



CARE 2020 Program Strategy: Indicators for Measuring Change

(Update - July 2017)

This document presents CARE's global and supplementary indicators for measuring change, in connection with the CARE 2020 Program Strategy.

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Questions and comments

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The 25 Global Indicators for Measuring Change towards the CARE 2020 Program Strategy

Our commitments by 2020

We have committed to the following impact: ***By 2020, CARE and our partners will support 150 million people from the most vulnerable and excluded communities to overcome poverty and social injustice.***

We have also committed to these specific outcomes by 2020:

- 20 million people affected by humanitarian crises receive quality, life-saving humanitarian assistance.
- 100 million women and girls exercise their rights to sexual, reproductive and maternal health and a life free from violence.
- 50 million poor and vulnerable people increase their food and nutrition security and their resilience to climate change.
- 30 million women have greater access to and control over economic resources.

The Program Strategy also indicates that CARE will use three main roles for achieving these outcomes (humanitarian action, promoting lasting change and innovative solutions and multiplying impact) and three elements of “the CARE Approach” (gender equality and women’s voice, inclusive governance and resilience), which aim at addressing what we consider to be the main underlying causes of poverty, namely gender inequality, poor governance and risk.

Why we need the global indicators

Our ability to measure progress towards our commitments and to explain how CARE contributes to lasting change has led to the establishment of a global evidence system. The core of this system is a **common set of 25 guiding indicators** applicable to CARE projects and initiatives worldwide, allowing for the collection and consolidation of coherent and comparable outcome and impact data.

The 25 global indicators have been selected in the light of the **Sustainable Development Goals (SDGs)** as in consideration of other elements like feasibility and relevance of measurement. They were initially proposed and crafted by technical teams working on the outcomes, approaches and roles, revised by CI Program Team, approved by the National Directors’ Committee in March 2016 and launched in June 2016. However, given that measuring change is a dynamic process and a learning experience for all CARE, this document is updated in July 2017 with support of the CI Monitoring and Evaluation group¹, in order to continuously improve the way we define and operationalize the indicators.

The menu of global indicators includes:

- ***Outcome or impact indicators (indicators 1 to 18):*** Projects/initiatives are expected to select and use **at least one** of these indicators, based on the relevance to their objectives and goals. These indicators are critical for CARE to explain the WHAT of the outcomes and impacts our work contributes to.

¹ The CI MEL group acts as a reference team to further advance improve and expand an interdependent MEL agenda for all CARE, and to facilitate learning and capacity building for a broader MEL network, including MEL and programs staff around the world. The group is composed of CARE staff who lead or are highly involved in the development and management of sector or outcome specific MEL systems and can consolidate a global MEL capacity for monitoring, reporting and learning around the outcomes and approach of the CARE 2020 Program Strategy.

- **Approach and Role indicators (indicators 19 to 25):** All projects/initiatives are expected to use **as many of these indicators** as relevant to their objectives and goals. Given that these indicators focus on what we consider to be the main underlying causes of poverty (gender inequality, poor governance and risk) as well as on the critical roles for achieving impact and outcomes (humanitarian action, promoting innovative solutions and multiplying impact), these indicators are critical for CARE to explain HOW the outcomes and impacts come about and HOW CARE contributes to the achievement of those changes.

Importantly, information for all of the proposed indicators should be disaggregated primarily by sex, as well as by age, income quintile, and urban/rural (wherever possible and disaggregated data is available or can be gathered). This is critical for showing impacts on target groups, particularly **women and girls**. While the list of indicators may seem long, the proposed menu is a **significant improvement** from the current 'state of affairs'. For example, in FY14, FNS projects across CARE used more than 350 different indicators. By using fewer indicators consistently, CARE will be able to share its impact story and contribution to tackling poverty and inequality world-wide.

What is expected from CARE International Members and Country Offices?

It is expected that all CI Members and Country Offices commit to the following:

- Incorporate the global indicators in proposals/new contracts (as appropriate and relevant) from 1 July, 2016 onwards: At least one relevant outcome indicator (indicators 1 to 18) and as many as possible from the indicators for the CARE approach and roles (indicators 19 to 25).
- In existing projects/programs/contracts, assess where indicators can be integrated in monitoring and evaluation plans. Please revise these plans accordingly and integrate indicators where possible.
- Include the proposed indicators in upcoming evaluations (from now onwards, wherever possible).
- Report data to the Project/Program Information and Impact Reporting System (PIIRS), every time an evaluative process takes place and a project or initiatives has collected and analyzed data on the indicators selected.

Regarding **CARE's outcome targets and their measurement**, a few important points:

- We need to distinguish between **impact/outcomes and reach**. Over the past three years, we have collected reach data through PIIRS. Not all people reached will have experienced a deeper impact. The proposed indicators seek to obtain outcome and impact information which will provide us with a clear picture, beyond reach, of CARE's contribution to fighting poverty and inequality. It is also critical to gain a better understanding of the interplay between reach and impact.
- The data on impact/outcomes is **cumulative** (over a 6-year period, from 1st July 2014 until 30 June 2020). We expect to have had an impact on 150 million people by 2020 and, more specifically, reached specific outcomes on SRMH and the right to a life free from violence, women's economic empowerment, food and nutrition security and resilience to climate change, and humanitarian.
- The outcome targets include our work with and through **partners**. CARE never works in isolation and the outcomes we seek will be the result of actions with others.
- Yearly in-depth **impact reports** will provide us with a deeper analysis of impact/outcomes. This year, we will complete and publish the SRMH and WEE impact reports, while in 2018 we aim to complete an FNS and resilience to climate change impact report.
- PIIRS has been expanded since the FY16 data collection process, and will continue to collect and report data on impact/outcomes and generate input for learning.

The 25 Global Indicators for Measuring Change

All indicators to be disaggregated by sex, age, type of organization (for gender equality, others), & marginalized group, where possible².

Poverty and social injustice	
<ol style="list-style-type: none"> 1. % of the population below the international poverty line (SDG indicator 1.1.1) 2. % of the population living below the national poverty line (SDG indicator 1.2.1) 3. % of the population living in households with access to basic services (SDG indicator 1.4.1) 	
<p style="text-align: center;">Humanitarian Assistance (HUM)</p> <ol style="list-style-type: none"> 4. # and % of disaster/crisis-affected people supported through/by CARE who obtained humanitarian assistance that is fully in line with CARE's and other global standards: <ul style="list-style-type: none"> (4a) obtained adequate emergency shelter or (4b) obtained or recovered adequate housing; (4c) accessed safe drinking water and (4d) accessed adequate sanitation facilities and (4e) used adequate hygiene practices; (4f) obtained adequate food quantities and quality or (4g) adopted adequate nutritional practices; (4h) accessed at least one SRH service; (4i) recovered household goods, assets, and/or income opportunities 5. % of disaster/crisis affected people in areas of CARE responses who report satisfaction with regards to relevance, timeliness and accountability of humanitarian interventions 	<p style="text-align: center;">Sexual, Reproductive & Maternal Health and Rights (SRMH)</p> <ol style="list-style-type: none"> 6. Demand satisfied for modern contraceptives among women aged 15-49 (SDG indicator 3.7.1) 7. Proportion of births attended by skilled health personnel (SDG indicator 3.1.2) 8. Adolescent birth rate (disaggregated by 10-14; 15-19 years) per 1,000 women in each age group (SDG indicator 3.7.2). Proxy indicator: Age at first delivery. 9. Proportion of women aged 15-49 who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care (SDG indicator 5.6.1) <p style="text-align: center;">The Right to a Life Free From Violence (LFFV)</p> <ol style="list-style-type: none"> 10. % of people who reject intimate partner violence 11. % of ever-partnered women and girls aged 15 years and older subjected to physical, sexual or psychological violence by a current or former intimate partner, in the last 12 months (SDG indicator 5.2.1) 12. % of women and girls aged 15 years and older subjected to sexual violence by persons other than an intimate partner, in the last 12 months (SDG indicator 5.2.2)
<p style="text-align: center;">Food & Nutrition Security and Climate Change Resilience (FNS&CCR)</p> <ol style="list-style-type: none"> 13. Prevalence of population with moderate or severe food insecurity, based on the Food Insecurity Experience Scale (FIES) (SDG indicator 2.1.2) 14. Prevalence of stunting among girls and boys under the age of five (SDG indicator 2.2.1) 15. % of people better able to build resilience to the effects of climate change and variability 	<p style="text-align: center;">Women's Economic Empowerment (WEE)</p> <ol style="list-style-type: none"> 16. # and % of women who are active users of financial services (disaggregated by informal and formal services) (related to SDG indicator 8.10.2) 17. % of women who report they are able to equally participate in household financial decision-making 18. # and % of women with union, women's group or cooperative membership through which they can voice their labor rights
<p style="text-align: center;">The CARE Approach (Gender Equality and Women's Voice, Inclusive Governance, Resilience)</p> <ol style="list-style-type: none"> 19. # and % of people of all genders who have meaningfully participated in formal (government-led) and informal (civil society-led, private sector-led) decision-making spaces 20. # of new or amended policies, legislation, public programs, and/or budgets responsive to the rights, needs and demands of people of all genders 21. % of people that have actively engaged in reducing their vulnerabilities to the shocks that affect them 	<p style="text-align: center;">CARE Roles</p> <p>Humanitarian action</p> <ol style="list-style-type: none"> 22. # and % of CARE's humanitarian projects and initiatives complying with gender marker requirements <p>Promoting lasting change and innovative solutions</p> <ol style="list-style-type: none"> 23. # and % of projects/initiatives that developed innovations for fighting poverty and inequality <p>Multiplying impact</p> <ol style="list-style-type: none"> 24. # and % of projects/initiatives that influenced policy change 25. # and % of projects/initiatives that linked or worked with strategic alliances and partners to take tested and effective solutions to scale

² Within the SDGs, there is [not yet a universal framework for disaggregation](#). You can use the framework that's most appropriate for your project/initiative, in line with already existing references (e.g. "[Sex and Age Matter for disaggregation in humanitarian work](#)")

Supplementary Indicators for Measuring Change towards the CARE 2020 Program Strategy

Why we need supplementary indicators

The supplementary indicators are a **complementary set of impact and outcome metrics** that projects and initiatives can use to assess change in areas or domains of change that may not be fully captured with the use of any of the 25 Global Indicators.

The incorporation and measurement of the supplementary indicators is optional for projects and initiatives around the world. However, their use can certainly support on the generation of comparable evidence across projects in different countries that explains how and to what extent CARE’s work contributes to change, and the progress towards the CARE2020 Program Strategy.

What is expected from CARE International Members and Country Offices?

It is expected that all CI Members and Country Offices commit to the following:

- Incorporate supplementary indicators in proposals/new contracts (as appropriate and relevant).
- Apply relevant supplementary proposed indicators in upcoming evaluations (from now onwards, wherever possible).
- Where appropriate, apply the supplementary indicators and their methodologies in existing projects/programs/contracts.
- When possible and relevant, report data to the Project/Program Information and Impact Reporting System (PIIRS), every time an evaluative process takes place and a project or initiative has collected and analyzed data on any of the supplementary indicators selected.

Supplementary Indicators for Measuring Change

All indicators to be disaggregated by sex, age, type of organization (for gender equality, others), & marginalized group, where possible³.

Poverty and social injustice
No supplementary indicators developed to date.
Humanitarian Assistance (HUM)
Humanitarian - Shelter HUM – S 1. #/% of households (women) with documentable / enforceable title / tenancy agreement HUM – S 2. #/% of people (SADD) / households or other equivalent groupings with sufficient & appropriate HH items / assets to live in dignity & safety
Humanitarian - WASH No supplementary indicators. All main outcomes already captured by global indicator 4c.
Humanitarian - FNS The following indicators can be used as supplementary indicators for his area: Global Indicator 13 (moderate or severe food insecurity FIES); FNS&CCR - NUT 1. (Wasting); FNS&CCR - NUT 2. (Minimum acceptable diet);

³ Within the SDGs, there is [not yet a universal framework for disaggregation](#). You can use the framework that’s most appropriate for your project/initiative, in line with already existing references (e.g. [“Sex and Age Matter for disaggregation in humanitarian work”](#))

FNS&CCR - NUT 3. (Minimum Dietary Diversity – Women);
FNS&CCR - NUT 6. (Mid-Upper Arm Circumference MUAC);
and FNS&CCR - HUM 1 to HUM 6.

Humanitarian - SRMH

HUM – SRMH 1. Proportion of health facilities providing at least 5 contraceptive methods within the last 30 days
HUM – SRMH 2. Proportion of births attended by skilled personnel within the last 30 days
HUM – SRMH 3. Proportion of health facilities providing services for the prevention and treatment of STDs and tuberculosis at least once within the past 30 days
HUM – SRMH 4. Clinical management of sexual violence (including psycho-social support)
HUM – SRMH 5. Proportion of health facilities with Emergency Obstetric Care (EOC) services
HUM – SRMH 6. Proportion of health facilities with WCMR capacity: provision / facilitation of access to Post-Exposure Prophylaxis – PEP, treatment of Sexually Transmitted Infection – STI, etc.

Humanitarian - Resilience

HUM – RES 1. #/% people obtained humanitarian assistance in the form of cash/vouchers
HUM – RES 2. Coping strategies Index (household asset base and coping ability)
The following indicators can also be used as supplementary indicators for this area: FNS&CCR - SE 1. (% increase in income) and FNS&CCR - SAS 6. (Increased adaptive capacity)

Humanitarian – Accountability to affected people

Please refer to global indicator 5 for details on different dimensions or lines of inquiry for measuring accountability.

Sexual, Reproductive & Maternal Health and Rights (SRMH)

Sexual, Reproductive & Maternal Health and Rights – Reproductive Health

SRMH – RH 1. Maternal mortality rate (and neonatal mortality rate where appropriate)
SRMH – RH 2. % of women provided with complete information on FP ever/during recent health worker contact
SRMH – RH 3. % respondents who know at least one modern family planning method (DHS)
SRMH – RH 4. % of live births for which the mother received at least 4 ante-natal care visits
SRMH – RH 5. % of live births for which the mother and newborn received post-natal care within 48 hrs.
SRMH – RH 6. % of abortion-related cases (excluding planned termination of pregnancy) admitted to service delivery points providing in-patient obstetric and gynecological services
SRMH – RH 7. % pregnant women (15-24) attending antenatal clinics, whose blood has been screened for HIV / who are sero-positive for HIV
SRMH – RH 8. % of live births by anti-retroviral (ARV) treatment-eligible women currently receiving ARV

Sexual, Reproductive & Maternal Health and Rights – Gender Equality and Women’s Voice

SRMH – GE 1. % women 20 – 24 who attended/completed secondary education
SRMH – GE 2. % of men supportive of their partners’ reproductive health practices
SRMH – GE 3. Gender-equitable attitudes toward women’s and girls’ sexual agency
SRMH – GE 4. Improvement in couples’ relations (intimacy)
SRMH – GE 5. Improved communications between adolescents and parents about ASRH

Sexual, Reproductive & Maternal Health and Rights – Inclusive Governance

SRMH – IG 1. #/% communities with spaces for dialogue and negotiation between service users and service
SRMH – IG 2. #/% of partners engaging in health governance with at least 30% women among members
SRMH – IG 3. % health facilities with functional complaints mechanism
SRMH – IG 4. % of providers paid on time

Sexual, Reproductive & Maternal Health and Rights – Resilience

SRMH - RES 1. #/% partners with emergency preparedness plans which include SRH
SRMH - RES 2. #/% facilities with functioning basic essential obstetric care per 500,000 population
SRMH - RES 3. #/% service delivery points providing appropriate medical, psychological, and legal support for women and men who have been raped or experienced incest
SRMH - RES 4. % facilities stocked out, by method offered, on the day of assessment

SRMH - RES 5. Level of community connectedness to the health system

SRMH - RES 6. Level of trust in the health delivery system

The Right to a Life Free from Violence (LFFV)

No supplementary indicators developed to date.

Food & Nutrition Security and Climate Change Resilience (FNS&CCR)

Food & nutrition security and climate change resilience – Sustainable Agriculture Systems

FNS&CCR - SAS 1. % of agricultural area under sustainable agricultural and natural resource management practices

FNS&CCR - SAS 2. Increased yield per unit area (or productivity per unit area which will also cover fisheries, livestock etc.)

FNS&CCR - SAS 3. % of women farmers with access to, control over, or ownership of a core set of productive resources, assets, and services

FNS&CCR - SAS 4. Months of Adequate Household Food Provisioning (MAHFP)

FNS&CCR - SAS 5. Increased adaptive capacity among households and communities dependent on small-scale food production

Food & nutrition security and climate change resilience – Nutrition

FNS&CCR - NUT 1. Wasting – Moderate and severe: % of children aged 0–59 months who are below minus two standard deviations from median weight-for-height (WHZ < -2SD) of the WHO Child Growth Standard

FNS&CCR - NUT 2. % of children 6–23 months of age who receive a minimum acceptable diet (apart from breast milk)

FNS&CCR - NUT 3. % of women (15-49 years) who consume at least 5 out of 10 defined food groups (Minimum Dietary Diversity – Women)

FNS&CCR - NUT 4. % of women of reproductive age (15-49 years) with anemia and % children 6-23months / 6-59 months with anemia

FNS&CCR - NUT 5. Exclusive breastfeeding under 6 months: % of infants 0–5 months fed exclusively with breast milk

FNS&CCR - NUT 6. Mid-Upper Arm Circumference (MUAC) for children 5-59 months and women of reproductive age 15-49

Food & nutrition security and climate change resilience – Sustainable Economies

FNS&CCR - SE 1. % increase in income compared to baseline for HH and/or impact population

FNS&CCR - SE 2. Total amount of savings made by impact population

FNS&CCR - SE 3. # of policies, norms and practices changes for more inclusive and sustainable economies

FNS&CCR - SE 4. # of sustainable enterprises supported contributing to FNS&CCR outcomes

FNS&CCR - SE 5. # of new employment created for impact population (women, youth)

FNS&CCR - SE 6. % of adults actively using a financial services (formal and informal, including a mobile money services) in the past 12 months

Food & nutrition security and climate change resilience – Humanitarian Assistance

FNS&CCR - HUM 1. Food Consumption Score

FNS&CCR - HUM 2. Household Dietary Diversity Score (HDDS) – Women Dietary Diversity Score

FNS&CCR - HUM 3. Coping strategies Index (household asset base and coping ability)

FNS&CCR - HUM 4. Livelihood Protection Deficit

FNS&CCR - HUM 5. Quantity of food consumed in terms of Kcals per person per day

FNS&CCR - HUM 6. Livelihood change (strategies and assets).

Women's Economic Empowerment (WEE)

WEE 1. # and % of women and men reporting net income increase per day; and US\$ value of increase

WEE 2. # and % of women and men who have increased capability to perform economic activity

WEE 3. # and % of women and men who own or control productive asset (including land) /technology and have the skills to use them productively

WEE 4.# and % of women and men who have universal access to social protection services relevant to their occupation

WEE 5. # and % of women and men who are aware of/understand gender barriers at workplace

WEE 6. # and % of women and men in managerial/senior decision- making position (SDG indicator 5.5.2)

The CARE approach

Gender Equality and Women's Voice (GEVV)

GEVV 1. Average total # and proportion of weekly hours spent on unpaid domestic and care work, by sex, age and location (for individuals five years and above)

GEVV 2. % of individuals reporting high self-efficacy (SADD)

GEVV 3. # of countries with laws and regulations that guarantee women aged 15-49 years access to sexual and reproductive health care, information and education

GEVV 4. % of individuals who report confidence in their own negotiation and communication skills (SADD)

GEVV 5. % of respondents who report gender equitable attitudes (GEM Scale)

GEVV 6. % of individuals reporting they can rely on a community member in times of need; SADD

GEVV 7. % of individuals reporting that they could work collectively with others in the community to achieve a common goal; SADD

GEVV 8. # of examples in the media representing relevant norms

GEVV 9. Proportion of women aged 20-24 years who were married or in a union before age 15 and before age 18

Inclusive Governance (IG)

IG 1. # and % of people of all genders with knowledge & awareness of their rights and responsibilities as citizens

IG 2. # of organizations/social movements (and # & % of leaders, disaggregated by sex) with strengthened capacities to channel demands of marginalized citizens and engage in decision-making

IG 3. # of CARE/partner-supported collective actions undertaken by organizations/ movements, to present marginalized people's demands to power-holders

IG 4. # of organizations/movements supported by CARE that are considered by their constituents to effectively represent marginalized groups

IG 5. # of new/strengthened inclusive accountability spaces in which marginalized citizens can negotiate with service providers, public authorities or other power-holders

IG 6. # and % of accountability spaces with joint plans of action agreed, over the last 3-6 months

IG 7. % of priority actions (in plans agreed in accountability spaces) that have been implemented

IG 8. # of power-holders (and # of their staff, disaggregated by sex), that have improved their skills to effectively fulfil their roles and mandate, through the support of CARE and partners

IG 9. Proportion of the population satisfied with their last experience of public services, disaggregated by sector, & sex (SDG 16.6.2)

IG 10. # and quality of transparency processes/actions (citizens' windows, public audits, open budgets, etc.) that are established or improved with support of CARE and partners

Resilience

No supplementary indicators developed to date.

Guidance for the Incorporation and Measurement of the 25 Global Indicators

This document provides further guidance for the incorporation and measurement for each of the 25 global indicators.

Poverty and Social Injustice – global indicators

INDICATOR 1: Proportion of the population below the international poverty line

Why this indicator? What will it measure and provide information for?

This is a globally used indicator that measures the share of the population living in households with per-capita consumption or income that is below the international poverty line. Reduction of poverty is a major objective in many countries and one of the SDG targets (Target 1.1 By 2030, eradicate extreme poverty for all people everywhere, currently measured as people living on less than \$1.90 a day)

What Sustainable Development Goal is the indicator connected to?

SDG Goal 1, indicator 1.1.1: Proportion of population below International poverty line disaggregated by sex, age group, employment status and geographical location (urban/rural)

Definitions and key terms

Poverty: Households with per-capita consumption or income that is below the international poverty line of US\$1.90 (updated by the World Bank in October 2015 from \$1.25 to \$1.90, using 2011 prices, applying the new 2011 purchasing power parity (PPP) conversion factors). Poverty lines across countries vary in terms of their purchasing power, with richer countries tending to adopt higher standards of living in defining poverty. But to consistently measure global absolute poverty in terms of consumption, we need to treat two people with the same purchasing power over commodities the same way—both are either poor or not poor—even if they live in different countries.

Data and information required to calculate the indicator

- Numerator: the number of persons living in households below the poverty line (disaggregated by sex, age and employment status)
- Denominator: the total number of persons (disaggregated by the same sex, age and employment status groups)

Suggested method for data collection

- Primary data sources: household surveys
- Secondary data analysis, from World Bank, ILO, UN and government statistics.
- For more information: <http://www.worldbank.org/en/topic/measuringpoverty>
- Qualitative methods such as focus group discussions and key informants interviews should supplement the quantitative data collection to provide a better understanding of barriers to decreasing rates of poverty.
- Alternate measures: The Progress out of Poverty Index (PPI) has been developed by the Grameen Foundation as a simple to use tool, based on 10 questions that a household member can answer in 5 to 10 minutes, to compute whether a household is likely to be below the poverty line. There are PPIs for 45 countries – see <http://www.progressoutofpoverty.org/>.

Possible data sources

- Primary data collection: household surveys, using standard questionnaires (as applied by national statistics agencies)
- Secondary data, living Standard Measurement Surveys (LSMS) and Social Dimensions of Adjustment (SDA) surveys in sub-Saharan Africa (funded by World Bank)

Resources needed for data collection

Quantitative data can be obtained household surveys carried out by National Statistics Offices and others. Qualitative research on CARE's contribution will require resources and possibly the support of a research or evaluation partner. Significant resources for household surveys would need to be included in the monitoring and evaluation plan and budgeted for, should CARE collect quantitative data (which would be rare).

Reporting results for this indicator: number of people for which the change happened

- A change in the percentage of people living in households below the international poverty line.
- An analysis of how CARE contributed to this change.

Questions for guiding the analysis and interpretation of data (explaining the how and why the change happened, and how CARE contributed to the change)

- What have been the main changes in poverty levels over the life of this project? Were there important differences in changes in poverty levels by gender, age, social or employment status or other factors?
- How has CARE contributed to the change? What were CARE's main strategies for contributing to this change?
- Have there been any changes in legislation, practice or Government programs (e.g. Social Protection) that have influenced the results? What other factors explain the change?

Other considerations

- At the country level, comparisons over time may be affected by such factors as changes in survey types or data collection methods. The use of PPPs rather than market exchange rates ensures that differences in price levels

across countries are taken into account. However, it cannot be categorically asserted that two people in two different countries, living below US\$1.90 a day at PPP, face the same degree of deprivation or have the same degree of need. This poverty line is not appropriate for high-income economies and may not be appropriate for upper-middle income countries.

- Changes in poverty levels are likely to be influenced by many different factors, beyond those affected by CARE & our partners' programs. Careful interpretation of data, and triangulation with other sources, is needed to avoid overstating our contribution to changes.

INDICATOR 2: Proportion of the population below the national poverty line

Why this indicator? What will it measure and provide information for?

This is a globally used indicator that measures the share of the population living in households with per-capita consumption or income that is below the national poverty line. Reduction of poverty is a major objective in many countries (SDG Target 1.2.1: By 2030, reduce at least by half the proportion of men, women and children of all ages living in poverty in all its dimensions according to national definitions)

What Sustainable Development Goal is the indicator connected to?

SDG Goal 1, indicator 1.2.1: By 2030, reduce at least by half the proportion of men, women and children of all ages living in poverty in all its dimensions according to national definitions.

Definitions and key terms

Poverty: Households having with per-capita consumption or income that is below the national poverty line. Cross-country comparisons should not be made using national poverty lines, as these do not reflect any single agreed-upon international norm on poverty. However, when the focus is narrowed to one country and the same poverty line has been used consistently over time, analyses of trends and patterns of poverty may be informative and in many cases more useful for national inferences than analysis of international poverty lines

Data and information required to calculate the indicator

- Numerator: the number of persons living in households below the national poverty line (disaggregated by sex, age and employment status)
- Denominator: the total number of persons (disaggregated by the same sex, age and employment status groups)

Suggested method for data collection

- Primary data collection: household surveys
- Secondary data analysis, from World Bank, ILO, UN and government statistics.
- For more information: <http://www.worldbank.org/en/topic/measuringpoverty>
- Qualitative methods like focus group discussions and key informants interviews should supplement the quantitative data collection to provide a better understanding of barriers and to decreasing rates of poverty.

Possible data sources

- Primary data collection: household surveys, using standard questionnaires (as applied by national statistics agencies)
- Secondary data provided by national statistics offices
- Living Standard Measurement Surveys (LSMS) and Social Dimensions of Adjustment (SDA) surveys in sub-Saharan Africa (funded by the World Bank)

Resources needed for data collection

Quantitative data can be obtained household surveys carried out by National Statistics Offices and others. Qualitative research on CARE's contribution will require resources and possibly the support of a research or evaluation partner. Significant resources for household surveys would need to be included in the monitoring and evaluation plan and budgeted for, should CARE collect quantitative data (which would be rare).

Reporting results for this indicator: number of people for which the change happened

- A change in the percentage of people living in households below the national poverty line.
- An analysis of how CARE contributed to this change.

Questions for guiding the analysis and interpretation of data (explaining the how and why the change happened, and how CARE contributed to the change)

- What have been the main changes in poverty levels over the life of this project? Were there important differences in changes in poverty levels by gender, age, social or employment status or other factors?
- How has CARE contributed to the change? What were CARE's main strategies for contributing to this change?
- Have there been any changes in legislation, practice or Government programs (e.g. Social Protection) that have influenced the results? What other factors explain the change?

Other considerations

- Changes in poverty levels are likely to be influenced by many different factors, beyond those affected by CARE and our partners' programs. Careful interpretation of data, and triangulation with other sources, is needed to avoid overstating our contribution to changes.

INDICATOR 3: Proportion of the population living in households with access to basic services

Why this indicator? What will it measure and provide information for?

This indicator measures access to basic services – it is a proposed SDG indicator 1.4.1 (to be confirmed). The indicator has been agreed by the Inter-agency Expert Group on SDG Indicators but no internationally established methodology or standards are yet available. Methodology/standards are being (or will be) developed or tested.

What Sustainable Development Goal is the indicator connected to?

SDG Target 1.4: By 2030, ensure that all men and women, in particular the poor and the vulnerable, have equal rights to economic resources, as well as access to basic services, ownership and control over land and other forms of property, inheritance, natural resources, appropriate new technology and financial services, including microfinance.

Additional information for this indicator to be added when available. In the meantime, projects can use this indicator as defined in the country/context in which they implement activities.

Humanitarian Assistance - global indicators

INDICATOR 4a: # and % of disaster/crisis-affected people supported through/by CARE who obtained adequate emergency shelter

INDICATOR 4b: # and % of disaster/crisis-affected people supported through/by CARE who obtained or recovered adequate housing

Why these indicators? What will they measure and provide information for?

These indicators relate to **one of CARE's four core sectors for humanitarian response: Shelter, FNS, SRH, WASH. They aim to gather disaggregated data on number of crisis / disaster affected households supported by CARE and/or its partners with shelter assistance and its grounding in relevant sector standards.**

Shelter and housing are critical determinants for safety and protection in the initial stages of a disaster and therefore is one of the priority areas for emergency assistance in most humanitarian disasters and crises. In cold climates shelter is an urgent life-saving priority. Beyond immediate urgent needs, shelter or housing is necessary to provide security of person and of possessions, to provide protection from the climate, and to resist ill health and disease, including avoidance of psychological ill health. It is also important for human dignity, to sustain family and community life and to enable affected populations to recover from the impact of disaster.

Shelter, housing and associated settlement and household non-food item responses should support existing coping strategies and promote self-sufficiency and self-management by those affected by the disaster. As such, recovery of adequate housing is a key pre-requisite for achieving many of CARE's objectives post-disaster including resilience.

In CARE's humanitarian responses three basic scenarios are possible with regards to the explicit distinction of shelter and housing interventions – all three scenarios requiring the application of specific supplementary indicators:

- We provide only emergency shelter, and not recovery support
- We provide only recovery support and not emergency shelter
- We provide both

Target (CARE Humanitarian & Emergency Strategy 2013-2020) :

Humanitarian assistance provided by/through CARE (partners) reaches at least 5-15% (depending on emergency type) of all households affected by a particular disaster / crisis (OR if appropriate and more precise: of all disaster / crisis affected households of a specific geographic area in need of particular technical assistance)

What Humanitarian Standards and Humanitarian Indicators are these indicators connected to?

These indicators refer to the [SPHERE minimum standards in Shelter and Settlement](#):

1. Shelter and settlement strategies contribute to the security, safety, health and well-being of both displaced and non-displaced affected populations and promote recovery and reconstruction where possible.
2. The planning of return, host or temporary communal settlements enables the safe and secure use of accommodation and essential services by the affected population.
3. People have sufficient covered living space providing thermal comfort, fresh air and protection from the climate ensuring their privacy, safety and health and enabling essential household and livelihood activities to be undertaken.
4. Local safe building practices, materials, expertise and capacities are used where appropriate, maximizing the involvement of the affected population and local livelihood opportunities.
5. Shelter and settlement solutions and the material sourcing and construction techniques used minimize adverse impact on the local natural environment.

The related Humanitarian Response Indicator(s) (see [Humanitarian Response Indicators Registry](#)) are:

- Indicator code S1-2-1: Number and percentage of households having received shelter assistance (outcome)
- Outcome indicators (19) related to various elements defining 'adequate housing' (see below)

[AusAid/OECD Gender Equality Toolkit](#) specifically requires monitoring of safety and privacy of temporary shelter and housing as well as equal tenure rights.

Definitions and key terms (see [Shelter Guidance Note 1](#) for more information)

These indicators measure **either** provision of adequate emergency shelter, **or** meaningful support to help people recovery adequate housing.

- **Provision of adequate emergency shelter:** this includes the provision of basic shelter materials (e.g. plastic sheeting, tents), household NFIs (e.g. bedding, clothes, cook sets, lighting and stoves), or other response modalities such as short-term cash for shelter, cash for rent, host family support, etc. **Note that, for measuring this indicator, the qualitative element of 'adequate' emergency shelter** implies that the recipients have temporary (max 12 months) shelter within 4 weeks which provides them with safety for themselves and their belongings, and a sufficient level of dignity.
- **Provision or recovery of adequate housing:** this includes projects and approaches which allow people to regain secure shelter in the longer term. This may include repair and reconstruction of housing, cash for recovery or longer term rental support, technical assistance, legal assistance on land rights and tenure, or livelihoods support to ensure sufficient income for sustainable recovery of shelter. It may also include settlement-wide support to ensure access to services and infrastructure.

