Methodological Notes

KPI 1 - # of teachers/facilitators trained on comprehensive sexuality education through GAC-funded projects

Section 1: Human Dignity, Health and Nutrition	
Indicator Number	SRHR KPI 1
Key Performance Indicator (KPI)	**# of teachers/facilitators trained on comprehensive sexuality education through GAC-funded projects**
Methodological Summary	This indicator is intended to capture the training of individuals who will be able to deliver curriculum-based comprehensive sexuality education (CSE). CSE can be delivered both within school settings and outside of school settings. Non-formal and community based settings including youth centers are in fact key points of entry to provide curriculum-based CSE, particularly for out-of-school children in countries where school attendance is low or where adequate CSE is not included as part of the national curriculum, however, as per the definition of CSE, there must be a clear curriculum to support these programs regardless of who will be delivering them
Reference(s)	UNESCO, International technical guidance on sexuality education Education 2030 http://unesdoc.unesco.org/images/0026/002607/260770e.pdf (January 2018, p. 16-17); UNFPA Operational Guidance for Comprehensive Sexuality Education: https://www.unfpa.org/sites/default/files/pub-pdf/UNFPA_OperationalGuidance_WEB3.pdf

Section 2: Indicator Terminology Definitions	
Provide definitions for terminology that is specialized or specific to the indicator	
Comprehensive Sexuality Education (CSE)	Comprehensive sexuality education (CSE) is a curriculum-based process of teaching and learning about the cognitive, emotional, physical and social aspects of sexuality. It aims to equip children and young people with knowledge, skills, attitudes and values that will empower them to: realize their health, well-being and dignity; develop respectful social and sexual relationships; consider how their choices affect their own well-being and that of others; and, understand and ensure the protection of their rights throughout their lives. CSE provides opportunities to acquire comprehensive, accurate, evidence-informed and age appropriate information on sexuality. It addresses sexual and reproductive health issues, including, but not limited to: sexual and reproductive anatomy and physiology; puberty and menstruation; reproduction, modern contraception, pregnancy and childbirth; and STIs, including HIV and AIDS. CSE covers the full range of topics that are important for all learners to know, including those that may be challenging in some social and cultural contexts. CSE is education delivered in formal and non-formal settings. It is scientifically accurate, incremental, age-and developmentally -appropriate, curriculum-based, comprehensive, based on a human rights approach, based on gender equality, culturally relevant and context appropriate, transformative, and able to develop life skills needed to support healthy choices. (UNESCO, International technical guidance on sexuality education Education 2030 http://unesdoc.unesco.org/images/0026/002607/260770e.pdf published January 2018, p. 16-17) Single programs/workshops conducted by outside organizations or agencies at the school or community level should be excluded as they are conducted on an ad-hoc basis and do not meet the incremental criteria for CSE. See UNESCO guide for further guidance and references for all definitions provided here.
Training in CSE	To be counted as a training, a session must be a minimum of one day based on a recognized curriulum or training package focused partly or in full on CSE topics as noted in the PMF indicator. If a training program takes place over a series of days, count the maximum number of health providers trained as reported in the project-level PMF. For distance learning or online learning programs, count the number of participants enrolled in the distance learning program, not the number of sessions they have taken using that modality.

GAC funded projects/GAC support	GAC support can be financial or non-financial (e.g. funding for core administrative functions, funding for program delivery or activities, technical assistance or capacity-building), provided directly or through an intermediary implementing partner.

Section 3: Indicator Type
Please select an indicator from the drop down menu
Consolidated Indicator: created by GAC from project level indicators that are clustered together with other related indicators (a family of indicators) to form one indicator that will allow aggregation (summarise) related data at the program, branch or corporate level

Section 4: For Consolidated Indicators fill out Section 4a. For Commonly Used (Standard) Indicators, fill out Section 4b.	
Section 4a: For Consolidated Indicators Only - Examples of Project-level Family Member Indicators	
If this is a consolidated indicator, provide a list of possible project-level indicators that could be included as 'family members'. Also specify how each of the family members will be used to calculate the consolidated actual data for this indicator and targets. Where family indicators are listed, also include indicator reference, where available.	
Number of teachers trained on comprehensive sexuality education	
Number of youth workers or community workers trained on comprehensive sexuality education	
Number of health education officers or community health workers trained on comprehensive sexuality education	
Number of government health supervisors trained on comprehensive sexuality education	
Section 4b: For Commonly Used (Standard) Indicators Only - Examples of Alternative Formulations	
Identify examples of alternative formulations for this standard or commonly-used (standard indicator)	

Section 5: Data Disaggregation
Specify the dimensions of disaggregation for this indicator, e.g. by sex, by age, by rural vs urban, etc. Specify how to handle any non-disaggregated data when reporting. Make sure to include units of measurement and the denominator. Although every effort should be made to disaggregate data, in the case where the project data contributing to this indicator not disaggregated, it will be important to report on non-disaggregated data, alongside the disaggregated data, eg. total: X (male: A; female: B, non-disaggregated: C)
Although not required by this indicator, if available, data could be disaggregated by sex of teachers/facilitators trained (male/female), and type of cadre trained (e.g. teacher, youth worker, community worker, health worker).

Section 6: Calculation Methodology
The calculation methodology is the basis for all data calculations. Tailor the calculation methodology below as required for this indicator.
The result for this indicator is calculated by totaling the results of all family member indicators, including the disaggregation groups: i) Total number of male teachers, youth workers and health education workers trained on CSE + Total number of female teachers, youth workers and health education officers trained on CSE

Section 7: Data Source
Project Reports, Performance Measurement Frameworks Original Source: Training registers

Section 8: Reporting Frequency
Annually
If Other, Specify

Section 9: Data Constraints and Limitations
i) This indicator is not a measure of the quality of comprehensive sex education training or curriculum. Different projects may interpret CSE somewhat differently and will be operating with particular cultural and social contexts, hence there will be variability in the types of programs offered by different regions/schools/ministries of education and in the extent to which each training package offered meets the full definition of "comprehensive" CSE according to UNESCO. ii) ii) This indicator has a potential for double counting as GAC-funded projects do not necessarily capture unique numbers (individuals that have received all training), but number of contacts (individuals who have received training in each session). While efforts should be made to avoid duplication, it is recognized that the indicator will capture the same health workers who have received multiple trainings.

KPI 2 - $ invested and # of GAC supported projects that promote the integration of CSE into school curriculums

Section 1: Tombstone Data	
Indicator Number	SRHR KPI 2
Key Performance Indicator (KPI)	**$ invested and # of GAC supported projects that promote the integration of CSE into school curriculums**
Methodological Summary	This indicator aims to capture two values and should be collected separately. (i) EDU4-A is the total amount of funds invested in projects that promote the integration of CSE into school curriculums. The indicator aims to capture those projects where at immediate and intermediate outcome levels, CSE integration into curriculums is clearly stipulated as an expected result, resulting in the need to review both project level PMFs and detailed budgets for a project to be counted. (ii) EDU4-B is the total number of projects that promote the integration of CSE into school curriculums. The indicator is intended to capture the curriculum-based process of teaching and learning about comprehensive sexuality education (CSE). This can occur both within school settings and outside of school settings. Specifically, it aims to capture those projects where at immediate and intermediate outcome levels, CSE integration into curriculums is clearly stipulated as an expected result, resulting in the need to review project level PMFs for a project to be counted. Non-formal and community based settings are in fact key points of entry to provide curriculum-based CSE, particularly for out-of-school children in countries where school attendance is low or where adequate CSE is not included as part of the national curriculum, however, as per the definition of CSE, there must be a clear curriculum to support these programs. For example the Ministry of Education or other organization could provide out-of-school children with curriculum based CSE at youth centres across the country that are delivered by local public health workers. What is key is that there is an established curriculum. Ad-hoc single program workshops delivered by community organizations should not be counted for this indicator.
Reference	UNESCO, International technical guidance on sexuality education Education 2030 http://unesdoc.unesco.org/images/0026/002607/260770e.pdf published January 2018, p. 16-17)

Section 2: Indicator Terminology Definitions	
Provide definitions for terminology that is specialized or specific to the indicator	
Comprehensive Sexuality Education (CSE)	Comprehensive sexuality education (CSE) is a curriculum-based process of teaching and learning about the cognitive, emotional, physical and social aspects of sexuality. It aims to equip children and young people with knowledge, skills, attitudes and values that will empower them to: realize their health, well-being and dignity; develop respectful social and sexual relationships; consider how their choices affect their own well-being and that of others; and, understand and ensure the protection of their rights throughout their lives. CSE provides opportunities to acquire comprehensive, accurate, evidence-informed and age appropriate information on sexuality. It addresses sexual and reproductive health issues, including, but not limited to: sexual and reproductive anatomy and physiology; puberty and menstruation; reproduction, modern contraception, pregnancy and childbirth; and STIs, including HIV and AIDS. CSE covers the full range of topics that are important for all learners to know, including those that may be challenging in some social and cultural contexts. CSE is education delivered in formal and non-formal settings. It is scientifically accurate, incremental, age-and developmentally -appropriate, curriculum-based, comprehensive, based on a human rights approach, based on gender equality, culturally relevant and context appropriate, transformative, and able to develop life skills needed to support healthy choices. (UNESCO, International technical guidance on sexuality education Education 2030 http://unesdoc.unesco.org/images/0026/002607/260770e.pdf published January 2018, p. 16-17) Single programs/workshops conducted by outside organizations or agencies at the school or community level should be excluded as they are conducted on an ad-hoc basis and do not meet the incremental criteria for CSE. See UNESCO guide for further guidance and references for all definitions provided here.

curriculum-based	Curriculum-based means that the intervention or information is included within a written curriculum that guides educators' efforts to support students' learning. The curriculum includes key teaching objectives, the development of learning objectives, the presentation of concepts, and the delivery of clear key messages in a structured way. It can be delivered in either in-school or out of-school settings.

Section 3: Indicator Type
Please select an indicator from the drop down menu
Consolidated Indicator: created by GAC from project level indicators that are clustered together with other related indicators (a family of indicators) to form one indicator that will allow aggregation (summarise) related data at the program, branch or corporate level

Section 4: For Consolidated Indicators fill out Section 4a. For Commonly Used (Standard) Indicators, fill out Section 4b.	
Section 4a: For Consolidated Indicators Only - Examples of Project-level Family Member Indicators	
If this is a consolidated indicator, provide a list of possible project-level indicators that could be included as 'family members'. Also specify how each of the family members will be used to calculate the consolidated actual data for this indicator and targets. Where family indicators are listed, also include indicator reference, where available.	
Projects where outcomes and output indicators focus on:	
CSE is integrated into curriculum (primary, secondary, madrasa, informal)	
# of CSE curriculum resources/materials developed and approved (*approval can be by government Ministry of Education, school board or educational institution)*	
TA provided to Ministry of Education for development of CSE curriculum resources and materials	
# and/or proportion of relevant Ministry staff / teachers / educators trained to deliver CSE materials	
For financial calculation of indicator:	
$ spent on TA to develop CSE curriculum resources	
$ spent on delivery of training about CSE curriculum materials for Ministry staff / teachers / educators	
$ invested on CSE - *note that this may be indicated for primary, secondary, madrassa, informal or other education level*	
$ provided to NGOs to work with Ministries of Education and/or Health on CSE	
Section 4b: For Commonly Used (Standard) Indicators Only - Examples of Alternative Formulations	
Identify examples of alternative formulations for this standard or commonly-used (standard indicator)	

Section 5: Data Disaggregation
Specify the dimensions of disaggregation for this indicator, e.g. by sex, by age, by rural vs urban, etc. Specify how to handle any non-disaggregated data when reporting. Make sure to include units of measurement and the denominator. Although every effort should be made to disaggregate data, in the case where the project data contributing to this indicator not disaggregated, it will be important to report on non-disaggregated data, alongside the disaggregated data, eg. total: X (male: A; female: B, non-disaggregated: C)
Although not required by this indicator, if available, data could be disaggregated by education level or type (primary/secondary/madrassa/informal); or single donor/multi donor

Section 6: Calculation Methodology
The calculation methodology is the basis for all data calculations. Tailor the calculation methodology below as required for this indicator.

