful considerations should be made to select appropriate data collectors from the communities (see point 6 below) who must maintain confidentiality in their daily interactions. All data collected, including notes, records, and photographs, must be stored in a safe and secure location, with limited staff access (locked or password protected). Names or any other identifiable information should not be included in interview forms, case records or documentations.

When using group discussions as a tool to collect M&E data, participants must be informed before starting any discussions about the need of confidentiality (both about the content of the discussion as well as who said what) and ways that the M&E staff will protect their privacy. Participants should be instructed not to share personal experiences or sensitive issues with the group unless comfortable doing so, but rather about their impression of others' experiences or the community as a whole and the facilitator is to stress everyone's responsibility to confidentiality.

- 4. Obtain informed consent from participants** for M&E activities that involve any probing into participants' experiences in projects (i.e. beyond monitoring basic project outputs, such as attendance). Do not force a person to take part

in M&E activities, and only engage with the individual with her/his explicit permission. This applies to most data collection activities, including photo-taking. Informed consent tells participants that participation is voluntary and that if they refuse to participate, they will not be in trouble or lose benefits, and that the participants may stop participating at any time. Informed consent should be obtained before and during data collection.

**Informed consent means that the participant knows:**

- **what** the M&E activity is about;
- the **expected length** of the activity/interview;
- the **risks and benefits** of participating in the M&E activity;
- the procedure to ensure confidentiality;
- what will be done with the information they share;
- **who to contact** if she or he has any questions; and
- **expectations** linked to participation (i.e. no incentives, etc.).

See **Annex 1.9.A** for an example of an informed consent form which includes details about obtaining consent from adolescents and persons with disabilities.

Discussion with participants about potential harms for participating in M&E activities may include such questions as:

- Are there people who might want to harm you because they know about your participation/contribution in this activity?
- How would your friends and family react?
- Are there people you need to protect?

**5. Identify local care and support services for survivors** – medical, psychosocial, protection/security, and legal – at the M&E planning stage and make them available throughout the M&E data collection. Availability of these services should be shared with participants to help them deal with any distress they may feel in cases where they may have disclosed information about their

GBV experience (whether from past or present). If local support services are limited or unavailable, set up temporary (particularly psychosocial) services that can be available during M&E data collection. It is good practice to share information about any available services even if collecting only general data about knowledge and attitudes relating to gender and violence.

- If there are no appropriate services for survivors of sexual violence, do not ask about people's experiences with sexual violence.
- Since we cannot guarantee that a participant will not be victim to further violence if someone finds out about her or his experiences with past violence, do not ask people to share about their personal experiences of violence (domestic violence, sexual violence, etc.) in a group setting.

- 6. Carefully select all members of the M&E team and ensure they receive training and support.** Because information from GBV projects may be highly sensitive, M&E teams must have proper training on M&E approaches, ethical considerations and skills in facilitation and interacting in interviews. It is important to train female data collectors and consider the minority status of M&E participants (whether gender, ethnicity, religion, language, disabilities, etc.)







so that the data collection team is as similar to the participants as possible. It is also important for the M&E team to be seen as being neutral within a community, not perceived as favoring any side related to existing conflicts.

What qualities make up a good M&E team?

- Integrity (being honest)
- Respect
- Compassion
- Professionalism
- Courtesy
- Sensitivity

If you do not follow ethical and professional M&E conduct, **you can put participants at risk.**

Key technical requirements beneficial for M&E staff members for GBV prevention and response:

- Experience in statistics and sampling frames and methodologies
- Experience with at least Excel-level data analysis
- Experience with GBV prevention and response interventions
- Experience with question design and translating indicators into effective tools for measurement
- Experience with supervising data collection in remote and restrictive contexts and data quality assurance methods to ensure high quality data is captured

- 7. Put in place extra safety measures if M&E activities involve children (under age 18).** Higher ethical and safety standards must be in place for involving children in M&E data collection as they are more vulnerable in many contexts and are not able to make informed consent. Deciding whether and how to involve children in M&E data collection requires a thorough consultation with technical experts with experience in working with children on sensitive topics such as sexual violence. If your project includes children and adolescents as primary beneficiaries, their participation in M&E activities may be a desired outcome itself and children's voices should be heard as much as possible while limiting situations where adults speak for children. In this case, data collectors must be trained and experienced in working with children on sensitive topics,



and parents and other adult stakeholders must be sensitized to support and commit to participatory M&E processes that safely include children. It is also important to work with technical experts at the planning stage to verify compliance with local laws, and to ensure appropriate child protection and referral process is in place if children disclose being in danger from people they are living with. See resources below that provide further ethical guidance and practical tools for gathering information from and with children.

Key Questions for M&E team to ask to determine if primary data collection is feasible and ethical:<sup>11</sup>

- 1. Could gathering data harm or re-traumatize GBV survivors?** If YES – do NOT gather information. Look for data where it is readily available or exists in other forms. Do NOT gather information from survivors where referral services are not available or where survivors may not feel comfortable accessing these services.
- 2. Could data collection increase or create new risks for GBV survivors or community members?** If YES – do NOT gather information. Data should be collected, reported/shared only if it will safely promote protection (as all project activities should). No data should be shared that may be linked back to an individual.
- 3. Is there sensitivity surrounding a discussion on GBV?** Sensitivity should not prevent data collection; follow these steps to ensure survivors are protected:

11. Adapted from USAID Toolkit for M&E of GBV Interventions along the Relief to Development Continuum <https://bit.ly/2vdrAzU>



- a. Carefully consider data collection methods and ensure they are appropriate
- b. Use less direct lines of questioning
- c. Ensure there is a trained staff to respond to possible stress or trauma from participants

In conclusion to this section, we must uphold the principle of ‘do no harm’ by avoiding negative effects on crisis-affected communities while strengthening local capacities to be more resilient to shocks as a result of humanitarian action. With this aim, see **Commitment 3** of the **Core Humanitarian Standards (CHS)**, which provides guidance on quality criteria, key actions and organizational responsibilities that can help to put people and communities at the heart of the M&E work in GBV projects.

#### Resources:

- WHO’s Ethical and Safety Recommendations for Researching, Documenting and Monitoring Sexual Violence in Emergencies
- The Core Humanitarian Standards: <https://corehumanitarianstandard.org/>
- IRC’s Caring for Child Survivors of Sexual Abuse
- Save the Children’s Toolkit for Monitoring and Evaluating Children’s Participation
- Handbook on Data Protection in Humanitarian Action
- Inter-Agency Standing Committee Minimum Standards for Gender-Based Violence in Emergencies Programming - <https://bit.ly/2CELSt1> - Pg. 122-130

#### Annexes:

- **Annex 1.9.A:** Informed consent form

## Section 2.

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# Developing an M&E Plan for Your Project

### 2.1 Ensure Project Design and M&E Is Informed by Initial Needs Assessments

Before you design your project and create your M&E plan, organizations should conduct a needs assessment. The assessment will provide the project team with an up-to-date understanding of the target community and the needs of its people. This information is used to determine if a project should occur there, and what type of project may be needed (scope, scale, services, etc.) For GBV prevention and response projects this information can often be gathered through secondary information or key informant interviews. Speaking with GBV survivors should only be done as a last option as there are many other data sources available and speaking with survivors can result in re-traumatization and added risks. If survivors are spoken to, all the ethical standards in Section 1 must be considered and applied.

Information gathered for needs assessments can include pre-existing reporting rates, support services available, case loads, NGOs operating in the area, and gaps in service provision compared to the needs of GBV survivors in the area, among others. Secondary data, discussions with cluster members, and review of reports or previous recent sector assessments (such as health, livelihoods, and gender) can often provide much of the data necessary for a needs assessment to inform the design of your GBV project. **Rather than conducting your own costly, time consuming, and possibly unnecessary data collection that could result in additional trauma for GBV survivors, first look at existing reports and data.**







**If data is not available elsewhere**, there are three key steps in conducting a needs assessment for GBV programming:

**1. Define the methodology for the assessment**

Determine what information you need to collect, who you need to collect it from, and how you will collect it. Think through these aspects and write down your plan for the assessment as a Terms of Reference (ToR) for the assessment (see template in **Annex 2.1.A**, including some guiding sections to fill in and develop the ToR). Keep in mind the human and financial resources available as well as the possible risks created by using a specific method for data collection, as these can all be limiting factors on what you are able to plan. See 'Specify the sampling frame & methodology' section on page 98 for more about sampling guidance.

**2. Develop the data collection tools**

Reflect on who you need to talk to in order to gather your necessary data; organize by stakeholder type, i.e. government official, NGO staff, service provider, beneficiary, etc. Consider what information you need to collect from each group and begin brainstorming topics and questions you would ask them. There are several data collection tools to consider for needs assessments, one or more can be combined to provide a fuller picture of needs. A full list of data collection tools can be viewed in **Annex 3.2.A**; however, the most widely used needs assessment tools are outlined below:

Please note that all needs assessment tools you use need to be changed to fit the country context!



Tool	Use/Objective
Safety audit tool <b>(Annex 2.1.B)</b>	To help understand the target community's layout, infrastructure, access for different people to basic services, presence of any risks, etc.
Service mapping tool <b>(Annex 2.1.C)</b>	To map out existing services within the community and to understand the gaps and challenges in services
Focus group discussion tool <b>(Annex 3.2.C)</b>	To understand group attitudes, perceptions, and beliefs relating to a particular issue
Key informant interview tool <b>(Annex 3.2.D)</b>	To gain a first-hand knowledge about needs and gaps in a particular topic and to learn about causes of a problem
Sample survey tool <b>(Annex 3.2.B)</b>	To quickly gather feedback from project stakeholders about project quality, practices and attitudes

Data collection staff should be trained on both the assessment methodology and data collection tools, as well as ethical approaches in data collection. Keep in mind the overall M&E resources (time and funds) and the capacities (experience and skills) of staff undertaking the needs assessment. It is also important for data



collection staff to have a coordinated way of asking questions such as the language to use. This will improve data quality.

### **3. Use the assessment results for project design**

Once the data has been collected, your team should review the data, looking for trends and analyzing the information collected. This analysis will help with making decisions on the priority of needs, identifying possible solutions, selecting which solution should best address the needs, and proposing an action plan.

#### **Resources:**

- RHRC Consortium Gender-based Violence Tools Manual For Assessment & Program Design, Monitoring & Evaluation in conflict-affected settings (Section II, Assessment Tools, p. 17) - <https://bit.ly/2MMkVFG>
- Humanitarian Needs Assessment: The Good Enough Guide - <https://bit.ly/2ZAK6ST>

#### **Annexes:**

- **Annex 2.1.A:** TOR template for needs assessments
- **Annex 2.1.B:** Safety audit tool
- **Annex 2.1.C:** Service mapping tool

## **2.2 Establish Your Project Goal, Objectives, Activities, and Logical Framework**

Projects have goals and objectives

**Goals:** the desired impact or major change we wish to see

**Objectives:** the desired program results that is specific, measurable, attainable, relevant, and time-bound (SMART)

Good goals:

- To improve the lives of women who experience gender-based violence
- To empower women and girls to participate in decision-making in society
- To reduce the incidence of GBV







Good objectives:

- To increase the perception of safety among women and girls in the target population as demonstrated from baseline to endline of project.
- To increase the % of men and women in the target population who believe that violence is not an acceptable way of dealing with conflict.
- To increase the % of GBV survivors who attend at least X psychosocial support sessions by the end of the project.
- To establish X% of family health centers that have health care providers who can provide referral for GBV services to high risk clients by the end of the project.

**SMART is a common acronym used to guide the setting of objectives and the creation of indicators. In summary, objectives and indicators should be:**

**S**

**Specific:** The objective/indicator should be narrow and focus on the 'who' and 'what' of the intervention.

**M**

**Measurable:** The objective/indicator has the capacity to be counted, observed, analyzed, or tested.

**A**

**Attainable:** The objective/indicator is realistic to achieve as a result of the intervention.

**R**

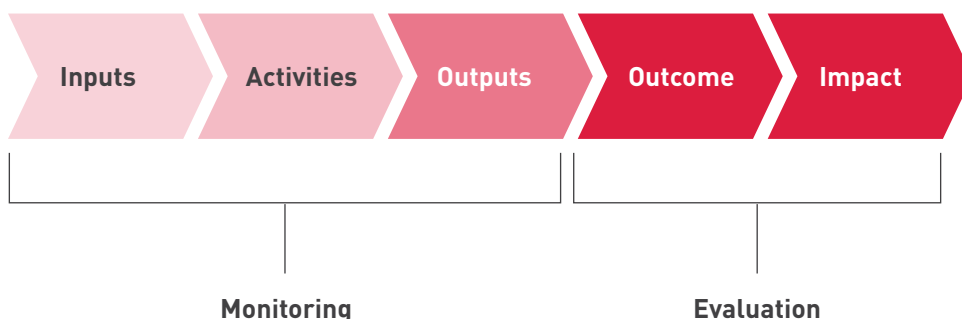
**Relevant:** The objective/indicator should be a valid measure of the objective and should relate to the desired impact of the intervention.

**T**

**Time-bound:** The objective/indicator is attached to a time frame.

**NOTE:** Objectives need to be refined and target values set by primary or secondary data, or other suggested targets by relevant clusters.

**Developing the “logic” of your project can help you create the logical framework (logframe).** The project logic explains how your project activities produce the desired outcomes (objectives) that in turn contribute to achieving the intended impact (goal). The logframe is a planning tool that helps to communicate what your project is about and how it leads to short- and long-term changes among your target beneficiaries. It can be a visual or a narrative representation which describes the necessary steps that needs to be taken to get to the impact and help define indicators at the different steps to measure whether or not the intervention is working. Below is a visual presentation of a project logic and where M&E takes place:



Once you have outlined a basic project logic, you can work out the details to create the logframe. The following steps describe how you can work through the logframe:

- Step 1: Define the project’s intended **impact** (the goal of the project) – What does your project hope to ultimately achieve? This can be larger than what the project can accomplish alone; this can be something that the project contributes to, such as the elimination of GBV.
- Step 2: Define the changes in effect of outcomes you desire for the target population (knowledge, attitudes, skills, behaviors, or practices the population will adopt due to the project) – What changes will the population need to experience to achieve your project’s goal?
- Step 3: Define the project’s outputs – What supports or services or actions are necessary to achieve the project outcomes?
- Step 4: Define the project’s activities – What activities will result in the project’s outputs?
- Step 5: List the essential inputs – What materials, staff, and resources are necessary to complete the project’s activities? (This list can help with your overall project budget.)

One way to confirm the linkages between your project results is to use **if/then logic**. To do this, ask yourself if your output occurs, then what will be the outcome? For example, if the project establishes and supports community protection networks, then survivors will have increased opportunities to access services, and GBV survivors are better supported in their communities. However, if the outputs do not logically result in the outcomes, then you need to re-examine your theory of change to ensure each linkage is logical and all results progress towards your goal. You can summarize your project's theory of change in a single statement: *This set of inputs and activities will result in these products and services (outputs), which will facilitate these changes in the population (outcomes), which will contribute to the desired goal (impact).*

Logframes typically contain at least four elements (while different donors will have different formats and requirements and you must comply with their logframe formats):

1. Project causal pathway (goal/impact, outcomes, outputs, activities, inputs) demonstrating the logic of how the project is supposed to work
2. Monitoring and evaluative indicators to help measure the progress on each component
3. How you will obtain the information to measure the indicators
4. Any assumptions that may underpin the success of achieving the results

Logframes should be created jointly by project and M&E staff and form the basis for project design and proposal development. Once the project begins, the indicators in the logframe form the basis for the M&E plan and activities.

See logframe template in **Annex 2.2.A** and illustrative logframe in **Annex 2.2.B**.

#### **Resources:**

- USAID toolkit for monitoring and evaluating gender-based violence interventions along the relief to development continuum - <https://bit.ly/37l89Hx>

#### **Annexes:**

- **Annex 2.2.A:** Logframe template
- **Annex 2.2.B:** Illustrative Logframe









## 2.3 Develop Indicators to Track Change

M&E uses **indicators** to track changes or progress a project is making towards achieving its intended activities and outcomes. Within the logframe, indicators should be developed and tied to project outputs, outcomes, and in cases where possible, impact. Indicators should be developed based on population data or estimates that are available; e.g. number of health centers in a district, number of health providers in a district, total population in a district, number of adolescent girls in an area, etc.; if this data is not available, some indicators you might wish to develop may not be able to be calculated accurately.

Indicators answer the questions:

“What information will show that the activities were delivered as intended?”

“What information will show that the intended target population has been reached?”

“What information will show that the intended outcome has occurred?”

Indicators can be:

- Simple counts of things: the number of hotlines available in a project region; the number of hours hotlines are open)
- Calculations: proportion of health facilities in a project region with a provider trained in GBV screening)
- Presence/absence: existence of a community safety plan to address GBV
- Pre-determined level or standard: 80% of communities (villages) in a district have a community action plan to address GBV

Indicators should not specify any level of achievement – words like “improved,” “increased,” or “decreased” do not belong in an indicator.

How many indicators are enough?

- At least one or two indicators for each key activity
- At least one outcome indicator for each objective
- No more than eight to ten indicators per project



What to consider when selecting indicators:

- Are the indicators I made relevant to my activities, outputs, or outcomes?
- Will it be possible for me to easily collect data on this indicator?
- What financial or human resource limitations do I have?
- Does the donor require any specific data to be collected?

Here are some examples of indicators:

**Output indicators** measure the use of inputs and resources, or the activities implemented, and the quality of these activities:

- # of districts that are covered by GBV project
- # of women and girls consulted in group discussions (including women and girls with disabilities)
- # of GBV training sessions delivered to targeted women

- % of health centers in X district with at least two providers trained in GBV case management
- # of new referrals to GBV services made to health centers in X district
- # of women who seek psychosocial services
- o % of women who seek psychosocial support, who actually receive psychosocial support
- # of participants attending at least 80% of the GBV training sessions, disaggregated by sex, age, and disabilities
- % of participants who attended at least 80% of the GBV training sessions and rank the quality of the training as 'good' or 'excellent'
- % of women/girls in the community who know where to safely receive GBV response assistance

**Outcome indicators** measure knowledge, attitudes, skills, behaviors and intention of the target population:

### **Knowledge**

- Average score on a knowledge assessment on GBV
- % of project participants, disaggregated by sex, who can identify at least three GBV service providers
- % of healthcare providers in a project area/district who agree that GBV is a health issue

### **Attitudes**

- % of men in a town/village/region who report favorable attitudes toward women participating in greater decision-making at home
- % of women in a town/village/region who report feeling more empowered to make family planning decisions
- % of community leaders in a town/village/region who believe women should participate in leadership roles

## Behaviors

- % of participants in X project who have taken some action (speaking out or otherwise) against GBV by the end of the project <sup>12</sup>
- % of healthcare providers reached with project training that self-rate, on a five-point scale effectiveness questionnaire, as more effective in responding to GBV cases six months after the project
- # of project participants who have accessed GBV services, as defined by attending at least two counseling sessions

Impact indicators measure longer-term benchmarks of health or well-being in the wider community that the intervention aims to influence:

- Prevalence of GBV in target region
- Access to justice for survivors of GBV

Before developing your own indicators, look for existing, field-tested ones. The strength of your project's M&E framework depends on how well the indicators are linked with the activities, output, and outcomes being tracked in your project.

## 2.4 Develop a Monitoring and Evaluation Plan

Once preparations for M&E have been made, and the logframe and project activities are finalized, an M&E plan should be developed. An M&E plan is your roadmap to successful implementation of your M&E activities.