Sphere standards referring to key international rights instruments defining "[Adequate Housing](#)" include:

- sufficient space and protection from cold, damp, heat, rain, wind or other threats to health, including structural hazards and disease vectors
- the availability of services, facilities, materials and infrastructure
- affordability, habitability, accessibility, location and cultural appropriateness
- sustainable access to natural and common resources; safe drinking water; energy for cooking, heating and lighting; sanitation and washing facilities; means of food storage; refuse disposal; site drainage; and emergency services
- the appropriate siting of settlements and housing to provide safe access to healthcare services, schools, childcare centers and other social facilities and to livelihood opportunities
- that building materials and policies relating to housing construction appropriately enable the expression of cultural identity and diversity of housing.

In addition, adequate housing requires also access to NFIs such as

- clothing and bedding materials that meet the most personal human needs for the maintenance of health, privacy and dignity.

- basic goods and supplies that enable affected populations to prepare and consume food, provide thermal comfort, meet personal hygiene needs and build, maintain or repair shelters

Data and information required to calculate these indicators

Unit Description: Number and percentage

Numerator: Number of households / people having received sector specific assistance by/through CARE (partners) = **caseload reached** (reference: guidance note for participant reporting, PIIRS project categories).

Denominator: Total number of disaster/crisis affected households / people = **overall caseload** (specify if possible: HH / people in need of specific assistance = **specific caseload**)

Disaggregation:

Mandatory: Sex, age and disability/special needs (specify Head of Household);

Sector specific: Type of shelter assistance received (shelter materials; household NFIs; cash/vouchers; labor; transportation; information; technical assistance; other); Shelter damage category; Occupancy (multiple occupancy; single family occupancy; collective shelter);

Context specific: legal status (host, IDP, refugee, registered / not registered, returnee); Household tenure situation (owner / owner-occupier; renter; squatter; no tenure); Type of settlement (urban / rural; formal / informal) or displacement site/situation (self-settled / planned camp; collective center; host family);

NOTE: some donors are interested specifically in counting shelter/housing units established/upgraded (e.g. in new camps or for dispersed IDPs). In this case use the appropriate output indicator (#units) but ensure that occupancy is monitored and documented according to this requirement.

Suggested method for data collection & Possible data sources

Monitoring these indicators will rely on a combination of primary and secondary/tertiary data sources with more or less comparable methodologies of data collection. Triangulation might be needed in order to consolidate confidence levels of data used. CARE should adopt data collection methodology for nominator to ensure alignment with most reliable sources for denominator data.

Nominator: assistance monitoring conducted by CARE directly, through partners or remotely (third party); data collected through activity reports, observation at location, end user surveys etc.

Denominator: mainly from secondary sources such Government/UN sanctioned general assessments (including MIRA or other multi-sectoral / interagency assessments); data can be further refined (e.g. with regards to disaggregation) / validated through more in depth assessments conducted by CARE including geo-data (coordinates)

Level of effort needed for data collection and reporting: MEDIUM HIGH

Household specific monitoring for nominator and denominator data requires **high level of effort** including detailed surveying of households, geo-data, establishment of databases etc. LoE can be reduced by

- limiting detailed surveying to robust samples with potential for longitudinal surveying of sentinel households / sites,
- combining monitoring with household level technical or legal assistance provision and community mobilization
- Collecting some qualitative non-technical data via focus groups and KII rather than door to door.

Frequency of reporting should be aligned with availability of secondary data for caseload (denominator) as well as with frequency of interventions by CARE and/or partners (e.g. post distribution monitoring, seasonal surveys, gender specific surveys).

Minimum requirement:

- Current status reported through **sitreps** (frequency varies);
- consolidated data reported **annually through PIIRS**

Data analysis and interpretation of results for this indicator: explaining trends (e.g. caseload needs, actors providing assistance) during reporting time, how and why the outcome was reached, and how CARE contributed to the outcome

This indicator requires constant adjustment of data based on the documentation of following trends:

- caseload (overall, sector specific, reached by CARE) and disaggregation (see above)
- assistance provided by CARE and others
- alignment of assistance with minimum standards (SPHERE) and/or multi-agency agreed standards
- recovery of housing by affected population

To assess **adequacy and gender sensitivity** of assistance provided (by CARE and others) more analysis is required with regards to:

- Extent to which assistance provided by CARE is aligned with minimum standards for adequate housing

- Extent to which CARE interventions reach the most vulnerable groups (women & girls in particular) as identified through relevant assessments
- Extent to which assistance supports building back stronger/safer housing (hazard mitigation, access and protection measures)
- Extent to which population recover (adequate) housing without external assistance

Other considerations

Data related to the technical adequacy of assistance provided should always be analyzed while taking into account the feedback received from the affected population itself. Their perceptions are captured through data and information collected under the **Global indicator related to the satisfaction of crisis/disaster affected people with the relevance, timeliness and accountability of humanitarian interventions in areas of CARE's response.**

INDICATOR 4c. # and % of disaster/crisis-affected people supported through/by CARE who accessed safe drinking water

INDICATOR 4d. # and % of disaster/crisis-affected people supported through/by CARE who accessed adequate sanitation

INDICATOR 4e. # and % of disaster/crisis-affected people supported through/by CARE who used adequate hygiene practices

Why these indicators? What will they measure and provide information for?

These indicators relate to **one of CARE's four core sectors for humanitarian response: Shelter, FNS, SRMH, WASH. It aims to gather disaggregated data on number of crisis / disaster affected households supported by CARE and/or its partners with WASH assistance and its grounding in relevant sector standards.**

Access to safe drinking water, use of adequate sanitation facilities and of good hygiene practices (WASH) are indivisible and critical determinants for survival in the initial stages of a disaster and therefore are priority areas for lifesaving assistance in most humanitarian disasters and crisis. Beyond survival, simply providing sufficient water and sanitation facilities will not, on its own, ensure their optimal use or impact on public health. In order to achieve the maximum benefit from a response, it is imperative that disaster-affected people have the necessary information, knowledge and understanding to prevent water- and sanitation-related diseases and to get involved (individually and/or collectively) in the selection, design and maintenance of these facilities.

Target (CARE Humanitarian & Emergency Strategy 2013-2020) :

Humanitarian assistance provided by/through CARE (partners) reaches at least 5-15% (depending on emergency type) of all households affected by a particular disaster / crisis (OR if appropriate and more precise: of all disaster / crisis affected households of a specific geographic area in need of particular technical assistance)

What Humanitarian Standards and Humanitarian Indicators are these indicators connected to?

These indicators refer to the [SPHERE minimum standards in water supply, sanitation and hygiene promotion](#) which aim to protect public health through ensuring the optimal use of all water supply and sanitation facilities and practicing safe hygiene. The focus on hygiene promotion is crucial and specific as it is vital to a successful WASH intervention. In general terms, hygiene promotion is integral to all of the sections and is reflected in the indicators for water supply, excreta disposal, vector control, solid waste management and drainage.

The [Humanitarian Response Indicators Registry](#) includes a wide range of WASH outcome indicators (total of 17) which include but are not limited to:

- Use of safe water for drinking and cooking (W1-7)
- Defecation practices (W1-8, W3-1)
- Hand washing (W1-9)
- Access and water quantity (W2-3 and W2.4)

[AusAid/OECD Gender Equality Toolkit](#) specifically requires monitoring of safety and privacy of water and sanitation sites and housing as well as equal control over use and maintenance of WASH facilities.

Definitions and key terms

Connected with Sphere standards, the provision of 'adequate' WASH implies the reduction of transmission of faeco-oral diseases and exposure to disease-bearing vectors through promotion of:

- good hygiene practices
- the provision of safe drinking water (including equitable access and sufficient quantity and quality)

- the reduction of environmental health risks
- conditions that allow people to live with good health, dignity, comfort and security.

Simply providing sufficient water and sanitation facilities will not, on its own, ensure their optimal use or impact on public health. In order to achieve the maximum benefit from a response, it is imperative that disaster-affected people have the necessary information, knowledge and understanding to apply safe and dignified practices that prevent water- and sanitation-related diseases and to get involved (individually and/or collectively) in the selection, design and maintenance of these facilities.

Data and information required to calculate the indicators

Unit Description: Number and percentage

Numerator: Number of households / people having received sector specific assistance by/through CARE (partners) = **caseload reached** (reference: guidance note for participant reporting, PIIRS project categories).

Denominator: Total number of disaster/crisis affected households / people = **overall caseload** (specify if possible: HH / people in need of specific assistance = **specific caseload**)

Disaggregation:

Mandatory: Sex, age and disability/special needs (specify Head of Household);

Sector specific: Type of WASH assistance received (supply, cash; material; labor; transportation; other); WASH infrastructure damage category; Occupancy (multiple occupancy; single family occupancy; collective shelter);

Context specific: legal status (host, IDP, refugee, registered / not registered); Household tenure situation (owner / owner-occupier; renter; squatter; no tenure); Type of settlement (urban / rural; formal / informal) or displacement site/situation (self-settled / planned camp; collective center; host family);

Suggested method for data collection & Possible data sources

Monitoring this indicator will rely on a combination of primary and secondary/tertiary data sources with more or less comparable methodologies of data collection. Triangulation might be needed in order to consolidate confidence levels of data used. CARE should adopt data collection methodology for nominator to ensure alignment with most reliable sources for denominator data.

Nominator: assistance monitoring conducted by CARE directly, through partners or remotely (third party); data collected through activity reports, observation at location, end user surveys etc.

Denominator: mainly from secondary sources such Government/UN sanctioned general assessments (including MIRA or other multi-sectoral / interagency assessments); data can be further refined (e.g. with regards to disaggregation) / validated through more in depth assessments conducted by CARE including geo-data (coordinates)

Level of effort needed for data collection and reporting: MEDIUM HIGH

Household specific monitoring for nominator and denominator data requires **high level of effort** including detailed surveying of households, geo-data, establishment of databases etc. LoE can be reduced by limiting detailed surveying to robust samples with potential for longitudinal surveying of sentinel households / sites.

Frequency of reporting should be aligned with availability of secondary data for caseload (denominator) as well as with frequency of interventions by CARE and/or partners (e.g. post distribution monitoring, seasonal surveys, gender specific surveys).

Minimum requirement:

- Current status reported through **sitreps (frequency varies)**;
- Consolidated data reported **annually through PIIRS**

Data analysis and interpretation of results for this indicator: explaining trends (e.g. caseload needs, actors providing assistance) during reporting time, how and why the outcome was reached, and how CARE contributed to the outcome

This indicator requires constant adjustment of data based on the documentation of following trends:

- caseload (overall, sector specific, reached by CARE) and disaggregation (see above)
- assistance provided by CARE and others
- alignment of assistance with minimum standards (SPHERE) and/or multi-agency agreed standards
- recovery of housing by affected population

To assess **adequacy and gender sensitivity** of assistance provided (by CARE and others) more analysis is required with regards to:

- Extent to which assistance provided by CARE and/or others is aligned with minimum WASH standards

- Extent to which CARE interventions reach the most vulnerable groups (women & girls in particular) as identified through relevant assessments
- Extent to which assistance provided supports sustainable change in hygiene practices
- Extent to which population recover (safe) WASH practices without external assistance

Other considerations

Data related to the technical adequacy of assistance provided should always be analyzed while taking into account the feedback received from the affected population itself. Their perceptions are captured through data and information collected under the **Global indicator related to the satisfaction of crisis/disaster affected people with the relevance, timeliness and accountability of humanitarian interventions in areas of CARE's response.**

INDICATOR 4f. # and % of disaster/crisis-affected people supported through/by CARE who obtained adequate food quantities and quality

INDICATOR 4g. # and % of disaster/crisis-affected people supported through/by CARE who adopted adequate nutritional practices

Why these indicators? What will it measure and provide information for?

These indicators relate to **one of CARE's four core sectors for humanitarian response: Shelter, FNS, SRMH, WASH. It aims to gather disaggregated data on number of crisis / disaster affected households supported by CARE and/or its partners with FNS assistance and its grounding in relevant sector standards.**

Access to food and the maintenance of an adequate nutritional status are critical determinants of people's survival in a disaster. The people affected are often already chronically undernourished when the disaster hits. Undernutrition is a serious public health problem and among the lead causes of death, whether directly or indirectly. The vulnerability of infants and young children means that addressing their nutrition should be a priority. Prevention of undernutrition is as important as treatment of acute malnutrition. Food security interventions may determine nutrition and health in the short term and their survival and well-being in the long term.

Target (CARE Humanitarian & Emergency Strategy 2013-2020) :

Humanitarian assistance provided by/through CARE (partners) reaches at least 5-15% (depending on emergency type) of all households affected by a particular disaster / crisis (of all households affected by a particular disaster / crisis in need of assistance in a particular technical area)

What Humanitarian Standards and Humanitarian Indicators are these indicators connected to?

This indicator refers to the [SPHERE minimum standards in food security and nutrition](#) with further references to SPHERE companion standards such as:

- The [Livestock Emergency Guidelines and Standards](#) (LEGS)
- [Minimum requirements for market analysis in emergencies](#) developed by CaLP

Furthermore some CARE FNLSR related indicators refer to

- [Minimum dietary diversity for women \(MMD-W\)](#) (FAO / FANTA)
- [Food Consumption Score](#) (WfP / Food Security Cluster)

The [Humanitarian Response Indicators Registry](#) includes a wide range of Food Security and Nutrition outcome indicators (total of 45) which cover but are not limited to:

- Food access and availability
- Food utilization (including intra-household food distribution)
- Prevention and Management of Acute Malnutrition (especially infants, pregnant and lactating women)
- Infant and Young Child Feeding

Definitions and key terms

The SPHERE minimum standards reflect the core content of the right to food and contribute to the progressive realization of this right globally. The right to food implies the obligations:

- to respect and protect existing access to adequate food and nutritional services, and
 - to proactively engage in activities intended to enhance availability, people's access to and utilization of resources and means to ensure their livelihoods, including food security.
- **Food security** exists when all people, at all times, have physical, social and economic access to sufficient, safe and nutritious food to meet their dietary needs and food preferences for an active and healthy life. **Availability** refers to the quantity, quality and seasonality of the food supply in the disaster-affected area especially through local sources. **Access** refers to the capacity of a household to safely procure sufficient food to satisfy the nutritional

needs of all its members. **Utilization** refers to a household's use of the food to which it has access, including storage, processing and preparation, and distribution within the household. It is also an individual's ability to absorb and metabolize nutrients, which can be affected by disease and malnutrition.

- **Livelihoods** comprise the capabilities, assets (including natural, material and social resources) and activities used by a household for survival and future well-being. A household's livelihood is secure when it can cope with and recover from shocks, and maintain or enhance its capabilities and productive assets. **Coping strategies** are defined as temporary responses forced by food insecurity.
- **Nutrition** is a broad term referring to processes involved in eating, digestion and utilization of food by the body for growth and development, reproduction, physical activity and maintenance of health.

[AusAid/OECD Gender Equality Toolkit](#) specifically recognizes that women often play a greater role in planning and preparation of food for their households. Following a disaster, household livelihood strategies may change.

Recognizing **distinct gender roles in family nutrition** is key to improving food security at the household level.

Understanding the unique nutritional needs of pregnant and lactating women, young children, older people and persons with disabilities is also important in developing appropriate food responses.

Data and information required to calculate the indicators

Unit Description: Number and percentage

Numerator: Number of households / people having received sector specific assistance by/through CARE (partners) = **caseload reached** (reference: guidance note for participant reporting, PIIRS project categories).

Denominator: Total number of disaster/crisis affected households / people = **overall caseload** (specify if possible: HH / people in need of specific assistance = **specific caseload**)

Disaggregation:

Mandatory: Sex, age and disability/special needs (specify Head of Household);

Sector specific: Type of FNS assistance received (cash; basic foods, supplemental feeds; food for work; other); FNS strategy (e.g. agriculture, livestock, food purchase, other)

Context specific: legal status (host, IDP, refugee, registered / not registered); Household tenure situation (owner / owner-occupier; renter; squatter; no tenure); Type of settlement (urban / rural; formal / informal) or displacement site/situation (self-settled / planned camp; collective center; host family);

Suggested method for data collection & Possible data sources

Monitoring this indicator will rely on a combination of primary and secondary/tertiary data sources with more or less comparable methodologies of data collection. Triangulation might be needed in order to consolidate confidence levels of data used. CARE should adopt data collection methodology for nominator to ensure alignment with most reliable sources for denominator data.

Nominator: assistance monitoring conducted by CARE directly, through partners or remotely (third party); data collected through activity reports, observation at location, end user surveys etc.

Denominator: mainly from secondary sources such Government/UN sanctioned general assessments (including MIRA or other multi-sectoral / interagency assessments); data can be further refined (e.g. with regards to disaggregation) / validated through more in depth assessments conducted by CARE including geo-data (coordinates)

Level of effort needed for data collection and reporting: MEDIUM HIGH

Household specific monitoring for nominator and denominator data requires **high level of effort** including detailed surveying of households, geo-data, establishment of databases etc. LoE can be reduced by limiting detailed surveying to robust samples with potential for longitudinal surveying of sentinel households / sites.

Frequency of reporting should be aligned with availability of secondary data for caseload (denominator) as well as with frequency of interventions by CARE and/or partners (e.g. post distribution monitoring, seasonal surveys, gender specific surveys).

Minimum requirement:

- Current status reported through **sitreps (frequency varies)**;
- consolidated data reported **annually through PIIRS**

Data analysis and interpretation of results for this indicator: explaining trends (e.g. caseload needs, actors providing assistance) during reporting time, how and why the outcome was reached, and how CARE contributed to the outcome

This indicator requires constant adjustment of data with the documentation of trends on

- caseload (overall, sector specific, reached by CARE) and disaggregation (see above)
- assistance provided by CARE and others
- alignment of assistance with minimum standards (SPHERE) and/or other multi-agency agreed standards
- recovery of food and nutrition security by affected population

To assess **adequacy and gender sensitivity** of assistance provided (by CARE and others) more analysis is required with regards to:

- Extent to which assistance provided by CARE and/or others is aligned with global FNS standards
- Extent to which CARE interventions reach the most vulnerable groups (women & girls in particular) as identified through relevant assessments
- Extent to which assistance supports sustainable change in food consumption and nutrition practices
- Extent to which population recover (sustainable) food and nutrition practices without external assistance

Other considerations

Data related to the technical adequacy of assistance provided should always be analyzed while taking into account the feedback received from the affected population itself. Their perceptions are captured through data and information collected under the **Global indicator related to the satisfaction of crisis/disaster affected people with the relevance, timeliness and accountability of humanitarian interventions in areas of CARE's response.**

INDICATOR 4h. # and % of disaster/crisis-affected people supported through/by CARE who accessed at least one SRH service

(Focus on women of and adolescent girls of reproductive age and access to SBA, contraception, GBV management)

Why this indicator? What will it measure and provide information for?

This indicator relates to **one of CARE's four core sectors for humanitarian response: Shelter, FNS, SRH, WASH.** It aims to **gather disaggregated data on number of crisis / disaster affected households supported by CARE and/or its partners with SRH assistance and its grounding in relevant sector standards.**

Access to healthcare is a critical determinant for survival in the initial stages of disaster. Disasters almost always have significant impacts on the public health and well-being of affected populations. All individuals, including those living in disaster-affected areas, have the right to reproductive health (RH). To exercise this right, affected populations must have access to comprehensive RH information and services to make free and informed choices. Quality RH services must be based on the needs of the affected population. They must respect the religious beliefs, ethical values and cultural backgrounds of the community, while conforming to international human rights standards. Women and girls are especially vulnerable during emergencies if their reproductive health needs are not met as it exposes them to elevated risk of maternal mortality including risks of unintended pregnancies and negative consequences of unsafe abortion in resource constrained settings.

Target (CARE Humanitarian & Emergency Strategy 2013-2020) :

Humanitarian assistance provided by/through CARE (partners) reaches at least 5-15% (depending on emergency type) of all households affected by a particular disaster / crisis (OR if appropriate and more precise: of all disaster / crisis affected households of a specific geographic area in need of particular technical assistance)

What Humanitarian Standards and Humanitarian Indicators is this indicator connected to?

This indicator refers to the [SPHERE minimum SRH standards for essential health services](#) which focus on priority reproductive health services of the Minimum Initial Service Package (MISP) at the onset of an emergency and comprehensive RH as the situation stabilizes.

The [Humanitarian Response Indicators Registry](#) includes **SRH outcome indicators** also focus on

- Basic and Comprehensive Emergency Obstetric Care (B/CEmOC) services
- Clinical management of sexual violence
- Birth assistance by skilled attendants

[AusAid/OECD Gender Equality Toolkit](#) specifically requires the monitoring of the number of pregnancy and hygiene packs delivered to women and girls (compared with the proportion of affected females) and of the percentage of women and girls with access to contraceptive services.

Definitions and key terms

Sphere standards defines the main objective of SRH programs as the availability of adequate SRH capacities and their coordination for ensuring that especially women and girls of reproductive age have access to:

- Emergency obstetric and newborn care services (and skills)
- MISP related supplies and common contraceptive methods

- Services for the prevention and treatment of STDs and tuberculosis
- Clinical management of sexual violence (including psycho-social support)

Emergency obstetric and newborn care: In order to prevent maternal and newborn mortality and morbidity resulting from complications (approx. 15% of pregnancies), skilled birth attendance at all births, Basic EmOC capacities and neonatal resuscitation should be available at all primary healthcare facilities with a referral system to and from a primary healthcare facility with BEmOC and newborn care, and to a hospital with newborn care services.

Minimum Initial Service Package: The MISP defines those services that are most important for preventing RH-related morbidity and mortality among women, men and adolescents in disaster settings. It comprises a coordinated set of priority RH services that must be implemented simultaneously to prevent and manage the consequences of sexual violence, reduce the transmission of HIV, prevent excess maternal and newborn morbidity and mortality.

RH supplies: Supplies for the MISP must be ordered, distributed and stored to avoid delay in getting these essential products to the population. Standard kits such as the Interagency Emergency Health Kit or the Interagency Reproductive Health Kits, facilitate the preparedness for the delivery of MISP.

Sexual violence: All actors in disaster response must be aware of the risk of sexual violence including sexual exploitation and abuse by humanitarians, and must work to prevent and respond to it. Incidence of sexual violence should be monitored and aggregate information safely and ethically compiled and shared to inform prevention and response efforts. Measures for assisting survivors must be in place in all primary-level health facilities and include skilled staff to provide clinical management. Survivors of sexual violence should be supported to seek and be referred for clinical care and have access to mental health and psychosocial support, protection and legal support.

Data and information required to calculate the indicator

Unit Description: Number and percentage

Numerator: Number of households / people having received sector specific assistance by/through CARE (partners) = **caseload reached** (reference: guidance note for participant reporting, PIIRS project categories).

Denominator: Total number of disaster/crisis affected households / people = **overall caseload** (specify if possible: HH / people in need of specific assistance = **specific caseload**)

Disaggregation:

Mandatory: Sex, age and disability/special needs (specify Head of Household);

Sector specific: SRH health status; Type of SRH assistance received; Proximity to SRH service facilities

Context specific: legal status (host, IDP, refugee, registered / not registered); Household tenure situation (owner / owner-occupier; renter; squatter; no tenure); Type of settlement (urban / rural; formal / informal) or displacement site/situation (self-settled / planned camp; collective center; host family);

Suggested method for data collection & Possible data sources

Monitoring this indicator will rely on a combination of primary and secondary/tertiary data sources with more or less comparable methodologies of data collection. Triangulation might be needed in order to consolidate confidence levels of data used. CARE should adopt data collection methodology for nominator to ensure alignment with most reliable sources for denominator data.

Nominator: assistance monitoring conducted by CARE directly, through partners or remotely (third party); data collected through activity reports, observation at location, end user surveys etc.

Denominator: mainly from secondary sources such Government/UN sanctioned general assessments (including MIRA or other multi-sectoral / interagency assessments); data can be further refined (e.g. with regards to disaggregation) / validated through more in depth assessments conducted by CARE including geo-data (coordinates)

Level of effort needed for data collection and reporting: MEDIUM HIGH

Household specific monitoring for nominator and denominator data requires **high level of effort** including detailed surveying of households, geo-data, establishment of databases etc. LoE can be reduced by limiting detailed surveying to robust samples with potential for longitudinal surveying of sentinel households / sites.

Frequency of reporting should be aligned with availability of secondary data for caseload (denominator) as well as with frequency of interventions by CARE and/or partners (e.g. post distribution monitoring, seasonal surveys, gender specific surveys).

Minimum requirement:

- Current status reported through **sitreps (frequency varies)**;
- consolidated data reported **annually through PIIRS**

Data analysis and interpretation of results for this indicator: explaining trends (e.g. caseload needs, actors providing assistance) during reporting time, how and why the outcome was reached, and how CARE contributed to the outcome

This indicator requires constant adjustment of data with the documentation of trends on

- caseload (overall, sector specific, reached by CARE) and disaggregation (see above)
- assistance provided by CARE and others
- alignment of assistance with minimum standards (SPHERE) and/or multi-agency agreed standards
- recovery of housing by affected population

To assess **adequacy and gender sensitivity** of assistance provided (by CARE and others) more analysis is required with regards to:

- Extent to which assistance provided by CARE and/or others is aligned with minimum SRH standards
- Extent to which CARE interventions reach the most vulnerable groups (women & girls in particular) as identified through relevant assessments
- Extent to which assistance provided supports BEmOC services and MISIP
- Extent to which BEmOC services recover without external assistance

Other considerations

Data related to the technical adequacy of assistance provided should always be analyzed while taking into account the feedback received from the affected population itself. Their perceptions are captured through data and information collected under the **Global indicator related to the satisfaction of crisis/disaster affected people with the relevance, timeliness and accountability of humanitarian interventions in areas of CARE's response.**

INDICATOR 4i. # and % of disaster/crisis-affected people supported through/by CARE who recovered household goods, assets and/or income opportunities

Why this indicator? What will it measure and provide information for?

This indicator relates to a **component which cuts across CARE's four core sectors for humanitarian response: Shelter, FNS, SRMH, WASH.** It aims to gather disaggregated data on number of crisis / disaster affected households supported by CARE and/or its partners with cash, skills and services for livelihood recovery and grounding it in relevant sector standards.

The resilience of people's livelihoods and their vulnerability to shocks/crisis are largely determined by the resources (or assets) available to them (at various stages post-acute crisis) and how these have been affected by a disaster.

These resources include financial capital (such as cash, credit, savings) and also include physical (houses, machinery), natural (land, water), human (labor, skills), social (networks, norms) and political (influence, policy) capital. Key to those who produce food is whether they have access to land that can support production and whether they have the means to continue to farm. Key to those who need income to get their food is whether they have access to employment, markets and services. For people affected by disasters, the preservation, recovery and development of the resources necessary for their food security and future livelihoods should be a priority. While most attention at the onset of a disaster /crisis will be given to life saving interventions, the sooner the planning and work on recovery begins, the sooner the affected areas are stabilized and the shorter and more effective the recovery process is likely to be.

Target (CARE Humanitarian & Emergency Strategy 2013-2020) :

Humanitarian assistance provided by/through CARE (partners) reaches at least 5-15% (depending on emergency type) of all households affected by a particular disaster / crisis (OR if appropriate and more precise: of all disaster / crisis affected households of a specific geographic area in need of particular technical assistance)

What Humanitarian Standards and Humanitarian Indicators is this indicator connected to?

This indicator refers to the relevant **SPHERE minimum standards in food security and nutrition** (4.2 and 4.3) with further references to SPHERE companion standards such as:

- The *Livestock Emergency Guidelines and Standards* (LEGS)
- *Minimum requirements for market analysis in emergencies*

and other standards developed by CaLP with regards to *Cash Transfer Programming (CTP)*.

The **Humanitarian Response Indicators Registry** includes early recovery indicators (5) focusing on

- Functional markets and formal / informal financial services
- Income support (transfer) and sources (generation); Workforce and employment
- Livelihood assets

Related indicators on **Community Restoration** focus on basic community infrastructure and civic services as well as reconciliation efforts where and when appropriate.

Definitions and key terms

UNDP as global cluster lead for Early Recovery defines this as multi-dimensional process which occurs in parallel with humanitarian activities, but its objectives, mechanisms and expertise are different as it is guided by development principles. It aims to generate self-sustaining nationally owned and resilient processes for post-crisis recovery through:

- augmenting on-going humanitarian assistance operations;
- supporting spontaneous recovery initiatives by affected communities; and
- establishing the foundations of longer-term recovery.

Early recovery encompasses the restoration of basic services, livelihoods, shelter, governance, security and the rule of law, environment and social dimensions, including the reintegration of displaced populations. Recovery programming works to restore services, livelihood opportunities and governance capacity. This must start as soon as possible in the humanitarian or emergency phase.

The SPHERE minimum standards on livelihood recovery reflect on capabilities, assets (including natural, material and social resources) and activities used by a household for survival and future well-being. A household's livelihood is secure when it can cope with and recover from shocks, maintain or enhance its capabilities and productive assets, and (re-)gain and sustain access to market and services. **Coping strategies** are defined as temporary responses forced by food or social-economic insecurity.

[AusAid/OECD Gender Equality Toolkit](#) specifically calls for **equitable access for women and men** to employment and livelihood opportunities, to financial and economic services during recovery and reconstruction, and to opportunities to increase capacity to prepare for humanitarian emergencies and recover from them.

Data and information required to calculate the indicator

Unit Description: Number and percentage

Numerator: Number of households / people having received sector specific assistance by/through CARE (partners) = **caseload reached** (reference: guidance note for participant reporting, PIIRS project categories).

Denominator: Total number of disaster/crisis affected households / people = **overall caseload** (specify if possible: HH / people in need of specific assistance = **specific caseload**)

Disaggregation:

Mandatory: Sex, age and disability/special needs (specify Head of Household);

Sector specific: Type of livelihood assistance received (cash; material; labor; services; other); Livelihood strategy (e.g. agriculture, livestock, paid labor); legal labor status (e.g. work permit, tax status)

Context specific: legal status (host, IDP, refugee, registered / not registered); Household tenure situation (owner / owner-occupier; renter; squatter; no tenure); Type of settlement (urban / rural; formal / informal) or displacement site/situation (self-settled / planned camp; collective center; host family);

Suggested method for data collection & Possible data sources

Monitoring this indicator will rely on a combination of primary and secondary/tertiary data sources with more or less comparable methodologies of data collection. Triangulation might be needed in order to consolidate confidence levels of data used. CARE should adopt data collection methodology for nominator to ensure alignment with most reliable sources for denominator data.

Nominator: assistance monitoring conducted by CARE directly, through partners or remotely (third party); data collected through activity reports, observation at location, end user surveys etc.

Denominator: mainly from secondary sources such Government/UN sanctioned general assessments (including MIRA or other multi-sectoral / interagency assessments); data can be further refined (e.g. with regards to disaggregation) / validated through more in depth assessments conducted by CARE including geo-data (coordinates)

Level of effort needed for data collection and reporting: MEDIUM HIGH

Household specific monitoring for nominator and denominator data requires **high level of effort** including detailed surveying of households, geo-data, establishment of databases etc. LoE can be reduced by limiting detailed surveying to robust samples with potential for longitudinal surveying of sentinel households / sites.

Frequency of reporting should be aligned with availability of secondary data for caseload (denominator) as well as with frequency of interventions by CARE and/or partners (e.g. post distribution monitoring, seasonal surveys, gender specific surveys).

Minimum requirement:

- Current status reported through **sitreps (frequency varies)**;
- consolidated data reported **annually through PIIRS**

Data analysis and interpretation of results for this indicator: explaining trends (e.g. caseload needs, actors providing assistance) during reporting time, how and why the outcome was reached, and how CARE contributed to the outcome

This indicator requires constant adjustment of data with the documentation of trends on

- caseload (overall, sector specific, reached by CARE) and disaggregation (see above)
- assistance provided by CARE and others
- alignment of assistance with minimum standards (SPHERE) and/or other multi-agency agreed standards
- needs for goods / assets / income opportunities (at various stages post-acute crisis)

To assess **adequacy and gender sensitivity** of assistance provided (by CARE and others) more analysis is required with regards to:

- Extent to which assistance provided by CARE and/or others is aligned with global standards
- Extent to which CARE interventions reach the most vulnerable groups (women & girls in particular) as identified through relevant assessments
- Extent to which assistance provided supports livelihood resilience / recovery
- Extent to which population recover goods / assets / income opportunities without external assistance

Other considerations

Data related to the technical adequacy of assistance provided should always be analyzed while taking into account the feedback received from the affected population itself. Their perceptions are captured through data and information collected under the **Global indicator related to the satisfaction of crisis/disaster affected people with the relevance, timeliness and accountability of humanitarian interventions in areas of CARE's response.**

INDICATOR 5: % of disaster/crisis affected people in areas of CARE responses who report satisfaction with regards to relevance, timeliness and accountability of humanitarian interventions

Why this indicator? What will it measure and provide information for?

This indicator relates to performance targets laid out by CARE's Humanitarian Accountability Framework (HAF) as well as to global commitments required of all humanitarian actors as stipulated in the Core Humanitarian Standards (CHS). In order to achieve high levels of relevance, timeliness and accountability to disaster/crisis affected people both, CARE's HAF and the CHS, call for humanitarian responses that are responsive:

- to impartially verified assistance needs expressed by all groups in the disaster / crisis affected population,
- to feedback and complaints expressed by disaster / crisis affected population groups especially women, girls and other marginalized groups, and
- to the resources and capacities of all humanitarian actors.