(i) For EDU4-A, the amount of funds invested in projects that promote the integration of CSE into school curriculums:
Total all of the amounts provided by GAC (from implementing agencies) at immediate and intermediate outcome levels where CSE integration is noted specifically as an expected results. Funds should be counted according to the level of the indicator. If CSE is an Ultimate-Outcome level result with associated indicators, all project funds can be counted. If CSE is an Intermediate-level or Immediate level indicator, only the funds related to that portion of the project should be counted as $ invested in CSE. If CSE is only mentioned in one-off training exercises, funds should not be counted.
(ii) For EDU4-B, the number of projects that promote the integration of CSE into school curriculums, the Total of all projects/programs funded by GAC that include any of the indicators noted in section 4a above, or similar indicators.

Note: There can be overlap in the counting of the two indicators as they are separate measures of the same activity; however, this should be clearly indicated. If GAC is one donor among others (e.g. Program-based Approaches, multilateral etc.) include the total number of projects supported in the past year; there is no need to calculate the proportion of projects supported through GAC-only funds.

For SWAP funding, the process of determining the result can be done using two methods, depending on availability of information:i) if the SWAP has a LM, follow EDU4-A and EDU4-B above;ii) if the SWAP does not have a LM or associated PMF, an estimated % of CSE within the SWAP will need to be determined and applied to total funds invested in the SWAP.

Section 7: Data Source

Project reports, project-level budgets, project-level data systems, performance measurement frameworks

Section 8: Reporting Frequency

Annually

If Other, Specify

Section 9: Data Constraints and Limitations

i) This indicator combines both the total investment in projects which contribute to CSE initiatives as well as the # of projects which focus on CSE initiatives and needs to be reported separately. ii) This indicator is not a measure of the quality of comprehensive sex education curriculum. Different projects may interpret CSE somewhat differently and will be operating with particular cultural and social contexts; hence there will be variability in the types of programs offered by different regions/schools/ministries of education and in the extent to which each project meets the full definition of "comprehensive" CSE according to UNESCO.

KPI 3 - # of women and girls provided with access to sexual and reproductive health services, including modern methods of contraception, through GAC-funded projects

Section 1: Tombstone Data	
Indicator Number	SRHR KPI 3
Key Performance Indicator (KPI)	**# of women and girls provided with access to sexual and reproductive health services, including modern methods of contraception, through GAC-funded projects**
Methodological Summary	This is a consolidated indicator intending to capture the number of people provided with sexual and reproductive health services supported by GAC projects, based on a series of relevant family member indicators listed below. Live births attended by skilled health personnel (PIP 1100b), for example, is also considered a reproductive health service, however data that informs that indicator is reported separately as a proportion, while the numerator can be used to inform this indicator. In summary, this indicator aggregates numbers of people provided with services and does not capture the coverage of these services. It should be noted, while services related to sexual and gender-based violence are considered sexual and reproductive health services these are not included, and captured via Policy indicator GE1. GE1 data will be added to this indicator as a family member. In summary, this indicator aggregates numbers of people provided with services, but does not capture the coverage rates of these services.
Reference	Reference for technical explanation of the family of indicators can be found in WHO Global Reference List of 100 Core Health Indicators http://www.who.int/healthinfo/indicators/2018/en/; Reference on SRHR: **https://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(18)30293-9.pdf**

Section 2: Indicator Terminology Definitions	
Provide definitions for terminology that is specialized or specific to the indicator	
Access	Access is the provision of services, information or commodities to SRH services. This includes 'provision of', 'received', 'people reached', and 'services utilized'. Access can be gained through health facility services, community health services, or by project staff.
Sexual and Reproductive Health Services (SRH)	SRH services pertains to the state of physical, mental, and social well-being in all matters related to the reproductive system. These services and commodities related to ante-natal care, delivery care, post-natal care, newborn care, abortion, post-abortion care, family planning and contraception including emergency contraception, treatment of sexually transmitted infections and cancers, information and counselling on sexual and reproductive health, including protection against STIs.

Sexual and Reproductive Health and Rights (SRHR)	Sexual and reproductive health is a state of physical, emotional, mental, and social wellbeing in relation to all aspects of sexuality and reproduction, not merely the absence of disease, dysfunction, or infirmity. Therefore, a positive approach to sexuality and reproduction should recognize the part played by pleasurable sexual relationships, trust, and communication in the promotion of self-esteem and overall wellbeing. All individuals have a right to make decisions governing their bodies and to access services that support that right. Achievement of sexual and reproductive health relies on the realisation of sexual and reproductive rights, which are based on the human rights of all individuals to: have their bodily integrity, privacy, and personal autonomy respected; freely define their own sexuality, including sexual orientation and gender identity and expression; decide whether and when to be sexually active; choose their sexual partners; have safe and pleasurable sexual experiences; decide whether, when, and whom to marry; decide whether, when, and by what means to have a child or children, and how many children to have; have access over their lifetimes to the information, resources, services, and support necessary to achieve all the above, free from discrimination, coercion, exploitation, and violence.The essential package of sexual and reproductive health interventions include: Comprehensive sexuality education; Counselling and services for a range of modern contraceptives, with a defined minimum number and types of methods; Antenatal, childbirth, and postnatal care, including emergency obstetric and newborn care; Safe abortion services and treatment of complications of unsafe abortion; Prevention and treatment of HIV and other sexually transmitted infections; Prevention, detection, immediate services, and referrals for cases of sexual and gender-based violence; Prevention, detection, and management of reproductive cancers, especially cervical cancer; Information, counselling, and services for sexual health and wellbeing. (Reference, Guttmacher/Lancet: https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)30293-9/fulltext?code=lancet-site)
Modern methods of contraception	Modern methods includes permanent methods (vasectomy, tubal ligation) and implants, Intrauterine devices (IUD), injectables, pills, male and female condoms, emergency contraceptive pills, vaginal barriers methods, (diaphragm, cervical caps, spermicidal foam, jelly cream and sponges)

Section 3: Indicator Type
Please select an indicator from the drop down menu
Consolidated Indicator: created by GAC from project level indicators that are clustered together with other related indicators (a family of indicators) to form one indicator that will allow aggregation (summarise) related data at the program, branch or corporate level

Section 4: For Consolidated Indicators fill out Section 4a. For Commonly Used (Standard) Indicators, fill out Section 4b.	
Section 4a: For Consolidated Indicators Only - Examples of Project-level Family Member Indicators	
If this is a consolidated indicator, provide a list of possible project-level indicators that could be included as 'family members'. Also specify how each of the family members will be used to calculate the consolidated actual data for this indicator and targets. Where family indicators are listed, also include indicator reference, where available.	
# of women of reproductive age (15-49) using modern means of contraception (Reference WHO "Demand for family planning satisfied with modern methods" (p.84))	also SRHR KPI 6
# of women and female adolescents (10-19) that have received modern means of contraception	
# of HIV-positive pregnant women and adolescent girls receiving treatment for HIV/AIDS (Reference WHO "Prevention of mother-to-child transmission" (p.95))	also females counted under SRHR KPI 5 or female in numerator of HD PIP 1210b
# of pregnant women receiving preventive therapy for malaria (Reference WHO "Intermittent preventive therapy for malaria during pregnancy (IPTp)" (p.104))	
# of women/adolescents girls receiving abortion and/or post abortion care services (# of admissions for (spontaneous or induced) abortion-related complications to service delivery points Reference WHO "Obstetric and gynaecological admissions owing to abortion" (p.117)	
# of women attended antenatal care services at least 4 times during pregnancy (Reference WHO "Percentage of women aged 15-49 who received four or more antenatal visits" (p. 86))	
# of women who received postnatal care within two days of childbirth (Reference WHO "Postpartum care coverage - women" (p.89))	

# of women and female adolescents who have received family planning counselling	
# of women of reproductive age that have been screened for breast cancer	
# of women of reproductive age that have been screened for cervical cancer	
# of female adolescents who have received HPV vaccine (Guttmacher,SDG proposal)	
# of female adults and adolescents who have been treated for STIs (DHS)	
# of births attended by skilled health personnel or # of institutional births	

Section 4b: For Commonly Used (Standard) Indicators Only - Examples of Alternative Formulations
Identify examples of alternative formulations for this standard or commonly-used (standard indicator)

Section 5: Data Disaggregation
Specify the dimensions of disaggregation for this indicator, e.g. by sex, by age, by rural vs urban, etc. Specify how to handle any non-disaggregated data when reporting. Make sure to include units of measurement and the denominator. Although every effort should be made to disaggregate data, in the case where the project data contributing to this indicator not disaggregated, it will be important to report on non-disaggregated data, alongside the disaggregated data, eg. total: X (male: A; female: B, non-disaggregated: C)total
Sex, if possible disaggregate by age groups of (10-14), (15-19) and (20-49)

Section 6: Calculation Methodology
The calculation methodology is the basis for all data calculations. Tailor the calculation methodology below as required for this indicator.
The result for this indicator is calculated by totaling the results of all family member indicators, including the disaggregation groups: Total number of female adolescents (10-14) that have received SRH services + Total number of female adolescents (15-19) that have received SRH services + Total number of women (20-49) that have received SRH services.

Section 7: Data Source
Project Reports, Performance Measurement Frameworks Original Source: Health Management Information Systems (HMIS), community health information systems, project data systems

Section 8: Reporting Frequency
Annually
If Other, Specify

Section 9: Data Constraints and Limitations
This indicator aggregates the number of women and girls provided with services and does not capture the coverage of these services, indicating the results of investments. The main limitations are:i) the potential for double counting as GAC-funded projects do not necessarily capture unique numbers, but number of contacts. While efforts should be made to avoid duplication, it is recognized that the indicator will capture people multiple times when they receive multiple services. An explanatory note is required to ensure clarity.ii) Please note that some family indicators here (users of modern contraceptions and those provided with modern contraceptions) are equally captured under Indicator SRHR 6 and will result in duplication. iii) in the use of disaggregations for a group of family indicators, disaggregation by age differs depending on indicatoriv) For GAC-funded projects which do not have access to facility or community health information systems or records, and rely solely on household coverage surveys, an underestimation of the indicator is equally possible. In the future, consideration to counting the number of services rather than the number of people accessing the total number of services would help reduce double counting.

KPI 4 - # of health care service providers trained in SRHR services through GAC-funded projects

Section 1: Sexual Reproductive Health and Rights	
Indicator Number	SRHR KPI 4
Key Performance Indicator (KPI)	**# of health care service providers trained in SRHR services through GAC-funded projects**
Methodological Summary	This is a consolidated indicator intending to capture the number of health care workers who have successfully completed a training program designed to build their skills in some aspect of SRHR service provision or strengthen the quality of SRHR services within the reporting period. Types of training can include: pre-service training, in-service; continuing education; on-the-job training; computer-based training or distance learning.
Reference	

Section 2: Indicator Terminology Definitions	
Provide definitions for terminology that is specialized or specific to the indicator	
Training in SRHR	To be counted as a training, a session must be a minimum of one day based on a recognized curriulum or training package focused partly or in full on SRHR topics as noted in the PMF indicator. If a training program takes place over a series of days, count the maximum number of health providers trained as reported in the project-level PMF. Training can refer to pre-service, in-service or distance learning. For distance learning or online learning programs, count the number of participants enrolled in the distance learning program, not the number of sessions they have taken using that modality. Training can be provided by GAC-funded projects, respective country ministries of health, or other trainers qualified to deliver the curriculum.
SRHR services	Sexual and reproductive health is a state of physical, emotional, mental, and social wellbeing in relation to all aspects of sexuality and reproduction, not merely the absence of disease, dysfunction, or infirmity. Therefore, a positive approach to sexuality and reproduction should recognize the part played by pleasurable sexual relationships, trust, and communication in the promotion of self-esteem and overall wellbeing. All individuals have a right to make decisions governing their bodies and to access services that support that right. Achievement of sexual and reproductive health relies on the realisation of sexual and reproductive rights, which are based on the human rights of all individuals to: have their bodily integrity, privacy, and personal autonomy respected; freely define their own sexuality, including sexual orientation and gender identity and expression; decide whether and when to be sexually active; choose their sexual partners; have safe and pleasurable sexual experiences; decide whether, when, and whom to marry; decide whether, when, and by what means to have a child or children, and how many children to have; have access over their lifetimes to the information, resources, services, and support necessary to achieve all the above, free from discrimination, coercion, exploitation, and violence. Essential sexual and reproductive health services must meet public health and human rights standards, including the “Availability, Accessibility, Acceptability, and Quality” framework of the right to health. The services should include: accurate information and counselling on sexual and reproductive health, including evidence-based, comprehensive sexuality education; information, counselling, and care related to sexual function and satisfaction; prevention, detection, and management of sexual and gender-based violence and coercion; a choice of safe and effective contraceptive methods; safe and effective antenatal, childbirth, and postnatal care; safe and effective abortion services and care; prevention, management, and treatment of infertility; prevention, detection, and treatment of sexually transmitted infections, including HIV, and of reproductive tract infections; and prevention, detection, and treatment of reproductive cancers. (Reference, Guttmacher/Lancet: https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)30293-9/fulltext?code=lancet-site)

Health care service providers	All trained people engaged in provision of services whose primary intent is to enhance health. This will include doctors, medical officers, clinical officers, nurses, midwives, community health workers (including paid or voluntary workers) and other associated health professionals. This does not include individuals working on management or support services in the health sector who are not involved in the delivery of health care services (http://www.who.int/whr/2006/06_chap1_en.pdf)
GAC funded projects	GAC support can be financial or non-financial (e.g. funding for core administrative functions, funding for program delivery or activities, technical assistance or capacity-building), provided directly or through an intermediary implementing partner.