By planning the M&E activities early in the project design phase, you can appropriately budget for M&E activities; clarify processes for data collection and data management; consider what tools will work best to collect the indicator data; and work through ethical and safety considerations as you review each data point. Your M&E plan can help reshape your outcome statements and indicators if necessary, to ensure that the planned activities maintain a survivor-centred approach.

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12. The action options listed in the indicator will be defined based on the messaging, training, etc. for your project activities.

Different donors request different templates for an M&E plan; however, the general format is an expanded version of the project's logframe. Both monitoring and evaluation activities should be captured in an M&E plan, encompassing measurement plans for project outputs, outcomes, and goal. See **Annex 2.4.A** for an M&E plan template.

Depending on donor and internal requirements, M&E plans may be in a table or narrative format, and can include the following information beyond what is provided within your logframe:

- Indicator definitions
- Baseline and target data (expected data at end of project)
- Activity timeline (expected timeframe in which to implement activity)
- Data source(s) and collection frequency (where the data on the indicator will come from and how often it will be collected)
- Person(s) responsible for the collection of monitoring data (who will collect the data)
- Person(s) responsible for ensuring data is collected in a timely, accurate, and complete manner
- Person(s) responsible for cleaning the data, following up on missing data, analyzing the data, and presenting/visualizing the data
- Person(s) responsible and accountable for carrying out the evaluation and collecting data
- Data use and dissemination plan (how data will be used and what will be the reporting schedules)
- Mechanisms for regular meetings between M&E and program staff, to ensure data is used to inform program management and decision-making

See **Annex 2.4.B** for a list of possible data sources to use for M&E plan.



Important considerations for an M&E plan:

- **Resources:** How much money and time will be needed to conduct the activities?
- **Capacity:** Does the project have internal capacity to carry out the proposed monitoring and evaluation activities, including analysis and reporting of data collected, or will outside expertise be needed?
- **Feasibility:** Are the proposed activities realistic? Can they be implemented?
- **Timeline:** Is the proposed timeline realistic for conducting the proposed activities?

**Ethics:** What are the ethical considerations and challenges involved with implementing the proposed activities, and is there a plan in place for addressing those considerations?

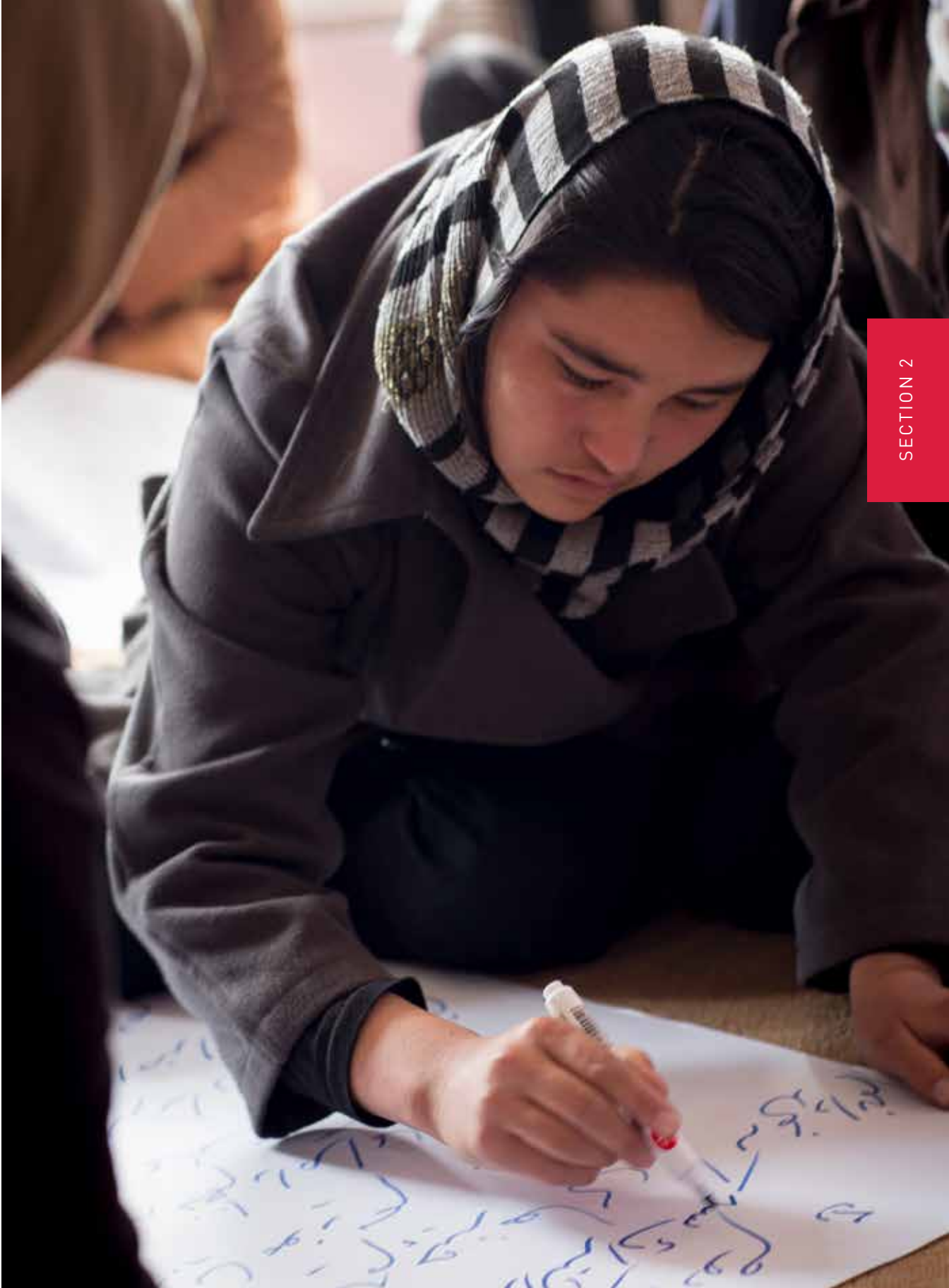
As much as possible, the M&E plan should be developed at the same time the program is designed, so that monitoring and evaluation is well aligned with program activities.

**Resources:**

- RHRC M&E tools guide - <https://bit.ly/2MMkVFG>
- USAID GBV M&E toolkit - <https://bit.ly/37l89Hx>
- IFRC M&E handbook, 2002 <https://bit.ly/2Z8cv28>
- CARE Methodologies for Monitoring & Evaluation in Emergencies - <https://bit.ly/3fcF2ZV>

**Annexes:**

- **Annex 2.4.A:** M&E plan example
- **Annex 2.4.B:** List of possible data sources



## 2.5 Ensure Adequate Staffing and Budgeting to Implement the M&E Plan

### Staffing

Once the M&E plan is completed, review the column showing which staff are responsible for data collection and ensure those staff members are funded in the project budget. There are two options for staff planning for organizations, firstly the organization can attach specific M&E staff to a project if it is large enough, and otherwise M&E staff should manage M&E deliverables for multiple projects. Always ensure that you consider geographical coverage when looking at M&E staffing, for example, only hiring one staff member based in the capital without having staff in the field offices to provide daily support on M&E activities can become problematic and logistically challenging. Plan accordingly.

When selecting members for the M&E team, consider language, ethnicity, religion, political affiliations, region of origin, sex, and general safety context to ensure the safety of staff and respondents. Members of the M&E team should have necessary technical M&E skills and GBV programming experience, with training and capacity building provided to ensure they are capable of carrying out necessary M&E activities for the project.<sup>13</sup> M&E team members should have training and experience to uphold safety, confidentiality, respect, and non-discrimination during M&E activities. Additional training should be provided to staff interviewing GBV survivors to ensure respect, safety, and support for survivors. Team members should also be provided with information about available services so they can safely provide referrals when appropriate for GBV survivors. GBV survivors should only be interviewed if services are available in their area, if there are no services available and you must interview survivors, your organization should have a counsellor available to speak with survivors before and after interviews.

### Budgeting

M&E tasks require separate, specific budget lines in the overall project budget. These costs should be allocated during the project proposal stage. The exact budget allocations will vary depending on the context and demands of the project activities, the complexity of the indicators, and how you structure your M&E plan.

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13. If it is not possible to recruit staff with both programmatic and M&E skillsets, priority should be placed on staff that are best able to maintain the ethical requirements of the evaluation and the Do No Harm approach necessary for M&E activities for GBV programming.



As it is difficult to have a full M&E plan for a project at the proposal stage, a good rule of thumb is to budget at least 5% of total project costs for M&E, although some donors specify the amount allowed for M&E (usually up to 10%). See Figure 2 for elements of M&E budgeting. Ensure staffing needs, including data collection and data entry staff (full, part-time, temporary), and transportation (rural, urban) needs are considered and included for both monitoring and evaluation activities. Refreshments for FGDs and enumerator trainings, transportation, enumerator labour costs, and other costs related to the activities in Figure 2 should all be rolled into the budget lines for each activity.

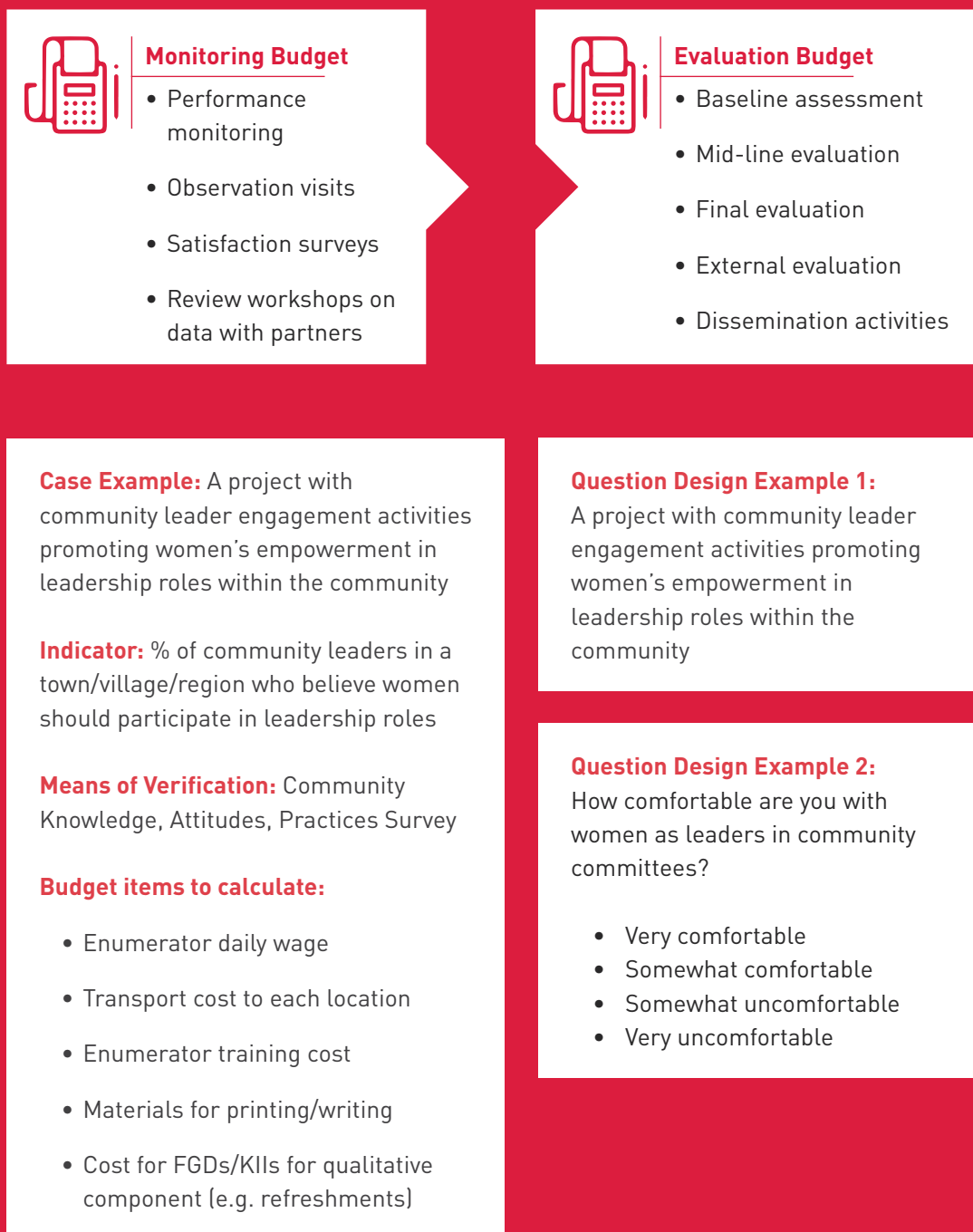
Materials and equipment are often required for M&E activities. Printing of paper forms and data tracking templates, laptops/computers for data entry and recording, tablets and mobile phones for digital data collection, and equipment such as mobile hotspots, SIM cards, and airtime should also be considered as M&E activities can incur costs throughout the project cycle. It is also important to consider costs associated with having to adapt activities due to unforeseen circumstances such as disease outbreaks and security restrictions.

### **Planning for M&E with limited funding or added restrictions**

If your organization has challenges completing M&E activities due to various restrictions, including resources and external risks such as disease outbreak and security, it is also possible to plan other methods to collect data. Consider using community volunteers to track output data and quality of implementation through a participatory approach. It is best to select community members with a sufficient level of literacy and provide simple paper templates for data entry if you are planning for them to record information, otherwise plan to verbally record their information through regular visits to the community or via phone call. Additionally community volunteers can also be used to conduct population-based surveys within the community with project staff supervision, although it is often suggested to pay the daily rate for community members and hire them as daily workers as the amount is often inexpensive. Project staff must ensure that the community volunteers receive adequate training on the methodology and ethics related to the data collection to ensure data quality. Close observation and review of daily data collection responses should be done by project staff in order to catch mistakes and provide constructive feedback to the community volunteers for both M&E efforts. More information can be found in the remote management and monitoring section (Section 1.7).



Figure 2: **M&E budget elements to include based on M&E plan requirements**



**Resources:**

- M&E of Gender-Based Violence (GBV) Prevention and Mitigation Programs - <https://bit.ly/2Yj2mhl>
- Violence Against Women and Girls: A Compendium of Monitoring and Evaluation Indicators. Bloom, Shelah S. MEASURE Evaluation 2008. - <https://bit.ly/2Ux8QZk>
- Toolkit for Monitoring and Evaluating Gender-based Violence Interventions along the Relief to Development Continuum 2014 (Annex J and F) - <https://bit.ly/37l89Hx>
- IRC's Outcome and Evidence Framework - <https://bit.ly/3cSMtUd>



## Section 3.

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# Conducting Monitoring and Evaluation

### 3.1 Implement Monitoring Activities

Monitoring the project activities can be broken into two parts: 1) collecting information in a useful format; and 2) analyzing the information for project management purposes.

Monitoring activities track changes and processes in the project implementation to measure progress towards project goals and to identify any problems. Monitoring primarily collects input- and output-focused data. What data and how to collect this data should be detailed in the project's M&E plan (**Annex 2.4.A**).

#### Select the monitoring tools

Tools for monitoring should be simple and specific to the project indicators and activities. Different monitoring tools should be utilized across project implementation to gather information in different ways that focus on both quality, quantity, and ways to adapt program activities due to unforeseen risks and barriers. This will help reduce methodological bias. The tools can be outlined in the M&E plan (Section 2.4) and should collect data on project activities and outputs from activities.

Monitoring tools can include but not limited to:

- Observations and in-person visits by organization staff
- Activity reports and attendance sheets
- Analysis of participant demographics
- Quality checks and surveys with stakeholders

#### Connect indicators to monitoring activities

Monitoring activities should provide data directly related to the quality and standards of a package of services. Therefore it is important for the indicators chosen in your

**Case Example:** A project activity rehabilitates safe women's spaces

**Indicator:** % of women's spaces rehabilitated/supported that are considered safe and private

**Means of Verification:** Women's Safe Space Checklist Tool

#### Example Questions for Tool:

- Are there washrooms available in working order?
- Is the location accessible for women with disabilities?
- Are case workers available in the space?

A combination of questions can give you an idea of whether the space is confirmed as safe and private

M&E plan to be properly translated into the monitoring tools you plan to use within the project. Where applicable, adapt existing tools or standards to ensure you are meeting a consensus of quality standards within the sector. It is important to define the terms used within the indicator when conducting monitoring for quality. For example 'safe' and 'private' and other markers of quality in different environments needs to be contextualized. Women's spaces as shown in the case example would look significantly different in South Sudan compared to Afghanistan but critical components will remain the same.

#### Review monitoring data regularly

Monitoring data should be reviewed jointly by M&E and project teams regularly to track progress towards targets, and make plans to adjust implementation to accelerate or slow down project implementation to stay on schedule. Regular reviews can also allow the team the opportunity to reflect on what they have been working on and how they have been working, examining approaches and possible



areas for increased effectiveness, and identifying trends in population dynamics, service usage, and participation from one month to the next.

Monitoring data can be stored in Excel or other database systems. The data should be presented in regular monitoring reports (monthly, quarterly, annually) for internal (your organization and partners) and external (donor and working group/cluster) use. However, the security of survivors and beneficiaries must be protected, and anonymity maintained at all times. See the section on ethics (Section 1.8 Participatory, Gender-Sensitive, and Inclusive Approaches to M&E) for more on the importance of security and anonymity of data collection for GBV interventions.

### **Track outputs and use the data to modify project implementation**

Outputs are the direct results of activities. They are generally easy to define and measure, compared to outcomes and goals. Monitoring systems should be put in place to track outputs and ensure project activities are continuing as planned.

A key piece of output-level information for GBV prevention and response projects is **types and incidents of GBV** occurring in the area. Project teams can collect this and other output-level data and activity counts using Excel databases. All teams working on the project should be provided the same template for the database to ensure consistency of data collection and to provide the opportunity for easier combination of database forms for a complete data set for the project. Counts for project results should be collected starting from the first project activity and continue until the last output is completed. This information can be recorded in a **Project Progress Report (PPR)** for each project. The PPR is an Excel database that records all project results (output, outcome, and goal) across the project implementation period. Calculations are built into the PPR to continuously calculate percentage progress towards targets and total reach for project results. The PPR template is provided in **Annex 3.1.A**.

The **Gender-based Violence Information Management System (GBVIMS)** is a structure for data collection, storage, analysis, and sharing for GBV prevention and response implementers worldwide.<sup>14</sup> GBVIMS is another set of tools for tracking output data, which has been developed by an international group of NGOs and UN agencies.

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14. <http://www.gbvim.com/>



GBVIMS has four key elements:

1. GBV classification tool
2. Intake and initial assessment form
3. Incident recorder
4. Inter-agency information-sharing protocol template

These tools are useful for organization to collect output-level data for GBV projects. If your organization registers with GBVIMS, the data you collect will be included in aggregate form for trend tracking through GBVIMS. Even without membership, these tools provide a solid basis for monitoring your project's output data. Additional tools have been included in the annex of this toolkit, including a monthly GBV report template (**Annex 3.1.B**).

**Monthly reports** are a good practice for sharing monitoring evaluation with project staff, partners, and other stakeholders. The information to be included in monthly reports, and who is responsible for data collection and reporting, should be outlined in your M&E plan (Section 2.4). The reports form the basis for discussions of project progress and any adaptations for implementation that may be necessary.