The basis of these commitments is the right of disaster/crisis affected people to be engaged in decisions and actions on which depend their physical and mental health, their livelihood and their stronger-than-before-crisis recovery.

Target (CARE Humanitarian & Emergency Strategy 2013-2020) :

90% of households affected by a particular disaster / crisis consider the humanitarian assistance provided by/through CARE and/or its partners (in a particular technical area) as timely and relevant, and the approaches used as promoting their engagement in design, decision making and monitoring.

What Humanitarian Standard and Humanitarian Indicator is this indicator connected to?

This indicator refers to the [Core Humanitarian Standard](#) in particular **Commitment 1**: Communities and people affected by crisis receive assistance appropriate to their needs. Performance indicator 1.1 states: *Communities and people affected by crisis consider that the response takes account of their specific needs and culture.*

Related performance indicators can be found under **CHS commitment 2**:

1. *Communities and people affected by crisis, including the most vulnerable groups, consider that the timing of the assistance and protection they receive is adequate.*
2. *Communities and people affected by crisis consider that their needs are met by the response.*
3. *Monitoring and evaluation reports show that the humanitarian response meets its objectives in terms of timing, quality and quantity.*

Furthermore **CHS commitment 4** establishes concrete expectations about the means by which communities and people affected by crisis should be able to express their considerations and expectations:

Indicator 4.4 states: *Encourage and facilitate communities and people affected by crisis to provide feedback on their*

level of satisfaction with the quality and effectiveness of the assistance received, paying particular attention to the gender, age and diversity of those giving feedback.

[ALNAP Resources on effective Feedback mechanisms](#) provides guidance for establishing feedback mechanisms and monitoring their effectiveness. [AusAid/OECD Gender Equality Toolkit](#) requires women’s participation in all aspects of humanitarian responses as well as effective gender-responsive feedback and complaints procedures.

Definitions and key terms (CHS guidance notes)

- **Effectiveness:** the extent to which an aid activity attains its objectives. The effectiveness of humanitarian response is a responsibility that is shared between responders and outcomes should be assessed in conjunction with crisis-affected communities.
- **Efficiency:** the extent to which the outputs of humanitarian programs, both qualitative and quantitative, are achieved as a result of inputs.
- **Engagement:** processes to communicate, consult and/or provide for participation of interested and/or affected stakeholders, ensuring that their concerns, desires, expectations, needs, rights and opportunities are considered in the establishment, implementation and review of the programs assisting them.
- **Vulnerability:** the extent to which some people may be disproportionately affected by the disruption of their physical environment and social support mechanisms following disaster or conflict, resulting in an increased risk of exploitation, illness or death. Vulnerability is specific to each person and each situation.

Data and information required to calculate the indicator

Unit Description: Number and percentage

Numerator: Number of households/people having received assistance by/through CARE (partners) expressing high levels of satisfaction with effectiveness, efficiency and engagement of CARE and/or its partner(s) = **caseload satisfied**

Denominator: (a) Total number of affected households / people = **overall caseload**; (b) Number of households / people having received assistance by/through CARE (partners) = **caseload reached**

Disaggregation:

Mandatory: Sex, age and disability/special needs (specify Head of Household);

Sector specific: Type of assistance received; Role in participatory mechanisms

Context specific: legal status (host, IDP, refugee, registered / not registered); type of relevant service providers

Suggested method for data collection & Possible data sources

Monitoring this indicator will rely on a combination of primary and secondary/tertiary data sources with more or less comparable methodologies of data collection. Triangulation might be needed in order to consolidate confidence levels of data used.

Nominator: Survey and scorecard with adequate sample of population groups representative of relevant sex, age and vulnerability categories amongst disaster/crisis affected population having received assistance by/through CARE. Technical guidance for FDG and scorecard exercise are required in order to ensure data consistency and comparability (e.g. coding of responses, scoring).

Denominator: (a) mainly from secondary sources such Government/UN sanctioned general assessments (including MIRA or other multi-sectoral / interagency assessments); (b) data from CARE’s records of assistance provided and people reached (reference: guidance note for participant reporting, PIIRS project categories).

Specific lines of inquiry that should be looked at when measuring this indicator:

% of disaster/crisis affected people in areas of CARE responses who report satisfaction with regards to assistance received is...

- ... appropriate and relevant to their needs.
- ... respectful of their rights
- ... effectively enhancing their resilience to future shocks / reducing their risks
- ... receptive to their aspirations and opinions
- ... responsive to feedback & complaint

See also guidance for community FGD and scorecard exercise as part of CARE standard **Rapid Accountability Reviews:**



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Level of effort needed for data collection and reporting: HIGH

Household specific monitoring for nominator and denominator data requires **high level of effort** including

- detailed databases of households / people having received assistance
- robust sampling for FGD and scorecard exercises with experienced facilitators
- high frequency of data collection in order to ensure early feedback and corrective action if required.

<p>Minimum requirement:</p> <ul style="list-style-type: none"> • FGDs with structured discussion guides at early stages and at the end of each intervention • Scorecard exercise during Rapid Accountability Review / After Action Review
<p>Data analysis and interpretation of results for this indicator: explaining trends (e.g. caseload needs, actors providing assistance) during reporting time, how and why the outcome was reached, and how CARE contributed to the outcome</p> <p>This indicator requires constant adjustment of data with the documentation of trends on</p> <ul style="list-style-type: none"> • caseload (overall, sector specific, reached by CARE) and disaggregation especially by vulnerability • needs as identified by comprehensive as well as sector specific and impartial assessments • assistance provided by CARE and others (blanket vs targeted, type of intervention) <p>As affected populations are invited to provide feedback on relevance, timing and effectiveness of the assistance received their responses and perceptions should be analyzed against:</p> <ul style="list-style-type: none"> ➤ actions taken to adapt the response strategy in a timely manner based on changing needs, capacities, risks and the context (e.g. accessibility, urgency, safety & security, other actors) ➤ consideration given to social and contextual factors that contribute to vulnerability, such as discrimination and marginalization as well as local capacities ➤ CARE’s internal policies and guidance regarding timely, impartial and independent action ➤ CARE’s internal procedures for referral of unmet needs to other relevant actors as well as advocacy ➤ CARE’s efforts to take corrective efforts and/or to mitigate adverse effects of deficiencies
<p>Other considerations</p> <p>This indicator is a necessary but insufficient on its own, indicator for CARE’s alignment with CHS commitments and performance indicators. Full alignment can only be assessed through coherent application of the full CHS verification framework either within a self-assessment or as part of a third-party verification.</p>

Sexual, Reproductive and Maternal Health and Rights - global indicators

<p>INDICATOR 6: Demand satisfied for modern contraceptives among women aged 15-49</p>
<p>Why this indicator? What will it measure and provide information for?</p> <p>This indicator measures a woman’s ability to access contraceptives in order to determine the timing and spacing of her pregnancies. This framing of the indicator attempts to emphasize women’s right and competence to freely choose, rather than maximum coverage. It is an indicator of both community support for and health system provision of contraceptives. It does not allow for analysis of which factors influence women’s ability to access contraception, however, or the extent to which women make decisions about their reproductive health on their own.</p>
<p>What Sustainable Development Goal is the indicator connected to?</p> <p>This indicator is linked to SDG 3 “Ensure healthy lives and promote well-being for all at all ages” and SDG 5 “Achieve gender equity and empower all women and girls.” It is one of the indicators for tracking these SDGs. Specifically this indicator is linked to the SDG3 target “Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all” and the SDG5 target “Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Program of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences”</p>
<p>Definitions and key terms</p> <p>Demand satisfied is defined as modern contraceptive prevalence / modern contraceptive prevalence + unmet need. Modern contraceptive prevalence is the percentage of women who are currently using modern contraception among women in union ages 15-49. Unmet need is the percentage of women non-pregnant, fecund women, who desire either to have no additional children or postpone the next pregnancy and are not using modern contraception.</p>
<p>Data and information required to calculate the indicator</p> <ul style="list-style-type: none"> • Numerator: number of women aged 15-49 who are sexually active, not pregnant, and fecund, who are using modern contraception

<ul style="list-style-type: none"> Denominator: number of women aged 15-49 who are sexually active, not pregnant and fecund, who are using modern contraception PLUS women aged 15 – 49 who are not pregnant, fecund, and who desire either to have no additional children or postpone the next pregnancy
<p>Suggested method for data collection</p> <ul style="list-style-type: none"> This information is collected via surveys, typically DHS surveys which include standard questions for obtaining data for this indicator. See DHS question numbers and wording to calculate this indicator.
<p>Possible data sources</p> <ul style="list-style-type: none"> Household surveys (DHS) conducted typically every 3 or 5 years. In some cases, data are available for disaggregation at sub-national level. Ministries of Health may have estimates available for regions or provinces. Data from national-level sources are compiled in the UNICEF global database. Latest available estimates for contraceptive prevalence rate and unmet need are available at www.undata.org, and % demand satisfied can be calculated from those two figures. If feasible and appropriate, CARE may also conduct household surveys, especially if sampling to represent marginalized impact populations or specific geographic areas
<p>Resources needed for data collection</p> <p>If the information will be gathered from secondary data sources, no investment is required for gathering this indicator at the national level. However, your evaluation may want to assess this directly in specific geographic areas or sub-populations or include questions on CARE’s contribution to the change, which will require resources for conducting interviews or focus groups.</p>
<p>Reporting results for this indicator: number of people for which the change happened</p> <ul style="list-style-type: none"> How many women are accessing contraceptives in the country/sub-nationally last year? Has there been an improvement of the % demand satisfied since the past measurement, has it stayed the same or worsened? Given CARE’s role and presence, to what extent has CARE contributed to this change and at which level (national, in a particular region or part of the country, marginally)? Please explain.
<p>Questions for guiding the analysis and interpretation of data (explaining the how and why the change happened, and how CARE contributed to the change)</p> <p>Higher rates of modern contraception contribute to greater intervals between births and delayed age at first birth and fewer unwanted pregnancies, directly contributing to lower maternal mortality</p> <ul style="list-style-type: none"> How has CARE contributed to the change? What were CARE’s main strategies for contributing to this change (e.g. capacity building of health staff, community awareness raising, advocacy and policy change, supporting the scale up of proven solutions, a combination of strategies, other ways)? Is the change in uptake of contraception influenced by increased participation and representation of women in decisions related to family planning? Is the change in satisfied demand for contraception influenced by new or amended policies, legislation, programs, accountability spaces and/or budgets responsive to providing contraception commodities and services?

<p>INDICATOR 7: Proportion of births attended by skilled health personnel</p>
<p>Why this indicator? What will it measure and provide information for?</p> <p>The indicator is a global measure of a health system’s ability to provide adequate care for pregnant women. Concerns have been expressed that the presence of a skilled attendant may not adequately capture women’s access to good quality care, particularly when complications arise, and information on the supplies and equipment a skilled attendant may or may not have is lacking. In some countries, information on the proportion of births in health centers/hospital may be available, which can be a useful, complementary indicator.</p>
<p>What Sustainable Development Goal is the indicator connected to? This indicator is linked to SDG 3 “Ensure healthy lives and promote well-being for all at all ages” and the SDG 5 “Achieve gender equity and empower all women and</p>

girls.” It is listed as one of the indicators for tracking this SDG. Specifically this indicator is linked to the SDG3 targets “By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live birth” and “Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all,” as well as the SDG5 target “Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Program of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences”

Definitions and key terms

Health personnel refers to personnel trained in providing life-saving obstetric care, including giving the necessary supervision, care and advice to women during pregnancy, labor and the post-partum period; conducting deliveries on their own; and caring for newborns. Traditional birth attendants, even if they receive a training course, are not included.

Data and information required to calculate the indicator

- Numerator: number of live births to women aged 15-49 attended by a skilled health personnel during delivery
- Denominator: total live births to women aged 15-49 in the same period

Suggested method for data collection

- This information is collected via surveys, typically DHS surveys which include standard questions for obtaining data for this indicator.
- See DHS question numbers and wording to calculate this indicator.

Possible data sources

- Household surveys (DHS) conducted typically every 3 or 5 years. In some cases, data are available for disaggregation at sub-national level. Ministries of Health may have estimates available for regions or provinces.
- Data from national-level sources are compiled in the UNICEF global database. Latest available estimates of skilled health personnel at delivery are available on www.childinfo.org
- If feasible and appropriate, CARE may also conduct household surveys, especially if sampling to represent marginalized impact populations or specific geographic areas

Resources needed for data collection

If the information will be gathered from secondary data sources, no investment is required for gathering this indicator at the national level. However, your evaluation may want to assess this directly in specific geographic areas or sub-populations or include questions on CARE’s contribution to the change, which will require resources for conducting interviews or focus groups.

Reporting results for this indicator: number of people for which the change happened

- How many births were attended by skilled personal in the country/sub-nationally last year? (based on total number of births multiplied by the proportion of births attended by skilled attendants)
- Has there been an improvement of the % of births attended by skilled personal since the past measurement, has it stayed the same or worsened?
- Given CARE’s role and presence, to what extent has CARE contributed to this change and at which level (national, in a particular region or part of the country, marginally)? Please explain.

Questions for guiding the analysis and interpretation of data (explaining the how and why the change happened, and how CARE contributed to the change)

- How has CARE contributed to the change? What were CARE’s main strategies for contributing to this change (e.g. capacity building of health staff, community awareness raising, advocacy and policy change, supporting the scale up of proven solutions, a combination of strategies, other ways)?
- Is the change in births attended by skilled personnel influenced by increased participation and representation of women in decisions related to obstetric care?
- Is the change in births attended by skilled personnel influenced by new or amended policies, legislation, programs, accountability spaces and/or budgets responsive to providing life-saving obstetric care?

INDICATOR 8: Adolescent birth rate (disaggregated by 10-14; 15-19 years) per 1,000 women in each age group**Why this indicator? What will it measure and provide information for?**

Early childbearing is associated with decrease in woman's decision-making power in areas related to her own reproductive health. The rate of adolescents giving birth measures the extent to which community norms and societal structures support adolescent girls delaying first childbirth. Factors influencing adolescent birth rate include pressure for early marriage, provision of reproductive health services to adolescents, support for girls' completion of secondary school, pressure for early childbearing and access to education and economic participation.

What Sustainable Development Goal is the indicator connected to?

This indicator is linked to SDG 3 "Ensure healthy lives and promote well-being for all at all ages" and SDG 5 "Achieve gender equity and empower all women and girls." It is listed as one of the indicators for tracking this SDG. Specifically this indicator is linked to the SDG targets "By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live birth," "Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all" and "Eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation."

Definitions and key terms

Adolescent girls are girls from 10 to 19 years of age. The birth rate measures all births to adolescent girls per 1000 adolescent girls. This indicator should be collected to allow for disaggregation by age into adolescent girls 10 – 14 and those 15 – 19. The standard indicator likely to be available from secondary data covers adolescent girls from 15 – 19. However if data are available for adolescent girls 10 – 14 they should be analyzed as well.

Data and information required to calculate the indicator

- Numerator: number of live birth occurring among women aged 15-19 (and 10 – 14 if available) in the reference time period
- Denominator: total person years represented among women aged 15-19 (and 10 – 14 if available) in the reference time period
- See specific DHS question numbers and wording to calculate this indicator.

Suggested method for data collection

- This information is collected via surveys, typically DHS surveys which include standard questions for obtaining data for this indicator.
- See Annex 1 for specific DHS question numbers and wording to calculate this indicator.

Possible data sources

- Household surveys (DHS) conducted typically every 3 or 5 years. In some cases, data are available for disaggregation at sub-national level. Ministries of Health may have estimates available for regions or provinces.
- Data from national-level sources are compiled in the UNICEF global database. Latest available estimates of adolescent birth rate are available on www.undata.un.org
- If feasible and appropriate, CARE may also conduct household surveys, especially if sampling to represent marginalized impact populations or specific geographic areas

Both the likely sample size of a survey conducted by CARE and the complexity of the calculations required to calculate person-years of exposure (adolescent age) and the total number of births (allowing for multiple births to one individual during the reference year) mean that this indicator is not feasible to calculate from a household survey on the scale appropriate for CARE to implement directly, thus this indicator is available only through secondary sources.

ALTERNATIVE INDICATOR: If CARE is collecting data related to this indicator, we recommend instead that you use an alternative indicator: **Age at first birth**. This can be asked directly of survey respondents. Delay of first birth is associated with positive outcomes for adolescent girls and women.

Resources needed for data collection

If the information will be gathered from secondary data sources, no investment is required for gathering this indicator at the national level. However, your evaluation may want to assess this directly in specific geographic areas or sub-

populations or include questions on CARE's contribution to the change, which will require resources for conducting interviews or focus groups.

Reporting results for this indicator: number of people for which the change happened

- Has there been an improvement in the rate of childbirth among adolescents (or in age of first birth) since the past measurement, has it stayed the same or worsened? In the broadest interpretation, all adolescent girls who delay first childbirth benefit from improvements in this indicator.
- Given CARE's role and presence, to what extent has CARE contributed to this change and at which level (national, in a particular region or part of the country, marginally)? Please explain.

Questions for guiding the analysis and interpretation of data (explaining the how and why the change happened, and how CARE contributed to the change)

- How has CARE contributed to the change? What were CARE's main strategies for contributing to this change (e.g. capacity building of health staff, community awareness raising, advocacy and policy change, supporting the scale up of proven solutions, a combination of strategies, other ways)?
- Is the change in births among adolescents influenced by increased concern for the health risk of premature childbearing, increased value placed on girl's completion of secondary school or other community norms?
- Is the change in births to adolescents influenced by new or amended policies, legislation, programs, accountability spaces and/or budgets responsive to increasing adolescent's access to reproductive health care including contraceptive information, services or supplies?

INDICATOR 9: Proportion of women aged 15-49 who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care

Why this indicator? What will it measure and provide information for?

The indicator is a measure of women's own agency with regard to their bodily integrity and reproductive lives. It assesses the level of support for the belief that women themselves control decisions about their bodies and reproductive lives including the right to decide if, when, and with whom to have sex; if, when and who to marry; and if, when and how many children to have.

What Sustainable Development Goal is the indicator connected to? This indicator is linked to SDG 3 "Ensure healthy lives and promote well-being for all at all ages" and to SDG 5: "Achieve gender equity and empower all women and girls." It is one of the indicators for tracking these SDGs. Specifically this indicator is linked to the SDG target "By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live birth" as well as the target "Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all" as well as the SDG5 target "Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Program of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences"

Definitions and key terms

Women's "making their own decisions" will be determined by respondents' answers to questions about whether women have the right to refuse sex with their husband, and whether they themselves have been the ones primarily responsible for decisions about use of contraceptives and about their own reproductive health care.

Data and information required to calculate the indicator

- Numerator: Women who express the belief that they can make their own informed decisions about sex and contraception, as determined by the questions above
- Denominator: Sexually active women of reproductive age

Suggested method for data collection

- This information is collected via surveys, typically DHS surveys which include standard questions for obtaining data for this indicator.
- See DHS question numbers and wording to calculate this indicator.

Possible data sources

- Household surveys (DHS) conducted typically every 3 or 5 years. In some cases, data are available for disaggregation at sub-national level. Ministries of Health may have estimates available for regions or provinces.
- If feasible and appropriate, CARE may also conduct household surveys, especially if sampling to represent marginalized impact populations or specific geographic areas

Resources needed for data collection

If the information will be gathered from secondary data sources, no investment is required for gathering this indicator at the national level. However, your evaluation may want to assess this directly in specific geographic areas or sub-populations or include questions on CARE's contribution to the change, which will require resources for conducting surveys or interviews or focus groups.

Reporting results for this indicator: number of people for which the change happened

- How many women or reproductive age have interacted directly with CARE programming?
- How do the results for this quantified indicator compare to qualitative findings on women's, men's and community influencers' beliefs, norms and experiences related to women's decision making about reproductive health?
- Has there been an improvement of women's decision making power since the past measurement, has it stayed the same or worsened?
- Given CARE's role and presence, to what extent has CARE contributed to this change and at which level (national, in a particular region or part of the country, marginally)? Please explain.

Questions for guiding the analysis and interpretation of data (explaining the how and why the change happened, and how CARE contributed to the change)

- How has CARE contributed to the change? What were CARE's main strategies for contributing to this change (e.g. shifting attitudes of health staff and community influencers, community awareness raising, advocacy and policy change, supporting social accountability and gender-equitable participation in decision making, a combination of strategies, other ways)?
- Is the change in women's decision making influenced by increased participation and representation of women in decisions related to their reproductive lives (health care, sexual behavior, household decision making, etc.)?
- Is the change in women's decision making power influenced by new or amended policies, legislation, programs, accountability spaces and/or budgets responsive to reinforcing women's power to take or enforce decisions?

The Right to a Life Free from Violence - global indicators

INDICATOR 10: % of people who reject intimate partner violence

Why this indicator? What will it measure and provide information for?

The indicator is a measure of attitudes by women and men, girls & boys (aged 15-49) with regard to the acceptability of intimate partner violence. It assesses the level of support for the belief that there are no situations under which a man is justified in hitting or beating his wife (or intimate partner). Rejecting intimate partner violence means that respondents agree that there are no situations or conditions when it is acceptable or justifiable for a man to physically, emotionally, or economically abuse his intimate partner. Changes in attitudes towards gender-based violence may be more achievable within the timeframe of the CARE 2020 Program Strategy than changes in reported levels of violence over the last 12 months (the other two GBV indicators), as increased public awareness of the problem of GBV can often lead to increases in levels of reported violence, at least in the short-term. Attitudinal questions towards wife-beating have traditionally been used to assess the acceptance of certain gender roles.

What Sustainable Development Goal is the indicator connected to? This indicator is linked to SDG 5: "Achieve gender equity and empower all women and girls", and in particular, SDG target 5.2 ("Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation"). It is not one of the formal indicators for tracking this SDG target, but is widely captured through DHS surveys and other means.

Definitions and key terms

Rejecting intimate partner violence requires the respondent to indicate “no” to all five options, in response to the standard DHS question: “In your opinion, is a husband justified in hitting or beating his wife in the following situations: a) If she goes out without telling him? b) If she refuses to have sex with him? c) If she argues with him? d) If she neglects the children? e) If she burns the food?”.

CARE defines **gender-based violence** as: a harmful act or threat based on a person’s sex or gender identity. It includes physical, sexual and psychological abuse, coercion, denial of liberty and economic deprivation whether occurring in public or private spheres. GBV is rooted in unjust and unequal power relations and structures and rigid social and cultural norms.

Some countries have adapted the standard DHS questionnaire to their social contexts by including different circumstances, such as if the woman spends too much money, if she disobeys, if she is unfaithful, if she insults him, if she neglects household chores, if she disrespects her in-laws, and if she speaks about the need to protect herself against HIV/AIDS. CARE should consult with national statistics offices or gender ministries before adapting the questionnaire in any context, to ensure compatibility with other studies.

Data and information required to calculate the indicator

- Numerator: Women & girls - and boys & men - who reject all 5 reasons for justifying a husband beating his wife, as determined by the question above
- Denominator: Total of women & girls - and boys & men – surveyed
- Questions are addressed to men and women surveyed, aged 15-49, regardless of their marital status and experience of violence.

Suggested method for data collection

- This information is collected via surveys, typically DHS surveys which include standard questions for obtaining data for this indicator (question 932 of the woman's DHS questionnaire, & question 618 of the man's – see <http://dhsprogram.com/publications/publication-dhsq7-dhs-questionnaires-and-manuals.cfm>). Data should only be collected by teams with specialized knowledge and pre-training to collect this type of sensitive data.

Possible data sources

- Household surveys (DHS) conducted typically every 3 or 5 years. In some cases, data are available for disaggregation at sub-national level.
- Other surveys on violence against women or gender-based violence.
- UNICEF maintains a global database - <http://data.unicef.org/child-protection/attitudes.html> - with estimates for this indicator, disaggregated by age, place of residence and wealth quintile by country and for some (flexible) regional groupings with sufficient population coverage. Fully comparable data are currently available for approximately 56 low- and middle-income countries.
- If feasible and appropriate, CARE may also commission household surveys, especially if sampling to represent marginalized impact populations or specific geographic areas, not covered by national statistics. However, data should not be collected by CARE or research partner teams unless they have specialized knowledge and pre-training to collect this type of sensitive data.

Resources needed for data collection

If the information will be gathered from secondary data sources, no investment is required for gathering this indicator at the national level. However, your evaluation may want to assess this directly in specific geographic areas or sub-populations or include questions on CARE’s contribution to the change, which will require resources for conducting surveys or interviews or focus groups.

Reporting results for this indicator: number of people for which the change happened

- How many women or men have interacted directly with CARE GBV programming? And with CARE programming more generally?
- Has there been an improvement of the % of people that reject intimate partner violence? Or has it worsened? Why?
- Given CARE’s role and presence, to what extent has CARE contributed to this change and at which level (national, in a particular region or part of the country, marginally)? Please explain.
- Are there changes in relation to responses to the individual 5 options for which violence might be justified (see the question above), even if not reflected in changes in those absolutely rejecting physical violence towards a wife by a husband?

Questions for guiding the analysis and interpretation of data (explaining the how and why the change happened, and how CARE contributed to the change)

- How has CARE contributed to the change? What were CARE’s main strategies for contributing to this change (e.g. shifting attitudes of community influencers or service providers, community awareness raising, advocacy and policy change, supporting social accountability and gender-equitable participation in decision making, a combination of strategies, other ways)?
- How do the results for this quantified indicator compare to qualitative findings on women’s, men’s and community influencers’ attitudes, norms and experiences related to gender based violence?
- With regards to those that did not answer 'no' to all the questions, what were the internal differences? What actions were considered more or less acceptable? Are there any difference between the sexes, youth and adults?
- What might explain any changes in relation to responses to the 5 options (see the question above)? Why might there be changes in response to some options, but not in others?
- Have there been any changes in attitudes since the past measurement, has it stayed the same or worsened?
- Is the change in attitudes towards GBV influenced by increased participation of women in decisions related to their lives (reproductive, political or economic decision making, etc.)?
- Is the change in attitudes towards GBV influenced by new or amended policies, legislation, programs, spaces and/or budgets, or widespread efforts to change public attitudes or social norms?

Other considerations

There are significant ethical considerations and do no harm principles in seeking to measure prevalence of or attitudes towards violence against women and girls, and so it is essential that research partners with experience in this area are used, applying international guidance and tools in ways that are appropriate to the local context.

INDICATOR 11: % of ever-partnered women and girls aged 15 years and older subjected to physical, sexual or psychological violence by a current or former intimate partner, in the last 12 months

Why this indicator? What will it measure and provide information for?

Intimate partner violence includes abuse perpetrated by a current or former partner within the context of marriage, cohabitation or any other formal or informal union. Violence directed at girls and women is the most common form of gender-based violence. Data are available by age, place of residence and wealth quintiles.

What Sustainable Development Goal is the indicator connected to?

This indicator is first indicator for SDG target 5.2 (“Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation”) for SDG 5 “Achieve gender equity and empower all women and girls.”

Definitions and key terms

CARE defines **gender-based violence** as: a harmful act or threat based on a person’s sex or gender identity. It includes physical, sexual and psychological abuse, coercion, denial of liberty and economic deprivation whether occurring in public or private spheres. GBV is rooted in unjust and unequal power relations and structures and rigid social and cultural norms.

The United Nations Declaration on the Elimination of Violence against Women defines **violence against women** as “any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life”. This definition encompasses physical, sexual and psychological violence occurring in the family, physical, sexual and psychological violence occurring within the general community and physical, sexual and psychological violence perpetuated or condoned by the State. These different forms of violence are defined further, with examples, in the [UN Guidelines for Producing Statistics on Violence against Women: Statistics Surveys](#). The Beijing Platform for Action further specifies that acts of violence against women include violation of the human rights of women in situations of armed conflict, such as systematic rape, sexual slavery and forced pregnancy, as well as forced sterilization, coercive/ forced use of contraceptives, female infanticide and prenatal sex selection. The definition also encompasses acts of violence particular to specific contexts, such as dowry-related violence and female genital mutilation.

An **intimate partner** is a person with whom a woman maintains an intimate relationship, whether formally (marriage), through a cohabiting relationship or by regular or steady dating. These relationships must be clearly differentiated as current marital partner, current de facto partner and current steady dating partner, and former marital partner, former

de facto partner and former steady dating partner. If a woman does not have a current partner, the most recent partner may be distinguished from other former intimate partners in the analysis, as needed. Occasional dating partners should not be considered intimate partners, but rather friends or acquaintances.

Data and information required to calculate the indicator

- Numerator: number of ever-partnered girls and women aged 15+ subjected to physical, sexual or psychological violence in the last 12 months by a current or former intimate partner.
- Denominator: total number of ever-partnered girls and women aged 15+ in the population.

Suggested method for data collection

- This information is collected via surveys, typically DHS or other surveys which include standard questions for obtaining data for this indicator. Data should only be collected by teams with specialized knowledge and pre-training to collect this type of sensitive data.

Possible data sources

- Household surveys (DHS) conducted typically every 3 or 5 years. In some cases, data are available for disaggregation at sub-national level. Ministries of Health may have estimates available for regions or provinces.
- There is an existing, standardized and validated measurement tool (the CTS) that is widely accepted and has been implemented in a large number of countries to measure Intimate Partner Violence.
- Other national violence against women surveys
- Data for 2015 can be downloaded from the UN report on the World’s Women - <http://unstats.un.org/unsd/gender/chapter6/chapter6.html>
- If feasible and appropriate, CARE may also commission household surveys, especially if sampling to represent marginalized impact populations or specific geographic areas, not covered by national statistics. However, data should not be collected by CARE or research partner teams unless they have specialized knowledge and pre-training to collect this type of sensitive data.

Resources needed for data collection

If the information will be gathered from secondary data sources, no investment is required for gathering this indicator at the national level. However, your evaluation may want to assess this directly in specific geographic areas or sub-populations or include questions on CARE’s contribution to the change, which will require resources for conducting surveys and focus groups (as long as teams involved have specialized knowledge and pre-training, as noted above).

Reporting results for this indicator: number of people for which the change happened

- How many women are affected by changes in % of women reporting intimate partner violence in the country/sub-nationally over the last year?
- Has there been an improvement of the % of women and girls aged 15 years and older reporting intimate partner violence? Or has it worsened?
- Given CARE’s role and presence, to what extent has CARE contributed to this change and at which level (national, in a particular region or part of the country, marginally)? Please explain.

Questions for guiding the analysis and interpretation of data (explaining the how and why the change happened, and how CARE contributed to the change)

- How has CARE contributed to the change? What were CARE’s main strategies for contributing to this change?
- Is the change in reported rates of intimate partner violence influenced by increased knowledge and awareness of the problem of GBV?
- Are there significant differences in changes seen in relation to the different forms of violence (physical, sexual or psychological), and if so, why?
- Is the change in reported rates of intimate partner violence influenced by new or amended policies, legislation, programs, spaces and/or budgets, or widespread efforts to change public attitudes or social norms?

Other considerations

The availability of comparable data remains a challenge in this area as many data collection efforts have relied on different study methodologies and used different definitions of partner or spousal violence. Diverse age groups are often utilized and in many high-income countries, data on intimate partner violence have largely been collected from the adult population (i.e., women and men over the age of 18). This is mostly due to the fact that relatively few adolescents in such countries can be found in marriages or other formal unions before the age of 18. This said, existing data collection mechanisms are already in place for many countries to monitor this indicator. Through standalone surveys, many countries are also collecting data for girls and women without specifying an upper age limit.

The [UN Guidelines for Producing Statistics on Violence against Women: Statistics Surveys](#) have been prepared to assist countries in assessing the scope, prevalence, and incidence of violence against women. These Guidelines provide methodological advice regarding selection of topics, sources of data, relevant statistical classifications, outputs, wording of questions and all other issues relevant for national statistical offices to conduct statistical surveys on violence against women.

There are significant ethical considerations and do no harm principles in seeking to measure prevalence of or attitudes towards violence against women and girls, and so it is essential that research partners with experience in this area are used, applying international guidance and tools in ways that are appropriate to the local context.

INDICATOR 12: % of women and girls aged 15 years and older subjected to sexual violence by persons other than an intimate partner, in the last 12 months

Why this indicator? What will it measure and provide information for?

Violence against women and girls is one of the most pervasive human rights abuses in the world today and takes place in all countries. In order to eradicate violence against women and girls, it is necessary to measure its prevalence in all its forms. By measuring the prevalence of sexual violence by persons other than an intimate partner, this indicator complements the other priority indicator (on physical, sexual or psychological violence by a current or former intimate partner). Furthermore, by disaggregating this indicator by place of occurrence and perpetrator, this indicator would measure sexual violence in the workplace and in public spaces.

What Sustainable Development Goal is the indicator connected to?

This indicator is second indicator for SDG target 5.2 (“Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation”) for SDG 5 “Achieve gender equity and empower all women and girls.”