Section 3: Indicator Type
Please select an indicator from the drop down menu
Consolidated Indicator: created by GAC from project level indicators that are clustered together with other related indicators (a family of indicators) to form one indicator that will allow aggregation (summarise) related data at the program, branch or corporate level

Section 4: For Consolidated Indicators fill out Section 4a. For Commonly Used (Standard) Indicators, fill out Section 4b.	
Section 4a: For Consolidated Indicators Only - Examples of Project-level Family Member Indicators	
If this is a consolidated indicator, provide a list of possible project-level indicators that could be included as 'family members'. Also specify how each of the family members will be used to calculate the consolidated actual data for this indicator and targets. Where family indicators are listed, also include indicator reference, where available	
Projects tracking training for health workers or health care service providers:	
Number of health workers trained in basic or comprehensive emergency obstetric care	
Number of health workers trained in neonatal resuscitation, essential newborn care, helping babies breathe or related topics	
Number of health workers trained in family planning	
Number of health workers trained in abortion services or post-abortion care	SRHR KPI 12 (see Indicator Reference Sheet 17)
Number of health workers trained in prevention of maternal-child transmission of HIV	
Number of health workers trained for provision of anti-retroviral treatment	
Number of health workers trained for prevention or treatment of sexually transmitted infections (STIs) and/or HIV	
Number of midwives graduated from midwifery programmes	
Number of doctors trained in fistula repairs	
Number of service providers trained to identify, refer, and care for SGBV survivors	SRHR KPI 9 (see Indicator Reference Sheet 14)
Section 4b: For Commonly Used (Standard) Indicators Only - Examples of Alternative Formulations	
Identify examples of alternative formulations for this standard or commonly-used (standard indicator)	

Section 5: Data Disaggregation
Specify the dimensions of disaggregation for this indicator, e.g. by sex, by age, by rural vs urban, etc. Specify how to handle any non-disaggregated data when reporting. Make sure to include units of measurement and the denominator. Although every effort should be made to disaggregate data, in the case where the project data contributing to this indicator not disaggregated, it will be important to report on non-disaggregated data, alongside the disaggregated data, eg. total: X (male: A; female: B, non-disaggregated: C)total
By sex. Although not required by this indicator, if available, data could be disaggregated by type of health worker

Section 6: Calculation Methodology
The calculation methodology is the basis for all data calculations. Tailor the calculation methodology below as required for this indicator.
Total number of female health care workers trained in SRHR within reporting period + Total number of male health care workers trained in SRHR within reporting period

Section 7: Data Source
Training registers (data source); Project Reports

Section 8: Reporting Frequency
Annually
If Other, Specify

Section 9: Data Constraints and Limitations
i) This indicator cannot capture or measure the quality of training received, nor does it measure the outcomes of the training in terms of the competencies of individuals trained or their job performance. This indicator also does not measure the placement or retention in the health workforce of trained individuals. ii) This indicator has a potential for double counting as GAC-funded projects do not necessarily capture unique numbers (individuals that have received all training), but number of contacts (individuals who have received training in each session). While efforts should be made to avoid duplication, it is recognized that the indicator will capture the same health workers who have received multiple trainings.

KPI 5 - # of people treated with antiretroviral therapy through GAC-funded projects

Section 1: Sexual Reproductive Health and Rights	
Indicator Number	SRHR KPI 5
Key Performance Indicator (KPI)	**# of people treated with antiretroviral therapy through GAC-funded projects**
Methodological Summary	This is a consolidated indicator intended to capture the number of people (adults and children) who receive anti-retroviral therapy (ART) in the reporting period. This includes pregnant women who are HIV positive and who have received PMTCT services.
Reference(s)	WHO: http://www.who.int/hiv/topics/treatment/en/ UNAIDS: http://www.unaids.org/en/topic/treatment

Section 2: Indicator Terminology Definitions	
Provide definitions for terminology that is specialized or specific to the indicator	
Antiretroviral therapy	Standard antiretroviral therapy (ART) consists of the combination of antiretroviral (ARV) drugs to maximally suppress the HIV virus and stop the progression of HIV disease. ART also prevents onward transmission of HIV. Huge reductions have been seen in rates of death and infections when use is made of a potent ARV regimen, particularly in early stages of the disease. WHO recommends ART for all people with HIV as soon as possible after diagnosis without any restrictions of CD4 counts. It also recommends offer of pre-exposure prophylaxis to people at substantial risk of HIV infection as an additional prevention choice as part of comprehensive prevention.
GAC funded projects/support	GAC support can be financial or non-financial (e.g. funding for core administrative functions, funding for program delivery or activities, technical assistance or capacity-building), provided directly or through an intermediary implementing partner.

Section 3: Indicator Type
Please select an indicator from the drop down menu
Consolidated Indicator: created by GAC from project level indicators that are clustered together with other related indicators (a family of indicators) to form one indicator that will allow aggregation (summarise) related data at the program, branch or corporate level

Section 4: For Consolidated Indicators fill out Section 4a. For Commonly Used (Standard) Indicators, fill out Section 4b.	
Section 4a: For Consolidated Indicators Only - Examples of Project-level Family Member Indicators	
If this is a consolidated indicator, provide a list of possible project-level indicators that could be included as 'family members'. Also specify how each of the family members will be used to calculate the consolidated actual data for this indicator and targets. Where family indicators are listed, also include indicator reference, where available.	
Number of children treated with antiretroviral therapy	
Number of pregnant women treated with antiretroviral therapy	
Number of adults treated with antiretroviral therapy	
Section 4b: For Commonly Used (Standard) Indicators Only - Examples of Alternative Formulations	
Identify examples of alternative formulations for this standard or commonly-used (standard indicator)	

Section 5: Data Disaggregation
Specify the dimensions of disaggregation for this indicator, e.g. by sex, by age, by rural vs urban, etc. Specify how to handle any non-disaggregated data when reporting. Make sure to include units of measurement and the denominator. Although every effort should be made to disaggregate data, in the case where the project data contributing to this indicator not disaggregated, it will be important to report on non-disaggregated data, alongside the disaggregated data, eg. total: X (male: A; female: B, non-disaggregated: C)
Sex and age. Minimum age disaggregation recommended by WHO is under 15 and 15+. Ideally child, adolescent adult (under 10, 10-19, 20+)

Section 6: Calculation Methodology
The calculation methodology is the basis for all data calculations. Tailor the calculation methodology below as required for this indicator.
The result for this indicator is calculated by totaling the results of all relevant indicators, including the disaggregation groups: Total number of individual female children (0-14) receiving ART within reporting period + Total number of individual male children (0-14) within reporting period, plus Total number of individual women (15+) receiving ART within reporting period + Total number of individual men (15+) within receiving ART reporting period

Section 7: Data Source
Project Reports Original Source: Health Management Information Systems, community health information systems, project data systems

Section 8: Reporting Frequency
Annually
If Other, Specify

Section 9: Data Constraints and Limitations

KPI 6 - # of people provided with modern contraception through GAC-funded projects

Section 1: Human Dignity, Health and Nutrition	
Indicator Number	SRHR KPI 6
Key Performance Indicator (KPI)	**# of people provided with modern contraception through GAC-funded projects**
Methodological Summary	This indicator is intended to capture the total number of people provided with various modern methods of contraception through distribution processes or accessed at facility or local pharmacies. Using the method mix provides a profile of the relative level of use of different contraceptive methods. Conversely, method mix can also signal: (1) provider bias in the system, if one method is strongly favored to the exclusion of others; (2) user preferences; or (3) both. Contraceptive method mix is a complex indicator, as the choice of a contraceptive method reflects individual preferences, societal and cultural norms, and local and regional issues affecting contraceptive availability and accessibility, including policies, cost, infrastructure, and provider training.
Reference	Measure Evaluation, Method Mix: https://www.measureevaluation.org/prh/rh_indicators/family-planning/fp/method-mix

Section 2: Indicator Terminology Definitions	
Provide definitions for terminology that is specialized or specific to the indicator	
Modern methods of contraception	Modern methods includes permanent methods (vasectomy, tubal ligation) and implants, Intrauterine devices (IUD), injectables, pills, male condoms, emergency contraceptive pills, vaginal barrier methods, (diaphragm, cervical caps, spermicidal foam, jelly cream and sponges)
Provision of	Includes contraceptions that are provided at a facility level through a skilled health personnel, or other health staff, obtained through purchase at a pharmacy, received free through national FP campaigns, or through community health workers

Section 3: Indicator Type
Please select an indicator from the drop down menu
Commonly-Used (Standard) Indicator: an indicator that is standard for a sector or a theme and used commonly by practitioners. Standard indicators are based on, either evolving best practice, or international standards where they exist.

Section 4: For Consolidated Indicators fill out Section 4a. For Commonly Used (Standard) Indicators, fill out Section 4b.	
Section 4a: For Consolidated Indicators Only - Examples of Project-level Family Member Indicators	
If this is a consolidated indicator, provide a list of possible project-level indicators that could be included as 'family members'. Also specify how each of the family members will be used to calculate the consolidated actual data for this indicator and targets. where family indicators are listed, also include indicator reference, where available.	
Section 4b: For Commonly Used (Standard) Indicators Only - Examples of Alternative Formulations	
Identify examples of alternative formulations for this standard or commonly-used (standard indicator)	
# of users of modern contraception methods (by method)	

# of first-time users of modern contraception methods	

Section 5: Data Disaggregation
Specify the dimensions of disaggregation for this indicator, e.g. by sex, by age, by rural vs urban, etc. Specify how to handle any non-disaggregated data when reporting. Make sure to include units of measurement and the denominator. Although every effort should be made to disaggregate data, in the case where the project data contributing to this indicator not disaggregated, it will be important to report on non-disaggregated data, alongside the disaggregated data, eg. total: X (male: A; female: B, non-disaggregated: C)total
Sex and modern method type and age group (10-14, 15-19, 20-49)

Section 6: Calculation Methodology
The calculation methodology is the basis for all data calculations. Tailor the calculation methodology below as required for this indicator.
The result for this indicator is calculated by totaling the results of all family member indicators, including the disaggregation groups: i) Total number of male adolescents (10-14) that have received a modern method of contraception; + Total number of female adolescents (10-14) that have received a modern method of contraception; ii) Total number of male adolescents (15-19) that have received a modern method of contraception; + Total number of female adolescents (15-19) that have received a modern method of contraception; iii) Total number of males (20-49) that have received a modern method of contraception + Total number of females (20-49) that have received a modern method of contraception

Section 7: Data Source
Project Reports Original Source: Health Management Information Systems, community health information systems, project data systems

