



INTEGRATING GENDER EQUALITY, DISABILITY EQUITY AND SOCIAL INCLUSION INTO MONITORING, EVALUATION, LEARNING AND REPORTING PROCESSES WITHIN DFAT HEALTH PROGRAMS

Guidance Note

Effective gender equality, disability equity and social inclusion (GEDSI) approaches and outcomes in health programs are important in addressing health inequities and improving development effectiveness. Good quality monitoring, evaluation and learning (MEL) enables program teams to identify the most effective implementation approaches to GEDSI and to monitor risks and unintended consequences of program activities (both positive and negative).

This guidance note outlines how to integrate gender equality, disability and social inclusion into design, monitoring, evaluation, and learning (MEL) processes and frameworks in DFAT health programs. It draws from and aligns with DFAT's guidance on gender equality, disability equity and monitoring and evaluation, and recognises quality design, MEL and GEDSI approaches as important requirements for DFAT's programs.

MEL systems for health programs should reflect program scale, funding size and available resources. The integration of GEDSI into design and MEL processes should be grounded in strong analysis and contextual understanding, reflect the scope of a program, and be adaptive to program learning and ongoing analysis of progress towards the achievement of outcomes.

KEY STEPS FOR EFFECTIVE GEDSI IN MEL PROCESSES AND REPORTING IN HEALTH PROGRAMS

1. Undertake GEDSI analysis during design phase to identify how the program can most effectively progress GEDSI objectives.
2. Utilise GEDSI analysis to inform the program's theory of change and integrate GEDSI into the program logic, developing clear GEDSI outcomes.
3. Integrate both qualitative and quantitative GEDSI indicators into MEL systems to measure End of Program Outcomes (EOPOs), Intermediate Outcomes (IOs) and the effectiveness of GEDSI inputs and outputs.
4. Collect, analyse and report disaggregated data that enables the monitoring of results by gender, disability and other relevant aspects of social inclusion.
5. Report on GEDSI-related processes and progress towards anticipated outcomes.
6. Actively explore avenues for learning and adjustment, embedding GEDSI data (qualitative and quantitative) into program learning and annual planning.
7. Embed GEDSI principles into evaluation exercises and ensure mid-term and end of program reviews include resources, processes and questions for evaluating GEDSI outcomes and lessons learned.

WHAT TO CONSIDER DURING DESIGN TO SUPPORT GEDSI-RESPONSIVE MEL PLANS

The foundation of effective GEDSI MEL and reporting is good program design. Integrating GEDSI considerations from the outset provides the foundation for accurately measuring the impact of health programs on women and girls, people of diverse genders, people with disabilities, and other groups who experience social disadvantage and health inequities. Good design helps identify the best GEDSI outcomes and ways to measure GEDSI and begins by using GEDSI analysis to shape outcomes and approaches. GEDSI analysis may challenge foundational assumptions about what is needed or how it should be delivered, particularly where a goal is related to ‘universal’ access and outcomes. It is more efficient and effective to integrate GEDSI analysis findings early in the program cycle rather than after implementation has begun.

GEDSI analysis and program design

- Ensure the design team has GEDSI expertise or, at a minimum, have a plan for how they will access it.
- Identify key local GEDSI stakeholders and engage them in informing analysis and design. This may include women in all their diversity, people with disabilities, LBGTQIA+ people, Indigenous and ethnic minority populations and other groups experiencing social disadvantage and health inequities.
- Undertake a GEDSI analysis. This may utilise both primary and secondary data and should seek to use a mix of qualitative and quantitative methods.

Areas of inquiry may include: health inequities in the local context; barriers to participation, access and uptake of health programs; the influence of social norms and power dynamics on progressing GEDSI outcomes across the health systems building blocks; the participation of diverse GEDSI stakeholders in health decision-making; and the capacity of health partners and stakeholders to integrate GEDSI into their work. Analysis should also seek to identify opportunities for progressing GEDSI.

[DFAT’s Gender Equality, Disability and Social Inclusion Analysis Good Practice Note](#) provides guidance on how to undertake high quality, evidence-based GEDSI analysis to inform design.