Definitions and key terms

Sexual violence as defined as “any sort of harmful or unwanted sexual behavior that is imposed on someone. It includes act of abusive sexual contact, forced engagement in sexual acts, attempted or completed sexual acts with a woman or girl without her consent, sexual harassment, verbal abuse, threats, exposure, unwanted touching, incest, etc.”

Persons **other than an intimate partner** include: Occasional dating partners (these are not be considered intimate partners, but rather friends or acquaintances); Relatives (a person within the immediate or extended family, such as a son, parent, brother, sister, grandparent, aunt, uncle, cousin or in-law. Relationships within this category must be clearly specified so that violence by fathers, for example, can be differentiated from violence by mothers, siblings or in-laws); Acquaintances and friends from the community (persons that belong to the same circle of friends within a community, neighborhood, or village); Supervisors or co-workers (persons in the workplace); Teachers, school officials, schoolmates (persons in educational settings); Civil and military authorities (officers or civil servants serving in their capacity as representatives of civil or military authorities); or Strangers (a person unknown to the victim).

Data and information required to calculate the indicator

- Numerator: number of girls and women aged 15+ subjected to sexual violence in the last 12 months by persons other than an intimate partner.
- Denominator: total number of ever-partnered girls and women aged 15+ in the population.

Suggested method for data collection

- This information is collected via surveys, typically DHS or other surveys which include standard questions for obtaining data for this indicator. Data should only be collected by teams with specialized knowledge and pre-training to collect this type of sensitive data.
- Recommended disaggregation for this indicator are: Age; Place of occurrence; Public space (including streets, parks etc.), employment etc.; Income; & Other characteristics such as disability, race, caste, ethnicity etc. as relevant

Possible data sources

- Household surveys (DHS) conducted typically every 3 or 5 years. In some cases, data are available for disaggregation at sub-national level. Ministries of Health may have estimates available for regions or provinces.
- There is an existing, standardized and validated measurement tool (the CTS) that is widely accepted and has been implemented in a large number of countries to measure Intimate Partner Violence.
- Other national violence against women surveys

- Data for 2015 can be downloaded from the UN report on the World's Women - <http://unstats.un.org/unsd/gender/chapter6/chapter6.html>
- If feasible and appropriate, CARE may also commission household surveys, especially if sampling to represent marginalized impact populations or specific geographic areas, not covered by national statistics. However, data should not be collected by CARE or research partner teams unless they have specialized knowledge and pre-training to collect this type of sensitive data.

Resources needed for data collection

If the information will be gathered from secondary data sources, no investment is required for gathering this indicator at the national level. However, your evaluation may want to assess this directly in specific geographic areas or sub-populations or include questions on CARE's contribution to the change, which will require resources for conducting surveys and focus groups (as long as teams involved have specialized knowledge and pre-training, as noted above).

Reporting results for this indicator: number of people for which the change happened

- How many women and girls are affected by changes in % of women reporting sexual violence by someone other than an intimate partner in the country/sub-nationally over the last year?
- Has there been an improvement of the % of women and girls aged 15 years and older subjected to sexual violence by persons other than an intimate partner? Or has it worsened?
- Given CARE's role and presence, to what extent has CARE contributed to this change and at which level (national, in a particular region or part of the country, marginally)? Please explain.

Questions for guiding the analysis and interpretation of data (explaining the how and why the change happened, and how CARE contributed to the change)

- How has CARE contributed to the change? What were CARE's main strategies for contributing to this change?
- Is the change in reported rates of sexual violence influenced by increased knowledge and awareness of the problem of GBV?
- Are there significant differences in changes seen in relation to the forms of disaggregation of data for this indicator, and if so, why?
- Is the change in reported rates of intimate partner violence influenced by new or amended policies, legislation, programs, spaces and/or budgets, or widespread efforts to change public attitudes or social norms?

Other considerations

The availability of comparable data remains a challenge in this area as many data collection efforts have relied on different study methodologies. Diverse age groups are often utilized and in many high-income countries, data on intimate partner violence have largely been collected from the adult population (i.e., women and men over the age of 18). This said, existing data collection mechanisms are already in place for many countries to monitor this indicator. In addition, most developing countries only collect data through a module in the DHS and therefore limit the age range to girls and women aged 15 to 49. However, many countries are also collecting data for women without specifying an upper age limit.

The UN Guidelines for Producing Statistics on Violence against Women: Statistics Surveys have been prepared to assist countries in assessing the scope, prevalence, and incidence of violence against women -

http://unstats.un.org/unsd/gender/docs/Guidelines_Statistics_VAW.pdf. These Guidelines provide methodological advice regarding selection of topics, sources of data, relevant statistical classifications, outputs, wording of questions and all other issues relevant for national statistical offices to conduct statistical surveys on violence against women.

There are significant ethical considerations and do no harm principles in seeking to measure prevalence of or attitudes towards violence against women and girls, and so it is essential that research partners with experience in this area are used, applying international guidance and tools in ways that are appropriate to the local context.

Food and Nutrition Security and Climate Change Resilience - global indicators

INDICATOR 13: Prevalence of population with moderate or severe food insecurity, based on the Food Insecurity Experience Scale (FIES)

Why this indicator? What will it measure and provide information for?

Developed by FAO from Voices of Hunger project, adopted by SDGs. Based on self-reporting, uses a continuum of food insecurity from worrying about access, to compromising quality, to reducing quantity / frequency, to experiencing hunger. Focus on access to food, collected at the household or individual level. Intended to complement (not to

substitute) other measures of food insecurity. Metric for the severity of food insecurity with a focus on the <u>access</u> dimension.
<p>What Sustainable Development Goal is the indicator connected to?</p> <p>SDG Goal 2.2, indicator 2.1.2 (green list, Nov 2015): “Prevalence of population with moderate or severe food insecurity, based on the Food Insecurity Experience Scale (FIES)”</p>
<p>Definitions and key terms</p> <p><u>Food (in)security</u>: Access to food (men and women) because of financial resources; also includes negative coping strategies (skipping meals, going an entire day without food), lack of quality and variety.</p>
<p>Data and information required to calculate the indicator</p> <ul style="list-style-type: none"> • Survey modules are for households or individual level.
<p>Suggested method for data collection</p> <ul style="list-style-type: none"> • Manual available at: http://www.fao.org/3/a-as583e.pdf • Survey module available at: http://www.fao.org/economic/ess/ess-fs/voices/fiessscale/en/ • Qualitative methods like focus group discussions and key informants interviews should supplement the quantitative data collection to provide a better understanding of barriers and potential negative consequences of access to food.
<p>Possible data sources</p> <p>Primary data collection using the above survey modules.</p>
<p>Resources needed for data collection</p> <p>The quantitative and qualitative data collection, storage, analysis will be responsibility of CARE and partners. It needs to be included in the monitoring and evaluation plan and budgeted for.</p>
<p>Questions for guiding the analysis and interpretation of data (explaining the how and why the change happened, and how CARE contributed to the change)</p> <ul style="list-style-type: none"> • What have been the main changes in people’s experience of food insecurity over life of this project? Were there important differences in how different types of people (by gender, age, social or economic status etc.) experienced food insecurity? • How has CARE contributed to the change? What were CARE’s main strategies for contributing to this change? • Have there been any changes in legislation or practice that have influenced the results? • What are the types of household decision making around food consumption that have seen a noticeable increase or decrease in the involvement of women? • If the following information is available from quantitative or qualitative sources it would help the analysis of the data: <ul style="list-style-type: none"> – How are women concretely benefitting from the change? How has the gender based division of labor inside the household changed? Have men contributed to the change and how? Has the level of conflict inside the household increased or decreased? – How have women changed? What strategies did they use to gain more power in decision making? How have men changed? What attitudes and behaviors did they change to share decision making more with women? – How do women and men know that their decision making is “more equal”? What behavior proves this? – How have any changes in these gender relations strengthened women’s ability to participate in, sustain and grow their economic activities/businesses? How has this change in dynamic contributed to women’s access to and control over financial assets and benefits?
<p>Other considerations</p> <ul style="list-style-type: none"> • Care needs to be taken when planning and conducting data collection (quantitative and qualitative) to avoid leading questions. • Establishing validity of results implies finding agreement on a definition of this food insecurity construct that can be measured along a scale of severity. In other words, it requires being able to speak legitimately of subjects to only in term of being food insecure or not, but also as being more or less food insecurity than others.

INDICATOR 14: Prevalence of stunting among children under five years of age (height for age <-2 SD from the median of the WHO Child Growth Standards)

Why this indicator? What will it measure and provide information for?

This is a globally used indicator applied to local and national levels. Reflects impact of chronic stunting “most often due to prolonged exposure to an inadequate diet and poor health.” Reduction of stunting is a major objective in many

countries; lifelong impacts on physical and mental capacity. (SDG Target 2.2 By 2030, end all forms of malnutrition, including achieving, by 2025, the internationally agreed targets on stunting and wasting in children under 5 years of age, and address the nutritional needs of adolescent girls, pregnant and lactating women and older persons.)

What Sustainable Development Goal is the indicator connected to?

SDG Goal 2.2, indicator 2.2.1 (green list, Nov 2015): Prevalence of stunting (height for age under 2 SD from the median of the WHO Child Growth Standards) among children under five years of age.

Definitions and key terms

Stunting: having a height (or length)-for-age more than 2 SD below the median of the NCHS/WHO international reference.

Data and information required to calculate the indicator

- Numerator: Number of children U5 who are stunted, disaggregated by sex.
- Denominator: Total number of children aged U5 years screened, disaggregated by sex.

Suggested method for data collection

- Primary data collection: anthropometric measurements
- Secondary data analysis.
- For more information: http://www.who.int/ceh/indicators/0_4stunting.pdf
- Qualitative methods like focus group discussions and key informants interviews should supplement the quantitative data collection to provide a better understanding of barriers and potential negative consequences of decreasing prevalence of stunting.

Possible data sources

- Primary data collection: anthropometric measurements
- Secondary data
- Local health care systems
- WHO Global Database on Child Growth and Nutrition (www.who.int/nutgrowthdb/)
- Demographic and Health Surveys (funded by USAID)
- Pan Arab Project for Child Development (PAPCHILD) survey (funded by Pan-Arab League and UNFPA)
- Living Standard Measurement Surveys (LSMS) and Social Dimensions of Adjustment (SDA) surveys in sub-Saharan Africa (funded by World Bank)

Resources needed for data collection

The quantitative and qualitative data collection, storage and analysis will have to be conducted by CARE and partners (potentially including research / university partners). It needs to be included in the monitoring and evaluation plan and budgeted for.

Reporting results for this indicator: number of people for which the change happened

- A change in the percentage of girls and boys U5 that are stunted.

Questions for guiding the analysis and interpretation of data (explaining the how and why the change happened, and how CARE contributed to the change)

- Calculation: $100 * (C_{stunt} / C_{tot})$ where: C_{stunt} is the number of children U5 who are stunted, and C_{tot} is the total number of U5 surveyed.
- This indicator provides a measure of success, or failure, of the actions taken to combat problems of undernutrition and impaired physical development of children.

Other considerations

- Reduced growth can also reflect problems of undernutrition, infection of other illnesses throughout the early years of life.
- Using stunting later in life as an indication of action also assumes that underweight children are surviving. Where rates of perinatal and infant mortality are high, this may not be the case, therefore the indicator needs to be applied and interpreted alongside other measures.

- Changing in stunting are long term; the likelihood is slim of seeing significant changes in the timeline of a project, so considerations must be made for long term measurement.

INDICATOR 15: % of people better able to build resilience to the effects of climate change and variability

Why this indicator? What will it measure and provide information for?

This indicator measures reductions in vulnerability and increases in adaptive capacity at community, household or individual levels. Interventions to be based on a climate vulnerability assessment (such as CVCA) of underlying causes that make people vulnerable to climate change and variability. It has been developed by DFID and IIED.

What Sustainable Development Goal is the indicator connected to?

SDG Goal 13 “Combat climate change” has no relevant indicator in Nov 2015 green list. All of this goal’s indicators are macro indicators that don’t target directly community-based or households’ resilience capacities; rather they target instructional, casualties and financial aspects related to climate change impacts and mitigation/adaptation initiatives.

Definitions and key terms

Tracking Adaptation and Measuring Development (TAMD) is a 'twin track' framework that evaluates adaptation success as a combination of how:

- Widely and how well countries or institutions manage climate risks (Track 1), and
- Successful adaptation interventions are in reducing climate vulnerability and in keeping development on course (Track 2).

TAMD allows a) assessing the adaptation process at multiple scales – from multiple-country initiatives to local projects; and b) linking Climate Risk Management (CRM), vulnerability and resilience, and broader human wellbeing.

Data and information required to calculate the indicator

- Numerator: Numbers of people (by gender) better able to build resilience to the effects of climate change and variability
- Denominator: Total number of people (by gender) affected by climate change and variability effects

Suggested method for data collection

- Primary data collection: household survey
- Secondary data analysis
- For more information: <http://pubs.iied.org/pdfs/10100IIED.pdf>
- Qualitative methods like focus group discussions and key informants interviews should supplement the quantitative data collection to provide a better understanding of Climate Risk Management activities, resilience initiatives; affected people’s perception of wellbeing in the face of climate change and variability.

Possible data sources

- Primary data collection: project household surveys
- Secondary data
- Local/national/regional weather information systems

Resources needed for data collection

The quantitative and qualitative data collection, storage and analysis will have to be conducted by CARE and partners (potentially including research / university partners). It needs to be included in the monitoring and evaluation plan and budgeted for.

Reporting results for this indicator: number of people for which the change happened

- A change in the percentage/number of people who are better able to build resilience to the effects of climate change and variability

Questions for guiding the analysis and interpretation of data (explaining the how and why the change happened, and how CARE contributed to the change)

- This indicator provides a measure of changes in household and people resilience (in different geographical/administrative areas) and contributes to documenting the success or failure of the actions taken to build people’s resilience to climate change and variability effects.

Other considerations

- This indicator should applied at several levels: institutional, community and people’s scales to allow a comprehensive analysis of the scope of observed resilience
- It should also apply to physical (infrastructures) and soft (committees, EWS, preparedness plans/strategies) measures adopted for building resilience.

Women's Economic Empowerment - global indicators

INDICATOR 16: # and % of women who are active users of financial services (disaggregated by informal and formal services)
<p>Why this indicator? What will it measure and provide information for?</p> <p>This indicator captures programs/projects which aim to ensure women's equal access to and use of financial services. Access to financial services can give women a better opportunity to invest in a business or other income generating activity (IGA). At the same time, access to financial services helps women to deal with fluctuating incomes and provides a safety net during difficult periods. Using a financial service reduces the safety concerns attached to having large amounts of cash at home.</p>
<p>What Sustainable Development Goal is the indicator connected to?</p> <p>This indicator is linked to</p> <ul style="list-style-type: none"> • SDG 5 "Achieve gender equality and empower all women and girls", because women and girls using financial services supports a more equal role in society for them. Use of financial services is a necessary precondition to be met to achieve economic empowerment for women and girls. However, it does not automatically lead to economic empowerment. • SDG 8 "Promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all".
<p>Definitions and key terms</p> <p><u>Women</u>: The data should be disaggregated between women (aged 25 and above) and youth (aged 15-24). We also want data on men and boys, so please record that as well.</p> <p><u>Active users</u>: The definition of an active user will depend on the type of financial service and needs to be defined according to the local context (for example, saves at least once a month, repays loans at least every two months, takes out a loan once a year or has monthly bank transactions; uses mobile money service).</p> <p><u>Financial services</u>: Financial services are economic activities and services provided by the finance industry and include business, credit union, banking service, insurance, accountancy, stocks and investments – particularly including mobile money services. The services include savings or deposit services, payment and transfer services, credit and insurance. The relevant financial services will be contexts specific. Only financial services that are considered beneficial to women should be included.</p> <p><u>Informal</u> financial services: Informal financial services are those that are provided outside the structure of government regulation and supervision.</p> <p><u>Formal</u> financial services: Formal financial service are economic services provided by financial institutions regulated and supervised by government, semi-formal financial services are not regulated by banking authorities but are usually licensed and supervised by other government agencies.</p>
<p>Data and information required to calculate the indicator</p> <ul style="list-style-type: none"> • Numerator: number of women (youth and adults) that are active users of formal financial services • Denominator: total women (youth and adults) surveyed
<p>Suggested method for data collection</p> <ul style="list-style-type: none"> • For VSLAs, the information should be regularly reported by COs in MIS⁴. • For a new project a baseline survey is required. Survey questions should align with information required for MIS, but you can ask for additional information if needed. Survey among a representative sample of the impact group. • In case it's unclear which financial services are to be included, this should be discussed with representatives of the impact group. It is important that financial services considered negative or exploitative are excluded. However, in case you find these, please report to WEE MEL Advisor! • Qualitative methods like focus group discussions and key informants interviews should supplement the quantitative data collection to provide a better understanding of barriers and potential negative consequences of inclusion in financial services.
<p>Suggested tool for data collection</p> <ul style="list-style-type: none"> • The information is collected through annual surveys by CARE and partners. • Baseline and end line survey questionnaire: align questions with what is required for reporting on MIS and add questions as needed.

⁴ <http://mis.thesavix.org/p:en/index.html>

(1) Are you an active member of a VSLA or savings group? (2) Do you have a bank account? (3) Do you regularly use any mobile banking service?
<p>Possible data sources</p> <p>The information is reported by COs/ local partner organizations in MIS on a monthly basis. For new projects and formal financial services, baseline survey data will need to be collected.</p>
<p>Resources needed for data collection</p> <p>The quantitative and qualitative data collection will have to be conducted by CARE and partners. It needs to be included in the monitoring and evaluation plan and budgeted for.</p>
<p>Reporting results for this indicator: number of people for which the change happened</p> <ul style="list-style-type: none"> How many women / youth were active users of (formal and informal) financial services in the last reporting month?
<p>Questions for guiding the analysis and interpretation of data (explaining the how and why the change happened, and how CARE contributed to the change)</p> <ul style="list-style-type: none"> What is the trend for numbers per impact group, country? (Have numbers increase / stagnated / decreased)? What does the change in women's and adolescent girls' use of informal financial services mean for the sustainability of their economic activity? Has the fact that women and girls use financial services contributed to an increase in their economic power? What does the change in women's and adolescent girls' use in formal financial services mean for women's ability to sustainably and competitively manage their business, job or other income generating activity? In cases of increase in formal linkages, has this increase led to women being more competitive? And, their businesses being more sustainable? What contributed to the change? What did women, men or financial service providers do differently. What was CARE's contribution? How has CARE contributed to the change? What were CARE's main strategies for contributing to this change (e.g. linking VSLAs to financial services, financial literacy trainings, etc.)? Has the overall accessibility (independent of CARE) of informal and formal financial services increased in the same period? Which type of financial services has proven most successful in this context? And, which ones have proven least successful - or even caused harm or had negative consequences? From the qualitative data: What are barriers for women's use of financial services? Are there any negative consequences of using financial service? What are the recommendations from women and youth on the utilization of formal and informal financial services?
<p>Other considerations; other related Global Impact Indicators and supplementary indicators</p> <ul style="list-style-type: none"> Data on women and girls should be compared to data on men and boys' financial inclusion rates. It will enrich the analysis to show whether CARE is really making an impact on the key inequalities in financial inclusion. In case data on repayment rate of loans or information about women who fail to pay on time (past dues) is available, this should be added to the analysis of the data as it sheds light on the appropriateness of the levels of the loans. If data about specific enablers or barriers for women's access to financial services is available, this should be added to the analysis. <p><u>This indicator can be complemented by the following:</u></p> <ul style="list-style-type: none"> Total amount of savings made by impact population (FNS supplementary indicator).

<p>INDICATOR 17: # and % of women who report they are able to equally participate in household financial decision-making</p>
<p>Why this indicator? What will it measure and provide information for?</p> <p>This indicator measures women's decision making power in relation to the household's finances. The indicator is a proxy to show change in social norms supporting women's economic and financial empowerment. Equal participation in financial decision increases women's access and control over the household's resources. This indicator is relevant for all WEE pathways: DW = Dignified Work; FI = Financial Inclusion; ENT = Female Entrepreneurship; VC = Women and Value Chains; RM = Women in Resilient Markets.</p>
<p>What Sustainable Development Goal is the indicator connected to?</p> <p>This indicator is linked to</p>

- SDG 5 “Achieve gender equality and empower all women and girls”, because women and girls using financial services supports a more equal role in society for them. Equal decision making power is a necessary precondition to be met to achieve economic empowerment for women and girls. However, it does not automatically lead to economic empowerment.
- SDG 8 “Promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all”.

Definitions and key terms

Equally: Women and men have equal decision making power (i.e. their voice weighs equally). Women or those in the “power down” position are able to hold their own during conversations with men, to use their knowledge of finances and business their own agency to speak out, posit arguments and make judgment calls. Men respect women’s opinion, give them the space to speak, and weigh women’s opinions and arguments as just as important as their own. Men and other power-holders begin the decision making exercise understanding that women have the same personal, social and political worth as them.

Financial decision-making: The relevant financial decision-making processes need to be determined based on the local context. It is important that the range of financial decisions is reflected: which business to enter and key business management decisions, purchase or sale of productive assets (like machines, fertilizers, tools), land, real estate, financial assets (like loans, savings).

Data and information required to calculate the indicator

- Numerator: number of women (female and male-headed households) who report they are able to equally participate in financial decision-making
- Denominator: total women (in female and in male-headed households) surveyed

Suggested method for data collection

- Baseline and end line among representative sample of the impact group (ask women and their male partners). The data should be collected at baseline, subsequently followed up every second year (depending on the programs length).
- Depending on context please chose 5 major financial decisions topics and ask proxy question for each one of these (see example proxy questions below). Preferably, discuss the major financial decision topics with representatives of the impact group as part of a gender analysis during the baseline.
- Survey couples, but ask male and female respond separately (at the same time, if possible).
- Count # of couples that either respond they jointly decide on all 5 (and the woman’s voice weighs equally), or women decide on at least 3 of 5 decision topics;
- Qualitative methods like focus group discussions and key informants interviews should supplement the quantitative data collection to provide a better understanding of barriers and potential negative consequences.

Suggested tool for data collection

- Survey questionnaire: (1) In your HH how do you decide (a) what to spend money on, (b) whether to take a loan, (c) what to do with loan amount or savings (or other financial asset?); (2) In your HH how do you decide how to spend the woman’s income?; (3) In your HH how do you decide how to spend the man’s income?; (4) In your HH, how do you decide on major household purchase [*needs to be contextualized, but can be TV, land, real estate, car etc.*]; (5) In your HH how do you decide what business to engage in?; (8) In your HH how do decide on taking a loan or open a savings account?; (6) In your HH how do you decide on major purchase of productive asset such as fertilizer, tools, machines, land, real estate (or other productive asset or income generation)? [*Response options: only female, only male, equally together*]; for female respondent: (7) Do you feel you have a stronger or weaker say in these decision since you have been participating in the project?; (8) Do you own land in your name?; (9) Do you own any major productive assets in your name (e.g. cattle, machine)?; (10) Have you ever used your savings for business or money-lending?
- Overall guidance: Ask for HOW financial decisions are made, instead of WHO decides.

Possible data sources

The information is collected through annual surveys by CARE and partners.

Resources needed for data collection

The quantitative and qualitative data collection will have to be conducted by CARE and partners. It needs to be included in the monitoring and evaluation plan and budgeted for.

Reporting results for this indicator: number of people for which the change happened

- How many women (female and male-headed households) report they are able to equally participate in household financial decision-making last year?

- What has been the trend in % of women who report they are able to equally participate in household financial decision-making? Has the % increase, stagnated or decreased?

Questions for guiding the analysis and interpretation of data (explaining the how and why the change happened, and how CARE contributed to the change)

- How has CARE contributed to the change? What were CARE's main strategies for contributing to this change (e.g. model men/engaging men, awareness raising, etc.)?
- Have there been any changes in legislation or practice that have influenced the results?
- What are the types of financial decisions that have seen a noticeable increase or decrease in the involvement of women?
- If the following information is available from quantitative or qualitative sources it would help the analysis of the data:
 - How are women concretely benefitting from the change? How has the gender based division of labor inside the household changed? Have men contributed to the change and how? Has the level of conflict inside the household increased or decreased?
 - How have women changed? What strategies did they use to gain more power in decision making? How have men changed? What attitudes and behaviors did they change to share decision making more with women?
 - How do women and men know that their decision making is "more equal"? What behavior proves this?
 - How have any changes in these gender relations strengthened women's ability to participate in, sustain and grow their economic activities/businesses? How has this change in dynamic contributed to women's access to and control over financial assets and benefits?

Other considerations

It is worthwhile to also monitor trends in the household's economic situation – and to assess whether economic advancement correlates with increase women's decision making power.

This indicator can be complemented by the following:

- # and % of women and men reporting net income increase per day (WEE supplementary indicator);
- # and % of women and men who own or control productive asset (including land) / technology and have the skills to use them productively (WEE supplementary indicator);
- # and % of women and men in managerial/senior decision- making position [in company, enterprise, producer group, cooperative, VSLA etc.];
- # and % of people of all genders with knowledge & awareness of their rights and responsibilities as citizens (Governance supplementary indicator);
- % of respondents who report gender equitable attitudes (GEM scale).

INDICATOR 18: # and % of women with union, women's group or cooperative membership through which they can voice their labor rights

Why this indicator? What will it measure and provide information for?

This indicator is relevant for programs/projects multiplying impact for Dignified Work.

For CARE, dignified work is about tackling underlying structural challenges that mean men and women have no or unequal access to Decent Work. Dignified Work is about women gaining respect and recognition through earning a living wage, exercising greater agency (the knowledge and ability to make choices) and experiencing equitable relations at work (labor rights & freedom of association) and in the home (shared household care responsibilities) and benefiting from structures that respond to the needs of women and men equally and with dignity. Access to and participation in collectives – both formal and informal – is critical to women's voice and agency, whether it is with a formal employer or the economic power holder in the family.

Realizing women's rights at work is essential for both, decent work and substantive equality for women and requires that women can access employment with decent pay, safe working conditions and social protection. Women normally find themselves with the most vulnerable work and job status whether they are in the formal sector or informal sector. Collective action makes a difference to improving women's access to decent work. This could be in the form of a formal union with collective bargaining, through co-operatives and through savings and self-help groups.

CARE supports ILO's Decent Work Agenda (as referenced in SDGs) which measures decent work across 4 pillars: job creation, labor protection, social protection, and social dialogue. CARE also supports the UN Women' Substantive

<p>Equality Framework. The Dignified Work Theory of Change is based on CARE’s Gender Equality Framework/ Women’s Empowerment Framework with 3 dimensions of empowerment to achieve transformative change: women’s agency, relations and structures; Empowerment is critical to enabling women to work with dignity.</p>
<p>What Sustainable Development Goal is the indicator connected to?</p> <p>This indicator is linked to SDG 5 “Achieve gender equality and empower all women and girls” and SDG 8 “Promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all”.</p>
<p>Definitions and key terms</p> <p><u>Membership (in a group/ co-op/ union):</u> Refers to women that are registered in a group</p> <p><u>Union, women’s groups or cooperatives:</u> The groups can be organized at different levels from local, regional to national and can be more or less formal.</p> <p><u>Voice labor rights:</u> Refers to collectives that are able to present demands to employers. This includes women’s voice and control over working conditions in value chains (e.g. agriculture) towards whoever is the power-holder (e.g. husband, employer).</p>
<p>Data and information required to calculate the indicator</p> <ul style="list-style-type: none"> • Numerator: number of women with union, women’s group or cooperative membership through which they can voice their labor • Denominator: number of women workers surveyed (disaggregated by age)
<p>Suggested method for data collection</p> <ul style="list-style-type: none"> • Appropriate and more exact definitions of membership and what are relevant groups should be discussed and agreed with representatives of the impact group. This could be part of a gender analysis. • The information should be collected from a baseline and end line survey among representative sample of the impact group. • Qualitative methods like focus group discussions and key informants interviews can supplement the quantitative data collection to provide a better understanding of the quality of representation the group, cooperative or union provides.
<p>Suggested tool for data collection</p> <ul style="list-style-type: none"> • Survey questionnaire: (1) Are you a member of a union, women’s group, or cooperative? • FGD questions: (1) What is the most significant achievement of the union, women’s group, or cooperative in terms of representing your labor / women’s rights?; (2) What has the union, women’s group, or cooperative achieved since you have been a member?; (3) What could the women’s group, or cooperative improve?; (4) Are you aware of any violations of labor of women’s rights (including molesting, grooming, physically or verbally abuse, pressure, mobbing or (sexual or other) harassment) related to work? If so, what has the union, women’s group, or cooperative done to tackle it? Has this been successful? If not, what else needs to be done
<p>Possible data sources</p> <p>The information is collected through surveys by CARE and partners. Qualitative methods applied on an annual basis such as FGD are also useful.</p>
<p>Resources needed for data collection</p> <p>The quantitative and qualitative data collection will have to be conducted by CARE and partners. It needs to be included in the monitoring and evaluation plan and budgeted for.</p>
<p>Reporting results for this indicator: number of people for which the change happened</p> <ul style="list-style-type: none"> • How many women were members of a union, women’s group or cooperative through which they can voice their labor rights last year? • How many women were members of a union, women’s group or cooperative through which they could voice their labor rights (but not necessarily listened to)? • Has there been an improvement of the % of women that were member of a union, women’s group or cooperative through which they can voice their labor rights has it stayed the same or has it worsened? Has there been an improvement of the % of women that were member of a union, women’s group or cooperative through which they can voice their labor rights (but not necessarily listened to), has it stayed the same or has it worsened?
<p>Questions for guiding the analysis and interpretation of data (explaining the how and why the change happened, and how CARE contributed to the change)</p> <ul style="list-style-type: none"> • How has CARE contributed to the change? What were CARE’s main strategies for contributing to this change (e.g. policy advocacy, issue-based advocacy, working with unions/cooperatives/collectives, trainings and capacity building, strategic partnerships, etc.)?

- Have there been any changes in legislation or practice that have influenced the results? (This could be by the government or global supply chains)
- Has there been a noticeable improvement or worsening in accessing decent work?
- If data about the number or % of women with access to named work is available this could be added to the analysis.
- If information about the changes in the women’s working conditions is available it should be added to the analysis.

Other considerations

CARE supports ILO’s work across the 4 pillars of job creation, labor protection, social protection and social dialogue. CARE’s 4 pillars CARE is measuring the following indicators that are relevant for decent work (please see next section for details on these):

Job creation:

- # and % of women and men reporting net income increase per day; and US\$ value of increase;
- Average total # and proportion of weekly hours spent on unpaid domestic and care work, by sex, age and location (for individuals five years and above);
- # of new employment created for impact population (women, youth);
- # and % of women and men in managerial/senior decision- making position [in company, enterprise, producer group, cooperative, VSLA etc.];

Labor protections:

- # of new or amended policies, legislation, public programs, and/or budgets that promote gender equity / rights, needs and demands of people of all genders;
- # and % of people of all genders with knowledge & awareness of their rights and responsibilities as citizens;
- # and % of women and men who are aware of/understand gender barriers at workplace;

Social protections (WEE supplementary indicator):

- # and % of women and men who have universal access to social protection services relevant to their occupation;
- % of women and girls aged 15 years and older subjected to sexual violence by persons other than an intimate partner, in the last 12 months;

Social dialogue:

- % of respondents who report gender equitable attitudes (GEM scale);
- # and % of women and men who are aware of/understand gender barriers at workplace
- # of organizations/social movements (and # & % of leaders, disaggregated by sex) with strengthened capacities to channel demands of marginalized citizens and engage in decision-making (Governance supplementary indicator);
- # of organizations/movements supported by CARE that are considered by their constituents to effectively represent marginalized groups;
- # of new/strengthened inclusive accountability spaces in which marginalized citizens can negotiate with service providers, public authorities or other power-holders.

CARE Approach and Roles - global indicators

INDICATOR 19: # and % of people of all genders who have meaningfully participated in formal (government-led) and informal (civil society-led, private sector-led) decision-making spaces

Why this indicator? What will it measure and provide information for?

The rationale for this indicator is to capture how CARE’s impact groups have participated in decision-making spaces, either formal or informal.

What Sustainable Development Goal is the indicator connected to?

5.1 Proportion of seats held by women in national parliaments and local governments

5.5 Ensure women’s full and effective participation and equal opportunities for leadership at all levels of decision-making in political, economic and public life

16.7 Ensure responsive, inclusive, participatory and representative decision-making at all levels

16.10 Ensure public access to information and protect fundamental freedoms, in accordance with national legislation and international agreements

17.18 By 2020, enhance capacity-building support to developing countries, including for least developed countries and small island developing States, to increase significantly the availability of high-quality, timely and reliable data disaggregated by income, gender, age, race, ethnicity, migratory status, disability, geographic location and other characteristics relevant in national contexts

Definitions and key terms

“All genders” acknowledges that gender justice is beyond the binary that has traditionally been used in development discussions (men, women, boys and girls), and in recognition that those who associate with genders outside of those binary classifications often face the harshest gender injustices⁵. Generally, CARE currently captures information about the ‘sex’ of individuals who attend our trainings, access services supported by CARE, or other otherwise reached indirectly or directly by our interventions; to do this we normally capture ‘sex-disaggregated data’. It is important to distinguish here that ‘sex’ is a biological distinction (e.g., male/female) while gender points more to individuals’ association of identity which go beyond binary to reflect individuals who may not associate as man or woman, boy or girl, but may be transgendered, gender variant, and many others. If your project/initiative is capturing data on “all genders”, please note that in the comments section explaining if you have captured sex-disaggregated data, or if your project/initiative has asked survey respondents or participants of focus groups, etc. about their gender identity.