The report template provided in **Annex 3.1.B** indicates information to collect for the monthly reports. The template includes key information such as:

- Incident report totals and report rates
- Additional contextual or situational information about GBV incidents (other than report rates)
- Description of contributing factors, issues, and problems needing action
- Status of progress towards project targets

Calculating the report rate allows for comparison of rates across time and areas. Using the formula below will give you the report rate for all types of GBV in the setting. The report rate can be calculated using the following formula:

$$\frac{\text{\# GBV cases reported during the month}}{\text{Total population in area during the month}} \times 10,000 = \text{GBV reports per 10,000 people during the month}$$



Project teams should also periodically share information verbally with the communities where they are working. Providing continuous updates and being open to participant feedback will increase transparency for your project and will demonstrate accountability to the people in your implementation area. Information shared with the communities should include achievements of the project thus far, progress towards targets, the management of the project, strengths and weaknesses of implementation, and cost effectiveness of the project.

It is important to remember that monitoring outputs is not the end goal, rather, the means to improve programming. Monitoring data should contribute to decision-making about the implementation, including making course adjustments, and if it does not, another look at the project M&E framework may be necessary. Decision-making about the implementation may involve revisiting the project logframe with your project and M&E staff and revising output indicators, output targets, method of data collection, or data collection tools. It may involve working with project participants to identify better ways to understand what output information is useful, how to collect the information, and what to do with the learning.



دوستوں! اگر تم کو بھی  
یہ سب باتیں یاد آجائیں  
تو تم بھی ان کی مثال بن سکتے ہو  
جو کہ ہماری مثال بن رہے ہیں  
اور ان کی باتیں یاد آجائیں  
تو تم بھی ان کی مثال بن سکتے ہو  
جو کہ ہماری مثال بن رہے ہیں  
اور ان کی باتیں یاد آجائیں  
تو تم بھی ان کی مثال بن سکتے ہو  
جو کہ ہماری مثال بن رہے ہیں





### Establishing community-based feedback mechanisms

Feedback mechanisms are essential for GBV projects and provide project and M&E teams with insights on how stakeholders are reacting to project activities. Feedback activities provide project stakeholders continuous opportunities to share their experience (compared to evaluations which occur at key points in the project cycle) and for project staff to learn how to improve or adapt project results to better match the needs and experience of beneficiaries. M&E staff should be responsible for the community feedback mechanism, recording feedback using the methods below and following up with project staff, depending on severity of complaint, within 2 weeks of receipt. The use of M&E staff for the management of feedback mechanisms provides an impartial recipient and mediator for stakeholder feedback. More severe cases such as fraud, malpractice, or protection issues, especially those that fall under the PSEA policy of the organization, need to be dealt with faster (see **Annex 3.1.C** for example system). M&E staff responsible for the feedback mechanism will be responsible for following the organization's guidelines for managing and sharing beneficiary feedback.

There are several **common types of feedback mechanisms** that can be employed, which are highlighted below. Be aware, approaches should be customized to match your programming contexts for feedback collection. **Do not** use any of the options below without considering stakeholders' literacy levels, access to communications technologies (phone, text, assistive device, etc.), mobility and transportation abilities, the sensitivity of the information possibly being conveyed, and levels of trust between beneficiaries and NGOs when deciding which feedback method to use.

Table: **Common Types of Feedback Mechanisms**



### **Suggestion Box**

Boxes should be made available at project sites or agreed community sites with visibility for War Child Canada in contexts where this is appropriate. The boxes should be locked and protected from water and other environmental factors. Designated staff should collect the complaints on a set schedule every few days and digitize the information into the country community feedback mechanism (CFM) database. With this method, consideration must be made as to whether local languages have a written script; literacy levels of the population; and access to writing materials of the population.



### **Toll-Free Phone Line, or Dedicated WhatsApp Number**

A toll-free line can be setup with a local network that does not charge incoming callers to call the number. A specified staff member, CFM officer, or M&E officer will have the designated phone and will accept incoming calls during specified times each day (usually working hours). For this option, consideration must be made of languages spoken by respondents to ensure the staff member responsible will be able to converse with incoming callers clearly and understand the nature of their concerns; and of phone network access. Alternatively, a dedicated WhatsApp number can be set up for people to use to provide feedback in contexts where this application (or similar) is commonly used. This virtual feedback mechanism is becoming increasingly accessible for people and is also easier to manage administratively.



### **In-Person Staff**

In places where it would be difficult to use feedback boxes or toll-free phone lines, it is best to establish an in-person feedback process. This can also be used as a secondary service, alongside one of the other options. Designated staff will set up a desk and fill out the complaint form and then enter these into the database at a later date. Communities should be well aware of those locations or sites where the help desks will be located ahead of time and allotted times to take complaints should not change from week to week. Particular attention should be made in gathering feedback from groups with specific needs, such as people living with disabilities, the elderly and children.



### **Community Volunteers**

Identifying and recruiting volunteers in the communities of implementation can be used in areas where staff are unable to travel or do not have regular access. Community leaders should

have some say in who is appointed, but not the final decision as they may have bias in their choices for volunteers. Community volunteers can be useful as they already have ties to the individuals and are familiar with the area of operation. It is important to designate several volunteers from different demographics, such as women and youth, to ensure in the area to ensure a more representative and objective (unbiased) reporting process; beneficiaries may feel more comfortable talking to people from groups similar to their own. However there can be limitations to what cases volunteers should be privy to as volunteers may be involved in the situation being reported or they may have ulterior motives that limit which cases they report and prioritize.



### Mobile Data Collection

Rather than recording feedback on paper forms, a smartphone system can be utilized both online and offline by creating a digital ODK or Kobo version of the standard paper complaint form. Each complaint or feedback would then be entered directly into the form on the smartphone or tablet as an individual instance and then uploaded to the Kobo server when Wi-Fi is available and added to the CFM database at a later date. See resource section for some instructions and practical tips on using Kobo Toolbox as a Community Feedback Mechanism and some of the benefits of this approach. As with all mobile data collection, security of the phones, staff, and the data recorded must be considered before this option is selected.



### Satisfaction surveys

GBV projects should also integrate satisfaction surveys into data collection as an additional component to feedback mechanisms, as part of the M&E plan (Section 2.4). These surveys gather feedback from direct beneficiaries of services, gathering information about the quality of the services they received, the performance of staff, and the impact of the project for the beneficiary (this also includes any negative effects of the project). Project or M&E teams can conduct the survey immediately after the provision of services or at a later date, depending on what is most appropriate for the beneficiary and for the team. If you are able to collect the contact information for beneficiaries and have been told by beneficiaries that it is safe to contact them at a later date and have given consent to being contacted, then this can be a good process. If beneficiaries consent to providing feedback immediately after a service is provided, this can reduce potential safety concerns related to future communications. The timing for surveys must be set out prior to the collection of data to ensure consistency of the approach and to ensure that the safety and needs of beneficiaries are prioritized. An example of a client feedback form is provided in **Annex 3.1.D**.

In the case of GBV projects, the provision of a feedback mechanism is integral, but must be implemented with consideration of the ethical and safety concerns explained earlier (Section 1.8). Key concerns are the anonymity of respondents and their ability to safely share information. Some considerations for feedback mechanism for GBV projects include:

- Survivors should **NOT** be expected to use a community feedback mechanism to seek support, they would plan to access services through counsellors or the proper protection pathways.
- Door-to-door data collection should be avoided, unless it is specifically identified as being best by some individuals, including those with mobility issues – by visiting beneficiaries of GBV services at their homes, you are telling the community that this person received services and you are not upholding the beneficiaries’ anonymity, privacy, or safety.
- Women’s and children’s access to mobile phones – if you conduct data collection by calling beneficiaries, you must be certain that beneficiaries can answer the phone safely and can speak on the phone privately. If you cannot be sure of the safety and privacy of beneficiaries to respond to a phone call, do not use this method for data collection.
- Women’s and children’s freedom of movement and privacy – if you provide a feedback desk you must be certain that women can travel to the desk and that there is privacy when women share their concerns. If women are not free to travel to the desk location, you will not be able to gather feedback from key beneficiaries this way and should consider alternatives for the context.
- Cultural taboos regarding GBV – survivors of GBV around the world face stigma and marginalization, which reduces their likelihood of seeking services or speaking out. Your feedback mechanisms must ensure the safety and security of people providing feedback.
- Gender of project staff receiving feedback – the standard practice for GBV service provision (including feedback mechanisms) is to have female and male staff available to speak to beneficiaries, with beneficiaries deciding who they feel most comfortable speaking with; most often female staff speak to female beneficiaries, and male staff speak to male beneficiaries.
- Languages spoken by stakeholders – feedback mechanisms need to be available in the languages spoken by beneficiaries, this means that staff

available must be able to converse with beneficiaries comfortably and that any written materials (depending on literacy levels of beneficiaries) must be in a language using words easily understood by beneficiaries.

- In assessing different types of feedback mechanisms, prioritize the best mechanism as identified by the survivor themselves, in line with a survivor-centred approach.

**Resources:**

- Feedback Mechanism Example (Macedonia) <https://bit.ly/2zkzn2n>
- KoBo Toolbox Support <http://help.kobotoolbox.org/>

**Annex 3.1.A:** PPR example

**Annex 3.1.B:** GBV monthly report template

**Annex 3.1.C:** Community feedback mechanism system

**Annex 3.2.D:** Client feedback form





## 3.2 Conduct Evaluations for Your Project

Evaluations can help you understand whether or not the project is achieving what it set out to do. They can focus on measuring process, outcomes, and impacts of a project. You may also choose to evaluate both process and outcomes of your project.

Evaluations are often carried out on a *baseline, midline, and endline* timescale:

- **Baseline:** The measure of the target population before the project has started
- **Midline:** The measure of the project when it is at the half-way mark. For example, the midline evaluation of a three-year project would happen at the end of quarter 2 of year 2 of the project
- **Endline:** The measure of the project when the project is finished. For example, the endline of a three-year project would take place after quarter 4 of year 3 of the project

Here are some common types of evaluations:

### **Process evaluation:**

- Complements ongoing monitoring, but goes a bit beyond
- Focuses on the processes of the intervention, looks at how the intervention was implemented, and the achievement of the outputs, rather than the intended outcomes or impact
- Determines what barriers/facilitators exist for the intervention to achieve progress toward their objectives
- Example: project participants' assessments of the quality of the intervention and the ability of project staff to complete planned activities within agreed timeline

### **Outcome evaluation:**

- Demonstrates whether and by how much the project achieved its intended outcomes
- Answers the question, "So what? What difference did the project make?"

- Assesses changes in knowledge, attitudes, behavior, skills or other conditions among project participants that is different following the intervention
- Measures change, thus “before and after” data is necessary
- Can be used by project staff, community members, and donors/governments to inform decisions to continue, improve, scale up, or replicate it elsewhere
- Cannot necessarily determine that the observed changes are due to the project; changes could be due to other causes or a combination of the project and other factors in the context. Evaluations generally measure how the project has contributed rather than attributing the change only to the project intervention.

### **Impact evaluation (For additional guidance see resource section):**

- Conducted later than outcome evaluation – typically years after the end of an intervention – to determine the lasting effect on the target population
- Attributes change to a particular intervention by ruling out all other possible explanations
- Seeks to measure the difference between outcomes with the project versus without the project
- Often completed through an external evaluator as it requires rigorous study design to isolate causal effects

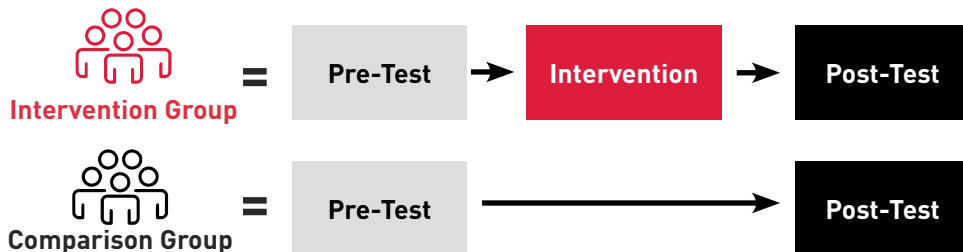
Evaluating the impact of your project requires rigorous methods to rule out any other explanation for the outcomes other than the project itself, and therefore may require hiring technical expertise to do so; organizations often hire consultants or external evaluators for this purpose, especially for impact evaluations.

For the purposes of this toolkit, we will focus on *outcome evaluations*.

### **Choose an evaluation design**

There are several ways (from strongest to weakest design) to assess whether or not the changes observed among participants are the result of the project intervention. The following are examples of assessing change in pre-test/post-test but similar designs can be used for baseline/endline and other types of outcome level evaluations:

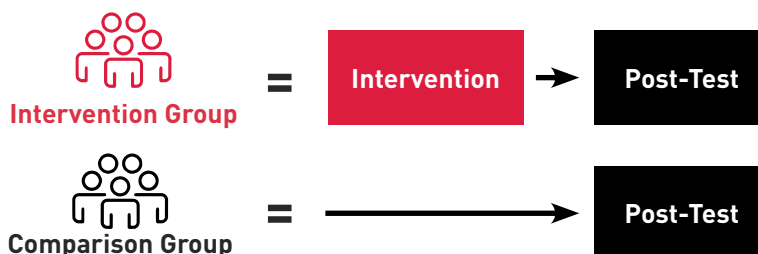
1. **Pre-test/post-test evaluation with comparison group:** collecting data from intervention group AND comparison group before the start of the project (baseline) and at the end of the project (endline).



2. **Pre-test/post-test evaluation without comparison group:** collecting data from intervention group only before the start of the project (baseline) and at the end of the project (endline).



3. **Post-test evaluation with comparison group:** collecting data from intervention group AND comparison group at the end of the project (endline).



4. **Post-test evaluation without comparison group:** collecting data from intervention group only at the end of the project (endline).





Evaluation Design	Advantages	Disadvantages
1. Pre-test/post-test evaluation with comparison group	<ul style="list-style-type: none"> <li>• Best when project has not yet begun.</li> <li>• Provides most certainty on whether or not the outcomes are actually the result of the project.</li> </ul>	<ul style="list-style-type: none"> <li>• Requires a comparison group that is similar to the intervention group.</li> <li>• More time and resources required.</li> </ul>
2. Pre-test/post-test evaluation without comparison group	<ul style="list-style-type: none"> <li>• Best when project has not yet begun and when it is not feasible or ethical to find a comparison group.</li> <li>• Simple to implement and same evaluation tools can be used to collect data before and after the project.</li> </ul>	<ul style="list-style-type: none"> <li>• Cannot account for other factors outside the project for the outcomes.</li> </ul>
3. Post-test evaluation with comparison group	<ul style="list-style-type: none"> <li>• Best to implement when project is already underway and a comparison group can be feasibly and ethically found.</li> </ul>	<ul style="list-style-type: none"> <li>• Requires a comparison group that is similar to the intervention group.</li> <li>• Outcomes cannot be attributed to project only.</li> </ul>
4. Post-test evaluation without comparison group	<ul style="list-style-type: none"> <li>• Best to implement when project is already underway and time is an issue.</li> <li>• Simplest and least expensive design.</li> </ul>	<ul style="list-style-type: none"> <li>• Cannot determine how much of the change occurred.</li> <li>• Cannot account for other factors outside the project for the outcomes.</li> </ul>



It is important to note that the comparison group should ideally receive the same intervention eventually to avoid the ethical dilemma of only providing information and services to only one group (for example staggered beneficiary groups). The comparison group also should be as similar (in age, gender, socio-economic status, religion, ethnicity, etc.) to the intervention group as possible so that an accurate comparison can be made.

In many contexts, the reality may be that an evaluation is planned after the project is already underway, so there is no way to collect baseline data, or there are other restraints that make it challenging to collect data from a comparison group. There are ways to work around this. If no baseline data was collected from the intervention group, it is possible to ask participants whether any knowledge, attitudes, or behaviors changed as a result of the project. If there is no comparison group, it may be possible to compare endline data from those who participated in the project to existing data on similar groups in the community. One valid way to get comparison data without an actual comparison group is to stagger the project so you have two groups of participants, and use the baseline data from the second group of participants as the comparison data for the group who has completed the project.

### Select and develop data collection methodologies and tools

Deciding how to collect the evaluation data and what tools to use depends on the indicators you have selected to measure the change toward your outcomes. Drawing from your logframe, consider what type of information is needed for each indicator to help you decide how to collect that information and what tools might work best.

There are two kinds of evaluation data you will likely collect – *quantitative and qualitative*. Below describes each kind:

**Quantitative data** is information that can be measured and written down in numbers. It answers the questions: “How many?” “How often?” or “What proportion?” and measures levels of behaviour and trends.

**Qualitative data** includes information that are about qualities or characteristics and cannot be measured easily in numeric form. It answers the questions: “Why?” “Why not?” or “What does it mean?” and allows insights into behaviour, trends, and perceptions.

Mixed-method designs are a strong approach to capturing accurate, informative information about the impact of your program.

The data collection tools listed below, while not exhaustive, are some that are commonly used to collect quantitative and qualitative data. See **Annex 3.2.A** for an overview of commonly used tools and their advantages and disadvantages.

Type of data	Describes	Tools Use (Not Exhaustive)	Advantages	Disadvantages
Quantitative	“How much?” “How many?” “To what extent?”	Surveys; Questionnaires; Project records (e.g. participant registers, attendance/ intake sheets); Observation checklists	Cheaper to implement. Comparisons can be easily made when tools are standardized.	Limited in their capacity to explain complex issues or unexpected differences. Does not provide explanations for project context.
Qualitative	“Why/Why not?” “What does it mean?” Insights into experiences, perceptions and beliefs	Focus group discussions (FGD) Key informant interviews (KII) Individual interviews Case studies	Good for exploring project results in detail and unintended consequences of the project.	Expensive and time consuming to implement. Findings are not generalized to participants outside the project and only apply to the group involved.

To see full examples of commonly used tools, see annexes below:

**Annex 3.2.B:** Sample survey tool

**Annex 3.2.C:** Sample FGD tool

**Annex 3.2.D:** Sample key informant interview tool

**Annex 3.2.E:** Sample individual interview tool and observation checklist

**Annex 3.2.F:** Sample case studies





### Forming the data collection team

Program evaluation processes require many resources, and may require hiring additional temporary staff to assist in carrying out the data collection required for the evaluation. This is especially true when considering that routine monitoring must still continue, even while the evaluation is going on. The success of an evaluation relies heavily on the selection, training, and supervision of a data collection team. When selecting data collectors, consider the following:

- **Gender:** If collecting data from women, the data collection team should be female. If there is to be any data collection from men, such as husbands or male key informants, there may be a need to hire male data collectors.
- **Age:** If collecting data from adolescent girls, they may feel more comfortable discussing personal information with someone closer to their age. If collecting data from older persons, consider using slightly older data collectors if feasible.
- **Locality:** It is sometimes best to have the data collection team made up of individuals who live in the same community as project participants. In other cases, enumerators from the location can also make people feel uncomfortable sharing information. The best option given the context should be used.
- **Inclusion:** Ensure you are considering refugee community members, disabled individuals, minority groups, and consider local dynamics.

### Specify the sampling frame and methodology

A sample is a subset of a population which aims to be representative of the entire population (participants of the project). Sampling reduces the amount of time and resources required for an evaluation by allowing you to select information from a representative subset of participants of a project, rather than having to collect data from all of them. The key to collecting data from a sample of your project participants is that you must take steps to ensure that the people you include are as representative of the whole group as possible. This means you must select participants you know are satisfied with the project activities and those who may not be. Participants who have attended many activities and those who only attended a few must both be included. You cannot select participants based on one characteristic and exclude others – this will “bias” your sample.