Section 8: Reporting Frequency
Annually
If Other, Specify

Section 9: Data Constraints and Limitations
(i) Because of the problems of monitoring the number of current users based on service statistics, method mix (as outlined in definition above) is generally based on acceptors, not on current users, when measured at the program level. (ii) As tracking individuals provided contraceptions is not uniquely tracked, but rather number of contraceptions provided, there is a high risk of double counting, especially in cases where people have contraceptions resupplied at the same service points. (iii) This indicator may present inflated service statistics, wastage in the system, or the sale of products outside the intended area for the program (iv) This indicator is more commonly expressed as contraception prevalence rate and the alteration to number of people provided contraceptions does not allow for meaningful understanding of coverage. (v) In a large number of cases, disaggregation by age group will not be available consistently across GAC-funded projects and should be noted as a limitation. Equally for younger adolescents 10-14, while acceptable to provide contraceptions as per WHO guidelines, programs will differ in their approaches and this data may be absent. (vi) Disaggregation by modern contraception method, coupled with age and sex, would require a total of 27 data points and may result in inconsistent disaggregations upon roll up of data. In these cases, only totals would be available and it should be noted in which regions, countries or the number of projects where this is missing. vii) Sex disaggregation may not be possible as data is often limited to women, sinces males often obtain condoms from various sources outside of health facilities (pharmacies, bars or other public and private venues)

KPI 7 - Percentage of primary service delivery points with at least 3 modern methods of contraception available on the day of the assessment

Section 1: Sexual Reproductive Health and Rights	
Indicator Number	SHRH KPI 7
Key Performance Indicator (KPI)	**Percentage of primary service delivery points with at least 3 modern methods of contraception available on the day of the assessment**
Methodological Summary	This indicator intends to capture availability of modern methods of contraception at primary level service delivery points, including health facilities, mobile clinics or other primary level delivery points on the day of the most recent assessment or according to the ending balance of most recent inventory report. t provides information about access to a range of contraceptive methods and is captured through standard health facility assessments or other checklists created. It is based on Family Planning 2020, Core Indicator 11a. This indicator considers methods such as injectables (3 or 6 month), oral contraceptives, emergency contraceptive pills, male and female condoms, implants, IUDs, female and male sterilization.
Reference(s)	FP2020: http://progress.familyplanning2020.org/en/measurement-section/contraceptive-stock-outs-and-availability-indicators-10-11

Section 2: Indicator Terminology Definitions	
Provide definitions for terminology that is specialized or specific to the indicator	
Primary service delivery points	Facilities, dispensaries, clinics which are community-based including health facilities, mobile clinics or other primary level delivery points as per national health system structures. These do not include any secondary or tertiary level facilities.
Modern methods of contraception	Modern methods includes permanent methods (vasectomy, tubal ligation) and implants, Intrauterine devices (IUD), injectables, pills, male and female condoms, emergency contraceptive pills, vaginal barriers methods, (diaphragm, cervical caps, spermicidal foam, jelly cream and sponges). In the case of sterilization, "available on the day of assessment" refers to the availability of supplies and/or trained staff at a health facility where the service is supposed to be available according to national health system guidelines

Section 3: Indicator Type
Please select an indicator from the drop down menu
Commonly-Used (Standard) Indicator: an indicator that is standard for a sector or a theme and used commonly by practitioners. Standard indicators are based on, either evolving best practice, or international standards where they exist.

Section 4: For Consolidated Indicators fill out Section 4a. For Commonly Used (Standard) Indicators, fill out Section 4b.	
Section 4a: For Consolidated Indicators Only - Examples of Project-level Family Member Indicators	
If this is a consolidated indicator, provide a list of possible project-level indicators that could be included as 'family members'. Also specify how each of the family members will be used to calculate the consolidated actual data for this indicator and targets. Where family indicators are listed, also include indicator reference, where available	
Section 4b: For Commonly Used (Standard) Indicators Only - Examples of Alternative Formulations	
Identify examples of alternative formulations for this standard or commonly-used (standard indicator)	
Percentage of SDPs that have at least three modern family planning methods (primary)	

Section 5: Data Disaggregation
Specify the dimensions of disaggregation for this indicator, e.g. by sex, by age, by rural vs urban, etc. Specify how to handle any non-disaggregated data when reporting. Make sure to include units of measurement and the denominator. Although every effort should be made to disaggregate data, in the case where the project data contributing to this indicator not disaggregated, it will be important to report on non-disaggregated data, alongside the disaggregated data, eg. total: X (male: A; female: B, non-disaggregated: C)
None, however where multiple types of primary service delivery points are used, the type of service delivery point (as per national health system) can be used

Section 6: Calculation Methodology
The calculation methodology is the basis for all data calculations. Tailor the calculation methodology below as required for this indicator.
This indicator is reported based on document review of Health Facility Assessments. Where national level assessments are not being used, an average (mean) of project level results is calculated for aggregation. If both numerator and denominators are available consistently for this indicator across all projects, calculation by country level is: Total number of primary service delivery points which have at least 3 modern methods on the day of the assessment, divided by, Total number of primary service delivery points assessed, *100.

Section 7: Data Source
UNFPA Facility Assessment for Reproductive Health Commodities and Services, PMA2020 Performance Monitoring and Accountability SDP survey, WHO Service Availability and Readiness Assessment (SARA) health facility survey

Section 8: Reporting Frequency
Annually
If Other, Specify

Section 9: Data Constraints and Limitations
i) This indicator will provide information if any primary level service delivery point has at least 3 modern methods of contraception available, however will not be able to capture the extent to which other stock outs are taking place across the range of contraception that the service delivery point can offer. See FP2020 Indicator 10: Percentage of facilities stocked out, by method offered, on the day of assessment. ii) Using an average (mean) for to carry out regional aggregation will result in outliers skewing the result to a certain degree.

KPI 8 - Percentage of women who decided to use family planning, alone or jointly with their husbands/partners

Section 1: Sexual Reproductive Health and Rights	
Indicator Number	SRHR KPI 8
Key Performance Indicator (KPI)	**Percentage of women who decided to use family planning, alone or jointly with their husbands/partners**
Methodological Summary	This indicator measures women and adolescents ability to make contraceptive decisions voluntarily and free from discrimination, coercion, or violence and is used as a measure of women's empowerment. A woman's ability to choose if and when to become pregnant has a direct impact on her health and well-being. Family planning allows spacing of pregnancies and can delay pregnancies in young women at increased risk of health problems and death from early childbearing. It prevents unintended pregnancies, including those of older women who face increased risks related to pregnancy. Family planning enables women who wish to limit the size of their families to do so (WHO). Based on FP2020, Core Indicator 16 and variation of SDG indicator 5.6.1: "the proportion of women aged 15–49 years who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care."
Reference(s)	Measure Evaluation: https://www.measureevaluation.org/prh/rh_indicators/gender/wgse/participation-of-women-in-household-decision PMA2020: Performance Monitoring and Accountability 2020: https://www.gatesinstitute.org/performance-monitoring-and-accountability-2020 and https://www.pma2020.org/ http://progress.familyplanning2020.org/en/measurement-section/measuring-components-of-rights-counseling-informed-choice-and-decision-making-core-indicators-14-16

Section 2: Indicator Terminology Definitions	
Provide definitions for terminology that is specialized or specific to the indicator	
Family planning	Family planning allows individuals and couples to have the desired number of children and to plan the spacing of pregnancies. It is achieved through use of contraceptive methods (including modern methods, including emergency contraception, and traditional methods) and the treatment of infertility.
Decide/Decision	Those who decide on the number of children and spacing of children is either the woman alone or jointly with a spouse. In DHS surveys, questions related to decision making considers those who have the 'final say'.

Section 3: Indicator Type
Please select an indicator from the drop down menu
Commonly-Used (Standard) Indicator: an indicator that is standard for a sector or a theme and used commonly by practitioners. Standard indicators are based on, either evolving best practice, or international standards where they exist.

Section 4: For Consolidated Indicators fill out Section 4a. For Commonly Used (Standard) Indicators, fill out Section 4b.
Section 4a: For Consolidated Indicators Only - Examples of Project-level Family Member Indicators

If this is a consolidated indicator, provide a list of possible project-level indicators that could be included as 'family members'. Also specify how each of the family members will be used to calculate the consolidated actual data for this indicator and targets. Where family indicators are listed, also include indicator reference, where available.

Section 4b: For Commonly Used (Standard) Indicators Only - Examples of Alternative Formulations
Identify examples of alternative formulations for this standard or commonly-used (standard indicator)
% of women aged 15–49 currently using a modern contraceptive method, reporting they decided on method themselves or jointly with a partner or provider
% of women aged 15–49 years who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care
% of women aged 15-49 who have decision making ability on family planning

Section 5: Data Disaggregation
Specify the dimensions of disaggregation for this indicator, e.g. by sex, by age, by rural vs urban, etc. Specify how to handle any non-disaggregated data when reporting. Make sure to include units of measurement and the denominator. Although every effort should be made to disaggregate data, in the case where the project data contributing to this indicator not disaggregated, it will be important to report on non-disaggregated data, alongside the disaggregated data, eg. total: X (male: A; female: B, non-disaggregated: C)
By age group (15-19) and (20-49)

Section 6: Calculation Methodology
The calculation methodology is the basis for all data calculations. Tailor the calculation methodology below as required for this indicator.
This indicator is reported based on document review of DHS, household coverage surveys or PMA2020 reports. Where national level DHS results are not being used, an average (mean) of project level results is calculated individually for each age group in the country.

Section 7: Data Source
DHS, Household coverage surveys, PMA2020

Section 8: Reporting Frequency
Annually
If Other, Specify

Section 9: Data Constraints and Limitations
i) The indicator only measures the decision-making power of women who are currently using a method, and gives no insight into the experiences of women who are not using a method or how that decision was made. FP2020 notes that future DHS surveys will adjust the questions to include women who are not currently using contraception as is done in PMA2020. ii) the use of average (mean) of multiple projects to aggregate results skews results, as outliers (highest and lowest) affect the calculation. Levels of aggregation should be done with some caution and where possible, drawing on national level surveys are preferable. iii) as the main source of data for this indicator is drawn from coverage surveys (DHS or household), availability of consistent data on a yearly basis will fluctuate and the number of projects and/or countries which aggregates represent should be noted.

KPI 9 - # of people who have experienced, or are at risk of, any form of SGBV that have received related services in the previous 12 months through GAC-funded projects

Section 1: Tombstone	
Indicator Number	SRHR KPI 9
Key Performance Indicator (KPI)	**# of people who have experienced, or are at risk of, any form of SGBV that have received related services in the previous 12 months through GAC-funded projects**
Methodological Summary	This indicator counts the number of people who have received services for any form of SGBV, including referral to health facilities, legal services, women's organizations, and treatment for physical or psychosocial symptoms as a result of an incident of SGBV, and those who have received services in emergency and conflict situations. The collection of this data must follow information-sharing protocols to ensure confidentiality of victim information and data.
Reference(s)	https://www.measureevaluation.org/prh/rh_indicators/womens-health/sgbv/number-of-individuals-using-sgbv-social-welfare Types of Services and Standards (UNFPA): https://www.unfpa.org/featured-publication/gbvie-standards; UNFPA: https://www.unfpa.org/sites/default/files/pub-pdf/GBVIE.Minimum.Standards.Publication.FINAL_.ENG_.pdf

Section 2: Indicator Terminology Definitions	
Provide definitions for terminology that is specialized or specific to the indicator	
SGBV	Any act violence that results in, or is likely to result in, physical, sexual, or psychological harm directed at any individual based on biological sex, gender identity or socially defined norms of masculinity and femininity occurring in public or private life, including in humanitarian emergencies and situations of armed conflict. Much of sexual and gender-based violence is perpetrated by men specifically against women and girls, which stems from the unequal power relations and influence of women and girls in society (social norms). Marginalized groups, including persons with disabilities and those in the Lesbian, Gay, Bi-sexual and Transgender community, are also at a higher risk of experiencing sexual and gender-based violence. It encompasses, but is not limited to physical, sexual and psychological violence occurring in the family, including battering, intimate partner violence, sexual abuse of female and male children in the household, dowry related violence, honour-based violence, marital rape, female genital mutilation, child early and forced marriage and other traditional practices harmful to women, non-spousal violence and violence related to exploitation; physical, sexual and psychological violence occurring within the general community, including rape, sexual abuse, sexual harassment and intimidation at work, in educational institutions and elsewhere; coercion, arbitrary deprivation of liberty or trafficking in women and girls and forced prostitution. It also encompasses violations in conflict situations, including systematic rape, sexual slavery and forced pregnancy; forced sterilization, forced abortion, coerced or forced use of contraceptives; prenatal sex selection; and female infanticide (references: UNPFA, WHO, USAID). Violations in conflict situations can also constitute violations of international humanitarian law, war crimes, and crimes against humanity or genocide. Sexual and Gender Based Violence (SGBV) and Gender Based Violence (GBV) are often used interchangeably, however GAC will use the terminology of SGBV which appears in the FIAP.
SGBV related services	Services include, but are not limited to safe space and shelter, crisis hotlines, case management services including counselling and psychosocial support, safety planning, legal aid, child welfare, programs for abused children, crisis intervention services, including training and self-defense, identification of survivors, necessary health services and treatment, and referrals to community-based resources such as legal aid, safe shelter and social services. In certain contexts services may also include referral help lines. Services are provided irrespective of sex or sexual identity, tribe, religion, geographical location or age.
GAC funded projects	GAC support can be financial or non-financial (e.g. funding for core administrative functions, funding for program delivery or activities, technical assistance or capacity-building), provided directly or through an intermediary implementing partner.