“Meaningful” is divided into two components: i) **participation** and ii) **leadership**. Participation refers to project participants who attend a meeting in a formal or informal space and are able to contribute to decisions in that space (i.e. they are able to voice their interests or demands publically). Leadership refers to project participants who assume positions that represent the interests of other groups or marginalized and excluded people (e.g. secretary, treasurer, chairperson).

Formal decision-making spaces: These are officially recognized spaces for engagement which are opened and led by public authorities (i.e. *invited* spaces where civil society has a seat and a vote/say), including traditional authorities. These may include constitutional assembly working groups or women’s caucuses, human rights commissions, national action plan committees, sectorial advisory groups, province/governorate/district assembly meetings, district participatory budget or public audit meetings, district nutrition coordination committees or disaster management committees, trade union congresses, community health and education committees, water or waste management committees, village/community/ward development committees or associations, etc.

*Some of these spaces may not exist or function in practice, so they may need to be (re)established or reactivated by CARE and its partners.

Informal decision-making spaces: These are spaces opened and led by civil society, i.e. *created* by CARE and its partners to raise the voice of marginalized groups or populations who typically do not participate in formal decision-making spaces. Generally, these informal spaces raise issues which are either not recognized or under-recognized in formal spaces.

These include: community development forums, community scorecards, social audits, community (adaptation) action plan monitoring committees, participatory scenario planning, gender action plan committees, citizens’ charter taskforces, peace clubs, citizen health monitoring groups, school management committees, advocacy steering committees, ward development forums, youth groups, cultural associations, village savings loans or producer groups and even mothers’ groups, if they are also used as a space for civic participation.

Data and information required to measure the indicator

The data may be divided into:

- a) # of people who are participating in formal and informal spaces where they can meaningfully contribute to decisions
- b) # of people (particularly women) in leadership positions of decision-making spaces

Suggested method for data collection

Each method on what level or degree of participation you want to capture:

⁵ CARE USA’s Gender Justice team, and other country offices, CMPs, and teams across CARE globally have started to integrate ‘all genders’ in their work.

- **Survey methods:** Baseline and endline surveys of group membership can help establish direct participant numbers and quantitative change over time.
- **Ethnographic methods** such as participant observation may help to understand the dynamics of formal and informal spaces, who participated, who spoke, and whether power-holders listened.
- **Semi-structured Key Informant Interviews (KIIs)** can also elicit key information about the quality of participation in formal and informal spaces, for example on women’s confidence speaking in public.
- **Focus Group Discussions (FGD)** with impact groups can draw out commonly held perceptions about the space for women’s leadership in formal and informal groups. You may also wish to consider mixing survey methods with vignettes in FGDs on [social norm perceptions](#) related to women’s participation in public spaces.
- **Theory-based methods** such as [Contribution Tracing](#), [Outcome Mapping](#) and [Most Significant Change](#) may be helpful in explaining the participation process (see indicator 20 for more info).

Possible data sources

- **Participants’ lists** show who attended the meeting and demographic or organizational composition.
- **Organizational registry data** show how many people are affiliated.
- **Meeting minutes** express which issues were raised and agreed in public meetings, and ideally who raised them.
- **Action plans** show what issues were agreed by decision-makers in public meetings.
- **Testimonial evidence** from participants may help to describe the nature of spaces and interaction between different groups.
- **Photographic evidence** can corroborate the participation of impact groups and other actors.

Resources needed for data collection

The resources needed to ensure this level of data quality will be:

- Time for training and piloting of the methodology proportional to the size of expected impact.
- Time for reviewing tools and the initial methodological approach during each evaluation.
- A number of appointed and trained data collectors for the whole duration of a project.
- Any additional costs to digitize and share large-scale evidence on selected evidence of change.

Reporting results for this indicator

The reporting of this result will be to the responsible team/focal point in overseeing the mainstreaming of the CARE approach.

Questions for guiding the analysis and interpretation of data (explaining the how and why the change happened, and how CARE contributed to the change)

- Who attended and who chaired the meeting CARE or partners organized?
- Who did public authorities (or other decision-makers) invite to participate? How has this changed over the course of the initiative?
- How/by whom are the most vulnerable stakeholders represented?
- Who spoke at the meeting? What kinds of needs and/or priorities were expressed?
- How were these needs/priorities recorded by the (formal or informal) authority?

Examples

The [JATRA](#) project in Bangladesh provides a good example showing different dimensions of **participation** CARE’s projects may consider. We often find that **formal spaces** such as official meetings for planning or budgeting at the local level are not happening in practice, and one aim of the project was to reestablish one of these, the Ward Shava budget planning meetings, to help ensure that resources reached the poorest areas. The Union Parishad Act of 2009 stipulates that at least 5% attendance. By tracking attendance records, among the 130 wards that conducted Ward Shava budget meetings in year 1 of the project, we found that a total of 49,761 community members participated (an average of 383 per meeting). This number was also **sex disaggregated** (25,184 men and 24,577 women). This represents just over 10% of the total voting population of these wards. So, we can show how project actions contributed to greater **representativeness** of formal spaces, and even how this has improved year-on-year. More specifically, the Ward Shava resolution book allowed the project to trace which individuals and groups made recommendations and which were included in the budget.

JATRA also promoted citizen participation in **informal spaces**, including Citizen Forums, Community Score Cards (CSC) and Social Audits. A Social Audit is a process in which citizens review official records to determine whether reported expenditures reflect actual spending on public development projects. The project can also demonstrate evidence of

the inclusion of an **impact group** because it conducted a participatory poverty mapping to identify the poorest groups. We can thus show that 91 people from poor and extremely poor households participated as Audit Committee members (60 men and 31 women). 1,709 citizens attended the 12 public meetings at which the Audit Committees presented their findings.

In terms of **leadership**, CARE enables various processes to support women’s leadership. However, one good example we can compare is the **Women’s Empowerment in Agriculture Index (WEAI)** developed for Feed the Future, as this has a common set of indicators on leadership and community including participation in formal and informal groups, confidence speaking about gender and other community issues at local level, and political participation. The Pathways Program in Malawi, Tanzania, India, Mali, and Ghana and the Women’s Empowerment: Improving Resilience, Income and Food Security (WE-RISE) Program in Ethiopia, Tanzania, and Malawi all gathered data under this index.

To understand change to **women’s participation and leadership** in formal and informal groups, the surveys first determined whether 10 different types of groups exist in the community. If groups exist, women were asked about their participation, reasons for not participating, amount of decision-making input they contribute, and whether they hold a leadership position. In WE-Rise Tanzania for example, we find credit or microfinance groups, agricultural/livestock producer’s group, other women’s groups, religious groups, local government, mutual help or insurance groups, trade, business, or cooperatives associations, civic groups or charitable group, water users’ group, forest users’ group, and other non-women's groups. In the two programs, women’s leadership was predominantly in informal groups, and especially credit or microfinance groups such as Village Savings and Loans Associations (VSLAs). In WE-Rise Tanzania, for example, most **leadership positions** in collectives were held by women because the majority of group members were women. One of the survey questions was therefore “have you expressed your opinion in a public meeting (other than VSLA, or producer group)?” Through progress markers, Outcome Mapping can also help projects understand how participation, membership and issues raised changed over time.

INDICATOR 20: # of new or amended policies, legislation, public programs, and/or budgets responsive to the rights, needs and demands of people of all genders

Why this indicator? What will it measure and provide information for?

The rationale for this indicator is to capture the *responsiveness* of power-holders to the rights, needs and demands of impact groups.

What Sustainable Development Goal is the indicator connected to?

- 16.5** Substantially reduce corruption and bribery in all their forms
- 16.6** Develop effective, accountable and transparent institutions at all levels
- 16.b** Promote and enforce non-discriminatory laws and policies for sustainable development
- 17.18** By 2020, enhance capacity-building support to developing countries, including for least developed countries and small island developing States, to increase significantly the availability of high-quality, timely and reliable data disaggregated by income, gender, age, race, ethnicity, migratory status, disability, geographic location and other characteristics relevant in national contexts

Definitions and key terms

“All genders” acknowledges that gender justice is beyond the binary that has traditionally been used in development discussions (men, women, boys and girls), and in recognition that those who associate with genders outside of those binary classifications often face the harshest gender injustices⁶. Generally, CARE currently captures information about the ‘sex’ of individuals who attend our trainings, access services supported by CARE, or other otherwise reached indirectly or directly by our interventions; to do this we normally capture ‘sex-disaggregated data’. It is important to distinguish here that ‘sex’ is a biological distinction (e.g., male/female) while gender points more to individuals’ association of identity which go beyond binary to reflect individuals who may not associate as man or woman, boy or girl, but may be transgendered, gender variant, and many others. If your project/initiative is capturing data on “all genders”, please note that in the comments section explaining if you have captured sex-

⁶ CARE USA’s Gender Justice team, and other country offices, CMPs, and teams across CARE globally have started to integrate ‘all genders’ in their work.

disaggregated data, or if your project/initiative has asked survey respondents or participants of focus groups, etc. about their gender identity

Responsive: ‘This refers to a kind of *behavior*. Mary is responsive to Jane if Mary makes some effort to do something to meet Jane’s needs or wants (Moore and Teskey, [2006](#)).’ In CARE’s case, it means whether power-holders listen to citizens and/or users demands and change their behavior by taking on board their demands and producing laws, policies, programs and budgets that reflects these demands.

Data and information required to measure the indicator

The link between inputs and a policy or budgeting change needs to look at:

- Existing laws, policies, budgets, plans and protocols linked to the specific thematic area.
- CARE-generated monitoring documents evidencing the kind of inputs linked with our influence
- Changes in budgets and annual operating plans (AOPs) at district, municipal or governorate level, or nationally.

Suggested method for data collection

Recommended methods

- **Most Significant Change:** [Most Significant Change](#) can help you define domains of change, gather personal accounts of change from impact groups, and provide a way to define which of these accounts is the most significant and why.
- **Outcome Mapping and Outcome Harvesting:** Outcome Mapping can help you define and track key behavioral changes and Outcome Harvesting can also help prioritize key changes to investigate and evaluate (see the [Outcome Mapping Learning Community](#), RAPID Outcome Mapping Approach – [ROMA](#) and [outcome harvesting.net](#)).
- **Contribution Tracing:** [Contribution Tracing](#) can help you demonstrate a sequential chain of an initiative’s influence over policy change, budget amendments, etc. and show how confident we are about our influence.

Data collection

- **Policy and content analysis:** amendments tracking, examination of government announcements on expected policy changes, government’s prioritization of a selected issue, etc.
- **Budget analysis and tracking:** government expenditure tracking, stakeholders’ interviews on resources allocation decision-making processes, etc.
- **Semi-structured Key Informant Interviews (KIIs):** a sample of opinion leaders and decision-makers (target groups) may be interviewed on the potential influence of our advocacy.
- **In-depth Interviews (IDIs):** In depth interviews with impact groups regarding the significance of changes and roles of different actors related to that change.
- **Focus Group Discussions (FGD) with impact groups:** a sample of community representatives who belong to vulnerable groups articulate if and how their set of interests were considered and addressed in a change of policy, budget, plan, etc.

Possible data sources

Given the complexity of measuring causality, a number of data sources will need to be integrated and closely monitored throughout the whole project cycle. The suggested data sources are:

- Selected laws and policies relevant to the project
- Program documents capturing input allocation
- Budgets and their yearly variations
- Key informant interviews on the process and reasons for change, and project contribution to this
- Impact groups’ views on the process and reasons for change. and project contribution to this

Resources needed for data collection

Policy-level framework monitoring will imply the design of tracking tools which explore the process of change towards the stated aim in a consistent way, therefore resources will be needed to design/pilot and scale-up appropriate tools linking resource allocation with the policy-level change to address needs expressed by the impact group.

Reporting results for this indicator

At the country level, details will be focused on resource allocation and contribution of change linked with primary sources of information (impact groups and target groups). To inform CI, evidence aggregation around key issues should demonstrate national/regional-level changes induced by bundles of inputs dedicated to similar outcome areas across projects.

Defining the scope of policy and budget changes is an important consideration. While each case is different, in general, we recommend looking at the guidance on indirect participants, including:

- Potential groups to benefit or be affected by a policy change (e.g. estimate number of women in a district who would be enabled to access a service, as a result of a policy change)
- Demographics related to policy (e.g. number of school-aged children in a specific location where an education policy may drive change)

Questions for guiding the analysis and interpretation of data (explaining the how and why the change happened, and how CARE contributed to the change)

- To what extent did decision-makers listen to proposals made by our impact group?
- Were commitments proposed by our impact group included in action plans? Were there follow up meetings on these commitments?
- Are policies, laws, programs, budgets reflecting the demands put forwards by our impact group?

Examples

The main way to improve how we can demonstrate responsiveness is by more clearly explaining how we and our partners **influenced actors** and evidence the **process** of change. The only way to do this effectively is to have a [Theory of Change](#) (ToC) with clearly expressed assumptions about the connections between the underlying causes and the problem that the stakeholders are trying to address, which explain why each change is necessary to achieve the proposed goal (assumptions behind the if-then hypotheses), and assumption about the context/environment in which the theory of change is situated.

Outcome Mapping can help you to articulate which **key actors** ([boundary partners](#), which can be both impact and target groups) are important to work with and support or **influence a change in behavior** (actions and interactions), and how best to **provide that support** (through an analysis of [strategy maps](#)).⁷ Outcome Mapping's [progress markers](#) can help organize that data into common milestones of change.

Process Tracing, which is a key component of Contribution Tracing, can help you better explain the **causal pathway(s) that led to a particular outcome**.⁸ The Social and Economic Transformation of the Ultra-Poor ([SETU](#)) project in Bangladesh employed a [Process Tracing](#) methodology in order to map out potential causal pathways. While the evaluation team did not carry out the four [formal tests](#) of process tracing (straw-in-the-wind hoop tests, smoking gun, doubly decisive), they did follow the general logic of tracing key factors and ways of working in the project which contributed to the program's various outcomes. The method was particularly useful in helping to explain how activities related to social solidarity and engaging public authorities contributed to economic outcomes and explain how this supported project sustainability.

CARE has also used [Contribution Tracing](#), which uses both Process Tracing and Bayesian (Confidence) Updating, in the Ghana Strengthening Accountability Mechanisms ([GSAM](#)) project in Ghana and the Journey for Advancement in Transparency, Representation and Accountability ([JATRA](#)) project in Bangladesh. The aim has been to better understand the responsiveness of public authorities related to infrastructure investment and budget allocation, respectively. The method was particularly useful in refining the projects' theories of change, in focusing data collection on the strongest evidence (highest "probative value"), and in defining the sequence of events towards intended outcomes.

CARE has employed [Most Significant Change](#) to support various projects in the Andes, including the

⁷ Other commonly used tools such as [decision-making trees](#) and [timeline drawings](#) can also help explain how, when and why change happened.

⁸ [Contribution analysis](#) also provides a similar but lighter approach to testing a "performance story" related to a theory of change.

[Strengthening Andean Organizations in Public Policy Advocacy in Food Security in Bolivia, Ecuador and Peru](#) project. The method was particularly useful in identifying the most (and least) successful practices which led to changes and lessons learned in the process. It also helped provide a clear framework for guiding questions in Focus Group Discussions (FGDs).

Outcome Mapping can also be used to help track and explain **household-level or intra-community behavioral changes**. And this can be significant in terms of understanding shifting gender norms at a local level. In the Pathways Program in Mali, Malawi, Tanzania, Ghana, India, and Bangladesh, CARE used [Outcome Mapping](#) at mid-term to help evaluate men's behavioral changes around production, access to land, and workload sharing, for example. The process helped the project to refine its indicators around behavioral change and show the relative significance of different changes.

The Redefining Norms to Empower Women (ReNEW) project in Sri Lanka, and the Towards Improved Economic and Sexual Reproductive Health Outcomes for Adolescent Girls (TESFA) and Improving Adolescent Reproductive Health and Nutrition through Structural Solutions (Abdiboru) projects in Ethiopia have also experimented with the measurement of [social norm perceptions](#) through the use of Knowledge, Attitude and Practices (KAP) surveys, with prompts on others behaviors and attitudes, alongside vignettes during Focus Group Discussions (FGDs). This has allowed impact groups to better understand the role of peer pressure by girls' friends in girls' own decisions about when to marry, sometimes against parents' wishes. Better understanding this type of changes can thus further help you to put formal changes, such as child marriage laws, in context.

INDICATOR 21: % of people that have actively engaged in reducing their vulnerabilities to the shocks that affect them

Why this indicator? What will it measure and provide information for?

The rationale for this indicator is to capture the *extent* to which CARE's impact groups have strengthened their capacity to anticipate, absorb and adapt to shocks and stresses by reducing the underlying causes of vulnerability as well as various other drivers of risk; and transform their lives in response to new hazards and opportunities.

What Sustainable Development Goal is the indicator connected to?

Though there is no one single SDG indicator that maps on to this indicator, SDG **target 1.5** is closely related. Target 1.5 aims by 2030, to build the resilience of the poor and those in vulnerable situations and reduce their exposure and vulnerability to climate-related extreme events and other economic, social and environmental shocks and disasters.

Definitions and key terms

Increasing resilience is an on-going process, not a final outcome that can be achieved within a specific time-frame. CARE's approach for increasing resilience can be summarized as.

- Resilience is increased when A.) the capacities and assets to deal with various shocks, stresses, uncertainty and change are built and supported; and B.) the drivers of risk are reduced; and C.) when these actions are supported by an enabling environment.
- It is important that change takes place and be sustained in all three domains to achieve this impact. The following activities can be included when measuring the total number of people that have actively engaged in reducing their vulnerability to shocks and stresses, including their underlying drivers

Actions that aim to :

- **Reduce the likelihood of shocks arising in the first place, or limiting their severity.** This usually requires action and advocacy at a level beyond the community. At an international level, examples might be reducing carbon emissions to limit climate change, which requires global action, or brokering peace negotiations between warring factions through third party mediation. At the national level, examples might be controlling price fluctuations using buffer stocks or tariffs, regulating commodity speculation, or setting up early warning and weather forecast information. Issues that can be addressed at a more local level might include reforestation of degraded landscapes, or adopting more tolerant crop varieties and animal breeds.
- **Address the conditions that make people more exposed to those shocks and stresses.** This is more likely to be within communities' sphere of influence (e.g. voluntary relocation, or building earthquake resistant housing), though will usually require action by others also (e.g. making alternative livelihood opportunities available).

- **Reduce Vulnerability to particular risks.** This is addressed by increasing capacities and assets, in ways that do not exacerbate or drive new risks (e.g. new economic activities that do not result in deforestation, harmful land use change or social divisions). We break this down in:
 - o **anticipate** risks: foresee and therefore reduce the impact of hazards that are likely to occur and be ready for them when events are unexpected through prevention, preparedness and planning;
 - o **absorb** shocks: accommodate the impact shocks and stresses have on their lives, well-being and livelihoods, by making changes in their usual practices and behaviors using available skills and resources, and manage adverse conditions:
 - o **adapt** to evolving conditions: adjust their behaviors, practices, lifestyles and livelihood strategies to respond to changed circumstances and conditions under multiple, complex and at times changing risks;
 - o **transform**: influence the enabling environment and drivers of risks to create individual and systemic changes on behaviors, market economics, and policies and legislation.

Data and information required to measure the indicator

Evidence is needed around both the measurable (quantitative) and intangible (qualitative) dimensions of resilience.

Suggested method for data collection

Qualitative:

- Semi-structured Key Informant Interviews (KIIs) can elicit key information about change processes
- Focus Group Discussions (FGD) with impact groups typically draw out commonly held perceptions of change
- Process tracing of how participants are reducing vulnerabilities and facing shocks and stresses
- Guided participatory observations
- Most significant change

Quantitative:

- Surveys among participants (% men, women, boys and girls) that report to have actively engaged in reducing their vulnerabilities to the drivers of shocks and stresses that affect them.

Possible data sources

- This indicator is not part of the SDG indicators, therefore, it will need to be measured by CARE and partners, when relevant.

Resources needed for data collection

The more intangible side of the indicator will require in-depth trainings of data collectors to ensure they can capture in the most unbiased way. The resources needed to ensure this level of data quality will be:

- Time for training and pilot of the methodology proportional to the size of expected impact
- Time for reviewing tools and the initial methodological approach during each evaluation
- A certain number of appointed and trained data collectors for the whole duration of a project in order to facilitate incremental quality of data collection processes
- Any additional costs to digitize and share large-scale evidence on selected evidence of change

Reporting results for this indicator

The reporting of this result will be to the responsible team/focal point in overseeing and streamlining the resilience approach tied with selected kind of changes across CARE-led projects.

Questions for guiding the analysis and interpretation of data (explaining the how and why the change happened, and how CARE contributed to the change)

- Are people aware of the shocks and stresses they face, and do people recognize and understand their vulnerabilities?
- Are vulnerabilities and drivers of risk different for women, men, girls and boys?
- How do people anticipate, absorb and adapt to shocks? Do women, men, girls and boys absorb shocks differently?
- Which capacities and assets enable a person's opportunities for anticipating, absorbing, adapting and transforming in the face of shock and stresses? Are these capacities and assets strengthened by CARE's work?
- What kind of strategies do people put in place to adapt their livelihoods and/or living conditions, even after having gone through a shock?
- What kind of enabling environment exists to help people increase their capacities and reduce various drivers of risks?
- Are there stories how CARE's actions have helped to prevent or mitigate shocks and stresses from happening. E.g. in comparison to neighboring communities
- How does CARE influence people's ability to become more resilient?

Other considerations

For further background information see the Increasing Resilience Guidance note ([hyperlink](http://careclimatechange.org/publications/increasing-resilience-theoretical-guidance-document-care-international/) <http://careclimatechange.org/publications/increasing-resilience-theoretical-guidance-document-care-international/>)

INDICATOR 22: # and %age of CARE's humanitarian initiatives complying with gender marker requirements

Why this indicator? What will it measure and provide information for?

This indicator relates to CARE's Gender Marker which draws on the concept of the Inter Agency Standing Committee (IASC) Gender Marker launched in 2010 to ensure gender equality as part of the Consolidated Appeals Process. More donors have adopted the system; most recently ECHO started using its own version of the Gender and Age Marker. CARE's expanded version of the Gender Marker is used to assess gender work in preparedness, strategy development, proposals and implementation of the response with regards to the equality of its benefits for men, women, boys and girls, and its potential to contribute to gender equality.

The Gender Marker is one of the indicators outlined in **CARE's Gender Equality and Women's Voice** Guidance (one of three components of the CARE Approach). A [unified Gender Marker](#) for humanitarian and development work along the CARE gender continuum was adopted in June 2016.

Target (CARE Humanitarian & Emergency Strategy 2013-2020) :

By 2020 100% of CARE's emergency initiatives comply at least with all the minimum requirements of Grade 2 at all stages (preparedness, strategy development, proposals and implementation)

What Humanitarian Standard and Humanitarian Indicator is this indicator connected to?

Apart from the direct link to the [IASC gender marker](#) this indicator refers also to the [Core Humanitarian Standard](#) in particular Commitment 1: Communities and people affected by crisis receive assistance appropriate to their specific needs, vulnerabilities and capacities.

[AusAid/OECD Gender Equality Toolkit](#) specifically requires equitable and safe access to humanitarian resources and services according to the needs of affected women, men, girls, and boys. Therefore needs of the most vulnerable are to be assessed and humanitarian assistance access related risks for these groups (e.g., male and female adolescents; unaccompanied children; single, widowed, and elderly women; people living with a disability) are monitored and addressed.

Definitions and key terms

- **Vulnerability:** the extent to which some people may be disproportionately affected by the disruption of their physical environment and social support mechanisms following disaster or conflict, resulting in an increased risk of exploitation, illness or death. Vulnerability is specific to each person and each situation.
- **Capacities:** Women and men affected by crisis (including older people and those with disabilities) already possess and can further acquire skills, knowledge and capacities to cope with, respond to and recover from disasters. They will usually be the first to respond. Actively engaging affected people in humanitarian response is an essential part of upholding their right to life with dignity.

Gender Marker scale ratings: [see Gender Marker Vetting Form.](#)

- **Grades 3-4 (GENDER RESPONSE – TRANSFORMATIVE)** Potential to contribute significantly to gender equality through programming that understands and meets the distinct needs of all genders and life stages
 - A gender and age analysis is included in the needs assessment.
 - Activities reflect the findings of the gender analysis.
 - Outputs are designed to contribute to gender equality goals with linkages to longer-term gender and development outcomes.
- **Grades 1-2 (GENDER NEUTRAL – SENSITIVE):** Potential to contribute in some limited way to gender equality. Some evidence of gender considerations, but gender does not appear in a comprehensive manner throughout all stages of the program cycle. Gender is part of only one or two of the three components of the Gender Marker: i.e. in needs assessment, activities or outcomes.
- **Grade 0 (GENDER HARMFUL) = No visible potential to contribute to gender equality.** Gender and age are not reflected anywhere, or only appear in the outcomes. There is risk that the project will unintentionally fail to meet the needs of some population groups and possibly even do some harm.

Data and information required to calculate the indicator

A [Gender Marker Vetting form](#) has been designed to ensure coherent data collection at various stages and by different units of the organization. Specific guidance for using the CARE Gender Marker at the implementation stage is available especially for self-assessment by the Country Offices.

Suggested method for data collection and possible data sources

Self-Assessment: Using this framework, COs would start the Gender Marking process by grading themselves across the four project cycles. Note that self-assessment of proposals is optional as short-time frames may make this difficult to do. This will be assisted by including the Gender Marker into other processes such as EPP, the ERF application, and the revision of the emergency strategy guidance. Agreement is needed about who within the CO is responsible for grading. Gender Marker information will also be provided by the CO through PIIRS.

External Review: The next level of Gender Marking would take place as a form on external review carried out by colleagues in Lead Members (LMs), CMPs and CEG. All of these review processes already exist within CARE. The inclusion of the Gender Marker into the Emergency Preparedness Planning (EPP), ERF, Strategy and After Action Review (AAR) would ensure the Gender Marker would be an integral part of the review process. Specific measures will be needed to be agreed with the CMPs about the best format to use for grading proposals outside the ERFs as there is no way to include the CARE Gender Marker within donor funding proposal templates.

Technical Review: Once the Gender Marker Grade is agreed it is shared centrally with CI who collects all the interim and final grades. A quality-check is conducted by expert assessment through the GiE team who will review 10% of the grades for each level of the project cycle.

Level of effort needed for data collection and reporting: Medium (see data collection process above)

Other considerations

Accountability: Accountability mechanisms are required to ensure the delivery of the Gender Marker including: responsibility to communicate grades with the CO; accountability for completing self-assessment and external review; and a system for reviewing the quality of the grades using expert review of a sample of grades. An Accountability Plan will be developed for the Gender Marker scale-up.

Impact Indicators: The CARE Gender Marker is an integration indicator monitoring the integration of CARE's gender approach into humanitarian programming. It needs to be used alongside the sex and age disaggregated outcome indicators that demonstrate impact on the communities of CARE's gender work in emergencies.

Indicators 23, 24 and 25 (role indicators) are measured through the PIIRS annual data collection process, reason why not specific guidance is included here.

Guidance for the Incorporation and Measurement of the Supplementary Indicators

This document provides further guidance for the incorporation and measurement of the supplementary indicators. Please note that no guidance has yet been finalized for all supplementary indicators, therefore, this update on the global and supplementary indicators includes only the guidance available to date.

Food and Nutrition Security and Climate Change Resilience - supplementary indicators

Important recommendations when incorporating and measuring these supplementary indicators

- All indicators should be collected in a sex + age + economic classification disaggregated way, looking at how we are impacting men and women differently. At the Household level, we should be looking at Male Headed Households and Female Headed Households
- All data should be coming at least at baseline and end line, if not also built into monitoring plans – data weight -should we count this or not? Mention if this would be population or participants based survey other key hints
- Wherever possible, we should be looking at counterfactuals—what is happening for people not in the program (especially at external mid-term and final evaluations)
- Data collection must be done at the same season/time of year for allowing relevant diachronic analysis
- Representative sample or census -- Data collection must follow the methodology developed for each indicator
- The CI MEL Group and FNs team will make available to project teams links to required materials (questionnaires, sampling methods and data analysis and interpretation methods) and will carry out required capacity building for practitioners
- Data quality should be at center – use appropriate tools and instruments across
- Unit of measures, direction of desired changes (+ or -)
- Gender, governance, environment, resilience, sustainability cost and time per indicator, etc. – should be taken into account adequately

Domain 1- Sustainable Agriculture Systems

FNS&CCR - SAS 1. % of agricultural area under sustainable agricultural and natural resource management practices ⁹
<p>Why this indicator? What will it measure and provide information for?</p> <p>This indicator measures the portion of land under use and on which is applied at least one sustainable agricultural and natural resource technology and/ or management practice, against the total area under use for productive activities for commercial or consumption purpose (agriculture, livestock/grazing areas, fisheries/aquaculture, and forestry)¹⁰. SDG goal 2, target 2.4 aims to ensure sustainable food production systems and resilient agricultural practices that increase productivity and production, maintain and enhance ecosystems and strengthen capacity for adaptation to climate change, and environmental degradation. CARE sees building community and system resilience to extreme weather, drought, flooding and other disasters and that progressively improve land and soil quality.</p> <p>The key main groups of sustainable agricultural practices include:</p> <ol style="list-style-type: none"> 1.1. Improved land and water management practices 1.2. Improved soil fertility and crop and livestock management practices 1.4. Other climate resilient, environment friendly agricultural practices (Fuel Efficient Energy, Improved fisheries and aquaculture management; climate information) <p><u>NB:</u> <i>As much as possible, this indicator should be applied to a local or regional scale (micro to medium scale), as national averages can mask significant variations.</i></p>
<p>What Sustainable Development Goal is the indicator connected to?</p> <ul style="list-style-type: none"> • SDG Goal 2.4.1 green list Nov 2015; • SDG Goal 6; • SDG Goal 7; • SDG Goal 13; • SDG Goal 14; • SDG Goal 15
<p>Definitions and key terms</p> <ul style="list-style-type: none"> • Total area of land under agricultural use • Total area of land under sustainable agricultural and natural resource management practices
<p>Data and information required to calculate the indicator</p> <ul style="list-style-type: none"> • Numerator: total area of land under productive activities (per administrative unit: ward, district, country, region, etc.) • Denominator: total area of (the above) which is under sustainable agricultural and natural resource management practices and technology adoption

⁹ We will need to list all practices that fall under this categories as a guide for users of this indicator

¹⁰ After assessing agricultural context vulnerabilities and climate change impacts (CVCA and/or other), the next step is to identify and evaluate both ongoing and promising agricultural practices in the key production systems that have shown potential in delivering SuPER outcomes. This can be done through literature reviews and interviews with key stakeholders but analysis should apply a SuPER lens to existing initiatives, and highlight opportunities. Practices/services/activities can then be designed in relation to SuPER principles. Seven primary practice options are listed by FAO [here](#). In this indicator, sub-components for sustainable practices should contribute to 'climate-resilience' (e.g. food, income, water, soil, risk, carbon, nitrogen, energy). This is a critical aspect of situation analysis, as it grounds the concept of sustainable practice and SuPER in specific actions.

Suggested method for data collection

- Primary data collection: household data survey + routine monitoring
- Secondary data Datasets and GIS information from technical partners such as FAO, ICRAF, CIAT and national meteorological offices/services
- Qualitative methods (FGDs and KIIs) supplement quantitative data collection to better understand climate change adaptation, Climate Smart Agriculture and other CARE resilience initiatives; affected people's perception of wellbeing in the face of climate change and variability.

Possible data sources

- Data from different administrative levels land use/occupation information systems: local, national, and regional
- Primary data collection: project household surveys
- Secondary data

Resources needed for data collection

The quantitative and qualitative data collection, storage and analysis can be conducted by CARE. Partners (including research, university partners in the CG system and in government). It needs to be included in the monitoring and evaluation plan and budgeted for.

Reporting results for this indicator: number of people for which the change happened

- Reporting Purpose: Baseline - Progress - Evaluation
- A change in the percentage of productive land area under sustainable agricultural and natural resource management practices
- The number of households practicing sustainable agriculture and/or natural resource management practices

Questions for guiding the analysis and interpretation of data (explaining the how and why the change happened, and how CARE contributed to the change)

- This indicator provides a measure of changes in the scale of application of sustainable agricultural and natural resource management practices and adoption of new technologies as a result of project support (in different geographical/administrative areas) and contributes to documenting the success or failure of the actions taken to promote sustainable productive systems and natural resource bases and ecosystems services.