The sampling process differs greatly depending on whether you are collecting quantitative or qualitative information. For **quantitative information**, we must ensure that everyone has an equal chance of being selected for the sample. To do this, we should calculate the number of participants needed based on the total

participants. See resource section for sample size calculator. Once a sample size has been determined, there are several approaches to selecting participants. Below are three options for quantitative sampling in GBV-related interventions:

Probability sampling (representative of larger population):

- **Random sampling:** one of the best ways to guarantee a representative sample. Random sampling requires listing all project participants and selecting at random from the list.
- **Systematic sampling:** a random participant from the full list of participants is selected, then using a set pattern, every nth person (e.g. every 5th person) is chosen until desired sample size is reached.
- **Cluster sampling:** clusters of participants are first organized – by creating subgroups of participants or geographic areas within the target communities – and then from each cluster select the participants or households using random or systematic sampling.

Non-probability sampling (not representative of larger population):

- **Convenience sampling:** when full lists of individuals is not available and it is difficult to locate them, the data collector can include any participant they can reach, based on time and resources (persons entering and exiting a health center)
- **Snowball sampling:** the data collector will interview one eligible participant and receive referrals to other eligible participants in the community (for example, persons who regularly attend a women's center sessions)

Although it's impossible to know how well a non-probability sampling represents the larger population, it is cost- and time-effective. It can also be used when probability sampling is impossible to conduct (e.g. when you have a very small number of participants).

When developing the sampling framework, the organization should have a plan in case you cannot reach specific locations or beneficiaries due to external circumstances. Cluster sampling, for example, should always have 'reserve clusters' which will be locations that are used instead of those which are unreachable for community-based data collection. If you are sampling from a beneficiary list for simple random sampling, you should keep a random selection of participants as



a buffer in case sampled participants cannot be reached. An example would be having 100 participants with 10 unreachable due to security or displacement. You should have a backup pool to select 10 beneficiaries from the original list to interview in order to replace the missing individuals and meet the required sample size.

For *qualitative information*, the sample size guidance above is not used. Instead, we aim to reach *saturation*. This means collecting data until further data collection adds little to what has already been observed. It is hard to know in advance how quickly this will happen. Methods of selecting participants is also important for qualitative information. Often, participants are selected to fulfill a quota defined by a particular set of characteristics, for example, women aged 25-59; older women aged 59 and up; women leaders; men leaders; older adolescent girls.

Individual in-depth interviews with a few project participants who are unable to join group discussions, or have details to contribute, can provide depth and supplement feedback from group discussions. Key informant interviews with other stakeholders, such as partner organizations, government authorities, such as ministry representatives, religious leaders, etc. who participated or supported protect activities, can be done to complement feedback from direct beneficiaries.

Once a sample of the participants have been selected to be engaged in the data collection, it is important to inform the participants about the evaluation. It can be a simple flier with the following content: information about the purpose and process of the evaluation; rights of confidentiality and anonymity should they decide to participate; and information about the time and place of the evaluation activities, and if any funds will be provided to compensate participants who have to travel to attend the activity.

See **Annex 1.8.A** for an example of an informed consent form.

### **Qualitative Data Collection Recommendations**

**Materials recommended:** note taking materials, refreshments for all participants, safe and secure location to carry out discussion

**Staff required:** staff speaking local language

**Gender Segregation:** Depending on the discussion subject it is recommended to segregate participants by gender

**Time limit:** 1 hour or less

## Analyze and interpret data

Collecting data is of no value if it is not analyzed and subsequently informs changes to an intervention. There are five major steps in analyzing information collected in an evaluation (applies to both quantitative and qualitative data):

1. **Develop a data analysis plan** describing what information will be analyzed, how, by whom, and by what dates. **See Annex 3.2.G** for a sample data analysis plan and template.
2. **Organize the information** so that all the evaluation data that has been gathered is in a clear and structured format. For quantitative data, a spreadsheet (Excel) can be used. There are other statistical software systems available (i.e. EpiData, CSDPro, STATA, SPSS), but often Excel or equivalent is sufficient for quantitative data analysis. For qualitative data, notes should be typed up with tracking labels, such as FGD 1. Create a table that can help track all the interviews (dates, location, group characteristics, facilitator, etc.). See **Annex 3.2.H** for an example of an organized list of interviews. If multiple questions are used to measure a single indicator, make a visual note of these in the data file to monitor the calculation of indicator results.



- 3. Analyze the data** to identify trends or patterns in the information collected for the evaluation. Focus the analysis on changes from before the intervention to after, as well as differences between the intervention group and comparison group. Specific to qualitative data, because of the large datasets it may involve, it helps to begin analyzing as data is being collected. Take note of recurring patterns and themes across participants or groups. Data analysis of qualitative data is not finding a few good quotes or identifying themes that confirm what you expected, but should be used to dive deeper into the context where the data originates from. For quantitative and qualitative data, no change or negative change in the data should also be noted.
- 4. Triangulate the data** to compare data from different sources.<sup>15</sup> Triangulating quantitative and qualitative data can provide deeper and more accurate account of why something happened. For example, your evaluation finds that women who participated in the project reported greater confidence in the endline survey. Qualitative data would help contextualize this finding and show why women who participated are more likely to feel confident than those who did not participate.
- 5. Interpret the data and make recommendations.** The process of analysis of the evaluation data should show whether or not the intervention achieved its objectives, and to what extent participants benefited; and find out what helped or hindered the project implementation. In reality, there may be gaps; we may see positive outcomes for some but not others, or only knowledge and attitudes improved but not behavior, or there may be negative outcomes that was not anticipated. The process of data interpretation will provide a comprehensive picture, from which conclusions can be drawn. From this the M&E team can make recommendations on how to improve programming. It is also important to interpret any negative findings or if the results show no change from before/after the intervention or between intervention and comparison groups. These findings are equally important to show what works and what does not work for future programming.

### **Disseminate and follow up on the findings and recommendations**

Findings from evaluations are only as valuable as the extent to which they are used by appropriate staff, participants, communities, and other project stakeholders.

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15. Triangulation means comparing more than one source of information to confirm the veracity of the data and findings from your evaluation.

Determine who the target audience is for sharing the evaluation findings (consider the stakeholders who were engaged at the planning of the M&E), and what you want them to do. It may be to fulfill program accountability to donors and the participants and their community, to support management decisions on future programming, or to raise additional funding for the project. Tailor the report to your audience; you may need a different version for different audience (donors, practitioners, communities, etc.).

Below are some good practices and considerations for dissemination and follow up:

- **Discuss and interpret the evaluation findings with stakeholders** before finalizing the evaluation report. One good practice is to conduct a validation workshop with the project participants in discussing the analysis and findings. Participants can contribute to the analysis and allow them to share whether or not they believe the interpretation is accurate and if the recommendations reflect their needs and priorities. Project staff can also facilitate opportunities for participants to share the findings with the wider community and other stakeholders, if they feel safe and prepared to do so. If this is the case, participants may communicate findings through sharing of a “stories of change” where they decide themselves how to share what was most important to them in terms of project outcomes.<sup>16</sup> See **Annex 3.2.I** for an example of “stories of change” tool.
- **Use multiple ways of communicating and reporting according to the needs of diverse audiences.** Alternative ways of sharing findings, particularly in low literacy settings, are helpful. This could be through songs, poems, drawings, and storytelling. Simpler key points on findings and recommendations could be written or presented to general project stakeholders.
- **Monitor changes from recommendations** to integrate into future programming. If recommendations were accepted, partially accepted, or rejected by different stakeholders, make note of them. If recommendations were not accepted (or accepted at first but eventually did not follow through), find out why this was the case so that in the future more feasible and realistic recommendations can be made of project evaluations.

16. Based on the Most Significant Change methodology, adapted for use in a stakeholder workshop where evaluation findings are disseminated and led by project participants.







**The following is an example outline for an evaluation report:**

- I. Executive Summary** (which can be the simplified report for general project stakeholders)
- II. Background:** context of the intervention; problem statement
- III. Project Description:** how the intervention addresses the problem; project goals and objectives; implementation process; description of participants
- IV. Evaluation Design and Methodology:** type of evaluation and design; data collection method and tools used
- V. Findings:** learning may be organized by objectives of the project
- VI. Interpretation:** what worked and what did not work (facilitators and barriers to programming, for participants to gain intended outcomes); what findings mean for future programming
- VII. Recommendations:** concrete and practical recommendations for future programming and for other stakeholders (similar organizations working in GBV, local government, donors)

#### **Resources:**

- Sample Size Calculator - <http://www.raosoft.com/samplesize.html>
- Global Women's Institute, Gender-based violence research, monitoring, and evaluation with refugee and conflict-affected populations - <https://bit.ly/2YmQH19>
- Impact Evaluation Design Resources - [https://www.betterevaluation.org/en/themes/impact\\_evaluation](https://www.betterevaluation.org/en/themes/impact_evaluation)

#### **Annexes:**

- **Annex 3.2.A:** Overview of common data collection tools
- **Annex 3.2.B:** Sample survey tool
- **Annex 3.2.C:** Sample FGD tool
- **Annex 3.2.D:** Sample key informant interview tool
- **Annex 3.2.E:** Sample individual interview tool & observation checklist
- **Annex 3.2.F:** Sample case studies
- **Annex 3.2.G:** Sample data analysis plan and template
- **Annex 3.2.H:** Sample organized list of interviews
- **Annex 3.2.I:** Example of "stories of change" tool

# Benefits and Challenges of Technology for Remote Monitoring

Techology	Applications	Benefits
Digital data entry and electronic databases	<ul style="list-style-type: none"><li>• Surveys and questionnaires</li><li>• Registration and distribution reporting</li><li>• GPS- and time-stamps in surveys</li></ul>	<ul style="list-style-type: none"><li>• Rapid transmission of data</li><li>• Reduced work steps (no data entry from paper forms)</li><li>• Surveys can be easily adjusted</li><li>• Easier detection of abuse in data collection</li><li>• Lower visibility for enumerators using small handheld devices</li><li>• Can prevent unauthorized views</li><li>• Enables the collection of multimedia data</li></ul>

Challenges	Recommendations
<ul style="list-style-type: none"> <li>• Requires physical access</li> <li>• Can attract attention, risk theft and attack and can increase the risk of being expelled by armed groups</li> <li>• Encourages closed-question formats</li> <li>• Can lead to unequal access to results</li> <li>• Technology can be viewed with suspicion by armed groups</li> <li>• Requires capacity and skill</li> <li>• Depends on connectivity and power</li> </ul>	<ul style="list-style-type: none"> <li>• Build acceptance and plan and budget for incremental rollout</li> <li>• Select software that offers digital privacy features</li> <li>• Coordinate with other aid organizations in the region to work with similar systems or standardize practices</li> <li>• Do not work with digital data entry where the necessary devices, Internet or phone networks are banned, compromised or culturally inappropriate</li> <li>• Make sure to understand the risks fully associated with digital data entry and compare with the risk for paper-based data collection</li> </ul>

## Annex 1.7.A:

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Techology	Applications	Benefits
<b>Mobile phone-based feedback mechanisms</b>	<ul style="list-style-type: none"><li>• Complaints/ information hotlines</li><li>• Household surveys</li><li>• Verification calls</li><li>• Focal point reports</li></ul>	<ul style="list-style-type: none"><li>• Enables direct contact between aid providers and beneficiaries in areas without physical access</li><li>• Phone-based data are technically easy to process</li><li>• Devices and software are inexpensive</li><li>• Aid organisations have increasing experience with these technologies</li></ul>

Challenges	Recommendations
<ul style="list-style-type: none"> <li>• Verification and follow-up are challenging</li> <li>• Bias: not everyone has access to a phone</li> <li>• Sensitive data shared via phone can be intercepted and cause risk</li> <li>• Requires literacy</li> </ul>	<ul style="list-style-type: none"> <li>• Set up shared channels with other organizations to prevent fragmentation</li> <li>• Plan and budget for long-term use</li> <li>• Do not set up a phone line if capacity to respond to and handle feedback is limited</li> <li>• Do not use phone-based systems to collect sensitive data that could put beneficiaries at risk</li> <li>• Do not use phone-based systems for short-term projects or without continuity</li> <li>• Do not create a new mechanism where other, similar mechanisms already exist or are planned</li> <li>• Do not use phone-based systems to replace all other monitoring or feedback channels</li> </ul>



**Annex 1.7.A:**

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Techology	Applications	Benefits
<b>Remote sensing with satellites or delivery tracking (unmanned aerial vehicles (UAVs))</b>	<ul style="list-style-type: none"><li>• Observation and analysis with satellite</li><li>• UAV imagery for close-up analysis</li><li>• Radar and sensor data</li></ul>	<ul style="list-style-type: none"><li>• Requires no access</li><li>• Enables unique complementary data</li><li>• Visible impact can be compared over time/scale</li><li>• One image = many applications</li><li>• Industry interest in collaboration</li><li>• UAV and sensor costs</li></ul>

Challenges	Recommendations
<ul style="list-style-type: none"> <li>• Costs for satellite images can be prohibitive</li> <li>• Host state, local communities and armed actors can object to their use</li> <li>• Limited experience and evidence of use</li> <li>• Information requires verification</li> <li>• Lack of ethical guidance and standards</li> <li>• Technical limitations (radius of operation)</li> </ul>	<ul style="list-style-type: none"> <li>• Use only when risks are understood and addressed</li> <li>• Engage industry and other humanitarians in developing funding and sharing models</li> <li>• Use crowdsourcing or experts to assess data</li> <li>• Do not use satellite or aerial imagery if clear guidelines on use and access of the information cannot be agreed and/or if the potential risk to local communities cannot be assessed and addressed</li> <li>• Do not work with UAVs or other remote sensing technologies if local stakeholders object to their use</li> <li>• Do not invest in technologies where weather or context conditions are prohibitive, and projects and their effects cannot be seen from the sky</li> </ul>

Annex 1.7.A:

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Techology	Applications	Benefits
Broadcasting with radios and other forms of media	<ul style="list-style-type: none"><li>• Outreach, advocacy and engagement</li><li>• Publicising feedback channels</li><li>• Community radio to stream local voices</li></ul>	<ul style="list-style-type: none"><li>• Wide and reliable reach</li><li>• Local engagement, input and ownership</li><li>• Increases accountability with better information</li><li>• Effective for awareness-raising</li></ul>

Challenges	Recommendations
<ul style="list-style-type: none"> <li>• Increases visibility and can create security risks for aid programs</li> <li>• Difficult to target specific audiences and verify who has been reached</li> <li>• Translation needs, especially for dialects</li> <li>• Costs can accumulate</li> </ul>	<ul style="list-style-type: none"> <li>• Design radio shows with locals</li> <li>• Include entertaining elements to make programs engaging</li> <li>• Target programming in volatile settings by playing pre-recorded shows in selected locations</li> <li>• Do not broadcast information on radio when it reveals the location or other sensitive data about vulnerable populations</li> <li>• Do not set up new radio programs if long-term commitment to cater to the need of the listeners cannot be guaranteed</li> <li>• Do not use radio to support monitoring efforts when it cannot be combined with other tools.</li> <li>• For monitoring and accountability, it is critical to use radio as part of a larger system</li> </ul>

# Example Question Topics for Remote Monitoring Tools

## Perceptions of safety

- Feelings of safety in the community in key areas (water collection, firewood collection, at work, while farming, at school, etc.)
- Feelings of safety to report an incident or problem that is affecting them (legal aid, social workers, community workers, health workers, etc.)
- Whether women/girls have a safe place/space to go in their community

## Life skills and psychosocial

- Skills learned in life skills that are being used in day-to-day life
- Types of skills learned in life skills
- Frequency of psychosocial visits/consultations provided
- Feelings on whether psychosocial visits have helped

## Perceptions of changes around risk reductions in the community

- Feelings of increasing or decreasing security incidents in the community over the past X months
- Feelings on access to reporting issues in the community and whether they have increased over past X months
- Perceptions on safe and unsafe areas of the community and how they have changed



### **Awareness of service provision and help-seeking behavior change**

- Where to access legal aid services in the community
- Who provides legal aid services in the community
- Where to access psychosocial services, health services, or other referral services in your community if they have a protection issue
- Comfort levels with reporting protection violations or potential risks in their community to the service providers or other stakeholders who are part of the project
- Whether they have witnessed/heard of successful cases of legal support or referral services in your family, friends

### **Example questions for helpdesk or toll-free hotline operators to gather project information**

- Have you witnessed program staff in your community from [insert names of relevant organizations] providing counselling and outreach services?
- Has an outreach worker ever visited your house?
- What support and information did the outreach worker provide you?
- Was the information the outreach worker gave you helpful?
- Was the information the outreach worker gave you accurate?
- How would you rate the quality of referral services in your community?

# Physical Device Protection Policy

## Digital Data Collection Equipment Storage & Logistics Policy

*This document is to be used as a guide for the use, transport, maintenance, and storage of all mobile data collection equipment in [Organization]'s field office use. This is to be considered organizational policy and should be enforced by logistics, with the support of the Senior Management Team and the Monitoring & Evaluation Department for each office. Please refer to the [Organization]'s 'Fixed Asset' Policy for further guidance on asset procedures.*

### Storage

1. Phones/laptops should be stored in a locked, centralized location, all phones should be turned off.
2. When charging overnight, phones/laptops should be in a locked room. (Do not lock inside a drawer while charging.)
3. All ancillary equipment should be stored alongside the phones/laptops (chargers, headphones, solar chargers).

### Transport

1. Phones/laptops should be transported within [Organization]'s vehicles between bases only.
2. The package of phones/laptops should be given to the driver and signed off both during receipt of the phones at departure and at arrival.
3. Personal use of organization smartphones/laptops is not tolerated, no apps should be installed without the permission of the Monitoring & Evaluation Manager's consent.

## **Maintenance & Log book, Data Uploading Procedures**

1. Each office should purchase one dongle, or hotspot, strictly to be used for the uploading of data in remote field locations. Held by the Monitoring & Evaluation staff.
2. Data should be uploaded on a daily basis without exception by the fieldwork supervisor, and confirmed to the [Job Title] responsible.
3. Each device should have an asset tag number as follows 'ORG-COUNTRY-BASE-01', for example 'WCC-AFGH-KAB-01' for Kabul Afghanistan devices. Provide a copy of the asset tag list to [Job Title] at HQ and [Job Title] for Master Asset Register.
4. A logbook should be available to sign out devices with the corresponding asset tag, and sign them back in at the end of the day.
5. Cases should be included in the initial quotation by vendors and purchased alongside the devices.

# Organization Self-Assessment for Mobile Data Collection

## Organizational Self-Evaluation

Collecting data in the field once or more per month

- ☐ Yes
- ☐ No

Require fast, real-time results to influence decision-making (within 1 week)

- ☐ Yes
- ☐ No

Have resources and staff to purchase and manage mobile data collection equipment

- ☐ Yes
- ☐ No

Have at least one staff member with an understanding of Android smartphones and online platforms, or the ability to learn

- ☐ Yes
- ☐ No

Can use mobile devices in the field where an organization is working without causing security concerns for staff or community members

- ☐ Yes
- ☐ No

Have staff with the ability to perform data analysis in Excel and manage simple databases

- ☐ Yes
- ☐ No

# MoU for Communal Focal Points

## MEMORANDUM OF UNDERSTANDING

### Between

*[Insert Community Focal Points Name]*

### And

*[Organization Name]*

## I Introduction

*[Insert Organization Name]:*

*[Insert project information text]*

## II Purpose:

This memorandum of understanding (MOU) is intended to present a framework of cooperation between [insert community focal points name] and [insert organization name]. Both parties to this MoU seek to improve the overall wellbeing of the affected population by strengthening protection mechanisms and providing services to those who are affected by GBV in [insert location/country]. It is further agreed that the implementation of this MoU will be based on the [insert applicable laws] laws in the country and will ensure that no harm is done and vulnerable persons are not put at risk while monitoring activities.