Section 3: Indicator Type

Please select an indicator from the drop down menu
Commonly-Used (Standard) Indicator: an indicator that is standard for a sector or a theme and used commonly by practitioners. Standard indicators are based on, either evolving best practice, or international standards where they exist.

Section 4: For Consolidated Indicators fill out Section 4a. For Commonly Used (Standard) Indicators, fill out Section 4b.	
Section 4a: For Consolidated Indicators Only - Examples of Project-level Family Member Indicators	
If this is a consolidated indicator, provide a list of possible project-level indicators that could be included as 'family members'. Also specify how each of the family members will be used to calculate the consolidated actual data for this indicator and targets. Where family indicators are listed, also include indicator reference, where available.	
Section 4b: For Commonly Used (Standard) Indicators Only - Examples of Alternative Formulations	
Identify examples of alternative formulations for this standard or commonly-used (standard indicator)	
# of children/adolescents (10- 19)/adults who used SGBV services during a specific time period	Measure Evaluation https://www.measureevaluation.org/prh/rh_indicators/womens-health/sgbv
# of children/adolescents (10-19)/adults who have received treatment for SGBV	
# of children/adolescents (10-19)/adults who have received psychosocial services as a result of SGBV	
# of children/adolescents (10-19)/adults who have received legal services as a result of SGBV	
# of children/adolescents (10-19)/adults who have been referred to legal services	
# of children/adolescents (10-19)/adults who have been referred to counselling and psychosocial services	
# of children/adolescents (10-19)/adults who have received safe shelter as a result of SGBV	
# of children/adolescents (10-19)/adults who have accessed referral help lines	
# of individuals using SGBV social services	Measure SGBV Indicator
# of cases of SGBV reported to health services	Measure SGBV Indicator

Section 5: Data Disaggregation
Specify the dimensions of disaggregation for this indicator, e.g. by sex, by age, by rural vs urban, etc. Specify how to handle any non-disaggregated data when reporting. Make sure to include units of measurement and the denominator. Although every effort should be made to disaggregate data, in the case where the project data contributing to this indicator not disaggregated, it will be important to report on non-disaggregated data, alongside the disaggregated data, eg. total: X (male: A; female: B, non-disaggregated: C)total
By sex and age group (0-5, 6-9, 10-14, 15-19, 20+) - *See limitations note on age disaggregation*

Section 6: Calculation Methodology
The calculation methodology is the basis for all data calculations. Tailor the calculation methodology below as required for this indicator.

The result for this indicator is calculated by totaling the results of all relevant indicators, including the disaggregation groups:

i)Total number of women that have received SGBV related services + Total number of men that have received SGBV related services
ii) Total number of female adolescents that have received SGBV related services + Total number of male adolescents that have received SGBV related services
iii) Total number of female children that have received SGBV related services + Total number of male children that have received SGBV related services

Section 7: Data Source

Project Reports, Performance Measurement Frameworks
Original Source: Service registers

Section 8: Reporting Frequency

Annually

If Other, Specify

Section 9: Data Constraints and Limitations

i) Data on gender-based violence reflects only reported incidents and cannot capture the scope of the problem. In addition, this indicator cannot capture or measure the quality of SGBV services provided, nor if such services were provided in a timely manner.
ii) This indicator has the potential for double counting as GAC-funded projects may not be able to necessarily capture unique numbers as records are highly sensitive and ethical guidelines do not permit identification of victims, rather it may include the number of contacts. Individuals who have experienced SGBV may access multiple services across the range of services required (treatment, psychosocial, referral, legal). While efforts should be made to avoid duplication, it is recognized that the indicator will capture people multiple times when they receive multiple services. An explanatory note is required to ensure clarity.
iii) The full compendium of SGBV services may include those outside of the scope of GAC-funded projects (e.g. legal services, other organizations providing services based on referrals made) and thus may only capture those related to first contact.
iv) Age groups for this indicator may differ by project and country age categorizations, particulatory beyond 20-24. Where possible the adolescent age group of 10-14 and 15-19 should be maintained, rather than the demographic breakdowns of youth where no global standard exists

KPI 10 - # of women and girls, men and boys, demonstrating positive attitudes towards ending SGBV through GAC-funded projects

Section 1: Sexual Reproductive Health and Rights	
Indicator Number	SRHR KPI 10
Key Performance Indicator (KPI)	**# of women and girls, men and boys, demonstrating positive attitudes towards ending SGBV through GAC-funded projects**
Methodological Summary	Developing “positive” attitudes toward ending SGBV is an important objective to reducing prevalence. This indicator is a composite measure that covers attitudes toward the select topics and issues of primary importance for protecting the RH of adolescents and/or those the program emphasized. It is based on the same indicator construction as the official DHS Measure indicator: % of adolescents who have "positive" attitudes toward key sexual and reproductive health issues. The indicator measures the current attitude and is not a reflection and does not necessarily predict future behaviours.
Reference(s)	For example of attitudes of health workers of SGBV survivors see Measure Evaluation: https://www.measureevaluation.org/prh/rh_indicators/womens-health/sgbv/attitudes-of-health-care-providers-towards-sgbv-survivors-or-services For example of 'positive attitude' measurement related to SRHR (not SGBV), see Measure Evaluation: https://www.measureevaluation.org/prh/rh_indicators/womens-health/arh/percent-of-adolescents-who-have-positive-attitudes

Section 2: Indicator Terminology Definitions	
Provide definitions for terminology that is specialized or specific to the indicator	
Positive attitudes	Positive" attitudes are those logically expected to lead to positive outcome towards ending SGBV, and the belief that SGBV should be ended. It is not merely one's attitudes specifically about the topic of sexual violence or other forms of gender-based violence that drive that behavior, necessarily, but rather ascribing to a broader worldview that reflects "harmful masculine norms" in all of its manifestations. As such, it is advised to include a scale of attitudes reflecting multiple aspects of these harmful norms, rather than just what people specifically tell us about S/GBV. It is also advised, if using surveys, to use negatively-framed attitude statements and ask participants whether they agree or disagree – these produce more accurate and useful response (PROMUNDO) The topics and issues included should reflect those of primary importance for protecting the rights of women and girls against SGBV and/or those the program emphasized. Can include distinguishing different types of violence, describing the characteristics of victims and perpetrators and to discuss about the psychological consequences for the victims of violence view of the intimate relationship between a man and a woman, etc.

SGBV	Any act violence that results in, or is likely to result in, physical, sexual, or psychological harm directed at any individual based on biological sex, gender identity or socially defined norms of masculinity and femininity occurring in public or private life, including in humanitarian emergencies and situations of armed conflict. Much of sexual and gender-based violence is perpetrated by men specifically against women and girls, which stems from the unequal power relations and influence of women and girls in society (social norms). Marginalized groups, including persons with disabilities and those in the Lesbian, Gay, Bi-sexual and Transgender community, are also at a higher risk of experiencing sexual and gender-based violence. It encompasses, but is not limited to physical, sexual and psychological violence occurring in the family, including battering, intimate partner violence, sexual abuse of female and male children in the household, dowry related violence, honour-based violence, marital rape, female genital mutilation, child early and forced marriage and other traditional practices harmful to women, non-spousal violence and violence related to exploitation; physical, sexual and psychological violence occurring within the general community, including rape, sexual abuse, sexual harassment and intimidation at work, in educational institutions and elsewhere; coercion, arbitrary deprivation of liberty or trafficking in women and girls and forced prostitution. It also encompasses violations in conflict situations, including systematic rape, sexual slavery and forced pregnancy; forced sterilization, forced abortion, coerced or forced use of contraceptives; prenatal sex selection; and female infanticide (references: UNPFA, WHO, USAID).Violations in conflict situations can also constitute violations of international humanitarian law, war crimes, and crimes against humanity or genocide. Sexual and Gender Based Violence (SGBV) and Gender Based Violence (GBV) are used interchangeably, however GAC will use the terminology of SGBV which appears in the FIAP.
GAC funded projects/GAC support	GAC support can be financial or non-financial (e.g. funding for core administrative functions, funding for program delivery or activities, technical assistance or capacity-building), provided directly or through an intermediary implementing partner.

Section 3: Indicator Type
Please select an indicator from the drop down menu
Commonly-Used (Standard) Indicator: an indicator that is standard for a sector or a theme and used commonly by practitioners. Standard indicators are based on, either evolving best practice, or international standards where they exist.

Section 4: For Consolidated Indicators fill out Section 4a. For Commonly Used (Standard) Indicators, fill out Section 4b.	
Section 4a: For Consolidated Indicators Only - Examples of Project-level Family Member Indicators	
If this is a consolidated indicator, provide a list of possible project-level indicators that could be included as 'family members'. Also specify how each of the family members will be used to calculate the consolidated actual data for this indicator and targets. Where family indicators are listed, also include indicator reference, where available	
Section 4b: For Commonly Used (Standard) Indicators Only - Examples of Alternative Formulations	
Identify examples of alternative formulations for this standard or commonly-used (standard indicator)	

Section 5: Data Disaggregation
Specify the dimensions of disaggregation for this indicator, e.g. by sex, by age, by rural vs urban, etc. Specify how to handle any non-disaggregated data when reporting. Make sure to include units of measurement and the denominator. Although every effort should be made to disaggregate data, in the case where the project data contributing to this indicator not disaggregated, it will be important to report on non-disaggregated data, alongside the disaggregated data, eg. total: X (male: A; female: B, non-disaggregated: C)total

By age group (6-9, 10-14, 15-19, 20+)

Section 6: Calculation Methodology

The calculation methodology is the basis for all data calculations. Tailor the calculation methodology below as required for this indicator.