Other considerations

- This indicator should be applied at several levels: institutional, community and people's scales to allow a comprehensive analysis of the scope of observed changes in sustainable agricultural and natural resources management practices
- CARE objects to any carbon sequestration burden being placed on vulnerable small scale food producers but where affordable and practicable it is possible to measure mitigation in farm landscapes (adaptation with mitigation outcomes). Agricultural sources (including energy, soils, livestock etc.) emit methane, nitrous oxide and/or carbon dioxide. Changes in land use, particularly conversion of high carbon land uses ('sinks') such as forests and peatland for agriculture is particularly damaging. The use of this indicator allows us to demonstrate positive action towards mitigation by returning or fixing carbon or nitrogen in the landscape. A simple metric for measuring mitigation is tracking fuel wood consumption.

FNS&CCR - SAS 2. Increased yield per unit area (or productivity per unit area which will also cover fisheries, livestock etc.)

Why this indicator? What will it measure and provide information for?

This indicator will provide information for agriculture yield growth rate (cereal, livestock, aquaculture, fisheries, etc.) (% p.a.), with sustainable agriculture practices. This will help to measure how well sustainable agriculture practices are helping to close the yield gap (Productive and Sustainable parts of the SuPER principles). Methodology includes standard monitoring of yields against baseline over time and at post-harvest intervals. FGDs and KIIs can provide qualitative verification.

What Sustainable Development Goal is the indicator connected to?

- SDG Goal 2;
- SDG Goal 13;
- SDG Goal 15

Definitions and key terms

Changes to productivity can be measured in different ways. The most common approach is to measure yields. Yield measurement techniques vary between crops, and range from weighing harvested grain from the entire field to weighing representative samples from a plot area after plants have reached physiological maturity (Lauer 2002). There are also many mathematical approaches for computing basic yield. Improving the nutritional relevance of food security measurement means using indicators that capture both macro- and micronutrient consumption, that can be measured at the individual level, and that give some sense of acute food insecurity (such as seasonal shortfalls or consumption shocks).

Examples of indicators used to measure productivity include:

- Yield (e.g. product per unit of land or area, water, energy, nutrients, labor)
- Income (e.g. gross margin, net present value – covered in Pillar 2)
- Labor (e.g. person hours, labor allocations by gender – covered in Indicator 4 below and Pillar 2)

In the case of agriculture, the most commonly used unit is kg/ha or MT/ha which can evolved depending on the physical elements (soil quality, water availability, temperatures, etc.) and on technological aspects (agricultural techniques).

Data and information required to calculate the indicator

- Numerator: total output per unit area for each crop/product (kg/ha or MT/ha for example)
- Denominator: total unit area cultivated for each crop (in ha for example)

Suggested method for data collection

- Methodology would include standard monitoring of yields against baseline over time and at post-harvest intervals.

Possible data sources

- Data from different administrative levels: local, national, and regional
- Primary data collection: project household surveys
- Secondary data

Resources needed for data collection

- Primary data collection: project household surveys
- Secondary data
- Local/national/regional agricultural statistics

Reporting results for this indicator: number of people for which the change happened

- Reporting Purpose: Baseline - Progress – Evaluation
- Number of households experiencing increased production
- Number of additional tons of food produced per hectare

Questions for guiding the analysis and interpretation of data (explaining the how and why the change happened, and how CARE contributed to the change)

- This indicator provides the total output per unit area and indicative information on the productive systems efficiency

Other considerations

- Focus group discussions can provide qualitative verification, especially regarding to external factors (climate, pests and diseases, insecurity, input markets, prices, etc.) which could have affected the productivity performance.
- Should be collecting data at the same time of year, ideally post-harvest, every year

FNS&CCR - SAS 3. % of women farmers with access to, control over, or ownership of a core set of productive resources, assets, and services

Why this indicator? What will it measure and provide information for?

Productive resources such as land, water, pasture, inputs, tools, extension, information, finance, and veterinary services etc. are important assets for women and for men. Methodology includes standard monitoring against baseline and through focus group discussions and household surveys.

What Sustainable Development Goal is the indicator connected to?

SDG Goal 1;
SDG Goal 2;
SDG Goal 5

Definitions and key terms

This indicator is focused on productive assets, services and capitals that enable women to make strategic life choices and build resilience. It aims to capture economic status and fallback position.

Data and information required to calculate the indicator

- Denominator: Total number of productive assets owned by the household and level of accessibility to women
- Numerator: number of those assets on which women can make their own decision [without] consulting their spouse regarding their use or sale or donation (*de facto* rights to inherit or bequeath to others through sale, gift, inheritance).

Suggested method for data collection

- Primary data collection: household survey
- Secondary data analysis
- Qualitative methods like FGDs and KIIs to supplement quantitative data collection to provide a better understanding of subjective dimensions of asset ownership such as social norms and barriers analysis.

Possible data sources

- Primary data; project participant surveys
- Local government services providers
- Other local stakeholders (agro-dealers, market actors, community leaders)
- Secondary data from government and partner reports
- Asset photography as a monitoring tool and validation of reporting

Resources needed for data collection

The quantitative and qualitative data collection, storage and analysis will have to be conducted by CARE and partners (potentially including research / university partners). It needs to be included in the monitoring and evaluation plan and budgeted for.

Reporting results for this indicator: number of people for which the change happened

- Reporting Purpose: Baseline - Progress – Evaluation
- A change in the level of women’s control over households’ assets: Number of households where women have increased control over assets.
- Number of households where women are reporting changes in receipt of extension, information and advisory services

Questions for guiding the analysis and interpretation of data (explaining the how and why the change happened, and how CARE contributed to the change)

- What are assets women have /don’t have control over and what are the services that they are receiving?
- What are the implications of that level of women’s control over assets and receipt of services on their ability to enjoy sustainable, productive, profitable and resilient livelihoods?
- Does the enabling environment support positive change in favor of women in regards to their level of control over household’s assets?
- What are the differences between Male Headed Households and Female Headed Households?

Other considerations

- Focus group discussions and social norms and barriers analysis can provide qualitative information and verification, regarding socio cultural and external factors (climate, pests and diseases, insecurity, input markets, prices, etc.). Further information from CARE [here](#), IFPRI [here](#) and at FAO [here](#).

FNS&CCR - SAS 4. Months of Adequate Household Food Provisioning (MAHFP)

Why this indicator? What will it measure and provide information for?

Food access depends on the ability of households to obtain food from their own production, stocks, purchases, gathering, or through food transfers from relatives, members of the community, the government or donors. A household’s access to food also depends on the resources available to individual household members and the steps they must take to obtain those resources, particularly exchange of other goods and services.

This indicator addresses aspects of household resilience, by providing information on the length of hungry seasons and is especially useful for families relying largely on their own food production. Consider combining with dietary diversity and either HHS or FCS to understand quantities and diversity at different times of year. Measuring the MAHFP has the advantage of capturing the combined effects of a range of interventions and strategies, such as improved agricultural production, storage, and interventions that can increase the household’s purchasing power.

What Sustainable Development Goal is the indicator connected to?

- SDG Goal 1
- SDG Goal 2

Definitions and key terms

Household food access is defined as the ability to acquire a sufficient quality and quantity of food to meet all household members’ nutritional requirements for productive lives. This indicator provides a proxy measure of household food access. Over time, the MAHFP indicator can capture changes in the household’s ability to address vulnerability in such a way as to ensure that food is available above at minimum level year round.

Data and information required to calculate the indicator

- Denominator: the total number of household surveyed
- Numerator: the number of households who are unable to provide adequate food supply throughout the past year to its members

Suggested method for data collection

- Manual available at: <http://bit.ly/2a5CmiS>
- Qualitative methods like focus group discussions and key informants interviews should supplement the quantitative data collection to provide a better understanding of underlying causes the prevailing situation.

Possible data sources

- Primary data collection: household survey
- Secondary data
- USAID FANTA project data
- FEWSNET/FAO: IPC data

Resources needed for data collection

The quantitative and qualitative data collection, storage and analysis will have to be conducted by CARE and partners (potentially including research / university partners). It needs to be included in the monitoring and evaluation plan and budgeted for.

Reporting results for this indicator: number of people for which the change happened

- Reporting Purpose: Baseline - Progress - Evaluation
- Percentage of households experiencing one or several food shortages periods over the yearly calendar

Questions for guiding the analysis and interpretation of data (explaining the how and why the change happened, and how CARE contributed to the change)

- Identify the households that were unable to adequately provide for the household for the entire year
- Identify also the households
- What is the number of months when the household did not have access to sufficient food to meet its needs?
- What do the numbers look like for the larger district/area? (Counterfactual)

Other considerations

- The data collection should take place during the period of greatest shortages (e.g.: immediately prior to harvest) and subsequent data collection must be done at the same period.
- The data must be collected over a 12-month recall period, starting with the current month
- The interview should be applied to an adult person who has the whole or partial responsibility of food preparation in the household and who had adequate food supply throughout the past year, which should be included in the tabulation of the denominator of the indicator (“total number of households”) or the level of food insecurity will be overestimated.
- Focus group discussions can provide qualitative verification, especially in regards to other external factors (pests and diseases, insecurity, inputs’ market instability, etc.) which could have affected the food availability/access.

FNS&CCR - SAS 5. Increased adaptive capacity among households and communities dependent on small-scale food production

Why this indicator? What will it measure and provide information for?

Resilience (including to climate change and variability – as per impact indicator above) is built through improving adaptive capacity of households and communities. This indicator is thus required in order to capture and describe progress in building resilience to climate change – meeting both FNS&CCR outcome area requirement and also delivering evidence on the success of CARE’s Resilience Approach.

Resilience indicators are challenging, with both proxy and process indicators commonly used but in here measurement relates to numbers of community-based adaptation approaches and/or risk reducing actions adopted – using Tracking Adaptation and Measuring Development (TAMD) (<http://pubs.iied.org/pdfs/10100IIED.pdf>) and other tools. CARE’s Adaptation Good Practice Checklist (AGP) describes metrics and should be consulted and the CARE CBA milestones and indicators framework is applicable: <http://bit.ly/29XW92W>

Other guidance of use is DFID/Garama 3C: <http://bit.ly/1t9xcn2>; and the Local Adaptive Capacity (LAC) Framework. This indicator should be documented at local, sub-national, national and regional scales in our programming context.

What Sustainable Development Goal is the indicator connected to?

- SDG Goal 5
- SDG Goal 7,
- SDG Goal 13,
- SDG Goal 15

Definitions and key terms

TAMD is a conceptual framework to monitor and evaluate climate change adaptation.

Measuring adaptation, adaptive capacity and resilience is complicated and they tend to be measured in terms of attributes of the system (rather than as outcomes for farms and people). Context-specificity is important – for example, a more diverse system is more adaptive in many cases (but not always; diversification should be pursued with caution). Examples of indicators used to measure adaptation and resilience include:

Social indicators

- Access to capitals (financial, human, social/political, physical, natural)
- Access to services (particularly climate information services)
- Level of skills, knowledge and access to extension on climate change
- Diversity in livelihoods and income sources
- Market access (for food, agricultural inputs and agricultural product markets)
- Gender equity (e.g. labor burden, income differences)

Biophysical indicators

- Biodiversity (e.g. species and landscape variety, nitrogen %)
- Pests/pathogens (e.g. % loss, damage rates, frequency/seasonality of attacks)
- Erosion/Soil loss (e.g. kg/ha)
- Soil quality (e.g. changes in carbon, nitrogen, soil water balance, etc.)

Economic indicators

- Income levels
- Savings and access to credit
- Land rights/tenure
- Access to insurance
- Proportion of income from climate-prone sources

Institutional indicators

- Enabling policy and regulation environment
- Incentive systems and subsidies (directed away from maladaptive practices towards resilience practices)
- Safety net schemes
- Early warning systems and disaster recovery strategies

Data and information required to calculate the indicator

- Numerator: Numbers of people (by gender) better able to build resilience to the effects of climate change and variability
- Denominator: Total number of people (by gender) affected by climate change and variability impacts

Suggested method for data collection

- TAMD manual: <http://pubs.iied.org/pdfs/10100IIED.pdf>
- CARE Community-Based Adaptation manual: <http://bit.ly/29XW92W>
- CARE (ALP) Adaptation Good Practice Checklist
- DFID/Garama 3C manual: <http://bit.ly/1t9xcn2>
- ACCRA Local Adaptive Capacity Framework (LAC): http://careclimatechange.org/files/adaptation/ACCRA%20Local_Adaptive%20Policy.pdf
- Qualitative methods (focus group discussions and key informants interviews, etc.) and thematic impact studies should supplement quantitative data collection.

<p>Possible data sources</p> <ul style="list-style-type: none"> • Primary data collection: household survey • Secondary data • National and local adaptation plans and data • CVCAs (or other vulnerability analyses such as social norms and barriers analysis – these will contain baseline data).
<p>Resources needed for data collection</p> <p>The quantitative and qualitative data collection, storage and analysis will have to be conducted by CARE and partners (potentially including research / university partners). It needs to be included in the monitoring and evaluation plan and budgeted for.</p>
<p>Reporting results for this indicator: number of people for which the change happened</p> <ul style="list-style-type: none"> • Reporting Purpose: Baseline - Progress - Evaluation • Risk management capacity levels in both soft forms (institutions, committees, tasks forces, etc.) and hard infrastructures (bridges, basins, dams, protection walls, etc.) • Changes in understanding of climate risks amongst populations and key stakeholders • Number of communities with community-based adaptation plans of action or with disaster risk management plans • Level of adoption (number of households) of sustainable agricultural and natural resource management practices (e.g. conservation agriculture, water-smart agriculture, safe and fuel efficient energy sources, agroforestry etc. Link to indicator 1.)
<p>Questions for guiding the analysis and interpretation of data (explaining the how and why the change happened, and how CARE contributed to the change)</p> <ul style="list-style-type: none"> • How are supported households and communities better able to adapt climate change and variability? • What are the adaptation practices used by supported households and communities? • How communities and households are prepared for anticipating and absorbing shocks? • What actions or interventions have transformed household and communities' ability to become resilient to climate change?
<p>Other considerations</p> <ul style="list-style-type: none"> • Focus group discussions, key informant interviews, secondary data reviews can provide qualitative verification, especially regarding other external factors (insecurity, political instability, disasters, etc.) which could have affected the implementation of adaptation plans/initiatives. • <u>Community-Based Adaptation (CBA)</u> is recognized as an approach to build the capacity of vulnerable communities and people to adapt to the impacts of climate change. The approach is grounded in good development practice, focusing on sustainable livelihoods, attention to differences within communities of impacts and adaptive capacities, integrating rights-based approaches, and addressing gender inequality and marginalization to ensure that the most vulnerable groups and people are able to adapt.

Domain 2 - Nutrition

FNS&CCR - NUT 1. Wasting – Moderate and severe: Percentage of children aged 0–59 months who are below minus two standard deviations from median weight-for-height (WHZ < -2SD) of the WHO Child Growth Standard

Why this indicator? What will it measure and provide information for?

Wasting or thinness indicates in most cases a recent and severe process of weight loss, which is often associated with acute starvation and/or severe disease and is strongly correlated with under-5 mortality. However, wasting may also be the result of a chronic unfavorable condition. Provided there is no severe food shortage, the prevalence of wasting is usually below 5%, even in poor countries.

If possible, measurements (height, weight, age) are generally taken at the same time. Hence, data for the stunting indicator (height-for-age) will also be collected.

What Sustainable Development Goal is the indicator connected to?

SDG 2: “End hunger, achieve food security and improved nutrition, and promote sustainable agriculture 2.1 by 2030 end hunger and ensure access by all people, in particular the poor and people in vulnerable situations including infants, to safe, nutritious and sufficient food all year round. 2.2 by 2030 end all forms of malnutrition, including achieving by 2025 the internationally agreed targets on stunting and wasting in children under five years of age, and address the nutritional needs of adolescent girls, pregnant and lactating women, and older persons”.

Definitions and key terms

Underweight: weight for age < -2 standard deviations (SD) of the WHO Child Growth Standards median

Stunting: height for age < -2 SD of the WHO Child Growth Standards median Wasting: weight for height < -2 SD of the WHO Child Growth Standards median Overweight: weight for height > +2 SD of the WHO Child Growth Standards median

Data and information required to calculate the indicator

- Numerator: a) number of children under five under moderate wasting and b) number of children under five under severe wasting
- Denominator: Total number of children under 5 surveyed
- Disaggregation: geographical area and sex

Suggested method for data collection

- **User Manuals:**
 - FANTA project (for method): <http://www.fantaproject.org/tools/anthropometry-guide>
 - WHO (for interpretation): http://www.who.int/nutrition/nlis_interpretation_guide.pdf
 - WHO: <http://www.who.int/childgrowth/software/en/>
 - WHO: http://www.who.int/childgrowth/standards/weight_for_length_height/en/
 - UNICEF: <http://data.unicef.org/resources/child-nutrition-interactive-dashboard-2015-edition.html#>

Possible data sources

- Household survey
- Local, sub-national, national or regional nutritional surveys
- WHO regional or global nutritional data
- UNICEF regional and global nutritional data

Resources needed for data collection

The quantitative and qualitative data collection, storage and analysis will have to be conducted by CARE and partners (potentially including research / university partners). It needs to be included in the monitoring and evaluation plan and budgeted for.

Reporting results for this indicator: number of people for which the change happened

- Reporting Purpose: Baseline - Progress - Evaluation
- The percentage and rate of children under five under moderate or severe wasting

Questions for guiding the analysis and interpretation of data (explaining the how and why the change happened, and how CARE contributed to the change)

- What is level of wasting amongst children under five year?
- What are the underlying causes of the deteriorated nutrition?
- How are boys and girls impacted differently?

This indicator provides information about the quality of food provision and of child care practices.

Other considerations

Focus group discussions can provide qualitative verification, especially in regards to other external factors (insecurity, political instability, disasters, fail crops, diseases outbreak, market's inflation, etc.) which could have affected food availability, access and utilization or hygiene, sanitation and health conditions.

FNS&CCR - NUT 2. % of children 6–23 months of age who receive a minimum acceptable diet (apart from breast milk)

Why this indicator? What will it measure and provide information for?

This indicator measures the proportion of children 6-23 months of age who receive a minimum acceptable diet (MAD), apart from breast milk. The “minimum acceptable diet” indicator measures both the minimum feeding frequency and minimum dietary diversity, as appropriate for various age groups. If a child meets the minimum feeding frequency and minimum dietary diversity for their age group and breastfeeding status, then they are considered to receive a minimum acceptable diet.

It is recommended that the indicator be further disaggregated and reported for the following age groups: 6–11 months, 12–17 months and 18–23 months of age, if sample size permits.

This indicator is primarily used for:

- *assessing*: to make national and sub-national comparisons and to describe trends over time;
- *targeting*: to identify populations at risk, target interventions, and make policy decisions about resource allocation;
- *monitoring and evaluating*: to monitor progress in achieving projects’ goals and to evaluate the impact of interventions;

What Sustainable Development Goal is the indicator connected to?

- SDG Goal 2.1.
- SDG Goal 2.2.

Definitions and key terms

This indicator measures the proportion of children 6-23 months of age who receive a minimum acceptable diet (MAD), apart from breast milk.

Data and information required to calculate the indicator

- Numerator: Number of children 6-23 months who receive a minimum acceptable diet
- Denominator: Total number of children 6-23 months surveyed

Suggested method for data collection

- WHO (for method): <http://bit.ly/2a6p18G>
- WHO (for definitions): <http://bit.ly/29Ly64V>

Possible data sources

- Household survey
- Demographic and Health Survey (DHS) is implemented every 5 years
- WHO regional or global nutritional data
- UNICEF regional and global nutritional data

Resources needed for data collection

The quantitative and qualitative data collection, storage and analysis will have to be conducted by CARE and partners (potentially including research / university partners). It needs to be included in the monitoring and evaluation plan and budgeted for.

Reporting results for this indicator: number of people for which the change happened

- Reporting Purpose: Baseline Progress Evaluation
- A Change in the number/percentage of children 6–23 months who receive a minimum acceptable diet (apart from breast milk)

Questions for guiding the analysis and interpretation of data (explaining the how and why the change happened, and how CARE contributed to the change)

- Breastfed children 6-23 months of age who had at least the minimum dietary diversity and the minimum meal frequency during the previous day?
- Breastfed children 6-23 months of age?
- Non-breastfed children 6-23 months of age who received at least 2 milk feedings and had at least the minimum dietary diversity not including milk feeds and the minimum meal frequency during the previous day?
- Non-breastfed children 6-23 months of age?

Other considerations

- Focus group discussions can provide qualitative verification, especially in regards to other external factors (insecurity, political instability, disasters, fail crops, diseases outbreak, market's inflation, etc.) which could have affected food availability, access and utilization or hygiene, sanitation and health conditions.
- DHS surveys are not conducted annually in any specific country, so data may not be available at the optimal intervals for evaluation.

FNS&CCR - NUT 3: % of women (15-49 years) who consume at least 5 out of 10 defined food groups (Minimum Dietary Diversity – Women)

Why this indicator? What will it measure and provide information for?

MDD-W is outcome focused and is promoted by USAID and FAO. It focuses on dietary diversity and quality. Lack of dietary diversity has been shown to be a crucial issue, particularly in the developing world where diets consist mainly of starchy staples with less access to nutrient-rich sources of food such as animal protein, fruits and vegetables. Women and children are particularly vulnerable to ill effects.

This indicator tracks dietary diversity, a vital element of diet quality, by measuring the consumption of a variety of foods across and within food groups, and across different varieties of specific foods, to ensure adequate intake of essential nutrients and important non-nutrient factors. Research has demonstrated a strong association between dietary diversity and diet quality, and nutritional status of children.

This indicator complements the "Minimum Dietary Diversity" (MDD) indicator previously defined for infants and young children; see: WHO. 2008. Indicators for assessing infant and young child feeding. Indicator should be linked to other household dietary diversity scores (HDDS) and can be used as a proxy to describe women's diet quality (micronutrient adequacy) at national and sub-national levels.

What Sustainable Development Goal is the indicator connected to?

- SDG Goal 2.1

Definitions and key terms

MDD-W is the acronym for "Minimum Dietary Diversity-Women." MDD-W is a dichotomous indicator of whether or not **women** 15-49 years of age have consumed at least five out of ten **defined** food groups the previous day or night.

Data and information required to calculate the indicator

- Numerator: Number of surveyed women 15-49 years of age have consumed at least five out of ten defined food groups the previous day or night
- Denominator: Total number of children 6-23 months surveyed

<p>Suggested method for data collection</p> <ul style="list-style-type: none"> • FAO (for method): http://www.fao.org/3/a-i5486e.pdf • WHO (for definition): http://whqlibdoc.who.int/publications/2008/9789241596664_eng.pdf
<p>Possible data sources</p> <ul style="list-style-type: none"> • Household survey • Demographic and Health Survey (DHS) is implemented every 5 years • WHO regional or global nutritional data • UNICEF regional and global nutritional data
<p>Resources needed for data collection</p> <p>The quantitative and qualitative data collection, storage and analysis will have to be conducted by CARE and partners (potentially including research / university partners). It needs to be included in the monitoring and evaluation plan and budgeted for.</p>
<p>Reporting results for this indicator: number of people for which the change happened</p> <ul style="list-style-type: none"> • Reporting Purpose: - Baseline - Progress - Evaluation • Changes in the quality of the diet of women 15-49 years of age
<p>Questions for guiding the analysis and interpretation of data (explaining the how and why the change happened, and how CARE contributed to the change)</p> <ul style="list-style-type: none"> • Numerator: What is the number of women (15-49 years) leaving in the project area who consume at least 5 out of 10 defined food groups? • Denominator: what is the number of women (15-49 years) leaving in the project area? • This indicator can help assess progress (success or failure) against food diversity activities targeting specifically women 15-49 years of age.
<p>Other considerations</p> <ul style="list-style-type: none"> • Focus group discussions can provide qualitative verification, especially in regards to other external factors (insecurity, political instability, disasters, fail crops, diseases outbreak, market's inflation, etc.) which could have affected food availability, access and utilization or hygiene, sanitation and health conditions. • The data collection for this indicator should be carried out at the same period of the year considering the food access and availability seasonality in low income and developing countries which can compromise data quality.

FNS&CCR - NUT 4. Percentage of women of reproductive age (15-49 years) with anemia and % children 6-23 months/6-59 months with anemia

<p>Why this indicator? What will it measure and provide information for?</p> <p>Anemia is associated with increased morbidity and mortality for children and women, and reduced work output among adults. Micronutrient deficiencies are especially devastating to pregnant women and children, as deficiencies during the first 1000 days can have lifelong effects on physical, mental, and emotional development. Anemia is a multi-factorial disorder caused mainly by iron deficiency and infections and to a lesser extent by deficiencies of vitamin A, vitamin B12, folate, and riboflavin. It is estimated that half the cases of anemia are due to iron deficiency. Anemia in women of reproductive age serves as a proxy for micronutrient deficiencies in the absence of more comprehensive indicators.</p>
<p>What Sustainable Development Goal is the indicator connected to?</p> <ul style="list-style-type: none"> • SDG Goal 2.1. • SDG Goal and 2.2.
<p>Definitions and key terms</p> <p><u>Anemia</u>, according to the WHO, is a condition in which the number of red blood cells or their oxygen-carrying capacity is insufficient to meet physiologic needs, which vary by age, sex, altitude, smoking, and pregnancy status.</p>

<p>Data and information required to calculate the indicator</p> <ul style="list-style-type: none"> • Numerator: Numbers of women of reproductive age (15-49 years) with anemia / number of children (boys and girls) of children 6-23 months/6-59 months with anemia • Denominator: Total number of surveyed women of reproductive age (15-49 years) / Total number of surveyed children 6-23 months/6-59 months
<p>Suggested method for data collection</p> <ul style="list-style-type: none"> • WHO: http://bit.ly/29NIVEN • WHO: http://www.who.int/vmnis/indicators/haemoglobin.pdf
<p>Possible data sources</p> <ul style="list-style-type: none"> • Household survey • Data from clinics/health centers • Demographic and Health Survey (DHS) is implemented every 5 years
<p>Resources needed for data collection</p> <p>The quantitative and qualitative data collection, storage and analysis will have to be conducted by CARE and partners (potentially including research / university partners). It needs to be included in the monitoring and evaluation plan and budgeted for.</p>
<p>Reporting results for this indicator: number of people for which the change happened</p> <ul style="list-style-type: none"> • Reporting Purpose: Baseline - Progress - Evaluation • Changes in percentage of anemia amongst women of reproductive age and children of 6-23 months/6-59 months
<p>Questions for guiding the analysis and interpretation of data (explaining the how and why the change happened, and how CARE contributed to the change)</p> <ul style="list-style-type: none"> • Denominator: What is the number of women (15-49 years) and children 6-23 months & 6-59 months) leaving in the project area? • Numerator: What is the number of women (15-49 years) and children 6-23 months & 6-59 months) leaving in the project area diagnosed with anemia? • This indicator can help assess progress (success or failure) against nutrition activities targeting specifically women of reproductive (15-49 years) and children of children 6-23 months/6-59 months
<p>Other considerations</p> <ul style="list-style-type: none"> • Focus group discussions can provide qualitative verification, especially in regards to other external factors (insecurity, political instability, disasters, fail crops, diseases outbreak, market's inflation, etc.) which could have affected food availability, access and utilization or hygiene, sanitation and health conditions. • The data collection for this indicator should be carried out at the same period of the year considering the food access and availability seasonality in low income and developing countries that may influence the prevalence of anemia amongst the targeted populations.

FNS&CCR - NUT 5. Exclusive breastfeeding under 6 months: % of infants 0–5 months of age fed exclusively with breast milk

Why this indicator? What will it measure and provide information for?

Breastfed children have at least a six-times greater chance of survival in the early months than non- breastfed children. An exclusively breastfed child is 14 times less likely to die in the first six months of life than a non-breastfed child, and breastfeeding drastically reduces deaths from acute respiratory infection and diarrhea, two major child killers.

The potential impact of optimal breastfeeding practices is especially important in developing country situations with a high burden of disease and low access to clean water and sanitation. Exclusive breastfeeding also has a protective effect against obesity and certain non-communicable diseases later in life.

It is recommended that the indicator be further disaggregated and reported for the following age-groups: 0–1 month, 2–3 months, 4–5? months and 0–3 months.

What Sustainable Development Goal is the indicator connected to?

- SDG Goal 2.1.
- SDG Goal 2.2.

Definitions and key terms

Exclusive breastfeeding: is defined as no other food or drink, not even water, except breast milk (including milk expressed or from a wet nurse) for 6 months of life, but allows the infant to receive ORS, drops and syrups (vitamins, minerals and medicines).

Data and information required to calculate the indicator

- Numerator: infants (girls and boys) 0-5+wk?? months of age who received only breast milk during the previous day
- Denominator: infants 0-5+wk?? months of age

Suggested method for data collection

- WHO (for method): <http://bit.ly/2a6p18G>
- WHO (for definitions): <http://bit.ly/2a6p18G>

Possible data sources

- Household survey
- Nutrition centers
- Demographic and Health Survey (DHS) is implemented every 5 years

Resources needed for data collection

The quantitative and qualitative data collection, storage and analysis will have to be conducted by CARE and partners (potentially including research / university partners). It needs to be included in the monitoring and evaluation plan and budgeted for.

Reporting results for this indicator: number of people for which the change happened

- Reporting Purpose: Baseline Progress Evaluation
- A change in the number/percentage of children (girls and boys) who are exclusively breastfed.

Questions for guiding the analysis and interpretation of data (explaining the how and why the change happened, and how CARE contributed to the change)

- What is the total number of children (girls and boys) under 5 months leaving the project area?
- What is the total number of these children (girls and boys) who are exclusively breastfed?
- This indicator provides a measure of changes in children under 6 months exclusive breastfeeding and contributes to documenting the success of failure of the actions taken to improve the adoption of children under 6 months best feeding practices and more broadly best children care practices

Other considerations

- Focus group discussions can provide qualitative verification, especially in regards to other external factors (insecurity, political instability, disasters, fail crops, diseases outbreak, market's inflation, etc.) which could have affected food availability, access and utilization or hygiene, sanitation and health conditions.
- The data collection for this indicator should be carried out at the same period of the year considering the food access and availability seasonality in low income and developing countries that may influence the breastfeeding women nutrition status and ability to exclusively breastfeed their child.

FNS&CCR - NUT 6. Mid-Upper Arm Circumference (MUAC) for children 5-59 months and women of reproductive age

Why this indicator? What will it measure and provide information for?

The MUAC is usually used by humanitarian health workers to screen and assess for acute malnutrition among children (5-59 months) and women of reproductive age (15-49 years).

At the individual level, MUAC can be used to initially screen individuals for admission to selective feeding programs or therapeutic nutrition care. For pregnant women of any age BMI is an inadequate nutritional index and MUAC is recommended. At the population level, it is recommended that MUAC information is collected in nutrition surveys for use in program planning, but that MUAC should not be used as the single measure in anthropometric surveys. Research is underway to determine appropriateness of using MUAC to estimate population level nutrition status. Excerpt from HTP, module 6: MUAC has been successfully used with low-skilled staff given training and supervisory support, and is especially suitable for use in the community. It does not require heavy material and can be used with a single cut-off for boys and girls. It is increasingly being incorporated into guidelines for the treatment of severe and moderate malnutrition. However, there are drawbacks to using MUAC in emergencies. The chance of inaccurate measurement is high due to differing techniques, and there is limited evidence documenting ethnic differences in MUAC measurements.

What Sustainable Development Goal is the indicator connected to?

- No SDG indicator

Definitions and key terms

Mid-Upper Arm Circumference (MUAC) is the **circumference** of the **left upper arm**, measured at the **mid-** point between the tip of the **shoulder** and the tip of the **elbow** (olecranon process and the acromium).

Data and information required to calculate the indicator

- Numerator: children 5-59 months and women of reproductive age 15-49 years with diagnosed severe and moderate malnutrition
- Denominator: children 5-59 months and women of reproductive age 15-49 years surveyed

Suggested method for data collection

- FANTA Project (for method): <http://bit.ly/2abA2IC>
- WHO (for definition & method): <http://bit.ly/2a0TLIY>
- UN SCN (for method): http://www.unscn.org/en/gnc_http/modul.php?modID=27

Possible data sources

- Household survey
- Nutrition/health centers
- Demographic and Health Survey (DHS) is implemented every 5 years

Resources needed for data collection

The quantitative and qualitative data collection, storage and analysis will have to be conducted by CARE and partners (potentially including research / university partners). It needs to be included in the monitoring and evaluation plan and budgeted for.