## III Guidelines

Both parties abides by its organizational visions and principles and is obligated to conduct its operations in accordance with these principles.

## IV Area of cooperation and coordination

*[Insert list of responsibilities here in bullet points]*

**On behalf of [Name of Community Focal Point]    On behalf of [Organization]**

Place: *[Insert location]*

Place: *[Insert location]*

Date: \_\_\_\_\_

Date: \_\_\_\_\_



# Washington Group's Short Set of Questions

The **Washington Group (WG) Short Set** is a set of questions designed to identify (in a census or survey format) people with a disability. The questions ask whether people have difficulty performing basic universal activities (walking, seeing, hearing, cognition, self-care and communication) and should be used in conjunction with other measurement tools, i.e. include the WG Short Set within a larger survey or registration form to enable disaggregation of other measures (employment status, educational attainment, etc.) by disability status. Due to the complexity of disability, the questions were not designed to measure all aspects of difficulty in functioning that people may experience, but rather those domains of functioning that are likely to identify a majority of people at risk of participation restrictions.

For additional information on how to use this tool, see **Implementation Guidelines**.

The next questions ask about difficulties you may have doing certain activities because of a HEALTH PROBLEM.

1. Do you have difficulty seeing, even if wearing glasses?

- ☐ No - no difficulty
- ☐ Yes – some difficulty
- ☐ Yes – a lot of difficulty
- ☐ Cannot do at all

2. Do you have difficulty hearing, even if using a hearing aid?

- ☐ No - no difficulty
- ☐ Yes – some difficulty
- ☐ Yes – a lot of difficulty
- ☐ Cannot do at all

3. Do you have difficulty walking or climbing steps?

No - no difficulty

Yes - some difficulty

Yes - a lot of difficulty

Cannot do at all

4. Do you have difficulty remembering or concentrating?

No - no difficulty

Yes - some difficulty

Yes - a lot of difficulty

Cannot do at all

5. Do you have difficulty (with self-care such as) washing all over or dressing?

No - no difficulty

Yes - some difficulty

Yes - a lot of difficulty

Cannot do at all

6. Using your usual (customary) language, do you have difficulty communicating, for example understanding or being understood?

No - no difficulty

Yes - some difficulty

Yes - a lot of difficulty

Cannot do at all

Disability is determined, according to the Washington Group Short Set on Functioning, as anyone having at least 'a lot of difficulty' on at least one of the six questions above.

# IASC Gender with Age Marker (GAM)

The IASC Gender with Age Marker (GAM) looks at the extent to which essential programming actions address gender- and age-related differences in humanitarian response. It was developed in response to requests to strengthen the original IASC Gender Marker by including age and, most significantly, by adding a monitoring component. In addition to measuring programme effectiveness, it is a valuable teaching and self-monitoring tool, allowing organizations to learn by doing in developing programs that respond to all aspects of diversity.

With the 2019 Humanitarian Planning Cycle (HPC), the GAM replaced the previous IASC Gender Marker applied to appeal projects since 2009. Its use will be similarly required in the Financial Tracking System (FTS), and Member States asked to commit to only funding partners who report to the FTS using the IASC Gender with Age Marker, and subsequently update the marker based on monitoring data.

For more on GAM please see: <https://interagencystandingcommittee.org/system/files/iasc-gam-information-sheet.pdf>



# Tip Sheet to Support Gender, Age & Disability Analysis

## Integrating Gender, Age, and Disability Analysis in GBV Interventions

*(Adapted from the Gender and Age Marker (GAM) Protection & Disability tipsheets)*

Gender analysis enables organizations delivering GBV interventions to identify the needs, priorities, and service preferences of different gender groups. Analysis should also explore age- and disability-related risks in accessing services, such as harassment on public transport, children taken out of school to accompany family members, and exploitation faced by mothers of children with disabilities. Some individuals may rely on family members to access services, and health providers may have discriminatory attitudes relating to people of different ages, genders and disabilities.

*This Tip Sheet offers interventions, guiding questions and an example of how to support gender, age and disability analysis in GBV interventions.*

Women, girls, boys, and men face different risks and potential rights violations in conflict and disasters. Persons with disabilities are often at heightened risk of violence due to stigma, discrimination and exclusion from society; women and girls with disabilities face heightened risk of sexual and gender-based violence due to the intersection of gender and disability. It is important to recognize that caregivers of persons with disabilities – often women and girls – are also excluded and marginalized in society. GBV prevention and response projects can be made more responsive to the needs of persons with disabilities and their caregivers by:

- Prioritizing safety and dignity, identifying and addressing physical and psychosocial risks most likely for different groups;
- Identifying the different situations and needs of diverse people with disabilities, as well as the distinct barriers they face in accessing services and assistance;
- Exploring the roles of women, girls, boys, and men with disabilities in households, including relationships with caregivers, and implications for accessing GBV services;



- Setting up/maintaining accessible feedback and complaints mechanisms for all affected gender and age groups, including with disabilities, to seek help and provide feedback;
- Supporting the participation of all women, girls, men, and boys, including those with disabilities, to protect themselves and claim their rights, including freedom from harm, rights to basic needs and to participate in community life;
- Mapping and sharing information on gender- and age-appropriate services and assistance, including women and girls' protection and empowerment, and support for people of diverse sexual orientation and gender identity;
- Measuring whether women, men, girls and boys, including with disabilities benefit equally from interventions;
- Identifying capacities and positive coping strategies of persons with disabilities to build on their resilience.

## Gender, Age, and Disability Analysis Example in GBV Programming

### Gender Analysis

*(The needs, roles, dynamics of women, girls, boys, and men in different age groups are understood)*

Refugees arriving in Bangladesh from Myanmar are mostly women and children, who were targeted by widespread violence including sexual violence. GBV service providers are rapidly scaling up operations to provide reproductive health care with an emphasis on clinical management of rape, mental health and psychosocial support, access to justice and legal aid, livelihoods support, dignity kits, and referrals to other life-saving interventions.

In Cox's Bazar, women and girls with disabilities face greater social discrimination and stigma because of gender norms and attitudes relating to disability. They also face greater risk of sexual violence and, as a result, are often isolated in their homes with little access to information on services and activities. Older women face emotional, financial and physical abuse as well as physical barriers to accessing services. Women and girls living with disabled family members generally assume greater care-giving roles and tend to be isolated with few support networks. Boys with intellectual disabilities experience violence and abuse in the community and are excluded from informal education activities due to assumptions and negative stereotypes about their capacity. Men with disabilities across the life course are also excluded from income generating activities but are better able to access rehabilitation services and assistance.

**Influence on Project** *(How women, girls, boys, and men with disabilities in different age groups were involved in decision-making)*

Women, girls, boys, and men in different age groups were asked about their needs and how they should be addressed; persons with disabilities were represented in all gender and age appropriate group discussions. All agreed on the need for mental health and psychosocial support services, and this has been prioritized by agencies, along with providing the reproductive health services requested by women and girls. Different gender and age groups were engaged in selecting items for the NFI kits, including clothing, bedding, menstrual hygiene materials, rehabilitation aids, diapers, urine bags and bed pans, etc. Girls and boys with disabilities reported that they are still not engaged meaningfully in planning with



### **Tailored Activities**

*(How did the project respond to the gender analysis?)*



A female mobile team made specific outreach to women of all ages with disabilities and caregivers, providing information, goods, services and referrals, including group psychosocial support sessions, in homes. Community committees have equal representation of women and men, including older and younger people, and 20% of community mobilizers were people with disabilities. Individuals are consulted, and safe transport arranged to access the safe spaces for women, where concurrent activities are run for female caregivers. Mobilizers also provided training on the Humanitarian Inclusion Standards and disability awareness-raising for humanitarian actors and community members, recognizing intersecting discrimination against women, girls, men, and boys with disabilities, and supporting their inclusion in other gender- and age-appropriate interventions in the community.



### **Benefits**

*(What benefits were gained by affected groups?)*

Women and girls with disabilities reported being able to access appropriate assistance, and better understanding the support services available. Female caregivers accessed services and support and expanded their networks through safe space activities. Boys with intellectual disabilities reported accessing child friendly spaces alongside others in their age groups. However, parents will not let girls with intellectual disabilities attend these activities for fear of abuse and exploitation when traveling to and from the child friendly spaces. Youth with disabilities, mostly men, reported eligibility and inclusion in livelihood activities and opportunities. However, older people with disabilities remain excluded from livelihoods opportunities. Women, girls, boys, and men with disabilities all reported being able to attend sensitization and awareness meetings where they were informed about their rights.



the organizers of child-friendly spaces, highlighting the need to strengthen participatory planning approaches of facilitators. Older women and men with disabilities report being excluded from community consultations and decision-making processes, highlighting the need for more targeted sensitization and awareness raising in the community.

## Annex 1.8.C:

Questions to Inspire Action	
Needs Analysis Set	<p><b>Gender Analysis (Key)</b> How does the crisis affect the protection needs of women, men, girls and boys in different age groups and with different disabilities? What distinct protection risks has the crisis caused or heightened? (E.g. loss of identity documents, sexual violence, child labor, early marriage, trafficking). Which gender/age/disability groups are most affected by these risks and how? What are the gender and age groups of caregivers? What cultural beliefs or practices related to gender norms and disabilities affect safety or access to rights?</p>
	<p><b>Disaggregated Data</b> How do service access rates, barriers and enablers vary by gender, age and disability?</p>
	<p><b>Good Targeting</b> Should interventions be for everyone, or do particular groups need special attention? How does gender, age and disability affect access and inclusion in projects? What efforts are made to reach people with mobility issues or who are isolated in their homes? Are services and distribution designed and located for safe access by all gender, age and disability groups?</p>
Adapted Assistance Set	<p><b>Tailored Activities (Key)</b> Do GBV interventions respond to needs, roles, and dynamics of different gender, age and disability groups identified in the analysis? What efforts are made to address barriers affecting different groups? Are skills and strengths of both women and men across the life course reinforced in the project? How are family members and caregivers engaged?</p>
	<p><b>Protect from GBV Risks</b> What steps are taken to reduce risk of sexual violence against women, girls, men, and boys, including those with disabilities, accessing services? Are women, girls, boys, and men with disabilities asked how to make interventions safer? Are staff trained in safe identification and referral of survivors of GBV, including those with disabilities? Is there a referral pathway so GBV survivors of different gender and age groups, including with disabilities, have access to specialist support?</p>
	<p><b>Coordination</b> Does the GBV project fit with cluster/response plan priorities and complement other clusters' actions? Is the gender analysis and data shared?</p>

Questions to Inspire Action	
Adequate Participation Set	<p><b>Influence on Project (Key)</b> Are different gender and age groups, including people with disabilities, consulted equally in project design, implementation, and review? Are women, men, boys, and girls, including those with disabilities represented in decision-making bodies?</p>
	<p><b>Feedback</b> Is there a process where people can safely raise issues about GBV interventions and projects, including complaints? Are they accessible to persons with disabilities? How does the organization ensure confidentiality and continued access to services in the event of a complaint? How are women, men, girls and boys with disabilities engaged in feedback processes?</p>
	<p><b>Transparency</b> Is information about services accessible, easy to understand, and appropriate for all gender, and age groups, including with disabilities? How is the information adapted for potentially isolated women, men, and caregivers across age groups?</p>
Review Set	<p><b>Benefits (Key)</b> Are targets and indicators disaggregated by sex, age and disability? Do they demonstrate that the intervention is reaching women and men, including people with disabilities and of different ages?</p>
	<p><b>Satisfaction</b> Are women and men in different age and disability groups, including caregivers, equally satisfied with assistance and delivery?</p>
	<p><b>Project Problems</b> Does the project regularly check with women, men, girls and boys, including those with disabilities and their caregivers, to identify problems? Are barriers or negative consequences different depending on gender, age and disability groups? How does the project plan to improve? Is discrimination or exclusion from GBV services addressed?</p>



# Informed Consent Form

## Obtaining Consent to Participate in M&E Activities for Project X

### *Individual Consent Form*

Hello, my name is \_\_\_\_\_ and I am from \_\_\_\_\_. I would like to talk to you about an activity we are doing. We would like to learn about your views about this project, specifically how [\_\_\_\_\_] *include specifics about your M&E activity, e.g. "you feel this project has changed (positively or negatively, or not at all) the way you access various services available in your community"*].

We are meeting with different people who participated in project X to hear different views. We want to learn from you and ask you to join this activity because a staff from \_\_\_\_\_ gave us your name as a *[participant of this project/member of this community]*. If you agree, we will ask you to participate in a *[group activity / group discussion / individual meeting]* to answer some questions about your experience and for ideas on how we can improve the project. The activity will take about *X [minutes or hour(s)]* in total with time to rest in between. Your participation is completely voluntary. There is no direct benefit from participating, but we may learn something that will help other people in this community. You are not required to answer all the questions and you may leave or stop the interview at any time.

We will take notes during the activity, but not record your name and all information you share will be kept confidential. Information and suggestions collected from this activity will be compiled – without using any names – with staff here and with our partners, so that we can work better with communities to *[goals/objectives of your project, e.g. "to increase participation of those groups whose voices are often not heard. We will also help the participants design activities that could increase participation among those groups".]*

### OBTAIN CONSENT:

- ☐ AGREES TO BE INTERVIEWED
- ☐ DOES NOT AGREE TO BE INTERVIEWED, THANK PARTICIPANT FOR HER TIME AND END.

Can we begin the activity? It's very important that we talk in private. Is this a good place to hold the interview, or is there somewhere else that you would like to go?

\_\_\_\_\_

TO BE COMPLETED BY INTERVIEWER

I certify that I have read the above consent procedure to the participant.

Signed: \_\_\_\_\_

### **For Adolescents and Persons with Disabilities**

#### **Who are we and what will we do?**

Hello, my name is \_\_\_\_\_ and I am from \_\_\_\_\_. I would like to talk to you about an activity we are doing.

#### **What is this activity about?**

We would like to learn about your views about this project, specifically how [\_\_\_\_\_ *include specifics about your M&E activity, e.g. "you feel this project has changed (positively or negatively, or not at all) the way you access various services available in your community"*].

#### **Who would we like to meet with?**

We would like to meet with women and men, and adolescent girls and boys, and with persons with disabilities, so that we can hear from many different people.

We are asking you to join this activity because a staff from \_\_\_\_\_ gave us your name as a *[participant of this project/member of this community]*.

#### **What will you do when you meet with us?**

If you agree to join this activity, we will ask you to participate in a *[group activity / group discussion / individual meeting]* to answer some questions about your views about *Project X*. We will also ask for ideas on how we can improve the project. The activity will take about *X [minutes or hour(s)]* in total with time to rest in between.

## **Annex 1.9.A:**

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You may feel there are some questions you do not wish to answer. That is okay. You do not have to answer all of the questions and you may *[leave / stop the interview]* at any time.

### **How will we protect your privacy?**

We will be taking notes during the activity, but we will not record your name anywhere. We will keep all information you share private. We will throw away our notes once we have understood the information.

### **What are the risks and benefits to participating?**

You will not receive any direct benefits from participating, but we may learn something that will help other people in this community.

### **Do you have to participate?**

You do not have to join this activity. It is up to you. You can say okay now, and you can change your mind later. All you have to do is tell us. No one will be mad at you if you change your mind.

### **How will we use the information you share?**

We will share your suggestions—without using any names—with staff here and with our partners, so that we can work better with communities to *[goals/objectives of your project, e.g. “to increase participation of those groups whose voices are often not heard. We will also help the participants design activities that could increase participation among those groups”.]*

### **Who can you contact if you have questions about this activity?**

You may contact \_\_\_\_\_ about your questions or problems with this work. Before you say yes to joining the activity, we will answer whatever questions you have.

I would also like to make sure I have explained everything properly by asking you a few questions:

1. What will we be talking about in the activity?
2. How long will the activity be?

3. Can you think of a reason why you might not want to join the activity?
4. If you do not want to answer any of the questions, what can you do?

*Questions 1 and 4 must be answered correctly.*

### **Would you like to participate in the group activity?**

Obtain yes/no.

#### **For adolescents:**

If you have said yes, because you are under 18 years old, I would like to ask permission from your parent or guardian for you to participate.

*Go to caregiver/family member permission.*

#### **For persons with disabilities, particularly persons with intellectual disabilities:**

If the person answers questions 1 and 4 correctly, no caregiver/family member permission is required.

*If the person does not answer questions 1 and 4 correctly, but still says or indicates "yes" to participate, obtain caregiver/family member permission.*

### **For Parent/Guardian/Caregiver/Family Member Permission**

Hello, my name is \_\_\_\_\_ and I am from \_\_\_\_\_. I would like to talk to \_\_\_\_\_ (name) about participating in *Project X* and how effective it has been at *[insert project goals/objectives and specific detail about the M&E activity, e.g. improving the lives of at-risk women and girls in X District, and whether there has been any change on their access to health, psychosocial, and legal services.]*

We are asking \_\_\_\_\_ (*name*) to help us in our work because she/he is a member of the community identified by \_\_\_\_\_. \_\_\_\_\_ (*name*) has already said yes, but you do not have to give permission, it is your choice.

## Annex 1.9.A:

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If you say yes, we will ask \_\_\_\_\_ *(name)* to join *[group activity / individual meeting]* to answer questions about how different people are currently participating in *Project X*. We will also ask for ideas on how we can improve the project. The activity will take about [X minutes/hour(s)] in total with time to rest in between.

We will be taking notes during the activity, but we will not record your name or \_\_\_\_\_ *(name)*'s name anywhere. The information we collect will be kept private. You or \_\_\_\_\_ *(name)* will not receive any direct benefits from participating in this activity. We will use the answers to learn more about different ways that [insert project goals/objectives, e.g. more women and girls' lives in this community can be improved.]

We will not pay you or \_\_\_\_\_ *(name)* to help us. [We can help pay you back for any travel costs that \_\_\_\_\_ *(name)* *might have had for participating in this activity, if relevant.*]

Do you have any questions? You may contact \_\_\_\_\_ about your questions or problems with this work.

Can \_\_\_\_\_ *(name)* participate in the activity?

*Obtain yes/no, then record on participant recruitment form. Tell the caregiver and participant the date/time of the activity.*



# ToR Template for Needs Assessments

## Terms of Reference Document

**Project Title:** \_\_\_\_\_

**Donor:** \_\_\_\_\_

**Location:** \_\_\_\_\_

### Project Overview

Include an overview of the project and the activities related to this data collection. Include updated information on the project and information on previous surveys performed.

### Objectives of Data Collection & Indicators to be captured

Include in this section some general information on the objectives of the survey itself and additionally a list of the specific indicators that will be captured in the questionnaire – this should be pulled from the logical framework or PMF submitted to the donor.

### Detailed Sampling Framework & Methodology

This section should be a detailed description of the sampling framework and methodology so that all relevant staff are aware of how the data collection will be performed and how the M&E staff will manage to prevent bias results through proper methodologies. Eg:

1. 2-stage cluster sampling, simple random sampling from beneficiary list, non-representative sampling (convenience, snowball)
2. Who is the primary target of the survey? (Women, women with child U5, children, young adults)
3. Process of fieldwork step-by-step

### Budget, Staffing, & Timeline Requirements

Budget, staff and vehicle requirements (# of enumerators) and number of days should be listed out with a total estimated budget. Please list budget line from budget.