The result for this indicator is calculated by totaling the results of all relevant indicators, including the disaggregation groups:
# of women and girls, men and boys, demonstrating positive attitudes towards ending SGBV through GAC-funded projects
i)Total number of women demonstrating positive attitudes towards ending SGBV + Total number of men demonstrating positive attitudes towards ending SGBV
ii) Total number of female adolescents demonstrating positive attitudes towards ending SGBV + Total number of male adolescents demonstrating positive attitudes towards ending SGBV
iii) Total number of female children demonstrating positive attitudes towards ending SGBV + Total number of male children demonstrating positive attitudes towards ending SGBV

Section 7: Data Source

Project Surveys, Project Reports, Performance Measurement Frameworks
Original Source: Knowledge, Attitude, Practice (KAP) Surveys, School-based surveys, Household survey

Section 8: Reporting Frequency

Annually

If Other, Specify

Section 9: Data Constraints and Limitations

i) the original calcualtion of this indicator is based on a series of agreement/disaggreement statements in which individuals rank on a likert scale. As there is no common global standard for this indicator, or GAC promoted methodology and questionnaire, aggregation of results from multiple projects which may use this indicator should be taken with some caution as individual GAC-funded intiatives may draw on a variety of methodologies and methods of computation.
ii) Age groups for this indicator may differ by project and country age categorizations, particulatory beyond 20-24. Where possible the adolescent age group of 10-14 and 15-19 should be maintained, rather than the demographic breakdowns of youth where not global standard exists

KPI 11 - # of health facilities that provide care for complications related to unsafe abortion or, where it is not against the law, that provide safe abortion through GAC-funded projects

Section 1: Sexual Reproductive Health and Rights	
Indicator Number	SRHR KPI 11
Key Performance Indicator (KPI)	**# of health facilities that provide care for complications related to unsafe abortion or, where it is not against the law, that provide safe abortion through GAC-funded projects**
Methodological Summary	This indicator aims to understand the scope of health facilities (primary, secondary, tertiary) supported by GAC-funded projects who provide post-abortion care for complications related to unsafe or incomplete abortions, based on legal frameworks) as well as those who provide safe abortions or post-abortion care by authorized and trained health care providers. Unsafe abortion continues to constitute a major mortality and morbidity burden especially in the developing world. Reducing complications from unsafe abortion also requires increased access to family planning, including emergency contraception, quality services for abortion care (as allowed by law) and post-abortion care (UNFPA). This indicators is based on guidelines from WHO that can help reduce the high levels of maternal morbidity and mortality associated with abortion, whether spontaneous or induced. Every service delivery site at every level of the health system should be equipped and have personnel trained to recognize abortion complications and to provide or refer women for prompt care, 24 hours a day (WHO).
Reference(s)	WHO Health Workers Roles in providing safe abortion care and post-abortion contraception (July 2015) http://apps.who.int/iris/bitstream/handle/10665/181041/9789241549264_eng.pdf;jsessionid=E10EAA2E3704F1D3F17830A2CF2590C2?sequence=1; WHO Technical and Managerial Guidelines for prevention and treatment: http://www.who.int/reproductivehealth/publications/unsafe_abortion/9241544694/en/ http://apps.who.int/iris/bitstream/handle/10665/97415/9789241548717_eng.pdf?sequence=1; https://www.guttmacher.org/abortion-legality-worldwide

Section 2: Indicator Terminology Definitions	
Provide definitions for terminology that is specialized or specific to the indicator	
Care for complications	Based on guidelines from WHO that can help reduce the high levels of maternal morbidity and mortality associated with abortion, whether spontaneous or induced. Five care areas are identified, including i) treatment and completion for incomplete abortion (use of Misoprostol, vacuum aspiration or D&E), ii) failed abortion (cases where women have undergone a surgical or medical abortion, but her pregnancy continues), iii) hemorrhage, iv) infection (facilities equipped and staff trained to provide treatment for infections that may result from unsafe abortions. Such treatment includes the administration of antibiotics and evacuation of the uterus where the infection is caused by retained products of conception, and v) uterine perforation (facilities must be equipped with antibiotics and be capable of conducting laparoscopies and laparotomies to diagnose and repair damaged tissue)
Safe abortions	Abortion is safe when done by a trained health professional using WHO-recommended methods and clinical guidelines, and is considered unsafe when only one of these conditions is met. Includes five core components including i) access to safe abortion to the full extent of the law, ii) access to treatment for complications of spontaneous and unsafe abortion, iii) WHO-recommended surgical and medical methods for uterine evacuation, iv) contraceptive information, counselling, and methods; and v) screening, treatment, and referral for other sexual and reproductive health needs. Refer to WHO Technical and Managerial Guidelines for prevention and treatment: http://www.who.int/reproductivehealth/publications/unsafe_abortion/9241544694/en/

GAC funded projects	GAC support can be financial or non-financial (e.g. funding for core administrative functions, funding for program delivery or activities, technical assistance or capacity-building), provided directly or through an intermediary implementing partner.

Section 3: Indicator Type
Please select an indicator from the drop down menu
Consolidated Indicator: created by GAC from project level indicators that are clustered together with other related indicators (a family of indicators) to form one indicator that will allow aggregation (summarise) related data at the program, branch or corporate level

Section 4: For Consolidated Indicators fill out Section 4a. For Commonly Used (Standard) Indicators, fill out Section 4b.	
Section 4a: For Consolidated Indicators Only - Examples of Project-level Family Member Indicators	
If this is a consolidated indicator, provide a list of possible project-level indicators that could be included as 'family members'. Also specify how each of the family members will be used to calculate the consolidated actual data for this indicator and targets. Where family indicators are listed, also include indicator reference, where available.	
# of health facilities that provide care for complications from unsafe abortions	
# of health facilities that provide safe and legal abortions	
Section 4b: For Commonly Used (Standard) Indicators Only - Examples of Alternative Formulations	
Identify examples of alternative formulations for this standard or commonly-used (standard indicator)	

Section 5: Data Disaggregation
Specify the dimensions of disaggregation for this indicator, e.g. by sex, by age, by rural vs urban, etc. Specify how to handle any non-disaggregated data when reporting. Make sure to include units of measurement and the denominator. Although every effort should be made to disaggregate data, in the case where the project data contributing to this indicator not disaggregated, it will be important to report on non-disaggregated data, alongside the disaggregated data, eg. total: X (male: A; female: B, non-disaggregated: C)total
By facility type (primary, secondary, tertiary)

Section 6: Calculation Methodology
The calculation methodology is the basis for all data calculations. Tailor the calculation methodology below as required for this indicator.
The result for this indicator is calculated by totaling the results of all indicators, including the disaggregation groups: i) Total number of primary/secondary/tertiary health facilities that provide care for complications from unsafe abortions, plus ii) Total number of primary/secondary/tertiary health facilities that provide safe abortion services

Section 7: Data Source
Project Reports, Performance Measurement Frameworks Original Source: Health facility surveys, Checklists

Section 8: Reporting Frequency
Annually

If Other, Specify

Section 9: Data Constraints and Limitations
i) This indicator is not a measure of the quality of services provided for complication, only those facilities which provide the service, irrespective of guidelines.

KPI 12 - # of health professionals trained to provide safe abortion and post-abortion care through GAC-funded projects

Section 1: Sexual Reproductive Health and Rights	
Indicator Number	SRHR KPI 12
Key Performance Indicator (KPI)	**# of health professionals trained to provide safe abortion and post-abortion care through GAC-funded projects**
Methodological Summary	This indicator aims to capture the number of properly trained health-care providers, including non-physician providers who are trained in basic clinical procedures related to reproductive health. Unsafe abortion continues to constitute a major mortality and morbidity burden especially in the developing world. Numerous barriers limit access to safe abortion – one of the most critical is the lack of trained providers.
Reference	WHO Health Workers Roles in providing safe abortion care and post-abortion contraception (July 2015) http://apps.who.int/iris/bitstream/handle/10665/181041/9789241549264_eng.pdf;jsessionid=E10EAA2E3704F1D3F17830A2CF2590C2?sequence=1; WHO Technical and Managerial Guidelines for prevention and treatment: http://www.who.int/reproductivehealth/publications/unsafe_abortion/9241544694/en/

Section 2: Indicator Terminology Definitions	
Provide definitions for terminology that is specialized or specific to the indicator	
Safe abortion care	Abortion is safe when done by a trained health professional using WHO-recommended methods and clinical guidelines, and is considered unsafe when not all conditions are met. Includes five core components including i) access to safe abortion to the full extent of the law, ii) access to treatment for complications of spontaneous and unsafe abortion, iii) WHO-recommended surgical and medical methods for uterine evacuation, iv) contraceptive information, counselling, and methods; and v) screening, treatment, and referral for other sexual and reproductive health needs.
Menstrual Regulation (MR)	In some countries the word 'abortion' is not used. For example, in Bangladesh, abortion is illegal but Menstrual Regulation is legal. Menstrual Regulation is uterine evacuation without laboratory or ultrasound confirmation - a procedure that uses manual vacuum aspiration or a combination of mifepristone and misoprostol to "regulate the menstrual cycle when menstruation is absent for a short duration." Menstrual Regulation performed using medication is referred to as MRM. See: https://www.guttmacher.org/fact-sheet/menstrual-regulation-unsafe-abortion-bangladesh
Post-abortion care	Includes treatment post abortion, including initial management of post-abortion infection, Initial management of post-abortion hemorrhage, Insertion/removal of intrauterine devices (IUDs), Tubal ligation, and post-abortion counselling.
Training in safe abortion/post-abortion care	To be counted as a training, a session must be a minimum of one day based on a recognized curriulum or training package focused partly or in full on the provision of safe abortion/post-abortion care as noted in the PMF indicator. Training can include pre-service, in-service or distance learning. If a training program takes place over a series of days, count the maximum number of health providers trained as reported in the project-level PMF. For distance learning or online learning programs, count the number of participants enrolled in the distance learning program, not the number of sessions they have taken using that modality.
GAC funded projects	GAC support can be financial or non-financial (e.g. funding for core administrative functions, funding for program delivery or activities, technical assistance or capacity-building), provided directly or through an intermediary implementing partner.

Section 3: Indicator Type
Please select an indicator from the drop down menu

Commonly-Used (Standard) Indicator: an indicator that is standard for a sector or a theme and used commonly by practitioners. Standard indicators are based on, either evolving best practice, or international standards where they exist.

Section 4: For Consolidated Indicators fill out Section 4a. For Commonly Used (Standard) Indicators, fill out Section 4b.	
Section 4a: For Consolidated Indicators Only - Examples of Project-level Family Member Indicators	
If this is a consolidated indicator, provide a list of possible project-level indicators that could be included as 'family members'. Also specify how each of the family members will be used to calculate the consolidated actual data for this indicator and targets. Where family indicators are listed, also include indicator reference, where available.	
Section 4b: For Commonly Used (Standard) Indicators Only - Examples of Alternative Formulations	
Identify examples of alternative formulations for this standard or commonly-used (standard indicator)	
# of health providers trained to provide safe abortion	Also counted under Indicator 10
# of health providers trained to provide post abortion care	Also counted under Indicator 10

Section 5: Data Disaggregation
Specify the dimensions of disaggregation for this indicator, e.g. by sex, by age, by rural vs urban, etc. Specify how to handle any non-disaggregated data when reporting. Make sure to include units of measurement and the denominator. Although every effort should be made to disaggregate data, in the case where the project data contributing to this indicator not disaggregated, it will be important to report on non-disaggregated data, alongside the disaggregated data, eg. total: X (male: A; female: B, non-disaggregated: C)total
Sex of health professional; health professional cadre

Section 6: Calculation Methodology
The calculation methodology is the basis for all data calculations. Tailor the calculation methodology below as required for this indicator.
The result for this indicator is calculated by totaling the results of all indicators, including the disaggregation groups: i) Total number of health professionals trained to provide safe abortions + ii) Total number of health professionals trained to provide post-abortion care.

Section 7: Data Source
Project Reports, Performance Measurement Frameworks Original Source: Training registers

Section 8: Reporting Frequency
Annually
If Other, Specify

Section 9: Data Constraints and Limitations
While efforts should be made to avoid duplication, it is recognized that the indicator may capture health professionals multiple times as training may be provided over several sessions. There may be inconsistency how GAC-funded projects track unique individuals who receive training and, in some cases, where aggregations by training is done, rather than total number of health professionals receiving the full complement of trainings. An explanatory note highlighting this limitation may be required.

KPI 13 - # of women provided with a safe, legal abortion or post-abortion care through GAC-funded projects

Section 1: Sexual Reproductive Health and Rights	
Indicator Number	SRHR KPI 13
Key Performance Indicator (KPI)	**# of women provided with a safe, legal abortion or post-abortion care through GAC-funded projects**
Methodological Summary	This indicator aims to understand the scope of women who are provided with safe abortions and post-abortion care, based on national legal frameworks. Information for this indicator is solely based on the collection at health facilities with trained professionals authorized to provide abortion or post-abortion care.
Reference	http://apps.who.int/iris/bitstream/handle/10665/97415/9789241548717_eng.pdf?sequence=1; https://www.guttmacher.org/abortion-legality-worldwide

Section 2: Indicator Terminology Definitions	
Provide definitions for terminology that is specialized or specific to the indicator	
Safe abortion	Abortion is safe when done by a trained health professional using WHO-recommended methods and clinical guidelines, and is considered unsafe when only one of these conditions is met.
Legal abortion	There is a 6 category country classification to compare the legality or illegality of abortions based on what is permitted under national laws. The categories classify countries according to those that permit abortions without any restrictions as to reason, those where abortion is prohibited altogether, and those which legally allow abortions in limited situations such as when a women's life is in physical danger, in cases of rape or incest, or incases of fetal abnormality. Legal abortions do not always equate to safe abortions. https://www.guttmacher.org/abortion-legality-worldwide
Menstral Regulation (MR)	In some countries the word 'abortion' is not used. For example, in Bangladesh, abortion is illegal but Menstrual Regulation is legal. Menstrual Regulation is uterine evacuation without laboratory or ultrasound confirmation - a procedure that uses manual vacuum aspiration or a combination of mifepristone and misoprostol to “regulate the menstrual cycle when menstruation is absent for a short duration.” Menstrual Regulation performed using medication is referred to as MRM. See: https://www.guttmacher.org/fact-sheet/menstrual-regulation-unsafe-abortion-bangladesh
Post-abortion care	Includes treatment post abortion, including initial management of post-abortion infection, Initial management of post-abortion hemorrhage, Insertion/removal of intrauterine devices (IUDs), Tubal ligation, and post-abortion counselling
GAC funded projects	GAC support can be financial or non-financial (e.g. funding for core administrative functions, funding for program delivery or activities, technical assistance or capacity-building), provided directly or through an intermediary implementing partner.