<p>Reporting results for this indicator: number of people for which the change happened</p> <ul style="list-style-type: none"> • Reporting Purpose: Baseline - Progress - Evaluation • A change in the number/percentage of children (girls and boys) and women of reproductive age suffering from acute malnutrition
<p>Questions for guiding the analysis and interpretation of data (explaining the how and why the change happened, and how CARE contributed to the change)</p> <p>This indicator provides a measure of changes in acute malnutrition amongst children 5-59 months and women of reproductive age 15-49 years and contributes to documenting the success of failure of the actions taken to improve children under five and women or reproductive health nutrition status.</p>
<p>Other considerations</p> <ul style="list-style-type: none"> • MUAC is not the best index for use in nutrition assessment surveys as it does not for example tell if children are chronically malnourished, and as in some areas, chronic malnutrition may be more important than acute malnutrition; this methodology may represent an important limit to the study carried out. Therefore, it is highly suggested to use (when possible) the weight-for-height tool for measuring acute malnutrition instead of the MUAC.

Domain 3 – Sustainable Economies

<p>FNS&CCR - SE 1. % increase in income compared to baseline for HH and/or impact population</p>
<p>Why this indicator? What will it measure and provide information for?</p> <p>Income is an important pathway for food and nutrition security as well as for resilience to financial shocks or disaster. Increased income is assumed to have a positive impact on all livelihoods components (assumptions will need to be tested and spending of additional income will vary depending on HH priority). As much as possible, this indicator should be analyzed against the minimum leaving wage for capturing also poverty levels.</p>
<p>What Sustainable Development Goal is the indicator connected to?</p> <ul style="list-style-type: none"> • SDG Goal 1 • SDG Goal 8
<p>Definitions and key terms</p> <ul style="list-style-type: none"> • Income: weekly income of entire family combined • Livelihoods: sources of income • HH Active member(s): who earns up to an income at HH level?
<p>Data and information required to calculate the indicator</p> <ul style="list-style-type: none"> • Numerator: income assessed among total sample at 2nd data point • Denominator: income assessed among total sample at 1st data point
<p>Suggested method for data collection</p> <ul style="list-style-type: none"> • Annual survey by CARE or CARE implementing partners
<p>Possible data sources</p> <ul style="list-style-type: none"> • Project household survey data
<p>Resources needed for data collection</p> <p>The quantitative and qualitative data collection will have to be conducted by CARE and partners. It needs to be included in the monitoring and evaluation plan and budgeted for.</p>
<p>Reporting results for this indicator: number of people for which the change happened</p> <ul style="list-style-type: none"> • Reporting Purpose: Baseline - Progress - Evaluation • A change in total income at household level (for both male and female headed household) • Livelihoods diversification level (sources of income), which can also inform on the household resilience status

Questions for guiding the analysis and interpretation of data (explaining the how and why the change happened, and how CARE contributed to the change)

- This indicator provides a measure of change in household income and contributes to documenting the level of success or failure of the actions taken to promote sustainable economies for project participants and their communities.
- What are the income trends (increase/decrease/unchanged) in the project area?
- Who (male/female) earns more?
- What are the main livelihoods of project male and female participants in project area?
- To what extent the implemented activities and adopted methodologies were successful in improving HH's income?

To what extent the implemented projects were able to increase female headed and male headed households' income towards living wage?

Other considerations

- Need to consider seasonal fluctuation in income;
- Groups of income;
- Needs to consider some religious/cultural events that may influence income;
- Need to consider dignified working conditions, including child labor; income could increase due to longer working hours, resulting in unsafe working practice or other kinds of exploitation.
- Should be analyzed and compared with asset or household expenditure (proxy-indicators), where possible

FNS&CCR - SE 2. Total amount of savings made by impact population

Why this indicator? What will it measure and provide information for?

Access to financial services is a decisive factor in eliminating poverty and generating local development. Informal saving is a corner stone of community social safety net and social entrepreneurship promotion, especially amongst poor women. The group saving also offers a safe and convenient space for women to discuss and raise their voices on issues of concern in their communities. Informal saving groups are self-managed, don't receive any external funding and provide to their members a safe place to save their money, to access loans and to obtain emergency insurance. Thus they contribute also to reinforcing women leadership and positioning them as key members of their community development mechanisms.

This is important given our reliance on informal savings (re-VSLA) in many of our programs.

What Sustainable Development Goal is the indicator connected to?

- SDG Goal 1

Definitions and key terms

A Village Savings and Loan Association (VSLA) is a group of people who save together and take small loans from those savings. The activities of the group run in cycles of one year, after which the accumulated savings and the loan profits are distributed back to members. The purpose of a VSLA is to provide simple savings and loan facilities in a community that does not have easy access to formal financial services.

Data and information required to calculate the indicator

- Number of VSLA groups established
- Total membership of VSLA groups
- Total amounts of savings
- Number of supported social small scale businesses

Suggested method for data collection

Methodology would include CARE VSLA monitoring /routine monitoring and evaluation tools

- CARE VSLA functionality tool 2: link?
- CARE VSLA form:

<p>Possible data sources</p> <ul style="list-style-type: none"> • Primary data: VSLA groups and members surveys • Baseline data (pre project data)
<p>Resources needed for data collection</p> <p>The quantitative and qualitative data collection, storage and analysis will have to be conducted by CARE and partners (potentially including research / university partners). It needs to be included in the monitoring and evaluation plan and budgeted for.</p>
<p>Reporting results for this indicator: number of people for which the change happened</p> <p>Reporting Purpose: Baseline (base value) - Progress - Evaluation</p> <ul style="list-style-type: none"> • A change in the total amount of savings achieved by informal saving groups and individual members
<p>Questions for guiding the analysis and interpretation of data (explaining the how and why the change happened, and how CARE contributed to the change)</p> <ul style="list-style-type: none"> • Is your household a member of an informal saving group membership? • What is the number of active informal saving groups? • What the total amount of savings the informal saving group has made for the most recent activity period? • What are savings trends in your informal saving group?
<p>Other considerations</p> <ul style="list-style-type: none"> • Recognizing the most of rural informal saving groups members livelihoods rely on productive (farming, animal husbandry or petty trade based on farm/livestock products) incomes, a particular attention needs to be paid to the seasonal fluctuation of their incomes. • Focus group discussion can provide valuable qualitative information for better documenting the informal saving groups performances

<p>FNS&CCR - SE 3. # of policies, norms and practices changes for more inclusive and sustainable economies</p>
<p>Why this indicator? What will it measure and provide information for?</p> <p>CARE's vision of a just world emphasizes on promoting good governance in each of its programming sectors, by a) empowering poor people to know and act on their rights and present their interests, b) influencing those in power (public servants and politicians, traditional/faith leaders, and private sector actors) to be more responsible, responsive and accountable, and c) brokering linkages and convening spaces which enable effective and inclusive relations and negotiation between project participants and power holders.</p>
<p>What Sustainable Development Goal is the indicator connected to?</p> <ul style="list-style-type: none"> • SDG Goal 1 • SDG Goal 8
<p>Definitions and key terms</p> <p>Inclusive: economies that enable effective and meaningful participation of women, men, youth, communities and private sector and public policies design, implementation, monitoring and review</p> <p>Sustainable: economies that are</p> <p>Practices: effective application and use of adopted policies (as sometimes rules are set, but not effectively or appropriately applied)</p>
<p>Data and information required to calculate the indicator</p> <p>count of changes in policies;</p> <p>log of norms and practices that have changed for more inclusive and sustainable economies</p>
<p>Suggested method for data collection</p> <ul style="list-style-type: none"> • Log / database for policy changes • Qualitative data collection (survey interviews) on changes in norms and practices

<p>Possible data sources</p> <ul style="list-style-type: none"> • Annual CARE survey or survey by CARE partners on norms and behavior. • Policy review by CARE or partners.
<p>Resources needed for data collection</p> <p>The quantitative and qualitative data collection will have to be conducted by CARE and partners. It needs to be included in the monitoring and evaluation plan and budgeted for.</p>
<p>Reporting results for this indicator: number of people for which the change happened</p> <p>Reporting Purpose: - Baseline - Progress - Evaluation</p> <p>Number policies, norms and practices changed/adopted that ensure more inclusive and sustainable economies</p> <ul style="list-style-type: none"> • Number of male and female who effectively benefit from changed/adopted policies and practices
<p>Questions for guiding the analysis and interpretation of data (explaining the how and why the change happened, and how CARE contributed to the change)</p> <p>What changes have happened in policies, norms and practices that support a stronger economic power of women in their communities?</p> <p>What changes have happened in men's attitudes towards women's economic participation and economic / financial decision making?</p>
<p>Other considerations</p> <p>Social norms are, in certain contexts, deeply rooted in centuries of communities' history and bringing change to these societal constructions may require long, hard and continuous long term effort. Thus, where appropriate proxy indicators should be used for documenting project impacts.</p>

<p>FNS&CCR - SE 4. # of sustainable enterprises supported contributing to FNS&CCR outcomes</p>
<p>Why this indicator? What will it measure and provide information for?</p> <p>Ending poverty can't be achieved without a local development environment which ensures a stable and competitive improved production, and increased service provision and market access opportunities, equally for men, women and youth. Markets, must work with and for the poorest in order to ensure productive and profitable livelihoods that can help end poverty.</p> <p>This is to encourage the use of a market based mechanism to sustain our work in development.</p>
<p>What Sustainable Development Goal is the indicator connected to?</p> <ul style="list-style-type: none"> • SDG Goal 1 • SDG Goal 8
<p>Definitions and key terms</p> <p>Sustainable: [From an economic point of view, you might want to define it depending on what stage the business is in: pre start up, start up, profitable business etc. For a mature business, sustainability includes financial viability (ratio profit/operating costs) and sustained profitability (trend of profit and growth), but for a start-up, you might want to look at growth rate, equity, ratio investment/profit, business plan/strategy in place, ratio profit/operating costs]. Relevant skills of entrepreneur and her/his perception about future viability and vision for growth business development are useful indicators, too.]</p> <p>Enterprise: [CARE supports a variety of enterprises, but primarily micro enterprises or subsistence enterprise (starting with one entrepreneur doing something in addition to household chores or other work). So, maybe refer to that, but include larger ones as well].</p>
<p>Data and information required to calculate the indicator</p> <ul style="list-style-type: none"> • Survey data collected by CARE or CARE partners annually, broken down by sex
<p>Suggested method for data collection</p> <ul style="list-style-type: none"> • Survey among supported entrepreneurs annually
<p>Possible data sources</p> <ul style="list-style-type: none"> • Survey data and statistical data from community, municipal and national level • Supported entrepreneurs surveys databases, broken down by sex

<p>Resources needed for data collection</p> <p>The quantitative and qualitative data collection will have to be conducted by CARE and partners. It needs to be included in the monitoring and evaluation plan and budgeted for.</p>
<p>Reporting results for this indicator: number of people for which the change happened</p> <p>Reporting Purpose: - Baseline - Progress - Evaluation</p> <p>Number of new effective enterprises created or effective enterprises supported</p> <p>[effective = annual increase in profitability; enterprise improving practices as a result of business development, of micro/small/medium enterprises diversified).</p> <p>Number of new sustainable enterprises created [contributing to FNS&CCR outcomes]</p> <p>Number of sustainable enterprises supported [contributing to FNS&CCR outcomes]</p> <p>[sustainable start up = annual growth rate, equity, ratio investment/profit, business plan/strategy in place, ratio profit/operating costs; sustainable scale up business = monthly trend in customers (churn rate), financial viability (ratio profit/operating costs) and sustained profitability (trend of profit and growth), growth rate[expected to rise sharply]; evidence of testing and revision approach or product;</p> <p>sustainable business = financial viability and sustained profitability, growth rate [expected to saturate]; evidence of testing and revision approach or product]</p> <p>Female entrepreneurs have relevant skills to run business profitable</p>
<p>Questions for guiding the analysis and interpretation of data (explaining the how and why the change happened, and how CARE contributed to the change)</p> <ul style="list-style-type: none"> • Do you run a micro-enterprise? • Is your micro-enterprise annually growing and profitable? • Do you have a business plan/strategy for your enterprise? • Is your customers' base growing annually? • Are your annual sales growing?
<p>Other considerations</p>

<p>FNS&CCR - SE 5. # of new employment created for impact population (women, youth)</p>
<p>Why this indicator? What will it measure and provide information for?</p> <p>Employment can be self-employment, informal or formal employment with wages. This helps to emphasize employment creation in addition to micro and small enterprise development.</p>
<p>What Sustainable Development Goal is the indicator connected to?</p> <p>SDG Goal 1 and 8</p>
<p>Definitions and key terms</p> <p>Employment: temporary? Or do we want to prescribe minimum time?</p>
<p>Data and information required to calculate the indicator</p>
<p>Suggested method for data collection</p> <ul style="list-style-type: none"> • Survey among representative sample of target group annually
<p>Possible data sources</p> <ul style="list-style-type: none"> • survey data
<p>Resources needed for data collection</p> <p>The quantitative and qualitative data collection will have to be conducted by CARE and partners. It needs to be included in the monitoring and evaluation plan and budgeted for.</p>
<p>Reporting results for this indicator: number of people for which the change happened</p>

Questions for guiding the analysis and interpretation of data (explaining the how and why the change happened, and how CARE contributed to the change)

Other considerations

FNS&CCR - SE 6. % of adults actively using a financial services (formal and informal, including a mobile money services) in the past 12 months

Why this indicator? What will it measure and provide information for?

This indicator is relevant for financial inclusion programs/projects which aim to ensure equal access to and use of financial services. Access to financial services allows for a better planning of the economy and the ability to invest in business. It gives people a better opportunity to deal with fluctuating incomes and provides a safety net during difficult periods. It also makes bigger loans and savings possible than what is offered by the VSLAs. It also addresses some of the safety concerns attached to having large amounts of cash at home.

What Sustainable Development Goal is the indicator connected to?

SDG 8: Inclusive and sustainable economic growth, indicator 8.10.2 (green list, Nov 2015)

Also linked to SDG 5 “Achieve gender equality and empower all women and girls” and SDG 8 “Promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all”. Yet, not actually listed amongst the SDG indicators.

Definitions and key terms

Financial services: Financial services are economic activities and services provided by the finance industry and include business, credit union, banking service, insurance, accountancy, stocks and investments. The services include savings or deposit services, payment and transfer services, credit and insurance. The relevant financial services will be contexts specific. Only financial services that are considered beneficial to women should be included.

Informal financial services: Informal financial services are those that are provided outside the structure of government regulation and supervision.

Formal financial services: Formal financial services are economic services provided by financial institutions regulated and supervised by government, semi-formal financial services are not regulated by banking authorities but are usually licensed and supervised by other government agencies.

Data and information required to calculate the indicator

- Number of people that have actively used a financial service over the past 12 months
- Denominator: total number of people surveyed

Suggested method for data collection

- The relevant financial services to be measured should be discussed and agreed with representatives of the impact group. It is important that financial services considered negative or exploitative are excluded. This could be part of a gender analysis.
- The information should be collected from a representative sample of the impact group.
- The data should be collected at baseline, then followed up annually (but will depend on the country context).
- Qualitative methods like focus group discussions and key informants interviews should supplement the quantitative data collection to provide a better understanding of barriers and potential negative consequences of inclusion in financial services.

Possible data sources

- Annual survey data collected by CARE or CARE partner

Resources needed for data collection

The quantitative and qualitative data collection will have to be conducted by CARE and partners. It needs to be included in the monitoring and evaluation plan and budgeted for.

Reporting results for this indicator: number of people for which the change happened

Reporting Purpose: - Baseline - Progress - Evaluation

Proportion changes in the number of project participants actively using at least one formal or informal financial service:

- Numerator: Number women, men, girls and boys actively using a least one formal or informal financial service
- Denominator: Number of women, men, girls and boys supported by the project

Questions for guiding the analysis and interpretation of data (explaining the how and why the change happened, and how CARE contributed to the change)

- What is the number of project participants (women, men, girls and boys) who actively use informal financial services?
- What is the number of project participants (women, men, girls and boys) who actively use formal financial services? What contributed to the change in the active use of formal financial services by (women, men, girls and boys)?
- What contributed to the change in the active use of formal financial services by (women, men, girls and boys)?
- Has the overall accessibility (independent of CARE) of informal and formal financial services increased in the same period for women, men, girls and boys?
- What are the types of financial services that have seen a noticeable increase or decrease in use for women, men, girls and boys?
- From the qualitative data: What are barriers for women's and adolescent girls' use of financial services?
- Are there any negative consequences of using financial service women and adolescent girls? What are the recommendations from women and youth (girls and boys) on the utilization of formal and informal financial services?

Other considerations

- If data about repayment rate of loans or information about women who fail to pay on time (past dues) is available, this should be added to the analysis of the data as it sheds light on the appropriateness of the levels of the loans.
- If data about the opportunities access to financial services have given to women is available, this should be added to the analysis.
- The appropriateness of the products in the market could also be considered.
- Care needs to be taken when planning and conducting data collection (quantitative and qualitative) to avoid leading questions.

Domain 3 – Humanitarian Action

FNS&CCR - HUM 1. Food Consumption Score

Why this indicator? What will it measure and provide information for?

Developed by WFP. Percentage of households with sufficient food consumption. Food access indicator, based on both dietary diversity, and the frequency of food groups consumed. The FCS is a score calculated using the frequency of consumption of different food groups consumed by a household during the 7 days before the survey. The FCS is used to classify the observed population into three groups (with poor, borderline and acceptable consumption).

What Sustainable Development Goal is the indicator connected to?

- SDG Goal 2

Definitions and key terms

The Food Consumption Score (FCS) is a proxy indicator of household food security based on the **weighted frequency** (no. of days in a week) of intake of 8 different **food groups**

<p>Data and information required to calculate the indicator</p> <ul style="list-style-type: none"> • Numerator: the number/percentage of people with poor, borderline or acceptable FCS index • Denominator: The total number of surveyed people
<p>Suggested method for data collection</p> <ul style="list-style-type: none"> • WFP (for method): http://documents.wfp.org/stellent/groups/public/documents/manual_guide_proced/wfp197216.pdf
<p>Possible data sources</p> <ul style="list-style-type: none"> • Primary data collection: project household surveys • Secondary data • Local/national/regional food security assessments
<p>Resources needed for data collection</p> <p>The quantitative and qualitative data collection, storage and analysis will have to be conducted by CARE and partners (potentially including research / university partners). It needs to be included in the monitoring and evaluation plan and budgeted for.</p>
<p>Reporting results for this indicator: number of people for which the change happened</p> <ul style="list-style-type: none"> • Reporting Purpose: - Baseline - Progress - Evaluation • Baseline: How have food consumption patterns changed as a result of the crisis? • Progress: Measuring results attributable to projects that aim to improve access to food? • Evaluation: Measuring the impact of projects in improving food access
<p>Questions for guiding the analysis and interpretation of data (explaining the how and why the change happened, and how CARE contributed to the change)</p> <ul style="list-style-type: none"> • What food items did you eat during the last 7 days? • How many times a day did you eat each of them during in your household during the last 7 days? • Listed food items should be classified by food group and the appropriate ranking applied (please refer to the tool guidance notes) <p>This indicator provides information on the frequency and diversity consumed food by people in specific geographical area and ultimately the quality of their diet</p>
<p>Other considerations</p> <ul style="list-style-type: none"> • Food access can be affected by several factors such as insecurity, markets' functionality, poverty, social discrimination. Thus, qualitative data collection is highly recommended to triangulate FCS score findings • Also, food availability and access is highly seasonal in developing countries, and more pronounced in fragile states. Therefore, it is highly recommended to carry diachronic FCS assessments during the same period of the year to allow data relevant data comparison over a period of time • The FCS does not consider foods consumed outside of the household; • It does not provide any information on intra-household food distribution; • It does not provide any information on intra-household food distribution; • By collecting data on the number of days each food item was consumed in the last 7 days, it makes it impossible to consider quantity of food eaten; • By using a seven day recall period, it provides a short term picture of food security irrespective of seasonality.

FNS&CCR - HUM 2. Household Dietary Diversity Score (HDDS)
<p>Why this indicator? What will it measure and provide information for?</p> <p>Used by WFP and FAO for food security assessments in emergencies the Household Dietary Diversity Score is a qualitative measure of food consumption that reflects household access to a variety of foods, and is also a proxy for nutrient adequacy of the diet of individuals. The dietary diversity questionnaire represents a rapid, user-friendly and easily administered low-cost assessment tool. Scoring and analysis of the information collected with the questionnaire is straightforward. It focuses on energy and micro-nutrients. The HDDS is often used to measure dietary diversity of children and adult women. It is the simple sum of the number of food groups (from 0 to 12) consumed at household level, based on a 24h recall.</p>
<p>What Sustainable Development Goal is the indicator connected to?</p> <ul style="list-style-type: none"> • SDG Goal 2
<p>Definitions and key terms</p> <p>Household dietary diversity, defined as the number of unique foods consumed by household members over a given period (24h recall).</p>
<p>Data and information required to calculate the indicator</p> <ul style="list-style-type: none"> • Food consumption patterns before the crisis in the specific cultural, social and economic context of the affected area/community • Food consumption patterns changes as the result of the crisis • Sex disaggregation: women and male
<p>Suggested method for data collection</p> <ul style="list-style-type: none"> • Primary data collection: household survey • Secondary data analysis. • For more information: http://www.fao.org/docrep/014/i1983e/i1983e00.pdf • Qualitative methods like focus group discussions and key informants interviews should supplement the quantitative data collection to provide a better understanding of barriers to food access.
<p>Possible data sources</p> <ul style="list-style-type: none"> • Primary data collection: household survey • Secondary data analysis. • Food Security surveillance / early warning systems: IPC, cadre harmonize, etc. • Qualitative methods like focus group discussions and key informants interviews should supplement the quantitative data collection to provide a better understanding of barriers to food access.
<p>Resources needed for data collection</p> <p>The quantitative and qualitative data collection, storage and analysis will have to be conducted by CARE and partners (potentially including research / university partners). It needs to be included in the monitoring and evaluation plan and budgeted for.</p>
<p>Reporting results for this indicator: number of people for which the change happened</p> <ul style="list-style-type: none"> • Changes in food consumption patterns, especially the increase in the frequency and diversity of consumed food groups
<p>Questions for guiding the analysis and interpretation of data (explaining the how and why the change happened, and how CARE contributed to the change)</p> <ul style="list-style-type: none"> • Baseline: How have food consumption patterns changed as a result of the crisis? How were food consumption patterns before the crisis? • Progress: What are changes in food consumption patterns that are attributable to projects that aim to improve access to food? • Evaluation: How projects have contributed to improving diversified food access in supported communities?

Other considerations

- Food access can be affected by several factors such as insecurity, markets' functionality, poverty, social discrimination. Thus, qualitative data collection is highly recommended to triangulate FCS score findings
- Also, food availability and access is highly seasonal in developing countries, and more pronounced in fragile states. Therefore, it is highly recommended to carry diachronic FCS assessments during the same period of the year to allow data relevant data comparison over a period of time

FNS&CCR - HUM 3. Coping strategies Index (household asset base and coping ability)

Why this indicator? What will it measure and provide information for?

Developed by WFP and CARE, the Coping Strategies Index (CSI) is an indicator of household food security that is relatively simple and quick to use, straightforward to understand, and correlates well with more complex measures of food security. Indeed, affected households may use coping strategies to deal with a reduced ability to access food.

Understanding the extent to which coping strategies are used can provide a quick indication of the level of food insecurity which is immediately useful for programmatic decision-making. Coping strategies can also be used to measure the /results impact of humanitarian assistance which can be assessed through several indicators, including the reduced Coping Strategy Index, the Household Hunger Scale or similar hunger experience indicator.

The CSI measures behavior change: the things that people do when they cannot access enough food. There are a number of fairly regular behavioral responses to food insecurity - or coping strategies - that people use to manage household food shortage. These coping strategies are easy to observe. It is quicker, simpler, and cheaper to collect information on coping strategies than on actual household food consumption levels.

What Sustainable Development Goal is the indicator connected to?

- SDG Goal 2

Definitions and key terms

The **Coping Strategies Index** (CSI) is a tool that measures what people do when they cannot access enough food.

Data and information required to calculate the indicator

- Behaviors applied to cover food and non-food items prior to the crisis under social, cultural, natural and economic context of the affected community/area
- Behaviors applied to cover food and non-food items prior to the crisis under social, cultural, natural and economic context of the affected community/area as a result of a crisis

Suggested method for data collection

- Primary data collection: household survey
- Secondary data analysis.
- For more information WFP: <http://bit.ly/12WYbdi>

Qualitative methods like focus group discussions and key informants interviews should supplement the quantitative data collection to provide a better understanding of barriers to food access.

Possible data sources

- Primary data collection: household survey
- Secondary data analysis.
- Food Security surveillance / early warning systems: IPC, cadre harmonisé, etc.
- Qualitative methods like focus group discussions and key informants interviews should supplement the quantitative data collection to provide a better understanding of barriers to food access.

<p>Resources needed for data collection</p> <p>The quantitative and qualitative data collection, storage and analysis will have to be conducted by CARE and partners (potentially including research / university partners). It needs to be included in the monitoring and evaluation plan and budgeted for.</p>
<p>Reporting results for this indicator: number of people for which the change happened</p> <ul style="list-style-type: none"> • Changes in behavior to cover food and non-food items, especially the decrease in the use of <i>negative or non-reversible</i> coping strategies as result of a humanitarian assistance
<p>Questions for guiding the analysis and interpretation of data (explaining the how and why the change happened, and how CARE contributed to the change)</p> <ul style="list-style-type: none"> • Reporting Purpose: - Baseline - Progress - Evaluation • Baseline: what were the behaviors applied to cover food and non-food items gaps before the crisis? What are behaviors applied to cover food and non-food items gaps as a result of the crisis? • Progress: Have pre-crisis behaviors change re-established? • Evaluation: Has provided humanitarian assistance triggered a decrease in the use of “negative or non-reversible” coping strategies?
<p>Other considerations</p> <ul style="list-style-type: none"> • Food access can be affected by several factors such as insecurity, markets’ functionality, poverty, social discrimination. Thus, qualitative data collection is highly recommended to triangulate FCS score findings • Also, food availability and access is highly seasonal in developing countries, and more pronounced in fragile states. Therefore, it is highly recommended to carry diachronic FCS assessments during the same period of the year to allow data relevant data comparison over a period of time

<p>FNS&CCR - HUM 4. Livelihood Protection Deficit</p>
<p>Why this indicator? What will it measure and provide information for?</p> <p>This indicator uses the household economy approach (HEA) methodology to determine households’ survival and livelihoods protection thresholds and with shocks, their ability to meet their needs, using their coping strategies, as per the baseline. People’s ability to gain access to enough food, rather than only their ability to produce it themselves, determines their level of food security. The Household Economy Approach is a livelihoods-based framework for analyzing the way people obtain access to the things they need to survive and prosper.</p>
<p>What Sustainable Development Goal is the indicator connected to?</p> <ul style="list-style-type: none"> • SDG Goal 1 • SDG Goal 2
<p>Definitions and key terms</p> <p>A livelihood protection deficit means that total resources are insufficient to cover both livelihood expenditures and survival costs. Households may have enough to meet their survival needs but income is insufficient to pay for necessary livelihood inputs as well as school fees and medicine.</p>
<p>Data and information required to calculate the indicator</p>
<p>Suggested method for data collection</p>
<p>Possible data sources</p>
<p>Resources needed for data collection</p>
<p>Reporting results for this indicator: number of people for which the change happened</p> <ul style="list-style-type: none"> • Change in expenditure patterns in % terms, especially on items such as food, health, education, housing, transportation, clothing fuel and water among others. • Change in % share devoted to food is a proxy of food insecurity. When a HH spend more than 75% of its resources on food other essential expenses have to be cut thus undermining the welfare of its individuals.

Questions for guiding the analysis and interpretation of data (explaining the how and why the change happened, and how CARE contributed to the change)

- Baseline: How did people meet their needs prior to the crisis?
- Progress: Have post-crisis levels been re-established?

Other considerations

FNS&CCR - HUM 5. Quantity of food consumed in terms of Kcals per person per day

Guidance not finalized

FNS&CCR - HUM 6. Livelihood change (strategies and assets)

Guidance not finalized

Women’s Economic Empowerment - supplementary indicators

WEE supplementary indicators are to be used to complement the WEE Global Indicators. They are optional and can be used if they are relevant to the project strategy - in addition to one of the three WEE Global Indicators.

The ‘menu’ presented below outlines the indicators and the WEE Pathways the indicator is applicable for in order to make it easier for Project Managers and Funding Officers to choose an indicator relevant to their project. Finally, the menu includes suggestions for methods and tools for data collection. Please note these are just suggestions and need to be adapted to the project’s context. In case the indicator requires proxy-questions (i.e. indicator cannot be directly translated into a question), the last column in the menu also suggests questions to track the indicator.

Important note: in case a WEE project is not in a position to incorporate and measure on any of the three WEE Global Indicators, it must report on another Global Indicator or at least one of the WEE supplementary indicators. Please use as few indicators as possible but, at the same time, as many as you need to provide evidence for all key objectives of the project.

The fewer indicators you have to monitor, the more you can focus on high quality data!

Even though most WEE indicators are focused on women only, data should be collected both for men (males aged 15 to 49 -younger age should be reported as boys) and women (females aged 15 to 49 - younger age should be reported as girls). This in order to understand gender equality in the program context and to understand the composition of the population that CARE aims at impacting.

In most cases, indicators are expressed both in total number and percentage. Both figures are necessary as the former shows the number of people who are experiencing change but the percentage figure allows to determine the size of the impact/outcomes in relation to the program’s target population.

Indicator	applicable for WEE Pathway	<p style="text-align: center;">1. Suggested methods and tools for data collection</p> <p style="text-align: center;">2. Suggested question to track indicator</p> <p style="text-align: center;">3. Further guidance on data analysis and definition of key terms</p>
<p>WEE 1. # and % of women and men reporting net income increase per day; and US\$ value of increase</p> <p>[from selling product or service, from formal/informal employment]</p> <p>[calculation of gender pay gap]</p>	<p>DW, RM, VC, ENT¹¹</p>	<p>1. Baseline and end line survey among representative sample of project participants. If you don't have baseline data, ask for income before project start and now. You can use national/local statistics on net income, but please try to verify using survey data.</p> <p>2. (1) <i>What do you earn now on a typical day from selling [specify product or service] – or from your employment?</i>; If baseline data is not available: <i>What did you earn on a typical day before joining the project?</i>; (2) <i>Have your working hours changed (increased/decreased)?</i>.</p> <p>3. Please count # women who report net income increase. To calculate % please use numerator = sum of women who report increased income, denominator = sum of women surveyed. Please document US\$ value of net income for men and women separately, calculate increase for men and women at baseline and end line and compare to know increase. Please calculate gender pay gap by comparing income difference between men and women (% of women's income from men's income for same job/source of income: numerator = sum of women's income, denominator = sum of men's income); Please ask for income in local currency and transfer to US\$ at current exchange rate in your analysis. If sale of seasonal product, ask for high and low season income and for alternative income source for respondent and family. To analyze increase/reduction, please compare baseline and end line numbers and indicate trend. Please survey all genders. Please investigate any reduction in pay and any increase in working hours (should not be more than 60 hours/week (ILO standard) as more can be potentially harmful); Net income = income after tax and other expenses net hourly pay from any economic activity. Income can be from any kind of economic activity, e.g. selling product or service, formal/informal employment. Please document in case net income at end line is below or above living wage (ILO standard).</p>

¹¹ DW = dignified work, RM = resilient markets, VC = women and value chains, ENT = female entrepreneurship

Indicator	applicable for WEE Pathway	<p style="text-align: center;">1. Suggested methods and tools for data collection</p> <p style="text-align: center;">2. Suggested question to track indicator</p> <p style="text-align: center;">3. Further guidance on data analysis and definition of key terms</p>
<p>WEE 2. # and % of women and men who have increased capability to perform economic activity</p>	<p>VC, ENT, RM</p>	<p>1. Baseline and end line survey among a representative sample of participants in capacity development activities (e.g. training, mentoring, advise or counselling service, rural extension service), participants who receive support to increase productivity/quality of service or product/business management/marketing etc.</p> <p>2. (1) <i>What additional skills have you learned/what skills have you improved thanks to the CARE intervention?</i>; If necessary, you can probe by asking: (1a) <i>Do you think that you now know more about calculating your operating costs, profit, growth rate, return on investment, or do you feel comfortable to develop a business plan or strategy, and whether to continue with a business pilot or not?</i>; (3) <i>Has your weekly net income (US\$) increased thanks to the CARE intervention?</i>; (4) <i>Are you now producing more than before (US\$ value in a typical week)?</i>; (5) <i>Have you been able to increase the quality of your product or service thanks to the CARE intervention? Has this increased your net income?</i>; Please modify questions according to specific skills covered in training/advice/mentoring etc. – the above are just examples; If US\$ is difficult to indicate for respondent, please ask for local currency and transfer to US\$ at current exchange rate. If sale of seasonal product, ask for high and low season income and for alternative income source for respondent and family.</p> <p>3. Please count all genders and disaggregate data by gender; Compare baseline and end line numbers and indicate trend (increase/reduction). You can use post-training/intervention questionnaires.</p> <p><u>Capability</u> to perform economic activity = <u>ability</u> to perform economic activity with increased <u>productivity</u> (increased productivity indicates growing business and is expected to lead to increase in profit; increase productivity can be caused by industrializing, making production more cost-effective and efficient), increased <u>profitability</u> (positive profit indicates healthy business; for this indicator it is measured by net income (i.e. income after tax and other expenses net hourly pay from any economic activity), or increased quality (<u>higher quality of product or service</u> should lead to increase in profit); capability also includes <u>skills, knowledge, financial and other resources, and assets</u>. <u>So, if a woman has at least two of those we can count her as having ‘increase capability’.</u></p> <p>Please ask for local currency and transfer to US\$ at current exchange rate during your data analysis. If sale of seasonal product, ask for high and low season income and for alternative income source for respondent and family.</p> <p>To calculate % please use numerator = sum of women who report increased capability, denominator = sum of women surveyed.</p> <p>This indicator can be used jointly with indicator 3 (below), as economic capability comprises ownership of or control over productive asset etc.</p>

Indicator	applicable for WEE Pathway	<p style="text-align: center;">1. Suggested methods and tools for data collection 2. Suggested question to track indicator 3. Further guidance on data analysis and definition of key terms</p>
WEE 3. # and % of women and men who own or control productive asset (including land)¹²/technology and have the skills to use them productively	VC, RM, ENT, FI ¹³	<p>1. Baseline and end line survey among a representative sample of project participants; Please ask same question to women and male partner/family or community member for triangulation. If available, you can also use land registry data or similar from local authorities, but please verify using survey data.</p> <p>2. (1) <i>Who in your HH owns (a) agricultural tools/seeds/machinery, (b) land that you cultivate, (c) technology used in your business, (d) assets in used in your business?</i> Please modify questions by using specific examples of input, technology or assets relevant in this context; (2) <i>Do you know how to productively use asset or technology?</i>; (3) <i>Is there anything you don't know about using it – or anything you would like to know in addition?</i></p> <p>3. Ownership = belongs to women, her name is on land title deeds; Productive asset = any machinery or item that is used to generate income, e.g. for a hairdresser equipment, restaurant cooking equipment, agricultural machinery, seeds, etc.; Productive technology = any technology that is used to generate income (e.g. accounting software). This indicator can be used jointly with indicator 2 (above), as economic capability comprises ownership of or control over productive asset. For analysis of increase/reduction, please compare baseline and end line numbers and indicate trend.</p>
WEE 4. # and % of women and men who have universal access to social protection services relevant to their occupation	DW, RM, VC, ENT	<p>1. Baseline and end line survey among a representative sample of project participants. Alternatively, you can request this information from government, but try to verify (e.g. by survey among representative population or employee sample).</p> <p>2. (1) <i>Do you have universal access to (a) paid annual leave, (b) paid sick leave, (c) pension, (d) health care/ insurance, (e) accident insurance, (f) paid maternity/paternity leave?</i> Please add other social protection services that are relevant in the project context; Alternatively ask for each relevant social protection service: (2) <i>Do you benefit from a policy for paid sick or annual leave, pension, health care, accident/health insurance?</i>; (3) <i>Do you use it?</i>; (4) <i>Could it be improved in any way?</i></p> <p>3. Health and accident insurance/care should be universally accessible to domestic workers and sex workers, so please include these occupations; Universal access = is not just limited to current employer. It is important to include domestic workers and workers in the informal sector in the survey. Please survey all genders and disaggregate data by gender. To analyze increase/reduction, please compare baseline and end line numbers and indicate trend.</p>

¹² Informs SDG indicator 5.a 1 (b) 'share of women among owners or rights-bearers of agricultural land, by type of tenure' (global data collected by FAO, UN Women).