If time constraints mean it is not possible to conduct a GEDSI analysis during design, the design must do the following:

- a) Draw on existing information to clearly articulate the main gender and social inequities (including specific reference to the barriers to disability inclusion);
 - b) Include a clear time frame and sufficient budget for in-depth analysis to be conducted during the inception phase; and
 - c) Provide flexibility to adapt program outcomes and activities based on the findings of the analysis.
- Integrate findings from the analysis and consultations with GEDSI stakeholders into program goals, outcomes, strategies, logic, and indicators.

[DFAT’s Gender Equality Program-Level Strategy Development Good Practice Note](#) provides guidance on developing a gender strategy for a development program. This guidance remains fit for purpose when developing a strategy with an expanded scope which may consider disability equity and social inclusion alongside gender equality.

- Ensure that the program logic integrates GEDSI considerations and assumptions and there is a ‘theory of change’ for how GEDSI outcomes will be achieved. That is, it is clear how change related to GEDSI will occur with a clear link between GEDSI inputs, outputs and outcomes. See Annex 1 for a mock program logic designed to demonstrate a theory of change on GEDSI.

HOW TO INTEGRATE GEDSI OUTCOMES INTO THE PROGRAM LOGIC

Developing GEDSI EOPOs and IOs for health programs at design stage requires GEDSI analysis, context-specific considerations, and collaborative consultations. The nature and context of each health program will significantly influence the most appropriate indicators and where they are positioned within the spectrum of ‘end of program’ or ‘intermediate’ outcome. What might constitute a substantial end-of-program outcome in one initiative might serve as a crucial steppingstone in another, depending on factors such as the program's size, scope and intended impact. Recognising that there is no universal solution, or standard GEDSI outcomes, the process of developing outcomes should consider several key principles. These principles, outlined in Table 1, will support GEDSI EOPOs and IOs to be well-informed, contextually relevant and responsive to the needs of GEDSI and health stakeholders.

Note, to support strengthened gender equality commitments in DFAT’s programs, there is a mandatory requirement for programs with a value greater than \$3 million to have a gender equality objective either as an End of Program Outcome or Intermediate Outcome. Consideration should be given to including reference to disability and social inclusion within this outcome, where possible to do so.

Table 1: Characteristics of strong GEDSI End of Program and Intermediate Outcomes

| Key principle | Guidance |
|--|---|
| Informed by GEDSI analysis/context specific | Develop outcomes based on GEDSI analysis that address the specific GEDSI challenges, barriers and opportunities within the program context. |
| Informed by stakeholders | Consult with diverse stakeholders such as GEDSI-focused organisations ¹ to co-create GEDSI outcomes |
| Clarity and specificity | Develop outcomes with explicit and measurable statements that clearly articulate the desired change. Specify the target population or group that will benefit from the outcomes. For example: <ul style="list-style-type: none"> Adolescent girls and women with disabilities in rural communities have increased access to sexual and reproductive health services. Community health workers trained in GEDSI-responsive health care increase vaccine uptake among rural women, children and people with disabilities by introducing targeted and differentiated vaccine delivery strategies. |
| Result-oriented focus | Develop outcomes that focus on tangible changes rather than vague or general objectives. Outcomes should clearly state the specific result expected and who will benefit. For example: <ul style="list-style-type: none"> Women in rural areas have increased knowledge, skills, and resources to lead and facilitate community-based initiatives that promote vaccine awareness and early detection of outbreaks of vaccine preventable diseases. Women, people with disabilities and other underserved populations have increased immunisation coverage through targeted vaccine distribution strategies that result in a measurable reduction in inequities in vaccine coverage. |
| Addresses key barriers to achieving GEDSI outcomes | Strong GEDSI outcomes are directly linked to addressing barriers impacting health outcomes for populations and groups who experience social disadvantage and health inequities. Identifying and directly addressing these obstacles supports programs to achieve meaningful change and lay the foundation for more inclusive health outcomes. For example: |

¹ This should consider engagement of all genders, people with disabilities, Indigenous Peoples, ethnic minorities, older populations and other groups who experience social disadvantage or that may be underrepresented, and the organisations representing the rights and interests of these groups (for example, women’s rights organisations, organisations of people with disabilities and Indigenous led and focused organisations).