Section 3: Indicator Type
Please select an indicator from the drop down menu
Commonly-Used (Standard) Indicator: an indicator that is standard for a sector or a theme and used commonly by practitioners. Standard indicators are based on, either evolving best practice, or international standards where they exist.

Section 4: For Consolidated Indicators fill out Section 4a. For Commonly Used (Standard) Indicators, fill out Section 4b.
Section 4a: For Consolidated Indicators Only - Examples of Project-level Family Member Indicators

If this is a consolidated indicator, provide a list of possible project-level indicators that could be included as 'family members'. Also specify how each of the family members will be used to calculate the consolidated actual data for this indicator and targets. Where family indicators are listed, also include indicator reference, where available.

Section 4b: For Commonly Used (Standard) Indicators Only - Examples of Alternative Formulations
Identify examples of alternative formulations for this standard or commonly-used (standard indicator)
# of women who are provided with safe abortion services and care
# of women who are provided with post-abortion care

Section 5: Data Disaggregation
Specify the dimensions of disaggregation for this indicator, e.g. by sex, by age, by rural vs urban, etc. Specify how to handle any non-disaggregated data when reporting. Make sure to include units of measurement and the denominator. Although every effort should be made to disaggregate data, in the case where the project data contributing to this indicator not disaggregated, it will be important to report on non-disaggregated data, alongside the disaggregated data, eg. total: X (male: A; female: B, non-disaggregated: C)total
Disaggregate where possible by age groups, 10-14, 15-19 and 20-49.

Section 6: Calculation Methodology
The calculation methodology is the basis for all data calculations. Tailor the calculation methodology below as required for this indicator.
The result for this indicator is calculated by totaling the results of all indicators, including the disaggregation groups: i) Total number of women/female adolescents who received safe abortions + ii) Total number of women/female adolescents who are provided with post-abortion care.

Section 7: Data Source
Health Management Information Systems, Project Reports, CHW registers

Section 8: Reporting Frequency
Annually
If Other, Specify

Section 9: Data Constraints and Limitations
i) The indicator is compounded and thus it should be noted that total values may result in double counting as a large proportion of women who obtain safe/legal abortions at a health facility may also receive immediate post-abortion care. Disaggregating the indicator further by abortion and post-abortion services and reporting this separately can mitigate against this,. ii) In terms of disaggregation, it should be noted that in some contexts the age group 10-14 is not appropriate, nor available and is depending on the quality of facility records where legal abortions are performed.

KPI 14 - # of advocacy and public engagement activities completed by GAC-funded partners which are focused on SRHR

Section 1: Sexual Reproductive Health and Rights	
Indicator Number	SRHR KPI 14
Key Performance Indicator (KPI)	**# of advocacy and public engagement activities completed by GAC-funded partners which are focused on SRHR**
Methodological Summary	This is a consolidated indicator intending to capture the range of activities intended to inform and engage public citizens about SRHR, and to solicit public citizen involvement in policy and programming decision-making related to SRHR. It may include activities aimed at informing citizens about their sexual and reproductive health and rights, including the provision of tools and resources, about activities or policies of government bodies related to SRHR. It may also include activities aimed at promoting change in laws or policies related to SRHR through a variety of platforms.
Reference	IPPF Institutional Data Guidelines: Measuring IPPF Performance, 2016-2022

Section 2: Indicator Terminology Definitions	
Provide definitions for terminology that is specialized or specific to the indicator	
Advocacy	IPPF Definition: An ongoing strategic process to influence an officially-established law or policy making authority to change, defend or ensure implementation of specific, laws, policies, regulations and funding. This can be conducted at different levels - subnational, national, regional and global - to improve, protect and fulfill sexual reproductive rights of people. In addition, it is the deliberate process of influencing the laws, policies and actions of governments at all levels, international institutions and the private sector in order to achieve positive changes in women's and girls' sexual and reproductive health and rights. Advocacy encompasses petitioning decision-makers inside and outside government, public campaigning, and policy analysis and research related to public campaigning efforts.
Public Engagement	Active participation both in-Canada and in-recipient country of civil society actors, women's organizations, and the general public in activities which aim to raise awareness, inform, inspire, or education about SRHR issues and topics. This can include anything from donation of funds to organization, the provision of feedback in forum, participating in a consultation, attending public events, training to the public or receipt of information related to SRHR. In some cases this can also include website hits or tweets on information related to SRHR. Public engagement can equally include new partnerships forged between institutions to collaborate on an initiative for public consumptions, or initiatives which inform, influence or change audience decisions and/or advocate for changes.
Advocacy Activities	Examples of advocacy activities include but are not limited to: activities aimed at the removal of judicial and legal barriers to the fulfillment of SRHR for marginalized or vulnerable groups, including access to safe and legal abortion; strengthening of accountability mechanisms for SRHR; and supporting SRHR advocacy and campaigns by women's rights, feminist, youth, indigenous, and LGBTQ2 civil society groups, particularly those that work to challenge social norms that limit an individual's control over their body and/or that limit their sexual and reproductive decision-making.If adovacy activities take place in a number of institutions (e.g. 200 schools), count each institutional advocacy activity as one (e.g. 200). One-off meetings which sole objective is to talk to existing policy or provide recommendations for changes to policy should also be included, as well as the number of events in a national campaign. Other inclusions include: being invited to a meeting to contribute expert opinion to bills on high level panels, public debates, convening advocacy coalitions, organizing a platform at various levels, training of advocates to champion work, etc.
GAC-funded partners	Organizations in receipt of financial support or funds originating from Global Affairs Canada, which can include funding for core administrative functions, funding for program delivery or activities, and provision of technical assistance or capacity-building. Funding may be provided directly or through an intermediary implementing partner.

SRHR	Sexual and reproductive health is a state of physical, emotional, mental, and social wellbeing in relation to all aspects of sexuality and reproduction, not merely the absence of disease, dysfunction, or infirmity. Therefore, a positive approach to sexuality and reproduction should recognize the part played by pleasurable sexual relationships, trust, and communication in the promotion of self-esteem and overall wellbeing. All individuals have a right to make decisions governing their bodies and to access services that support that right. Achievement of sexual and reproductive health relies on the realization of sexual and reproductive rights, which are based on the human rights of all individuals to: have their bodily integrity, privacy, and personal autonomy respected; freely define their own sexuality, including sexual orientation and gender identity and expression; decide whether and when to be sexually active; choose their sexual partners; have safe and pleasurable sexual experiences; decide whether, when, and whom to marry; decide whether, when, and by what means to have a child or children, and how many children to have; have access over their lifetimes to the information, resources, services, and support necessary to achieve all the above, free from discrimination, coercion, exploitation, and violence. Essential sexual and reproductive health services must meet public health and human rights standards, including the "Availability, Accessibility, Acceptability, and Quality" framework of the right to health. The services should include: accurate information and counselling on sexual and reproductive health, including evidence-based, comprehensive sexuality education; information, counselling, and care related to sexual function and satisfaction; prevention, detection, and management of sexual and gender-based violence and coercion; a choice of safe and effective contraceptive methods; safe and effective antenatal, childbirth, and postnatal care; safe and effective abortion services and care; prevention, management, and treatment of infertility; prevention, detection, and treatment of sexually transmitted infections, including HIV, and of reproductive tract infections; and prevention, detection, and treatment of reproductive cancers. (Reference, Guttmacher/Lancet: https://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(18)30293-9.pdf)

Section 3: Indicator Type
Please select an indicator from the drop down menu
Consolidated Indicator: created by GAC from project level indicators that are clustered together with other related indicators (a family of indicators) to form one indicator that will allow aggregation (summarise) related data at the program, branch or corporate level

Section 4: For Consolidated Indicators fill out Section 4a. For Commonly Used (Standard) Indicators, fill out Section 4b.	
Section 4a: For Consolidated Indicators Only - Examples of Project-level Family Member Indicators	
If this is a consolidated indicator, provide a list of possible project-level indicators that could be included as 'family members'. Also specify how each of the family members will be used to calculate the consolidated actual data for this indicator and targets. Where family indicators are listed, also include indicator reference, where available.	
# of advocacy activities completed by GAC-funded partners which are focused on SRHR	
# of public engagement activities completed by GAC-funded partners which are focused on SRHR	
# of activities from SRHR KPI 16	
Section 4b: For Commonly Used (Standard) Indicators Only - Examples of Alternative Formulations	
Identify examples of alternative formulations for this standard or commonly-used (standard indicator)	

Section 5: Data Disaggregation

Specify the dimensions of disaggregation for this indicator, e.g. by sex, by age, by rural vs urban, etc. Specify how to handle any non-disaggregated data when reporting. Make sure to include units of measurement and the denominator. Although every effort should be made to disaggregate data, in the case where the project data contributing to this indicator not disaggregated, it will be important to report on non-disaggregated data, alongside the disaggregated data, eg. total: X (male: A; female: B, non-disaggregated: C)total)

By geography (Canada versus International), and Type (public engagement versus advocacy).

Section 6: Calculation Methodology

The calculation methodology is the basis for all data calculations. Tailor the calculation methodology below as required for this indicator.

The result for this indicator is calculated by totaling the results of all family indicators, including the disaggregation groups:
i) Total number of advocacy activities focused on SRHR + ii) Total number of public engagement activities focused on SRHR

To report on this indicator, a review of both output and outcomes of project-level PMFs should be carried out as advocacy activities can appear at both levels.

Section 7: Data Source

Project Reports, Performance Measurement Frameworks
Original Source:

Section 8: Reporting Frequency

Annually

If Other, Specify

Section 9: Data Constraints and Limitations

i) Please note that this indicator only captures advocacy (and PE activities) and not the effect of the adovacy activities. As per IPPF, a documented record of policy changes as it relates to SRH should be kept in order to report to the higher level result.