¹³ FI = financial inclusion

Indicator	applicable for WEE Pathway	<p style="text-align: center;">1. Suggested methods and tools for data collection 2. Suggested question to track indicator 3. Further guidance on data analysis and definition of key terms</p>
<p>WEE 5. # and % of women and men who are aware of/understand gender barriers at workplace</p>	<p>DW, VC, ENT</p>	<p>1. Baseline and end line survey among representative sample of project participants.</p> <p>2. (1) <i>From your perspective, what are major barriers at the workplace for women in general?</i>; If necessary, please unpack question/probe for potential barriers; please modify or add questions to suit specific context: (2) <i>What challenges do women face in formal employment, informal employment, domestic work, employment in agriculture (e.g. buying or owning land, access to agricultural extension services, access to market, training, power to decide what to do with own income, getting a paid job, balancing burden of unpaid care work, accessing formal sector jobs (or having to work informally near the home to juggle care demands), working in male-dominated industries, getting promotion and senior positions, getting better paid and more skilled positions, accessing male dominated departments and job types, equal pay, maternity benefits, representation and voice, harassment, GBV, controlling how wages are used in the home)?</i>; (3) <i>What challenges do women face when running a business (e.g. access to information, access to training, registering a business in their own name/owning a business, having a bank account in their own name)?</i>; (4) <i>What challenges do women face when trying to get into a senior political or economic position?</i>; (5) <i>What is dominant public attitude towards women running a business/in a senior political or economic position?</i></p> <p>3. Gender barrier = any kind of obstacle that prevents women from (a) accessing employment or income generating activity equally to men, (b) fair and equal treatment at work (e.g. equal pay , promotion to senior positions, social protection services, (c) control over income and productive assets.</p> <p>To analyze increase/reduction, please compare baseline and end line numbers and indicate trend; To calculate % please use numerator = total # of women who are aware of/understand gender barriers at work, denominator = total # of women surveyed.</p> <p>This indicator can be used jointly with indicator GE/Governance indicator #20, as awareness of barriers can be the first step towards removal of the same barriers brought about by change in policy or legislation.</p>
<p>WEE 6. # and % of women and men in managerial/senior decision-making position</p> <p>[in company, enterprise, producer group, cooperative, VSLA etc.]</p>	<p>VC, ENT, DW, FI</p>	<p>1. Baseline and end line survey among a representative sample of companies, enterprises, groups etc. that CARE works with; Alternatively, you can request this information from the company or group leader, but try to verify (e.g. list of members, terms of reference, members' survey etc.); Compare baseline and end line #s and indicate trend (increase/reduction).</p> <p>3. managerial position = all positions above middle-management/managerial/supervisor positions in company or enterprise or producer group (e.g. head of team, director, board member, head/chair of group (also VSLA) or committee; also supervision and all senior roles (i.e. any role that has significant decision making power).</p> <p>To analyze increase/reduction, please compare baseline and end line numbers and indicate trend.</p> <p>To calculate % please use numerator = total # of women in managerial positions, denominator = total # of managerial positions available in all companies and enterprises CARE works with.</p>

CARE Approach: Gender Equality and Women's Voice - supplementary indicators

GEVV 1. Average total # and proportion of weekly hours spent on unpaid domestic and care work, by sex, age and location (for individuals five years and above)
<p>Why this indicator? What will it measure and provide information for?</p> <p>The provision of unpaid care and domestic work has a profound implication on our understanding of poverty and well-being. As a result of their socially ascribed roles, women and girls do the bulk of unpaid care and domestic work, which includes household maintenance activities such as cooking and cleaning as well as person-to-person care activities such as child and elder care. Producing time use statistics thus contributes to increasing the visibility of women's work through better statistics on their contribution to the economy – with particular emphasis on the value of goods and services they produce (sourced from SDG Meta Data).</p>
<p>What Sustainable Development Goal is the indicator connected to?</p> <p>SDG Indicator 5.4.1</p>
<p>Definitions and key terms</p> <p>Unpaid domestic and care work activities include the unpaid production of goods for own final consumption, these include:</p> <ul style="list-style-type: none"> – Unpaid work that involves the production of goods for self-consumption (e.g., collecting water or firewood); – Unpaid work that involves the provision of services for self-consumption (e.g., cooking or cleaning as well as person-to-person care for other people); and – 'Voluntary work' which consists of service or activity undertaken without pay for the benefit of the community, the environment, and persons other than close relatives or those within the household
<p>Data and information required to calculate the indicator</p> <p>Collected data from surveyed population on hours spent weekly (or possible to use a 24-hour diary and adjust as needed).</p> <p>Numerator: total number of hours spent on unpaid domestic and care work</p> <p>Denominator: total number of hours in the week</p>
<p>Suggested method for data collection</p> <p>HH Survey</p> <p>Recognizing the time-intensive nature of doing a comprehensive time analysis, one adaptation to consider if this is not a possibility is a card-sorting exercise. This can be used to highlight the activities that take the greatest amount of time for each target segment (e.g., men, women, boys, and girls) of interest.</p> <p>To do so, have a set of cards – on each card have a picture of an activity (e.g., collecting water, drinking tea, cooking, taking care of children, socializing with friends and neighbors, doing school-work). Ask participants to choose and rank the top 5 cards according to how much time they spend doing these activities in an average day.</p> <p>Use qualitative methods to investigate key points of interest that arise out of this exercise.</p>
<p>Possible data sources</p> <p>At the international level, UN Women, UNDP and UNSD have compiled statistics from national and international surveys on time use.</p>
<p>Resources needed for data collection</p> <p>This indicator is generally derived through time use surveys or time use modules in general purpose or labor force surveys. Multi-purpose household surveys can also be used to produce time use statistics, for example through a modular approach [2].</p>
<p>Reporting results for this indicator: number of people for which the change happened</p> <p>A change in the total and percentage of hours spent on un-paid care. Data should be reported disaggregated by age and sex to the degree possible.</p>
<p>Questions for guiding the analysis and interpretation of data (explaining the how and why the change happened, and how CARE contributed to the change)</p> <p>Has CARE implemented activities and/or interventions amongst the survey group demonstrating the change? If so, were these interventions intended to promote more gender-equitable roles? If so, how and for how long? Are other organizations working to promote gender equality (or specifically focused on roles or division of labor) within the same community? Amongst the same people? Is there a comparison group to demonstrate that CARE's interventions within this area can be correlated with an increase in more gender-equitable roles or sharing or responsibilities with some evidence?</p>

Other considerations:

This supplementary indicator will be shared with WEE.

Time surveys are difficult and we should consider “primary” and “secondary” activities to get a correct estimate (e.g. a woman engaged in agricultural or micro-enterprise work where she is simultaneously caring for her child, which thus limits her productivity and possibilities in the “paid” work...etc.). Further guidance on how to collect and analyze time-use data can be accessed from UNSTAT [here](#) including a sample reporting form on pg. 235.

GEVV 2: % of individual reporting high self-efficacy (SADD)**Why this indicator? What will it measure and provide information for?**

This indicator looks specifically at individual self-efficacy and was chosen to look at changes over time in the percentage of individuals that report high self-efficacy. Self-efficacy (defined below), has been defined and studied by many ranging from psychologists to behavior change specialists, to those engaged in development and humanitarian work. Recognizing the instrumental role that self-efficacy has on all human endeavors, their power with and over other individuals, and their relationships with individuals, groups, and entities in their lives, this indicator was selected to help us look more closely as changes in perceived high-self efficacy among CARE project direct and indirect participants over time. Information and data collected against this indicator will CARE staff and programmers to understand more about the inter-relationships between groups’ individual perceived self-efficacy and the correlation(s) this may have with behaviors of interest (e.g., health practices and behaviors).

What Sustainable Development Goal is the indicator connected to?

WEE has several indicators that look at individual capability as it relates to fiscal autonomy and productive assets.

Definitions and key terms

Self-efficacy: Is one’s individual belief in their capability to achieve their goals and/or complete tasks.

Data and information required to calculate the indicator

To collect data against this indicator, we recommend using the following measure and likert scale:

Possible option for survey measure/question: Despite the challenges that exist in your life, think about one self-defined goal that you would like to achieve in your personal life over the next year.

How confident are you that you could achieve this goal in your personal life?

- (1. Not at all confident; 2. Somewhat confident; 3. Fairly confident; 4. Very confident; 5. Extremely confident)

Additional suggestions for measures that have been suggested for the humanitarian context (but could be used in longer-term development contexts as well):

How confident are you that you could access education services?

How confident are you that you could access health services without permission if you were ill?

How confident are you that you could leave your home without permission?

Suggested method for data collection

HH Survey

Possible data sources

HH survey

Resources needed for data collection

Significant resources for household surveys would need to be included in the monitoring and evaluation plan and budgeted for, should CARE collect quantitative data.

Reporting results for this indicator: number of people for which the change happened

- A change in the percentage of people (respondents) reporting high self-efficacy.
- An analysis of how CARE contributed to this change.

Questions for guiding the analysis and interpretation of data (explaining the how and why the change happened, and how CARE contributed to the change)

Has CARE implemented activities and/or interventions amongst the survey group demonstrating the change? If so, were these interventions intended to increase self-efficacy or to increase self-efficacy amongst specific individuals or groups (e.g., women and girls)? If so, how and for how long? Are other organizations working to increase self-efficacy within the

same community? Amongst the same people? If so, (or even if not) is there a comparison group to demonstrate that CARE's interventions within this area can be correlated with increases in self-efficacy with some evidence?

Other considerations

WEE also has several indicators that look at individual capability as it relates to fiscal autonomy and productive assets.

GEWV 3. # of countries with laws and regulations that guarantee women aged 15-49 years access to sexual and reproductive health care, information and education

Why this indicator? What will it measure and provide information for?

This indicator is connected with SDG Indicator 5.6.2 and looks to measure against the more 'structures' domain of CARE's Gender Equality Framework. This indicator can constitute several domains and qualitative policy analysis should be used to provide further texture to the understanding and interpretation of the quantitative figures provided.

What Sustainable Development Goal is the indicator connected to?

SDG Indicator 5.6.2

Definitions and key terms

From UNWOMEN: "Legal/regulatory frameworks covered by this indicator include laws and regulations that explicitly guarantee:

1. Access to SRH services without third party authorization (from the spouse, guardian, parents or others);
2. Access to SRH services without restrictions in terms of age and marital status;
3. Access by adolescents to SRH information and education.

Data and information required to calculate the indicator

Access to detailed descriptions of laws and regulations related to SRH care, education, and information within said country.

Special consideration should be made to conduct a thorough policy analysis to discern the degree to which the law and/or policy affects different segments of the population (e.g., adolescents versus adults) differently.

Suggested method for data collection

- **County Office Tracking** (to avoid double-counting); data against laws, regulations and policies should be disaggregated by type (e.g., those ensuring access to: care; education; information).
- Suggest using UNWOMEN/UNFPA criteria to assess the degree to which these laws and regulations are in place.
- CO should conduct complementary qualitative policy analysis to provide more texture to this quantitative indicator data with a particular focus on the degree to which these laws and policies are: 1) adopted, 2) implemented, and if possible, 3) **effective** as well as any limitations or restrictions (e.g. AYSRH).
- Take special note to disaggregate data surrounding the laws/regulations by the area of SRH covered by it (e.g., care and/or information and/or education) as these are different things.

Possible data sources

Originally sourced laws, policies and regulations; third-party (secondary source) policy analyses

Resources needed for data collection

Time; SRHR Policy and Law knowledge

Reporting results for this indicator: number of people for which the change happened

Population estimates should be made based on the # of people affected by said law, policy, or regulation

Questions for guiding the analysis and interpretation of data (explaining the how and why the change happened, and how CARE contributed to the change)

Consider the implications of CARE's efforts to support and/or pass the laws/regulations/policies being reflected. Did CARE have an advocacy role? Did groups supported by CARE have an advocacy role?

If CARE **did not have a role or has not had a role in the past**, then this should be noted upon reporting to ensure that our advocacy efforts are not mis-represented.

Other considerations

Additional guidance including research questions for policy analysis can be found [here](#).

This would be shared with the SRHR outcome area.

GEWV 4: % of individuals who report confidence in their own negotiation and communication skills (SADD)
Why this indicator? What will it measure and provide information for? Focusing this individual agency-related indicator on reported confidence in communication and negotiation as anecdotal and formal evidence suggest that this is one of the areas reported most important by women and girls especially as it relates to their agency and a key asset/skill for all individuals ranging from those working in the marketplace to health service providers and clients.
What Sustainable Development Goal is the indicator connected to? N/A
Definitions and key terms
Data and information required to calculate the indicator To collect data against this indicator it is recommend that the following measures and likert scale be used: How confident do you feel that you can: <ol style="list-style-type: none"> 1. Negotiate for your needs with the head of household 2. Negotiate for my needs within external forums and structures (e.g., local council, NGOs, markets, government, service providers) 3. Negotiate for my wants with the head of household (e.g., within your family, with relatives, household) 4. Negotiate for my wants within external forums and structures (e.g., local council, NGOs, markets, government, service providers) (1. Not at all confident; 2. Somewhat confident, 3. Fairly confident 4. Very confident; 5. extremely confident) To note: in displacement situations, “external forums and structures” can be replaced by community leader. - If the person being asked is the head of household, do not ask 1 or 3
Suggested method for data collection HH survey
Possible data sources HH Survey
Resources needed for data collection Significant resources for household surveys would need to be included in the monitoring and evaluation plan and budgeted for, should CARE collect quantitative data.
Reporting results for this indicator: number of people for which the change happened <ul style="list-style-type: none"> • A change in the percentage of people (respondents) reporting confidence in their communication and negotiation skills. • An analysis of how CARE contributed to this change.
Questions for guiding the analysis and interpretation of data (explaining the how and why the change happened, and how CARE contributed to the change) Has CARE implemented activities and/or interventions amongst the survey group demonstrating the change? If so, were these interventions intended to improve communication and/or negotiation skills? If so, how and for how long? Are other organizations implementing activities to improve communication and negotiation skills within the same community? Amongst the same people? Is there a comparison group to demonstrate that CARE’s interventions within this area can be correlated with an increase in individuals reporting increased confidence in their communication and negotiation skills with supporting evidence?
Other considerations FNS and WEE are looking to include several indicators that look at different domains of skills and productive assets, adaptive capacity/resilience; best just to cross-tag. FNS Indicator 4: Percentage of women farmers with access to, control over, or ownership of a core set of productive resources, assets, and services FNS Indicator 5: Increased adaptive capacity among households and communities dependent on small-scale food production WEE supplementary indicator 1: US\$ value of net income increase per day, by gender; [from selling product or service, from formal/informal employment]; [plus calculation of gender pay gap] WEE supplementary indicator 2: # of women who have increased capability to perform economic activity

WEE supplementary indicator 3: # of women who own or control productive asset (including land)¹⁴/technology and have the skills to use them productively

GEVW 5. % of respondents who report gender equitable attitudes (GEM Scale)

Why this indicator? What will it measure and provide information for?

The 'domestic chores and daily life domain' sub-scale of the Gender Equitable Men (GEM) scale was selected to glean insights about the changing perceptions of roles and responsibilities between men and women among surveyed respondents. While the entire sub-scale could be used (and adapted to the context), this 5-point sub-scale can be used to measure attitudes on a 3-point likert scale of agree-; partially agree; and do not agree.

What Sustainable Development Goal is the indicator connected to?

N/A

Definitions and key terms

'Domestic chores and daily life domain' sub-scale of GEM Scale. While the entire scale could be used and measured against, it is quite large.

<https://www.c-changeprogram.org/content/gender-scales-compendium/pdfs/5.%20Gender%20Norm%20Attitudes%20Scale,%20Gender%20Scales%20Compendium.pdf>

Data and information required to calculate the indicator

How strongly do you agree with the following statements:

1. Changing diapers, giving a bath, and feeding kids is the woman's responsibility
2. A woman's main role responsibility is taking care of her home and family.
3. The man should decide to buy the major household items.
4. A man should have the final word about decisions in his home.
5. A woman should obey her the man/men in her life (e.g., husband, boyfriend, father) in all things.

(1. agree, 2. partially agree, and 3. do not agree)

(High scores represent high support for gender equitable norms. Certain items were reverse scored if a high score would reflect low support for gender equity. Responses to each item were summed.)

Additional recommendations for measures/questions that could be used in the humanitarian context (or longer-term development if applicable and/or appropriate):

MEASURES FOR HUMANITARIAN

1. How has your role in the household changed from before the crisis until now?

2. Do you feel has been a positive or negative change in your life?

(1. Very negative, 2. Negative 3. Neutral 4 Positive 5. Very positive)

3. Do you have more help with your workload?

Yes / No

Suggested method for data collection

HH survey (or survey of target-segmented individuals)

Possible data sources

HH Survey; or additional surveys of the same population area that have included GEM scale measures (less reliable)

Resources needed for data collection

Significant resources for household surveys would need to be included in the monitoring and evaluation plan and budgeted for, should CARE collect quantitative data.

Reporting results for this indicator: number of people for which the change happened

- A change in the percentage of people (respondents) reporting gender-equitable attitudes.

¹⁴ Informs SDG indicator 5.a 1 (b) 'share of women among owners or rights-bearers of agricultural land, by type of tenure' (global data collected by FAO, UN Women).

<ul style="list-style-type: none"> An analysis of how CARE contributed to this change.
<p>Questions for guiding the analysis and interpretation of data (explaining the how and why the change happened, and how CARE contributed to the change)</p> <p>Has CARE implemented activities and/or interventions amongst the survey group demonstrating the change? If so, were these interventions intended to promote more gender-equitable attitudes? If so, how and for how long? Are other organizations working to promote gender equality within the same community? Amongst the same people? Is there a comparison group to demonstrate that CARE’s interventions within this area can be correlated with the increase in gender-equitable behaviors with supporting evidence?</p>
<p>Other considerations</p>

<p>GEVV 6. % of individuals reporting they can rely on a community member in times of need; SADD</p>
<p>Why this indicator? What will it measure and provide information for?</p> <p>This indicator was adapted to look specifically at social capital with our operating hypothesis being that social capital is instrumental to individual and collective agency and also an important illustrator of relationships. Notably, this adaptation of the indicator focuses on being able to rely on community members in times of need, not thinking that they could, or whether or not they have in the last 12 months (as many indicators of social capital do).</p>
<p>What Sustainable Development Goal is the indicator connected to?</p> <p>N/A</p>
<p>Definitions and key terms</p> <p>Social capital: Social capital refers to the norms and networks that enable collective action. Increasing evidence shows that social cohesion — social capital — is critical for poverty alleviation and sustainable human and economic development. (Source from World Bank here: http://www.worldbank.org/en/webarchives/archive?url=httpzxxweb.worldbank.org/archive/website01360/WEB/0_MEN-2.HTM&mdk=23354653)</p>
<p>Data and information required to calculate the indicator</p> <p>How strongly do you agree with the following statement: “I can rely on a community member in a time of need”</p> <p>(1. Strongly disagree; 2. Disagree; 3. Neither agree nor disagree; 4. Agree; 5. Strongly agree)</p> <p>Numerator: total # of individuals reporting that they can rely on a community member in times of need Denominator: total # of surveyed respondents</p> <p>Recommendations for additional qualitative data collection: Where possible use qualitative methods to unpack what type of needs and the social network. How to unpack look at page 15 of WE-MEASR)</p> <p>ALTERNATIVE OPTION FOR MEASURING</p> <p><i>Using a multi-select survey tool function and allowing respondents (and enumerators) to tick all that apply:</i></p> <p>Who would you reach out to if faced with a day-to-day problem?</p> <p>Husband/wife; extended family member; neighbor; friend; community/religious leader; police; other _____</p> <p>Who would you reach out to if you had a critical problem?</p> <p>Husband/wife, extended family member; neighbor; friend; community/religious leader; police; other _____</p>
<p>Suggested method for data collection</p> <p>HH Survey (or survey of target-segmented individuals)</p>
<p>Possible data sources</p> <p>Survey</p>
<p>Resources needed for data collection</p>

Significant resources for household surveys would need to be included in the monitoring and evaluation plan and budgeted for, should CARE collect quantitative data.
<p>Reporting results for this indicator: number of people for which the change happened</p> <ul style="list-style-type: none"> • A change in the percentage of people (respondents) reporting that they could rely on a community member in times of need. • An analysis of how CARE contributed to this change.
<p>Questions for guiding the analysis and interpretation of data (explaining the how and why the change happened, and how CARE contributed to the change)</p> <p>Has CARE implemented activities and/or interventions amongst the survey group demonstrating the change? If so, were these interventions intended to promote more gender-equitable attitudes? If so, how and for how long? Are other organizations working to increase social capital among individuals (participants) within the same community? Amongst the same people? Is there a comparison group to demonstrate that CARE's interventions within this area can be correlated with the increase in perceived social capital with supporting evidence?</p>
<p>Other considerations</p>

<p>GEVW 7. % of individuals reporting that they could work collectively with others in the community to achieve a common goal; SADD</p>
<p>Why this indicator? What will it measure and provide information for?</p> <p>This indicator was adapted in recognition that collective efficacy (beyond individual efficacy) is instrumental to individuals' realization of their human rights as well as health and development outcomes more broadly.</p>
<p>What Sustainable Development Goal is the indicator connected to?</p> <p>N/A</p>
<p>Definitions and key terms</p> <p>Collective efficacy: is the belief that a group has the capability to affect change within their environment; within this is the inherent believe that individual contributions add to the collective effort.</p> <p>This indicator was not pulled from a specific source, but it was adapted from multiple sources of measures looking at social cohesions and collective efficacy including the collective efficacy and collective action sub-scales of WE-MEASR.</p>
<p>Data and information required to calculate the indicator</p> <p>How strongly do you agree with the following statement:</p> <ol style="list-style-type: none"> 1. I could collaborate with other members of the community to address a community need. 2. We can collaborate as a community to improve our quality of life. <p>(1. Strongly disagree; 2. Disagree; 3. Neither agree nor disagree; 4. Agree; 5. Strongly agree)</p> <p>(Consider disaggregation by different associations by identity etc. For guidance on how to unpack, consider looking at page 19 of WE-MEASR).</p> <p><i>Note: There may be different understandings and interpretations of what constitutes 'community' depending on the context, target segment, situation, etc.; to the degree possible, please use the comments and qualitative sections of the PIIRS and supplementary indicator forms to describe what 'community' may constitute in the case of your project (if applicable).</i></p>
<p>Suggested method for data collection</p> <p>HH survey (or survey of target-segmented population)</p>
<p>Possible data sources</p> <p>HH Survey</p>
<p>Resources needed for data collection</p> <p>Significant resources for household surveys would need to be included in the monitoring and evaluation plan and budgeted for, should CARE collect quantitative data.</p>
<p>Reporting results for this indicator: number of people for which the change happened</p>

<ul style="list-style-type: none"> • A change in the percentage of people (respondents) reporting high certainty that they could work collectively with other in the community to achieve a common goal. • An analysis of how CARE contributed to this change.
<p>Questions for guiding the analysis and interpretation of data (explaining the how and why the change happened, and how CARE contributed to the change)</p> <p>Has CARE implemented activities and/or interventions amongst the survey group demonstrating the change? If so, were these interventions intended to promote more gender-equitable attitudes? If so, how and for how long? Are other organizations working to increase collective efficacy among groups (of participants) within the same community? Amongst these same groups? Are there comparison group(s)/communities to demonstrate that CARE's interventions within this area (amongst these group(s)) can be correlated with the increase in perceived collective efficacy with supporting evidence?</p>
<p>Other considerations</p> <p><i>The Inclusive Governance approach supplementary indicators look at organizational capacity and collective action this indicator looks more at collective efficacy (perceptions of collective capability).</i></p>

<p>GEWV 8. # of examples in the media representing relevant norms</p>
<p>Why this indicator? What will it measure and provide information for?</p> <p>Myriad groups within and across CARE are beginning to looking to understand and address the role that social norms play in relation to seeing positive behavior change. Much of CARE's work to-date in the area of social norms measurement has been in recognition that in order to measure changes in social norms, the metrics used must be quite tailored and context specific. In recognition of both this and the surmounting interest (and need) in measuring social norms at an impact level, the idea has been proposed to look at the representation of social norms at an impact level through the lens of mass media. Mass media is an un-tapped space for CARE and the aim is to look at both norms and media throughout the activities recommended to measure against this indicator.</p>
<p>What Sustainable Development Goal is the indicator connected to?</p> <p>N/A</p>
<p>Definitions and key terms</p> <p>Total number of representations of relevant social norms 'flagged' during the FY.</p> <p>Social norms: Social norms are unspoken rules that influence human behavior. They are made up of 2 kinds of expectations we have about other people: 1) what I expect or think other people do, and, 2) what I expect other people think that I should do.</p> <p>Together these social expectations about others tell us whether a behavior or practice is a social norm. Example of a norm: waiting your turn in line at a bank or at a shop in the marketplace. Individuals wait in line for service because everyone else around him/her does, and because they think he/she should, too. We know this because if that person skipped the line, we expect that people around him/her would be upset and would probably voice their disapproval. Changing norms can entail abandoning a norm, or creating a new norm.</p>
<p>Data and information required to calculate the indicator</p> <p>Total number of counted examples (representations) of the identified 'relevant' social norms over the course of the FY (counting period).</p>
<p>Suggested method for data collection</p> <ul style="list-style-type: none"> • Each project should identify the norms they will 'watch' (short exercise prior to the start of implementation) • Each project should then identify which media (e.g., newspaper advertisements, radio, television shows, etc.) they are going to monitor and at what level (e.g., local, national, etc.) • Each project should then assign a staff person to review those identified media on a monthly basis (or other previously established frequency) and count the number of times the relevant norms have been 'flagged' as present in the media channels/platforms being monitored
<p>Possible data sources</p> <p>Project monitoring and evaluation</p>
<p>Resources needed for data collection</p> <p>Time; access to identified media channels/platforms</p>

<p>Reporting results for this indicator: number of people for which the change happened</p> <p>Possible to do population estimates of who can be reached with the media channels/platforms that are being monitored.</p>
<p>Questions for guiding the analysis and interpretation of data (explaining the how and why the change happened, and how CARE contributed to the change)</p> <p>Has CARE implemented activities and/or interventions with an explicit focus on social norms and the representation of social norms in media? Is CARE working with the media on the representation (upholding) of social norms in different media streams/channels/platforms? What does the increase or decrease in the number of social norms reflected in the media tell us about CARE's work in this area? What is the potential impact of this work with the media (e.g., target-segmented population reach, changes in perceptions, attitudes, etc.).</p>
<p>Other considerations</p> <p>This is an area of CARE's work that is being piloted and will require further testing to discern if this measurement approach (and indicator) are functional.</p>

<p>GEVW 9. Proportion of women aged 20-24 years who were married or in a union before age 15 and before age 18</p>
<p>Why this indicator? What will it measure and provide information for?</p> <p>Marriage before the age of 18 is a fundamental violation of human rights. Child marriage often compromises a girl's development by resulting in early pregnancy and social isolation, interrupting her schooling, limiting her opportunities for career and vocational advancement and placing her at increased risk of intimate partner violence. In many cultures, girls reaching puberty are expected to assume gender roles associated with womanhood. These include entering a union and becoming a mother (pulled from SDG justification here).</p>
<p>What Sustainable Development Goal is the indicator connected to?</p> <p>SDG Indicator 5.3.1</p>
<p>Definitions and key terms</p> <p>From SDG: This indicator provides the proportion of women aged 20 to 24 years who were first married or in union by age 18. It is calculated by dividing the number of women aged 20-24 who were first married or in union by age 18 by the total number of women aged 20-24 in the population.</p>
<p>Data and information required to calculate the indicator</p> <p>For proportion married before 15: Numerator: total # of women aged 20-24 who were married before 15 Denominator: total # of women aged 20-24 who were surveyed</p> <p>For proportion married before 18: Numerator: total # of women aged 20-24 who were married before 18 Denominator: total # of women aged 20-24 who were surveyed</p>
<p>Suggested method for data collection</p> <p>HH Survey</p>
<p>Possible data sources</p> <p>MICS; DHS</p>
<p>Resources needed for data collection</p> <p>Significant resources for household surveys would need to be included in the monitoring and evaluation plan and budgeted for, should CARE collect quantitative data.</p>
<p>Reporting results for this indicator: number of people for which the change happened</p> <ul style="list-style-type: none"> • A change in the percentage of people (respondents) reporting high certainty that they could work collectively with other in the community to achieve a common goal. • An analysis of how CARE contributed to this change.
<p>Questions for guiding the analysis and interpretation of data (explaining the how and why the change happened, and how CARE contributed to the change)</p> <p>Has CARE implemented activities and/or interventions with an explicit the prevention of child, early, and/or forced marriage (CEFM)? What does the increase or decrease in the proportion of women and girls who have been married within the ages denoted tell us about CARE's work in this area? What is the potential impact of this work with the communities within which it is implemented (e.g., target-segmented population reach, changes in perceptions, attitudes,</p>

etc.)? Has CARE been doing advocacy work in this area? If so, to what degree can a policy analysis and process documentation help to support CARE's contributions to changes in CEFM practices and/or prevalence?

Other considerations

To be shared with LFFV + SRHR

Additional information and guidance on collection and disaggregation of this indicator can be found in the SDG indicator document on pages 16-17 [here](#).

Birth certificates are not always used and/or accurate especially in more rural contexts; in geographies where CEFM practices are prevalent, the age of the girls in particular is less known and contributes to ambiguity around data collected against this indicator as well as whether laws against CEFM are being 'broken'.