# Safety Audit Tool

## Part 1: Safety Audit<sup>1</sup>

***Note:** This tool is based upon observation. It may or may not be relevant in all contexts. In areas of insecurity, you should not fill in the questionnaire while walking around the site/community; rather, take mental note of questions and observations and fill in the form later, after leaving the site/community.*

Team: \_\_\_\_\_

Geographic Location: \_\_\_\_\_

Overall Layout	Problem?		Comments
Night lighting	Yes	No	_____
Walkways/movement	Yes	No	_____
Overcrowding	Yes	No	_____

*Observations related to movements of women and girls outside the camp for water, firewood, etc.:*

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<sup>1</sup> Adapted from IRC's Assessment Toolkit 2011

<b>Water and Sanitation</b>	<b>Problem?</b>		<b>Comments</b>
Water points	Yes	No	_____
Latrines	Yes	No	_____
Showers	Yes	No	_____

<b>Household</b>	<b>Problem?</b>		<b>Comments</b>
Safety/privacy	Yes	No	_____
Cooking spaces	Yes	No	_____

<b>Community</b>	<b>Problem?</b>		<b>Comments</b>
Schools	Yes	No	_____
Markets	Yes	No	_____

<b>Presence of actors</b>	<b>Presence?</b>		<b>Comments</b>
State military	Yes	No	_____
Other armed actors	Yes	No	_____
Barriers/checkpoints	Yes	No	_____

**Other Comments**

\_\_\_\_\_

\_\_\_\_\_

# Service Mapping Tool

## Service Mapping<sup>2</sup>

*Note: This tool is for use during interviews with service providers.*

Team: \_\_\_\_\_

Geographic location: \_\_\_\_\_

1. Organization: \_\_\_\_\_

2. Did you provide services before the crisis?    Yes        No

3. What type of services do you provide to survivors of GBV?

- ☐ Health
- ☐ Psychosocial / case management
- ☐ Legal
- ☐ Protection/ security
- ☐ Sensitization / prevention

### Health

Geographic location: \_\_\_\_\_

4. What type of medical personnel work for your organization here?

- ☐ Nurses:            How many? \_\_\_\_\_
- ☐ Doctors:            How many? \_\_\_\_\_
- ☐ Midwives:            How many? \_\_\_\_\_

<sup>2</sup> Adapted from IRC's Assessment Toolkit 2011

- ☐ Gynecologists: How many? \_\_\_\_\_
- ☐ Surgeons: How many? \_\_\_\_\_
5. Do you have GBV focal points? Yes No
6. Have the medical personnel received any specialized training on clinical care for survivors of GBV? Yes No
7. Have the medical personnel received any specialized training on the provision of care for child survivors of GBV? Yes No
8. Do you have complete post-rape kits available? Yes No
- ☐ PPE
- ☐ Emergency contraception
- ☐ STI medicines
- ☐ Hepatitis B vaccination
- ☐ Tetanus vaccination
9. Do you have trained social workers on staff? Yes No
10. Do they have a safe, confidential space to receive survivors? Yes No

### **Psychosocial**

Geographic location: \_\_\_\_\_

11. What specific services do you provide?
- ☐ Basic emotional support
- ☐ Case management / psychosocial support
- ☐ Group activities
- ☐ Other? \_\_\_\_\_
12. Do you have GBV focal points? Yes No

## Annex 2.1.C:

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13. What specific age groups do your activities serve?

- ☐ Children
- ☐ Young adolescents (10-14)
- ☐ Older adolescents (15-18)
- ☐ Adult women (18+)

14. Are your psychosocial services provided by:

- ☐ Trained volunteers
- ☐ Partners (NGO, CBO, etc.)
- ☐ Staff of your organization

15. If you work with local NGOs/CBOs, what organizations are they and how many practitioners do they have on staff?

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16. What kind of training have your volunteers and social workers receive?

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### Safety and protection

Geographic location: \_\_\_\_\_

17. What specific services do you provide?

- ☐ Safety and security planning for survivors
- ☐ Safe houses
- ☐ Patrols
- ☐ Others? \_\_\_\_\_



18. What specific age groups do your activities serve?

- ☐ Children
- ☐ Young adolescents (10-14)
- ☐ Older adolescents (15-18)
- ☐ Adult women (18+)

### **Difficulties / Challenges**

19. What are the significant challenges your organization faces in service provision?

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20. Do you turn away women and girls because of a lack of available resources?

Yes                      No

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### **Other Comments**

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### **Contact Person for the Organization**

Name: \_\_\_\_\_

Telephone: \_\_\_\_\_

Email: \_\_\_\_\_

# Logframe Template


	Project Summary/ Intervention Logic	Indicator	Means of Verification	Risks/ Assumptions
Goals				
Outcome				
Output				
Activities				

# Illustrative Logframe

	Project Summary/ Intervention Logic	Indicator	Means of Verification	Risks/Assumptions
<b>Goals</b>	Improve the lives of GBV survivors in X District in Afghanistan	% of GBV survivors who report improved sense of health and wellbeing	External evaluation, to be conducted in X years	Service providers in X district are committed to collaboration and coordination to continually improve their services to GBV survivors
<b>Outcome</b>	Strengthened institutional capacities of health, psychosocial and legal services to address the needs of GBV survivors	<ul style="list-style-type: none"> <li>• Changes in knowledge, attitudes, and practices of service providers regarding GBV</li> <li>• Changes in institutional policies/practices regarding its services</li> <li>• % of service providers with ability to identify GBV survivors and make appropriate referral (internal &amp; external)</li> </ul>	<ul style="list-style-type: none"> <li>• Survey among service providers</li> <li>• FGDs with service providers</li> <li>• Key informant interviews with institutional leadership</li> </ul>	Institutions are interested in increasing their capacities and provide time and space for capacity building for their staff
	Increased knowledge among service providers on effective interventions that address the problem of GBV	<ul style="list-style-type: none"> <li>• Change in knowledge among service providers about effective GBV interventions</li> <li>• % of service providers who express increased confidence in addressing the needs of GBV survivors</li> <li>• % of clients who express satisfaction with services received</li> </ul>	<ul style="list-style-type: none"> <li>• Survey among service providers</li> <li>• Training evaluations</li> <li>• FGDs with service providers</li> <li>• Client exit survey</li> </ul>	Better information leads to better services

## Annex 2.2.B:

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	Project Summary/ Intervention Logic	Indicator	Means of Verification	Risks/Assumptions
<b>Output</b>	100 service provider staff from health, psychosocial and legal sectors complete GBV training	<ul style="list-style-type: none"><li>• # of trainings conducted</li><li>• # of training participants, by sectors</li></ul>	Monitor Training Activities	Training participants are supported by leadership from their institutions for capacity building
<b>Activities</b>	Conduct training needs assessments in health, psychosocial and legal service sectors	<ul style="list-style-type: none"><li>• Training needs from health, psychosocial and legal services for GBV prevention and response identified</li></ul>	Training Assessment Report	Political, economic, security situations within project areas does not disrupt project activities
	Develop training materials by sectors	<ul style="list-style-type: none"><li>• X number of tailored training curricula developed</li></ul>	Monthly Reports	

# M & E Plan Template

Expected Results	Expected Results	Target	Baseline	Data Collection Method	Frequency	Responsibility	Tool required and responsible person
Insert the expected results from the project proposal or logframe under the appropriate outcome categories below	Insert the performance indicators being used in the project		If applicable, enter baseline data	Describe who data will be collected from	Include how often data should be collected, e.g. quarterly, annually, baseline and endline, etc.	Insert who is responsible for data collection. It could be an M&E person, a partner organization or someone else.	Identify any required tools, whether they currently exist or need to be developed, and who is responsible for developing them.
Objective 1							
Objective 2							

# List of Possible Data Sources

## Secondary Data Sources:

- Existing national statistics, databases, and reports, including national census (Quantitative)
- Existing national and local plans, strategies, policies, laws, and frameworks related to GBV and gender equality (Quantitative and Qualitative)
- Existing institutional/academic demographic, socioeconomic, reproductive health, and GBV surveys (Quantitative) - USAID.  
[http:// www.measuredhs.com/publications/Publication-Search.cfm](http://www.measuredhs.com/publications/Publication-Search.cfm)
- Existing evaluations, baseline surveys, or other documents from existing projects in the area of influence, or assessments and reports from other clusters/sectors (child protection, etc.) (Quantitative and Qualitative) - WHO. Multi-country study on women's health and DV:  
[http://www.who.int/gender/violence/who\\_multicountry\\_study/en/](http://www.who.int/gender/violence/who_multicountry_study/en/)
- UN Women. 2011.  
[http://www.endvawnow.org/uploads/browser/files/vaw\\_prevalence\\_matrix\\_15april\\_2011.pdf](http://www.endvawnow.org/uploads/browser/files/vaw_prevalence_matrix_15april_2011.pdf)
- Existing mapping (stakeholders/ services) (Qualitative)  
<http://www.gbvresponders.org/emergency-toolkit>
- GBV AoR 3/4/5W Service Mapping tool (Quantitative and Qualitative)
- Regular project/program reporting, reviews and evaluation reports (Quantitative and Qualitative)

## Primary Data Sources:

- Multi-Cluster/Sector Initial Rapid Assessment (MIRA) (Quantitative)  
[https://docs.unocha.org/sites/dms/CAP/mira\\_final\\_version2012.pdf](https://docs.unocha.org/sites/dms/CAP/mira_final_version2012.pdf)
- Review and analyze case data or trends (from GBVIMS) (Quantitative)  
<http://www.gbvims.org>



- Police reports and court records review/analysis (Quantitative and Qualitative)
- GBV legal case files review/analysis (Quantitative and Qualitative)
- Ministry of Health statistics data or GBVIMS reporting (Quantitative)
- Tracking of referral documents (Quantitative and Qualitative)
- On-site observation (Qualitative)
- Surveys (Quantitative)
- Key stakeholder analysis (Qualitative)
- Key informant interviews/peer-to-peer interviews (Qualitative)  
<http://gbvaor.net/wp-content/uploads/sites/3/2012/10/Handbook-for-Coordinating-Gender-based-Violence-in-Humanitarian-Settings-GBV-AoR-2010-ENGLISH.pdf>  
<http://www.gbvresponders.org/emergency-toolkit>
- Mapping of GBV prevention and response services provision (Quantitative and Qualitative)  
<http://www.gbvresponders.org/emergency-toolkit>
- Community mapping (Qualitative)  
<http://www.gbvresponders.org/emergency-toolkit>
- Safety and security mapping (Qualitative)  
<http://gbvaor.net/wp-content/uploads/sites/3/2012/10/Handbook-for-Coordinating-Gender-based-Violence-in-Humanitarian-Settings-GBV-AoR-2010-ENGLISH.pdf>
- Focus groups (Qualitative)  
<http://gbvaor.net/wp-content/uploads/sites/3/2012/10/Handbook-for-Coordinating-Gender-based-Violence-in-Humanitarian-Settings-GBV-AoR-2010-ENGLISH.pdf>  
<http://www.gbvresponders.org/emergency-toolkit>
- Case Studies (Qualitative)
- Expert Panels (Qualitative)
- Protection Monitoring (Qualitative)

## Annex 2.4.B:

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- Community consultations to discuss issues, contributing factors, and specific problems requiring action (Qualitative)  
<http://raisingvoices.org/about/>
- Pre- and post-tests, or other method to assess changes in knowledge as a result of awareness- raising activities (Quantitative and Qualitative)
- SASA Outcome Tracking Tool, based on skills, behavior, attitude and knowledge (Qualitative)  
<http://raisingvoices.org>

\*This list is available in USAID's Toolkit for Monitoring & Evaluating Gender-based Violence Interventions Along the Relief to Development Continuum:  
[https://www.usaid.gov/sites/default/files/documents/2151/Toolkit%20Master%20\(FINAL%20MAY%209\).pdf](https://www.usaid.gov/sites/default/files/documents/2151/Toolkit%20Master%20(FINAL%20MAY%209).pdf)

# PPR Template

## Part 1: General Project Information

Country: \_\_\_\_\_

Base(s): \_\_\_\_\_

Project Title: \_\_\_\_\_

Donor: \_\_\_\_\_

Project Manager: \_\_\_\_\_

Start Date: \_\_\_\_\_

End Date: \_\_\_\_\_

Total Budget (with currency): \_\_\_\_\_

					Q1				
Results/Project Objectives - Based on Logical Framework	Indicator	Goal (number)	Total achievement to date	% of achievement to date	1	2	3	4	Project Cumulative

# GBV Monthly Report Template

NGO: \_\_\_\_\_

Date: \_\_\_\_\_

Location: \_\_\_\_\_

Contact names and information: \_\_\_\_\_

\_\_\_\_\_

## Planned Activities for the Month

*Describe activities that were planned for the month and explain any deviations in implementation from original plan.*

## Activities and Achievements this month

### Activity 1

Activity and Topic: \_\_\_\_\_

Date(s): \_\_\_\_\_

### Attendance:

Total # people: \_\_\_\_\_

# female \_\_\_\_\_

# male \_\_\_\_\_

Target Groups: \_\_\_\_\_

Constraints for this activity: \_\_\_\_\_

Action taken to address constraints: \_\_\_\_\_

**Results of activity:**

Organization results: \_\_\_\_\_

Beneficiary results: \_\_\_\_\_

**Activities and Achievements this month**  
*Activity 2*

Activity and Topic: \_\_\_\_\_

Date(s): \_\_\_\_\_

**Attendance:**

Total # people: \_\_\_\_\_

# female \_\_\_\_\_

# male \_\_\_\_\_

Target Groups: \_\_\_\_\_

Constraints for this activity: \_\_\_\_\_

Action taken to address constraints: \_\_\_\_\_

**Results of activity:**

Organization results: \_\_\_\_\_

Beneficiary results: \_\_\_\_\_

### Annex 3.1.B:

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#### Beneficiary Count

*Additional disaggregation can be included depending on target groups for your project (i.e. age, location, etc.)*

Total # beneficiaries reached: \_\_\_\_\_

# female beneficiaries \_\_\_\_\_

# male beneficiaries \_\_\_\_\_

#### GBV Reporting

# reports this period: \_\_\_\_\_

Reporting rates: \_\_\_\_\_

Total # reports from project start: \_\_\_\_\_



Type of Incident	Number of reports this month	Number of reports from start of project to present	Report rate
Rape			
Attempted rape			
Sexual harassment			
Forced marriage			

### Contextual and Situational Update

*Describe any changes in the implementing area or context that may have impacted the reporting rates or rates of GBV.*

### Action Points

*Describe actions to be taken to address implementation challenges or successes, or any other actions to be taken to address problems, issues, or factors impacting project implementation.*

# Community Feedback Mechanism System

Low Priority	Medium Priority
Appreciation of comment regarding project activities - no action required	Feedback or complaint regarding project activities – action required within 2 weeks and formal feedback provided (includes non-critical project implementation issues)
<b>Example</b> Community member who has a child in ECD program calls to say thank you	<b>Example:</b> Community member complains they did not receive ECD kit for child, but name was on the list
<b>Action Required</b> To be dealt with in-country by CFM focal points	<b>Action Required</b> To be dealt with between CFM focal point and project staff to rectify issue and provide response to beneficiary through process detailed above

High Priority	Critical Priority
Issues requiring response within 24 hours from project staff	Reports of exploitation, abuse, or other major concerns - requires elevation, within 24 hours, to key focal persons on PSEA/Child Safeguarding/Senior Management Team, Ombudsman
<b>Example</b> Community member reports a child who is not a part of the project intervention, but is separated/orphaned child requiring referral	<b>Example:</b> Staff or person of authority is reported by a community member to be requesting economic or sexual bribes to be registered in a project
<b>Action Required</b> To be dealt with between CFM focal point and project staff, with field/base manager, to rectify issue, with inclusion of other relevant staff, or stakeholders depending on the type of issue (includes referrals to other organizations)	<b>Action Required</b> Dealt with immediately involving focal persons listed above, and if necessary, the child safeguarding reporting mechanism

### Annex 3.1.C:

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INDIVIDUALS  
GROUPS  
FAMILIES



Formal complaint or feedback  
is reported to War Child Canada

WAR CHILD  
CANADA

#### Recording

1. Complaint is shared by the individual/group/family, and recorded on the paper or mobile complaint form.
2. Complaints are digitized in the CFM database for tracking and review.
3. A single master database, with all up-to-date complaints will be held by the CFM focal point.

### Response to Initial Report

1. Providing feedback to the beneficiary/group/family is the primary priority
2. Project staff should address the issue and work to resolve it. Refer to the Code of Conduct for actions related to breaches in the Code.
3. The case should be set to 'closed' in the database only after the beneficiary has been notified.

### Feedback Processing

1. The CFM focal point will address each issue according to the severity of the case (see below for classifications)
2. Cases will be discussed directly with Program Managers or other staff/authorities to be addressed within the required follow up period.
3. Investigation of cases will include different staff depending on the issue or concern.
4. The severity of the cases will require different lengths of time between reporting and the response to the beneficiary.
5. Some cases may require referrals to other organizations/services and the details should be documented in the complaint form & database
6. Complaints or feedback related to the Child Safeguarding Policy must be recorded and forwarded to the Child Safeguarding Focal person and relevant staff.

### Lessons Learned

1. Lessons will be documented by staff.
2. Shared at project review workshops.

# Client Feedback Form

*Things to consider when creating a feedback form or satisfaction survey:*

- *Did services received by client comply with existing standard operating procedures for GBV survivors?*
- *Did the client feel respected during service delivery?*
- *Were there any points for follow-up and did follow-up occur?*
- *Was there any change in the life of the client due to the services?*
- *Was service available and provided in an appropriate timeframe?*
- *What was the attitude of the service provider?*

*The information below is a sample of a very brief client feedback form/survey. You can expand it to better match the specifics of your project implementation.*

## Client Feedback Form

We would like to know what you think about the services we provide. Your responses to this short survey are completely anonymous and will not affect your treatment in any way. You do not have to fill out the survey but your responses will help us ensure that we provide the best possible treatment. Please circle/say your response to the following questions, or write your answer in the space provided.

1. How satisfied were you with the treatment you received here today?

- ☐ Not satisfied
- ☐ Neutral
- ☐ Satisfied



2. Please describe what was most helpful for you.

---

3. Please describe what could have been done better.

---

4. Were you assisted in a respectful way?

☐ Yes

☐ No

5. Did the person assisting you help you to feel comfortable?

☐ Yes

☐ No

6. Were you given information or help related to this issue?

☐ Yes

☐ No

7. If provided information, was the information helpful?

☐ Yes

☐ No

Thank you for taking the time to complete this survey. Your responses will help us improve the quality of care we are able to provide.