KPI 15 - # of national laws, policies and strategies relating to SRHR implemented or strengthened, through GAC-funded projects

Section 1: Sexual Reproductive Health and Rights	
Indicator Number	SRHR KPI 15
Key Performance Indicator (KPI)	**# of national laws, policies and strategies relating to SRHR implemented or strengthened, through GAC-funded projects**
Methodological Summary	This is a consolidated indicator focused on the legislative, policy, regulatory and strategy environment for SRHR. It combines attention to reduction of barriers that prevent the implementation and realization of sexual and reproductive health and rights, with attention to strengthening the facilitative factors enabling SRHR achievement or realization. Laws, policies and regulations that have an impact on achievement of SHRH may include laws constraining access to SHRH options or services (including age-related restrictions on family planning access, and abortion laws), tax and import policies focused on contraceptive commodities or SRHR-related medicines or devices; advertising and promotion regulations; and restrictive regulations affecting non-profit organizations or commercial sectors involved in provision of SRHR information or services. GAC's support may contribute to actions leading to changes in these laws, policies or strategies.
Reference(s)	Reference on SRHR: https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)30293-9/fulltext?code=lancet-site

Section 2: Indicator Terminology Definitions	
Provide definitions for terminology that is specialized or specific to the indicator	
Sexual and Reproductive Health and Rights (SRHR)	Sexual and reproductive health is a state of physical, emotional, mental, and social wellbeing in relation to all aspects of sexuality and reproduction, not merely the absence of disease, dysfunction, or infirmity. Therefore, a positive approach to sexuality and reproduction should recognize the part played by pleasurable sexual relationships, trust, and communication in the promotion of self-esteem and overall wellbeing. All individuals have a right to make decisions governing their bodies and to access services that support that right. Achievement of sexual and reproductive health relies on the realisation of sexual and reproductive rights, which are based on the human rights of all individuals to: have their bodily integrity, privacy, and personal autonomy respected; freely define their own sexuality, including sexual orientation and gender identity and expression; decide whether and when to be sexually active; choose their sexual partners; have safe and pleasurable sexual experiences; decide whether, when, and whom to marry; decide whether, when, and by what means to have a child or children, and how many children to have; have access over their lifetimes to the information, resources, services, and support necessary to achieve all the above, free from discrimination, coercion, exploitation, and violence.The essential package of sexual and reproductive health interventions include: Comprehensive sexuality education; Counselling and services for a range of modern contraceptives, with a defined minimum number and types of methods; Antenatal, childbirth, and postnatal care, including emergency obstetric and newborn care; Safe abortion services and treatment of complications of unsafe abortion; Prevention and treatment of HIV and other sexually transmitted infections; Prevention, detection, immediate services, and referrals for cases of sexual and gender-based violence; Prevention, detection, and management of reproductive cancers, especially cervical cancer; Information, counselling, and services for sexual health and wellbeing. (Reference, Guttmacher/Lancet: https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)30293-9/fulltext?code=lancet-site)

Implemented	Implemented for laws implies enacted (coming into force) with some evidence of monitoring or enforcement. For policies, strategies or regulations, "implemented" implies that they are being carried-out by the appropriate or designated agencies or institutions (Ministries of Health, local health departments, health facilities, communities) fully or at least substantially. Assessment of implementation requires some form of monitoring or review and could also potentially include surveys of facilities or service users.
Strengthened	Within the context of SHRH, "strengthened" means that a law, policy, strategy or regulation was altered in a way that moved it closer to embracing the full components of SRHR according to the Lancet/Guttmacher definition, and/or closer to meeting public health and human rights standards including equity and removal of all types of discrimination. High priority legal and policy reforms supporting SRHR include outlawing child marriage or female genital mutilation, promoting gender equality and women's autonomy, liberalizing abortion laws, prohibiting discrimination against people with diverse sexual orientations or gender identity and expression, and putting in place strategies and service delivery standards that make SRHR services more comprehensive and ensure all individuals can receive the information and services needed to protect and implement their reproductive choices. See also the section on "Advancing human rights to reduce stigma, discrimination and violence related to HIV" (paragraphs 77-85) within http://files.unaids.org/en/media/unaids/contentassets/documents/document/2011/06/20110610_UN_A-RES-65-277_en.pdf
Strategies/policies	Refer to government strategies or policy designed to achieve a major or overall aim. Strategies can be at the local level all the way up to the national level, however this indicator is concerned with the highest level national strategies, such as National Health Strategies or Policies and National Plans related to Reproductive, Maternal, Neonatal, Child, Adolescent Health at the as these represent the most important documents guiding country health programming. It does not include action plans, a policy working group, or training provided.
GAC funded projects/GAC support	GAC support can be financial or non-financial (e.g. funding for core administrative functions, funding for program delivery or activities, technical assistance or capacity-building), provided directly or through an intermediary implementing partner.

Section 3: Indicator Type
Please select an indicator from the drop down menu
Consolidated Indicator: created by GAC from project level indicators that are clustered together with other related indicators (a family of indicators) to form one indicator that will allow aggregation (summarise) related data at the program, branch or corporate level

Section 4: For Consolidated Indicators fill out Section 4a. For Commonly Used (Standard) Indicators, fill out Section 4b.
Section 4a: For Consolidated Indicators Only - Examples of Project-level Family Member Indicators
If this is a consolidated indicator, provide a list of possible project-level indicators that could be included as 'family members'. Also specify how each of the family members will be used to calculate the consolidated actual data for this indicator and targets. Where family indicators are listed, also include indicator reference, where available.
Projects working on improving the legal, policy, strategy and regulatory environments for SHRH may contain indicators such as those below. This is intended to be an indicative rather than an exhaustive list. Additional indicators may be developed by individual projects, but should include reference to strategies, regulations, policies or laws.
Number of policy, regulatory, or legislative barriers preventing full, equitable or affordable access to SRHR information and services identified and reduced
Evidence that policy barriers to equitable and affordable SRHR information and services have been addressed or removed
Number of SRHR-related strategies, policies, regulations or laws adopted or improved
Existence of national/subnational policies or strategic plans that promote equitable and affordable access to high-quality family planning and reproductive health services and information
Number of improvements made to laws policies, strategies and regulations to enable improved accessibility, affordability or equity of SRHR information and services

Evidence from monitoring systems that progress has been made in implementing family planning/reproductive health/SRHR policies and plans
Existence or improvements of legal and policy frameworks to promote, enforce and monitor equality and non-discrimination on the basis of sex, gender or sexual orientation
Section 4b: For Commonly Used (Standard) Indicators Only - Examples of Alternative Formulations
Identify examples of alternative formulations for this standard or commonly-used (standard indicator)

Section 5: Data Disaggregation
Specify the dimensions of disaggregation for this indicator, e.g. by sex, by age, by rural vs urban, etc. Specify how to handle any non-disaggregated data when reporting. Make sure to include units of measurement and the denominator. Although every effort should be made to disaggregate data, in the case where the project data contributing to this indicator not disaggregated, it will be important to report on non-disaggregated data, alongside the disaggregated data, eg. total: X (male: A; female: B, non-disaggregated: C)total)
No disaggregation required by the indicator. Optional disaggregation could be by intervention area strengthened (law, policy, strategy, regulation) Global regions (for aggregation)

Section 6: Calculation Methodology
The calculation methodology is the basis for all data calculations. Tailor the calculation methodology below as required for this indicator.
The result for this indicator is calculated by totaling the results of all family indicators, including the disaggregation groups:i) Total number of laws, policies and strategies considered to be fully or substantially "implemented" (enacted in the case of law) + ii) Total number of laws, policies and strategies considered to be strengthened in relation to SRHR

Section 7: Data Source
Project Reports, Performance Measurement Frameworks Original source: Review of relevant national laws, national or regional policies, strategic frameworks and documents; surveys (e.g. of health facilities, to assess policy or strategy implementation, or of public opinion, to assess access or treatment changes)

Section 8: Reporting Frequency
Other
Biennial

Section 9: Data Constraints and Limitations
i) This is a compound indicator in that it measures two things: both the implementation of laws, strategies and policies where are developed and/or enacted, as well as those which are strengthened including where revisions or adaptations are made to increase their effectiveness. ii) As legislative and policy work is a lengthy process, it is not anticipated that new policies or laws will come into play on a yearly basis.

KPI 16 - # of women's rights organizations and networks (international and local) advancing SRHR that receive direct GAC support or that receive support from GAC-funded partners

Section 1: Sexual Reproductive Health and Rights	
Indicator Number	SRHR KPI 16
Key Performance Indicator (KPI)	**# of women's rights organizations and networks (international and local) advancing SRHR that receive direct GAC support or that receive support from GAC-funded partners**
Methodological Summary	This indicator refers to understanding the scope of GAC-funded projects whereby women's organizations, networks or coalitions promote SHRH including advancements towards policy, improved services, and/or provision of information on SRHR to its constituents, including providing space for women and girls to make informed decisions related to their sexual and reproductive health and rights. It should not be interpreted as mere participation in the project, but is intended to reflect meaningful input into advancing SHRH in targeted areas.
Reference(s)	

Section 2: Indicator Terminology Definitions	
Provide definitions for terminology that is specialized or specific to the indicator	
Women's groups/organizations	Local, national or international women's groups including feminist organizations, women-led organizations, as well as groups representing women's interests. These groups advance women's rights and gender equality. Also inclusive of civil society organizations founded and led by women and girls. They are active at the grassroots, national, regional and international levels and exist to bring about transformative change for gender equality and the rights and empowerment of women and girls, including the right to safe abortions. Their activities include advocacy, policy and budget dialogue, awareness-raising, service provision, research, and alliance and network building.
Networks	Local, national or international networks of organizations, including women's coalitions, that share similar thematic agendas and associations. Specifically these networks aim to advance women's rights and gender equality and can be either formal or informal groups of organizations, and, sometimes, individuals coming together voluntarily to pursue shared aspirations for transformative change for gender equality and the rights and empowerment of women and girls that they cannot achieve alone. Through networks and alliances, the power and influence of a collective voice is enhanced. They may address common social goals, express their identities as a community or social group, exchange information and resources or develop and implement coordinated activities. In civil society networks, member organizations retain their basic autonomy, with their own identity, mission, and governance.
Advancing SHRH	Advancing SHRH includes a wide range of interventions both in terms of advancements towards policy, services and/or information. These are initiatives that contribute to health sector reforms, including from civil society advocates and social movements in demanding legislative, social and policy reforms for advancing sexual and reproductive rights in line with human rights principles and by ensuring that financing, services, supplies, human resources training and deployment, management, regulation and monitoring of SRH services achieve the key elements of the right to health, i.e., availability, accessibility (including affordability), acceptability and quality (UNESCO, 2000; WHO, 2005); empower women and girls to make informed decisions about their bodies and sexuality by providing them information and training on various issues related to their sexual and reproductive health and rights (SRHR).
GAC support	GAC support can be financial or non-financial (e.g. funding for core administrative functions, funding for program delivery or activities, technical assistance or capacity-building), provided directly or through an intermediary implementing partner.

Section 3: Indicator Type
Please select an indicator from the drop down menu
Consolidated Indicator: created by GAC from project level indicators that are clustered together with other related indicators (a family of indicators) to form one indicator that will allow aggregation (summarise) related data at the program, branch or corporate level

Section 4: For Consolidated Indicators fill out Section 4a. For Commonly Used (Standard) Indicators, fill out Section 4b.

Section 4a: For Consolidated Indicators Only - Examples of Project-level Family Member Indicators	
If this is a consolidated indicator, provide a list of possible project-level indicators that could be included as 'family members'. Also specify how each of the family members will be used to calculate the consolidated actual data for this indicator and targets. Where family indicators are listed, also include indicator reference, where available	
# of women's rights organizations advocating for SRHR policy change	
# of networks or coalitions advocating for SRHR policy change	
# of women's rights organizations disseminating SRHR information to constituents	
# of networks or coalitions disseminating SRHR information to constituents	

Section 4b: For Commonly Used (Standard) Indicators Only - Examples of Alternative Formulations
Identify examples of alternative formulations for this standard or commonly-used (standard indicator)

Section 5: Data Disaggregation
Specify the dimensions of disaggregation for this indicator, e.g. by sex, by age, by rural vs urban, etc. Specify how to handle any non-disaggregated data when reporting. Make sure to include units of measurement and the denominator. Although every effort should be made to disaggregate data, in the case where the project data contributing to this indicator not disaggregated, it will be important to report on non-disaggregated data, alongside the disaggregated data, eg. total: X (male: A; female: B, non-disaggregated: C)total)
International and local organizations. Global regions (for aggregation)

Section 6: Calculation Methodology
The calculation methodology is the basis for all data calculations. Tailor the calculation methodology below as required for this indicator.
The result for this indicator is calculated by totaling the results of all family indicators, including the disaggregation groups: i) Total number of local women's rights organizations/coalitions that advance SRHR + ii) Total number of international women's rights organizations/coalitions that advance SRHR

Section 7: Data Source
Project Reports, Performance Measurement Frameworks Original Source: Meeting minutes, news broadcasts, event reports,

Section 8: Reporting Frequency
Annually
If Other, Specify

Section 9: Data Constraints and Limitations
i) The primary limitation is that women's organizations, in some cases, may also hold membership or be associated with national networks or associations and thus some double counting may occur. If the organization is a coalition, there may be multiple groups with the coalition or organization. If the work is primarily with a coalition, then it is considered one group and not all groups within the coalition are counted. If the individual groups within the coalition or organization take separate actions and implementing partner engages with the group individually, then the group can be counted. If the implementing partner works with the group or organization on several actions in one year, it is still counted as one as it is the unique organization that is counted and not the individual actions. For example, if in Y2 the organization is delivering actions, it is counted as one.