# Overview of Common Data Collection Tools

Tool	Description/Purpose	Advantages	Challenges
<b>Case Study</b>	A detailed descriptive narrative of individuals, communities, organizations, events, or projects. Useful in evaluating complex situations and exploring qualitative impact.	<ul style="list-style-type: none"> <li>• Can provide people's full experience in project's input, process, outcomes</li> <li>• Can be a powerful way of sharing about the project externally</li> </ul>	<ul style="list-style-type: none"> <li>• Can take much time to collect, organize and analyze</li> <li>• Represents depth of information, not breadth</li> </ul>
<b>Direct Observation</b>	A record of what observers see and hear at a specific place using an observation form. Observation may be of physical surroundings, activities, or processes. A good technique for collecting information on physical conditions or people's behaviors.	<ul style="list-style-type: none"> <li>• Able to view the project as it is actually being implemented</li> <li>• Can record actual behaviors versus self-reports</li> <li>• Provides insight into interactions between people and their physical or social settings</li> </ul>	<ul style="list-style-type: none"> <li>• Can be difficult to interpret behaviors</li> <li>• Can influence participants' behaviors</li> <li>• May not be helpful to understand why people behave in such ways</li> </ul>

Tool	Description/Purpose	Advantages	Challenges
<b>Document Review</b>	Reviewing existing information about project through program documents or from existing data sources, e.g. demographic statistics	<ul style="list-style-type: none"> <li>• Can find historical information</li> <li>• Information already exists</li> <li>• Does not require direct human interaction</li> <li>• Does not interrupt project activities</li> </ul>	<ul style="list-style-type: none"> <li>• Can take much time</li> <li>• Information may be incomplete or limited</li> <li>• May be secondary data</li> </ul>
<b>Focus Group Discussion (FGD)</b>	Discussion with a small group (usually 6 to 12 people) of participants to record attitudes, perceptions, and beliefs relating to a particular issue. A facilitator introduces the topic and uses a prepared guide or questions to facilitate a discussion and solicit opinions and reactions.	<ul style="list-style-type: none"> <li>• Can quickly and reliably get common impressions</li> <li>• Can be efficient way to get a range and depth of information</li> <li>• Can convey key information about the project</li> </ul>	<ul style="list-style-type: none"> <li>• Can be difficult to analyze responses</li> <li>• Results will be influenced by group dynamics – requires skill in group facilitation</li> <li>• Scheduling for 6-12 people may be difficult</li> </ul>

### Annex 3.2.A:

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Tool	Description/Purpose	Advantages	Challenges
<b>In-Depth Interview (IDI)</b>	An interview with an individual who may not be able to participate in a group discussion due to mobility issues, such as persons with disabilities.	<ul style="list-style-type: none"><li>• Can get a full range and depth of information that may not be disclosed in a group discussion or survey</li><li>• Allows obtaining information from minority perspectives</li><li>• Can help to craft case study</li></ul>	<ul style="list-style-type: none"><li>• Can take much time</li><li>• Can be costly</li><li>• Interviewer can bias responses</li><li>• Can be difficult to analyze and compare</li><li>• Less anonymous</li></ul>

Tool	Description/Purpose	Advantages	Challenges
<b>Key Informant Interview (KII)</b>	A participatory monitoring and/or evaluation technique based on stories about important or significant changes among beneficiaries, based on how they perceive the changes. They can provide a rich picture of project outcomes and provide the basis for dialogue on key objectives and the value of projects.	<ul style="list-style-type: none"> <li>• Opportunity to establish trust and get insider's view</li> <li>• Can provide in-depth information about causes of a problem</li> <li>• Allows many different perspectives</li> </ul>	<ul style="list-style-type: none"> <li>• Can be time consuming for both participants and M&amp;E staff</li> <li>• Can be difficult to analyze and interpret</li> </ul>

### Annex 3.2.A:

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Tool	Description/Purpose	Advantages	Challenges
<b>Survey/ Question- naires</b>	Structured questionnaires with a limited number of closed-ended questions. Used to generate quantitative data that can be collected and analyzed.	<ul style="list-style-type: none"><li>• Can be done anonymously</li><li>• Easy to compare and analyze</li><li>• Can be done with many people</li><li>• Can result in a lot of data</li><li>• Tested questionnaires already exist</li><li>• Not too costly</li></ul>	<ul style="list-style-type: none"><li>• How questions are worded can create bias</li><li>• Behaviors are self-reported (and may be biased)</li><li>• Lack of depth/ unable to probe for details</li><li>• May need sampling/ statistical expertise</li></ul>
<b>Assess- ments/ Tests</b>	Measures the status of knowledge or change in status of knowledge over time. Pre- or post-training tests are examples and can determine if the training has been successful in transmitting information or influencing skills of participants.	<ul style="list-style-type: none"><li>• Can provide objective information on knowledge or skills</li><li>• Can be scored, easy to analyze and compare</li><li>• Easily accepted as a credible indicator of learning</li></ul>	<ul style="list-style-type: none"><li>• Can be superficial change in knowledge that may not influence behavior</li><li>• Can be biased</li></ul>



# Sample Survey Tool

## Notes and tips on this tool:

- This provides an example of a survey but should be modified to reflect the indicators you wish to measure.
- Survey questions and response options should be piloted before use to ensure the exact language used is culturally relevant.
- All the ethical considerations covered under Section 1 should apply to implementing a survey and should follow consent processes highlighted in Annex 1.6.A.
- M&E staff should only ask participants about their experiences of violence if it is critical to the project learning and all ethical considerations in Section 1 is fully met.
- As much as possible, use existing resources and scales to create questions that are relevant for your project M&E.<sup>3</sup>
- Depending on the level of literacy, this survey can be self-administered or administered by a facilitator.
- If working with low literacy groups, consider using simpler responses, such as only “agree” or “disagree” rather than longer scale (strongly agree to strongly disagree).

<sup>3</sup> Compendium of Gender Scales: <https://www.c-changeprogram.org/content/gender-scales-compendium/gem.html> and WHO multi-country study on women’s health and domestic violence against women (Annex 4): <https://www.who.int/reproductivehealth/publications/violence/24159358X/en/>

### **Annex 3.2.B:**

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#### **Potential Survey Questions**

##### Demographics:

Age: \_\_\_\_\_

Marital status: \_\_\_\_\_

Number of children: \_\_\_\_\_

Last grade of school completed: \_\_\_\_\_

Disability status: \_\_\_\_\_

##### GBV knowledge, attitudes and service utilization questions

- Knowledge about rights and entitlements
- Knowledge about where to go should a GBV incidence occurs
- Use of GBV case management, health, psychosocial, legal services
- Access to safety net/relationship of trust
- Attitudes around gender roles and norms that condone violence
- Perceptions about gender
- Self-esteem/confidence

### Sample Survey Template

Questionnaire identification number: |\_\_|\_\_|\_\_|\_\_|

Date of interview: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ (Day/Month/Year)

Location of interview: \_\_\_\_\_

#### Socio-demographic characteristics

1. How old are you?

- ☐ 15-19 yrs
- ☐ 20-49 yrs
- ☐ 50 and up

2. Have you ever attended school?

- ☐ Yes
- ☐ No

3. What level of education have you completed successfully?

- ☐ None
- ☐ Primary
- ☐ Secondary
- ☐ Vocational training
- ☐ Higher education

4. Can you read and write?

- ☐ Read and write
- ☐ Only read
- ☐ Neither

### Annex 3.2.B:

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5. What is your marital status?

- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Separated
- ☐ Widowed

6. Which one of the following statements best describes your current living arrangement?

- ☐ Living alone with children
- ☐ Living with a husband/partner with or without children
- ☐ Living with friends or other family members
- ☐ Other

If other, please specify: \_\_\_\_\_

7. Do you identify as having a disability\*?

*\*Persons with disabilities include “those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others” (CRPD, 2006). Such individuals may have:*

- *difficulty moving and walking (since birth or acquired later in life)*
- *difficulty seeing, even when wearing glasses*
- *difficulty hearing, even when using a hearing aid*
- *difficulty understanding, learning, and remembering new things*
- *mental health conditions*
- *multiple disabilities, often confined to their homes and may need assistance with personal care.*

- ☐ Yes
- ☐ No

### Knowledge

8. Do you know how to register a marriage in Country X?

- ☐ Yes
- ☐ No
- ☐ Don't know

9. There are laws in my country that address domestic violence.

- ☐ True
- ☐ False
- ☐ Don't know

10. Women are more likely to suffer violence from men they know.

- ☐ True
- ☐ False
- ☐ Don't know

11. Do you know where a woman or a girl can go if she needs help after experiencing violence?

- ☐ Yes
- ☐ No → Skip Q12
- ☐ Don't know → Skip Q12

12. Can you name 2 organizations where she can go?

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_

13. It is possible for a couple to plan when and how many children they will have.

- ☐ Agree
- ☐ Somewhat agree
- ☐ Somewhat disagree
- ☐ Disagree
- ☐ Don't know

### **Annex 3.2.B:**

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14. Name two methods of family planning.

1. \_\_\_\_\_
2. \_\_\_\_\_

### **Attitudes**

15. Violence against women is a significant problem in my community.

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly disagree
- ☐ Don't know

16. If a husband is provoked, he has the right to beat his wife.

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly disagree
- ☐ Don't know

17. A man has the right to hit his wife if she disobeys him.

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly disagree
- ☐ Don't know



18. Men cannot control their sexual behavior.

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly disagree
- ☐ Don't know

19. Forced sexual relations within a marriage is sexual assault.

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly disagree
- ☐ Don't know

### **Perceptions about Gender**

20. Women should always do what their husbands say.

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly disagree
- ☐ Don't know

21. Women have the right to decide what to do with the money they earn.

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly disagree
- ☐ Don't know

### Annex 3.2.B:

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22. Girls are not as good as boys in schools.

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly disagree
- ☐ Don't know

23. Women can be as good leaders as men.

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly disagree
- ☐ Don't know

### Training on GBV

24. In the past 3 years, how many times have you received training or sensitization related to gender-based violence?

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25. On which of these topics related to gender-based violence would you like to receive training?

- ☐ Indicators of violence
- ☐ Health effects of violence
- ☐ Legal issues related to violence
- ☐ What GBV services are available in the community
- ☐ Other (Please Specify) \_\_\_\_\_
- ☐ None

## **Service Utilization**

26. Is there a place in your community where you are able to visit to talk and find out about relationships, sex, contraception, sexually transmitted infections, etc.?

- ☐ Yes
- ☐ No
- ☐ Don't know

27. What kinds of sexual and reproductive health services are provided for women in your community?

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28. Have you visited a health facility or other place to get sexual and reproductive health services in the last 6 months?

- ☐ Yes
- ☐ No
- ☐ Don't know

29. Do you have someone other than a friend whom you trust to get information about your health from?

- ☐ Yes
- ☐ No
- ☐ Don't know

## **Women's Empowerment**

30. Have you ever been to the hospital/clinic/doctor?

- ☐ Yes
- ☐ No
- ☐ Don't know

### Annex 3.2.B:

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31. Have you ever gone there alone?

- ☐ Yes
- ☐ No
- ☐ Don't know

32. Do you, in your own name, own any land or your house?

- ☐ Yes
- ☐ No
- ☐ Don't know

33. Do you yourself own any productive assets (for example, cattle or sewing machine)?

- ☐ Yes
- ☐ No
- ☐ Don't know

34. Do you have any cash savings?

- ☐ Yes
- ☐ No
- ☐ Don't know

# Focus Group Discussion Guide and Tool

*This tool is provided as a guide to help M&E teams to design their own tools. It should be adapted to the given context and piloted and adjusted for appropriateness.*

In planning a focus group discussion (FGD), consider the overall objectives of the project M&E (refer to your M&E plan): is this FGD for a needs assessment or an evaluation?; do you want to learn about attitudes towards GBV?; or about survivors' coping mechanisms and utilization of GBV-related services?; or about the general nature and scope of GBV in a community? If possible, consult local women regarding cultural appropriateness of topics and methodologies for conducting group discussions. Issues of safety and security for both participants and staff should be paramount. The FGD should be led by a facilitator and there should be a separate note taker.

It is important for purposes of representation and comparison to conduct at least 2 focus groups for each representative population, e.g., women; men; married; unmarried; different ethnic groups; different age cohorts; etc. One rule of thumb is to conduct focus groups until they no longer provide any new information. This may occur after only 2 or 3 focus groups; sometimes it may take more before you feel that you have sufficient information.

## **Purpose of this tool:**

This tool provides guidance on how to gather information from a group of project participants (may be direct or indirect beneficiaries).

## **Selection of group members:**

To recruit participants for this group discussion, please share information about the evaluation activities with the project beneficiaries and community members (if relevant). Group discussions should have 6-12 participants. Group members should be relatively similar to one another in terms of age, culture, sex, social

### **Annex 3.2.C:**

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class, etc., to increase group comfort level when discussing sensitive topics. Unless agreed otherwise prior to the data collection, only adults should be recruited for this discussion.

#### **Location of the group discussion:**

The location where the discussions will be held should be somewhere private so that participants may speak without being overheard or seen by others not in the group. Avoid noisy areas where it will be difficult for participants and the facilitator to hear each other. The space should be comfortable, non-threatening, and easily accessible for participants. Seating should be arranged to encourage participation and interaction, preferably in a circle where everyone can see each other.

#### **Length of the interview:**

Group discussions should not be longer than 1.5 – 2 hours total. It is important to pace the interview and prioritize questions accordingly.

#### **The topic guide:**

The FGD questions and topic outlined below are organized to elicit knowledge, attitudes, and behaviors associated with GBV among the target population. The questions are meant to provide prompts for establishing your own focus group topic guides, and can be reorganized or edited as the M&E team deems useful. Keep in mind, when adapting the questions to your project, to move the questions that are more general to specific, and be sure NOT to ask questions that encourage participants to disclose their own histories of GBV to the group.

Location: \_\_\_\_\_

Date: \_\_\_\_\_

Facilitator: \_\_\_\_\_ Note Taker: \_\_\_\_\_

Group composition (i.e. Women, men, adolescent girls, etc.): \_\_\_\_\_

\_\_\_\_\_

Language used: \_\_\_\_\_ Translation used: Yes No

\_\_\_\_\_



## **Introduction**

*Introduce yourself & ask the group to introduce themselves.*

*Explain why you are there:*

*"I am here today because I'm interested in learning about your views about [project-specific details, e.g. improving the lives of those who are survivors of gender-based violence; how effective service provision is to address the problem of GBV; making our community safer for women and girls; etc.]. Your answers will help us to design activities that can better improve the lives of women and girls and other marginalized groups within the community.*

*I have a list of questions that I'd like to ask. All your answers will be treated confidentially and I will not identify who said what or use your names in any way, so you can feel comfortable to talk freely. Please also keep what you share here confidential to only this group. I expect the discussion will take about 1.5-2 hours. There is no direct benefit from participating. This interview is completely voluntary and you do not have to answer any questions you don't want to answer.*

*Let me give you a few quick rules for the group.*

- 1. First, everyone's opinion is valued, and it's OK to disagree with each other. There are no right or wrong answers. We are very interested in hearing all points of view.*
- 2. It's OK to talk to each other and not just to me. I encourage everyone to listen to each other, treat each other with respect.*
- 3. We would like to know your collective opinions; please do not share personal experiences of safety concerns or violence. Should you wish to share those experiences, we are available to speak with you at the end of this group discussion.*
- 4. Also, since our time is limited, I may need to interrupt you and ask you to change topics from time to time.*

*Does anyone have any questions on how this discussion works?*

### **Annex 3.2.C:**

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*Can we begin?"*

#### **Questions**

*First, I would like to ask you some general questions about your community:*

1. How do men spend time in your community?
  - a. Probe about their daily activities, social activities, how they keep themselves busy.
2. How do women spend time in your community? What are their daily activities?
  - a. Probe about their daily activities, social activities, how they keep themselves busy.
3. How do children spend their time?
  - a. Probe about how they play, where and with what; ask about school – to what age do children typically stay in school?
4. Who is responsible for making decisions for this community? Who is responsible for making decisions in the family?
  - a. Probe about who controls resources in the community and family.
5. How do men get information about what's happening in the community?
6. Who do men go to for help when they have problems?
7. How do women get information about what's happening in the community?
8. Who do women go to for help when they have problems?

*Now I would like to ask you some questions about the safety of women and girls in your community:*

1. What are the circumstances that cause problems of safety for women and girls in this community? (Ask for examples.)
2. What has been done here to improve the safety of women and girls?
3. What about specific forms of violence or practices that are harmful for women and girls? Can you give examples of what exists in your community?

4. When and where does sexual violence occur?
5. Without mentioning names or indicating anyone specific, who are the perpetrators? What happens to the perpetrators (are there different consequences if the perpetrator is known/unknown)?
6. Without mentioning names or indicating anyone specific, which groups of women do you think feel the least safe, or feel at most risk for sexual violence? Which groups of women do you think feel the most safe?
7. Has the problem of sexual violence gotten worse, better, or stayed the same in the last year? What particular types of sexual violence have gotten worse, better, or stayed the same? If there has been a change, what has caused it?
8. Without mentioning names or indicating anyone, do you know women who have been sexually assaulted? If yes, how do you know who they are? What problems do they have? How are they treated by the community?
9. Is there ever a situation where a woman might be partially responsible or to blame (or at fault) for her rape/sexual assault?
10. Is it possible that some women ask for sexual assault through their behaviors or attitudes? If a survivor is not crying or is not emotional after a rape, what do you think must have happened?
11. Do women look for help when they experience sexual violence? Do they tell anyone (family members, other women, health worker, community leader, police/security people/authorities, someone else)?
12. In your home country, where would women get help if they had been raped? What would the community have done? What services were available for this kind of thing?
13. How do women cope with violence against their family members or friends?
14. How do men cope with violence against their daughters, sisters, mothers, wives, friends?
15. How do families and communities cope with violence against women and girls?

### **Annex 3.2.C:**

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16. How have people not been able to cope?
17. What are community responses when violence occurs? What is done to prevent violence? What is done to help survivors?
18. How could these efforts be improved?
19. Do women's support networks exist to help survivors? What social and legal services exist to help address problems associated with violence (e.g., health, police, legal counseling, social counseling)?
20. Who provides these services? How could these efforts be improved?

### ***Wrap up***

*Ask the participants if there are any other things they'd like to add or if there are any questions for you. Thank them for participating.*

# Key Informant Interview Guide and Tool

## *Guidance for selection of key informants*

Key informants should have a good knowledge of the priorities and needs of communities in which Project X is being implemented and understand the objectives of the project. Key informants must be **non-beneficiaries**, i.e. [Organization] field staff, service provider staff, partner staff, government officials, religious leaders, etc., who are key stakeholders to the project.

*(Interviews for key informants should be undertaken by [organization] staff.)*

Location: \_\_\_\_\_

Date: \_\_\_\_\_

Interviewer: \_\_\_\_\_ Note Taker: \_\_\_\_\_

Interviewee: (i.e. position, organization): \_\_\_\_\_

Language used: \_\_\_\_\_ Translation used: Yes No

## *Introduction*

*Introduce yourself & ask the interviewee to introduce him/herself.*

*Explain why you are there:*

*"We are conducting this interview to explore how strengthened support structures in [community], such as social, health and legal services, can contribute to reducing*

### Annex 3.2.D:

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*GBV risks/violence experienced by certain groups, such as women and girls. You have been selected for this interview, as a key informant to help us understand what changes, if any, within the community you have observed in relation to those support structures. The findings will help us learn how effective Project X's activities were in assisting at-risk women and girls in this community.*

*I have a list of questions about these topics, and I would like you to speak from your own perspectives, given your experiences in the community. I will be interviewing many informants from different agencies and based on these interviews, I will summarize the findings as a whole and produce a report, which we will share with you. No references will be made to statements by specific individuals, only to trends observed. The information shared with us will be treated confidentially and your identity will not be disclosed in any report.*

*The discussion will take about 1 hour. This interview is completely voluntary and you do not have to answer any questions you don't want to answer.*

*I will be taking some notes as I listen to what you say. Can we begin?"*

#### **Questions**

Can you describe your role and what your organization/agency does?

1. What is your general impression about our project activities? (Probe for extent of knowledge about the project so that the key informant can speak directly to its effects.)
2. How do you think that the social/healthcare/legal services are serving women, girls and other marginalized groups in this community? (Probe for each service type.)
3. Have you noticed anything different in the last several months in how your agency (or other service agencies the informant can speak about) approaches the way they provide services for women, girls and other marginalized groups? (Probe for specific service – if they mention any change, probe whether it is positive, negative, or no change.)

- a. Probe about changes in service provider's knowledge, attitudes, and practices
  - b. Probe about changes in policies among service providers
- 4. How do you think they differ from how they provide services for men?
- 5. Can you share anything you have noticed recently among the women, girls, or anyone else who are accessing these services that is positive or negative?
- 6. Do you have any recommendations on how our project can improve access to support services or improve the quality of those services for women, girls and other marginalized groups?

### ***Wrap up***

*Ask the interviewee if there are any other things he/she would like to add or if there are any questions for you. Thank him/her for their time and for sharing their views.*



# Sample Individual Interview Tool and Observation Checklist

## Individual Interview Guide

### **Purpose of this tool:**

This tool provides guidance on how to gather information from a woman or adolescent girl with a disability who may not be able to participate in a group discussion. The tool includes questions to guide the interview and an observation checklist to help the interviewer get a sense of the environment in which the woman or adolescent girl lives.

### **Location of the interview:**

It is critical to prioritize safety when conducting an individual interview. While the purpose of individual interviews is to reach those who may not be able to participate in group discussions, that does not necessarily mean the interview should take place in the person's home. When arranging an individual interview, the interviewer should ask the individual whether they prefer the interview be conducted in their home, or if they would feel more comfortable in another location. This may mean delaying or rescheduling the interview until you can identify a safe, quiet space and help the person get to the location.

### **Length of the interview:**

Individual interviews should not be longer than one hour total. Given the time required to properly initiate the interview (i.e., introduce yourself, get informed consent) and to conclude the interview appropriately, the time the interviewer has for the discussion itself is closer to 45 minutes. It is important to be mindful of this so that you can pace the interview and prioritize questions accordingly.

### **Instructions:**

Identify and approach the woman or adolescent girl with a disability, and introduce yourself. Greet them in the same way that you would greet others in your community. Talk to the person directly to try to establish an optimal method of communication. This includes asking them which mode of communication will be best for them. Ask if they would like to participate and whether they feel safe doing so, and watch

for any signs that they not want to or do not feel safe participating. If this is the case, do not proceed — the interview should be stopped immediately.

If the individual has shown interest and consents to participate, present the purpose and ethical guidelines that will be followed during your visit:

- Provide general information about your organization.
- State that the purpose of the meeting.
- Explain what you will do with this information, and make sure you do not raise any false expectations.

### **Individual Interview Tool**

- Explain that participation is voluntary.
- Explain that no one is obligated to respond to any questions if they do not wish.
- Explain that no one is obligated to share personal experiences if they do not wish.
- Explain that if they don't wish to continue with the interview, it can be stopped at any time. It should be explained that this will not affect the services that they are already receiving or their opportunity to seek services in the future.

For people with limited communication abilities, ask the caregiver (if present): **How does [state the name of the person] tell you that she/he is unhappy or uncomfortable with something? What makes her/him happy or sad?** Use this information to facilitate the interview if verbal communication is not possible and respect any indications that the participant is not comfortable or willing to continue.

You can also ask the person if they are comfortable with you asking questions to the caregiver. If this option is pursued, the individual should be able to hear the discussion, and continue to be engaged and contribute in whatever way possible. It will be important to support the caregiver to use language that will not harm

### Annex 3.2.E:

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or disempower the person with a disability. If this happens, help to rephrase the conversation so that the individual is talked about in a more positive way. For example, you might use the term “has a disability” rather than “suffers from disability.” It is also important to remember that the caregiver will often give different information than the individual would, and thus talking with them not a substitute for talking with the individual. As always, respect any indications that the participant is not comfortable or does not want the interview to continue. If this is the case, the interview should be stopped immediately.

#### Interview Questions

1. Tell me a bit about yourself. **Additional prompts:** What kind of things do you enjoy doing? How long have you been living here? Who lives in your household?
2. What kind of community activities do you participate in? **Additional prompts:** Ask about education, women’s groups, health and livelihoods activities, as appropriate. What things do you like about these activities? What things do you find difficult about these activities?
3. Are there any places or activities in the community where you feel uncomfortable or unsafe? What makes these places uncomfortable or unsafe for you?
4. Are there any places or activities in the community where you feel most comfortable or most safe? What makes these places comfortable or safe for you?
5. Do you have contact with other women and girls your age? If so, who provides you support? Where to you go to meet them? If not, what are the challenges to meeting and socializing with other women and girls?
6. Where do you go or who do you talk to if you have problems and concerns?
7. Are there any services or programs for women/girls in the community that you would like to access or participate in? What has prevented you from accessing these services or activities in the past? How could we help you to participate in this activity or access this service?

## Observation Checklist

During an individual interview, it can be useful to make some notes about what you observe about the project participant and their environment. This can help to determine other things in the participant's home life and relationships that may affect their health, safety and well-being. It can also help to identify additional needs, concerns and ways to support the person with a disability to participate in your program and access your services.

The questions below may be useful for guiding your observations.

### Communication

How does the person communicate? Watch other family members to see how they interact with the person. Do they use speech, writing or gestures?

Notes: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Physical

Describe the person's personal appearance and hygiene. Are they dressed in an appropriate way compared with other men and women in the household or community (e.g., Are they naked or partially clothed when others are fully clothed? If so, ask caregivers for a blanket and/or clothing before continuing with the interview). Do they appear to have good hygiene (e.g., Are they more clean or less clean than other women or men in the household)? How are they moving around the room?

Notes: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### **Annex 3.2.E:**

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#### **Environmental**

What is the current state of the individual's home? Is the home of the same quality and/or standard as nearby homes? What is the current state of their surrounding community? How close are they to important facilities (e.g., health centers, schools and community meeting points)?

Notes: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

#### **Conclude the Interview**

- Thank the person (and the caregiver if present) for their time and their contributions.
- Remind the interviewee that the purpose of this discussion was to understand the safety and security concerns of persons with disabilities and how we can improve our GBV programs.
- Explain what you will do with this information and what purpose it will eventually serve.
- Ask the interviewee (and caregiver) if they have questions.
- Provide information to the interviewee (and caregiver) about the services and activities available through your organization, and facilitate referrals to psychosocial support or other assistance, as requested.

## Sample Case Studies

**The purpose of reviewing the below case studies is to identify barriers to access and participation of particular vulnerable groups in community activities. As you read through the case studies, consider the following types of barriers:**

- Attitudinal barriers: negative stereotyping, social stigma and discrimination by staff, families and community members.
- Physical/environmental barriers: such as buildings, schools, clinics, water pumps, latrines, roads, and transport that are difficult or unsafe to access for adolescent girls or women with disabilities.
- Communication barriers: from written and spoken information, including media, flyers, and meetings, and complex messages that are not understood by young people or persons with disabilities.
- Other barriers: rules, policies, systems and other norms that may disadvantage adolescent girls and persons with disabilities, particularly women and girls.

**Then ask yourself the following questions:**

1. What barriers are preventing access to services, or inclusion in meetings and other community programs of adolescent girls? How is it different from adolescent boys? Are there differences between girls with and without disabilities?
2. What barriers are preventing access to services, or inclusion in meetings and other community programs of women with disabilities? How is it different from women without disabilities?
3. Does this barrier only affect women and girls with disabilities? Who else is affected?
4. What barriers do you think are most common in this community?

**Allow other participants to comment and make suggestions.**

## Annex 3.2.F:

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**1. Cecilia is an adolescent girl aged 16 and has been living in Bentiu Protection of Civilian (PoC) site for the past year with her uncle and aunt.**

She wakes up as soon as the sun rises to collect water, help feed the younger children in the household and do other household chores before she goes to school with her friends in the sector. She feels lucky that she gets to go to school and that her uncle and aunt are supportive of her getting an education – as long as she does all her work before and after school. She has lately been under pressure from her uncle to get married. He says that she is getting too old and that no man will want to marry her if she waits too long. Cecilia loves learning and wants to stay in school, but her aunt had married her uncle when she was 14, and does not understand why Cecilia should not. Besides, her aunt is far too busy trying to feed her own children and also been warned by her friends in the market that if she waits too long to marry her, they would not get as much in bride price. Cecilia wants to talk to someone who could convince her uncle and aunt to keep her in school, but she does not know where/whom to go.

**2. A 45-year-old woman named Mary lives with her six children in Bentiu PoC.**

“Every second day, I leave the PoC and I walk for five hours to find firewood that I then sell in the community. I don’t feel that it is safe to leave the site, but it is the only way to get a little money to buy cooking oil, soap or food for the children,” Mary says.

**3. Mary is happy that all her children attend school, except one.**

Mary explained about her adolescent daughter, “Before the war, Nyakuol was OK. But then, she started to insult everyone and run away from home for many days at a time. At the hospital, they didn’t know what she has, but they gave her medicine to treat anxiety problems. Now, she can’t even go to school here in the PoC. Otherwise she gets into fights with other children or just runs away, and there is no fence around the school to keep her in there.”

**4. Reluctantly, Mary leaves Nyakuol at home while she goes to collect firewood, and Nyakuol is often found by neighbors or NGO staff around common community spaces, such as youth centers, or water points.**

Sometimes the staff bring Nyakuol back to Mary and reprimand her, “A child like her with mental retardation like this needs to be restrained. Could you please keep her from roaming around the community? She is being disruptive in the community.”

**5. Maria is an elderly woman who recently came to live in this community.**



she has mostly lost the use of her legs due to a disease, cannot walk around properly and is often confined to her home unless her adult children, mostly her daughter, come around to help her or bring firewood to her for cooking. Once a local NGO came by for an assessment and suggested she qualifies for receiving a wheelchair. However, it was a model that did not accommodate the rough gravel roads of the community. It now sits idle in the corner of her home. There has been no other effort by any other NGO staff to follow up on her. Maria's elderly husband sits drunk most of the days and pays little attention to her, while her daughter is out all day selling small goods in the market to earn enough income to feed her own small family. Maria's neighbors know of her, but since she is can barely move, assumes she cannot participate in any activities outside and does not need information about such activities.

# Sample Data Analysis Plan and Template

Outcome	Outcome Indicators	Means of Verification
Strengthened institutional capacities of health, psychosocial and legal services to address the needs of GBV survivors	<ul style="list-style-type: none"><li>• Changes in knowledge, attitudes, and practices of service providers regarding GBV</li><li>• Changes in institutional policies/ practices regarding its services</li><li>• % of service providers with ability to identify GBV survivors and make appropriate referral (internal &amp; external)</li></ul>	<ul style="list-style-type: none"><li>• Survey among service providers</li><li>• FGDs with service providers</li><li>• Key informant interviews with institutional leadership</li></ul>

How Data Will Be Analyzed	Who Will Collect the Data	Timeline
<ul style="list-style-type: none"> <li>• Comparison of average KAP survey results from baseline to endline – quantitative/ qualitative</li> <li>• Thematic &amp; pattern analysis from endline FGDs and KIs – qualitative</li> </ul>	<ul style="list-style-type: none"> <li>• M&amp;E staff; temporary research assistants</li> </ul>	<ul style="list-style-type: none"> <li>• Baseline (month X to month X)</li> <li>• Endline (month X to month X)</li> </ul>

### Annex 3.2.G:

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Outcome	Outcome Indicators	Means of Verification
Increased knowledge among service providers on effective interventions that address the problem of GBV	<ul style="list-style-type: none"><li>• Change in knowledge among service providers about effective GBV interventions</li><li>• % of service providers who express increased confidence in addressing the needs of GBV survivors</li><li>• % of clients who express satisfaction with services received</li></ul>	<ul style="list-style-type: none"><li>• Survey among service providers</li><li>• Training evaluations</li><li>• FGDs with service providers</li><li>• Client exit survey</li></ul>
Enhanced coordination of services for GBV survivors	<ul style="list-style-type: none"><li>• # of referrals made from service providers, by sectors</li><li>• # of clients who receive services related to GBV by type of service</li></ul>	<ul style="list-style-type: none"><li>• Service statistics/ intake forms</li><li>• Client exit survey</li></ul>

How data will be analyzed	Who will collect the data	Timeline
<ul style="list-style-type: none"> <li>• Comparison of average KAP survey results from baseline to endline – quantitative/ qualitative</li> <li>• Training evaluation results analysis - quantitative</li> <li>• Thematic &amp; pattern analysis from endline FGDs - qualitative</li> <li>• Exit survey results analysis - quantitative</li> </ul>	<ul style="list-style-type: none"> <li>• Project staff; M&amp;E staff; temporary research assistants</li> </ul>	<ul style="list-style-type: none"> <li>• Baseline (month X to month X)</li> <li>• Endline (month X to month X)</li> </ul>
<ul style="list-style-type: none"> <li>• Review statistics &amp; forms, simple tally - quantitative</li> <li>• Exit survey results analysis - quantitative</li> </ul>	<ul style="list-style-type: none"> <li>• Project staff; M&amp;E staff</li> </ul>	<ul style="list-style-type: none"> <li>• Periodic throughout project implementation</li> </ul>

# Sample Organized List of Interviews

Focus Group Discussions		
Participants	Age	Additional Attributes
2 groups of: <b>Adolescent girls (Unmarried)</b>	Between 15-19 years old	<ul style="list-style-type: none"> <li>• Unmarried</li> <li>• Out of school</li> <li>• Include at least 1 disabled participant</li> <li>• IDPs and local</li> <li>• Residing in community</li> </ul>
2 groups of: <b>Women (Married)</b>	Between 20 and 24 years old	<ul style="list-style-type: none"> <li>• Married</li> <li>• At least some women have children</li> <li>• Include at least 1 disabled participant</li> <li>• IDPs and local</li> <li>• Residing in community</li> </ul>

Focus Group Discussions		
Participants	Age	Additional Attributes
2 groups of: <b>Women (Married)</b>	25-49 years old	<ul style="list-style-type: none"> <li>• Married</li> <li>• At least some women have children</li> <li>• Include at least 1 disabled participant</li> <li>• IDPs and local</li> <li>• Residing in community</li> </ul>
1 group of: <b>Women (Widows)</b>	19-49 years old	<ul style="list-style-type: none"> <li>• Head of household</li> <li>• Women who lost their husbands during conflict</li> <li>• Single women whose husbands passed away</li> <li>• At least some should have children</li> <li>• Include at least 1 disabled participant</li> <li>• IDPs and local</li> <li>• Residing in community</li> </ul>



### Annex 3.2.H:

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Focus Group Discussions		
Participants	Age	Additional Attributes
2 groups of: <b>Men (Married)</b>	19-24 years old	<ul style="list-style-type: none"><li>• Include at least 1 disabled participant</li><li>• IDPs and local</li><li>• Residing in community</li></ul>
2 groups of: <b>Men (Married)</b>	25-49 years old	<ul style="list-style-type: none"><li>• Include at least 1 disabled participant</li><li>• IDPs and local</li><li>• Residing in community</li></ul>

# Example of “Stories of Change” Tool

## **Purpose of this tool:**

The goal of the “Stories of Change” participatory M&E tool is to capture the most significant change that project participants themselves identify relating to their participation in your project over a period of time (midterm for example). This tool is designed to do in groups to build participants’ teambuilding skills, their confidence in presenting their achievements and ideas to project stakeholders, including staff, family members and caregivers, and community members, and, finally, to be used as a feedback mechanism for project managers to improve programming. This activity is best conducted if participants have been meeting with each other for some time.

## **Group composition:**

Groups should be made up of 6 – 12 individuals, preferably close to each other in age, gender, social class, culture, e.g., women, men, adolescent boys, adolescent girls, and including 1 or 2 persons with disabilities in each group.

## **Key questions for [Name of Organization] to explore:**

1. How have the capacities of the participants changed over the last few months? Consider their communication skills, knowledge, self-esteem, confidence, and access to wider networks in the community.
2. How did the project contribute to these changes (positive or negative)?
3. What were the barriers and facilitators to positive changes occurring?
4. What recommendations do participants have to improve the situations for women and girls in the community?

These questions will be explored through participants’ stories of change – positive and negative, or lack of change – using this tool.

## Annex 3.2.1:

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### Methodology for collecting participants' "Stories of Change":

#### 1. Story Set-up Meeting: (Objective: get participants to think about a **story** and **how they want to tell the story**) – 15 min

- a. Tell the participants that you will be facilitating a group discussion to find out what they think were the most important stories or change they see for themselves.
- b. Ask the participants to think ahead of time about a "story" that they can share with each other that reflects an important or significant change relating to their involvement in the project activities over the last X months. They can do it individually or as a group – leave it to them to decide what they prefer.
- c. Set up another meeting next week to share those stories with each other and with you.
- d. Ask how they want to collect the story: it can be through a photograph, picture, a drawing, a story in their heads, a written down story on paper, a typed story (may need your help to type up as they dictate), or any other way they want to express themselves.
- e. Provide the following materials so participants can go and collect or write their stories: camera, paper, colored cards, markers, pens, tape, etc.

#### 2. Our Stories Our Vision Meeting: (Objective: get participants to work on a **group "story" together**) – 1 hr – 1.5 hrs

- a. Provide 2 posters or flip chart papers for participants to create:
  - i. "Our stories – What was most important to us": get participants to work on a collage of their stories of change; and
  - ii. "Our vision – What we want to do next": get participants to think about their collective vision for the future.
- b. They may have brought their ideas or already prepared written stories, drawings, etc.

- c. Let participants decide who should present on their posters at the next meeting. They may choose to present on one representative story, or a few.<sup>5</sup>

**3. Feedback Meeting:** (Objective: **present participants' stories of change**, discuss what these stories mean to the participants, and **formulate findings/recommendations relating to "facilitators" and "barriers"**) – 1.5 hr – 2 hrs

- a. Invite family members and community leaders (if appropriate and safe for participants, for the final feedback meeting, to showcase participants' achievements and their larger visions for their futures) to see what participants learned, achieved, and recommend.
- b. Have the representative(s) of the project participants discuss the posters to everyone. If needed, provide the representative a brief prompt/text to facilitate an introduction to the audience.
- c. Program managers ask key questions after participants present their stories & visions – this will support the representatives to expand on their perspectives and ideas:
  - i. Why did you choose this photo/drawing/story?
  - ii. Which photo/drawing/story is most interesting to the group & why?
  - iii. How do you feel now when you look at these photos/drawings/stories?
  - iv. What are the things that helped you to achieve these successes (facilitators)?
  - v. What were some of the things that made it difficult to achieve this change (barriers)?
  - vi. What do you want to achieve next?

<sup>5</sup> If none of the participants feel comfortable presenting, then ask them if it is ok for you to present on their behalf. Ask them to still appoint representatives who will come to the meeting to assist you and to feed back to the other participants. Over time, as participants become more familiar with the process, they can be encouraged to present for themselves.

### Annex 3.2.I:

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- vii. What type of support or resources might you need – from us in the project, from your family or anyone else in the community?
- d. Congratulate the participants on their work, and invite audience members to also comment. It is OK to also clarify any expectations that may not be realistic in the scope of your project. Always finish by acknowledging the opinions and ideas of the participants, and recognizing their contribution to the project.

Make sure you have a note taker or record the presentations by the participants (with their permission). You can then use these notes to document the outcomes of your project, barriers and facilitators to positive changes, and the next steps in programming.