| Key principle | Guidance |
|--|--|
| | <ul style="list-style-type: none"> • <i>Women with disabilities in target communities experience less physical and attitudinal barriers to accessing health services.</i> • <i>Health care workers in rural health centres have strengthened capacity to address barriers to vaccine access and provide disability-inclusive and gender-responsive vaccine services.</i> • <i>Health care workers have improved skills in adaptive communication and are able to address communication barriers for people with disabilities, older persons and linguistically diverse populations.</i> |
| <p>Promote equitable access and outcomes</p> | <p>GEDSI outcomes should promote equity and access to services, resources, and opportunities and ensure that gender, disability, or social circumstances do not hinder health outcomes. This should consider the experience of all genders and recognise that social norms and health behaviours, including health seeking behaviours, can result in poorer health outcomes for men, women and people of diverse gender. For example:</p> <ul style="list-style-type: none"> • <i>Adolescents from different genders, sexual orientations and socio-economic backgrounds have equitable access to comprehensive sexual education that meets their specific needs.</i> • <i>Women and people with disabilities in target communities have increased awareness and demand for vaccines.</i> • <i>XX% more men are accessing early screening and treatment for TB and HIV.</i> |
| <p>Seek to influence outcomes across the health system building blocks to support your program goal</p> | <p>To achieve health equity, there is a need to address outcomes across all health systems building blocks. Where there is opportunity to do so, programs should seek to influence GEDSI outcomes within health information systems, health workforce, access to essential medicines and vaccines, health financing, service delivery, and governance and leadership. For example:</p> <ul style="list-style-type: none"> • <i>XX% more women in health leadership and decision-making positions, fostering a more inclusive and diverse health governance structure.</i> • <i>Health systems have strengthened health information systems that systematically collect, analysis and report disaggregated data (by sex, age and disability).</i> • <i>Women’s groups and organisations of persons with disabilities have increased engagement in informing microplanning for immunisation.</i> • <i>National health planning authority have institutionalised gender-responsive budgeting processes, leading to improved GEDSI resourcing in health systems.</i> |
| <p>Grounded in evidence-based strategies, policies and priorities</p> | <p>GEDSI outcomes should be underpinned by evidence-based strategies that have proven successful in promoting GEDSI. GEDSI outcomes should also align with priorities of partner countries and DFAT’s approach to and guidance on gender equality and disability equity. For example:</p> <ul style="list-style-type: none"> • <i>Local women’s groups and disability organisations have increased opportunity to inform and lead initiatives addressing CD/NCD/SRHR, promoting local ownership.</i> • <i>Partner government uses comprehensive and accurate data and information, disaggregated by sex, age, disability and other relevant aspects of social inclusion, to support evidence-based decision-making for targeted interventions.</i> |
| <p>Relevant to your Program</p> | <p>Outcomes should be contextually relevant and be achievable within the scope and focus areas of the program.</p> |

WHAT GEDSI ELEMENTS TO INCLUDE IN THE MEL PLAN

Sound design provides the foundation for effective MEL. This foundation can be built on by ensuring MEL plans and frameworks integrate GEDSI elements. The below outlines key steps to support GEDSI-responsive MEL.

Collect disaggregated data, supported by qualitative data:

- Identify what data you will need to support effective implementation, to demonstrate progress and to support learning – and how you will collect it. For example: ‘Do you or your household require a dignity kit?’ may provide the information you need more so than ‘Are you male or female?’
- Seek to collect data that is disaggregated by sex, disability status and other relevant aspects of social inclusion, ensuring data enables consideration of intersectionality. Note: sex and gender-disaggregated data are terms often used interchangeably but mean different things and serve different purposes.
- Where a program relies on health data from government systems and there are difficulties in accessing data, including disaggregated data, invest in understanding the barriers to accessing the data and identify any entry points to address those barriers.
- Collect both qualitative and quantitative data to monitor results by gender, disability and other relevant aspects of social inclusion, for both GEDSI specific outcomes and outcomes that are not focused on GEDSI.
- Consider the ‘Do No Harm’ approach in choosing what data to collect and store, particularly with respect to data privacy and security.

Design indicators to measure GEDSI outputs and outcomes:

- Develop indicators to measure EOPOs and IOs and other GEDSI outcomes such as equity in health service utilisation. See Annex 2 for example indicators.
- Monitor both the processes (what and how GEDSI activities are being implemented) and the outcomes (what is being achieved on GEDSI).
- Incorporate indicators to measure shifts in attitudes, behaviours, and social norms (how people think and act in relation to gender, disability and other aspects of social inequities).
- Ensure the MEL plan is collecting data to track the likelihood or realisation of risks related to GEDSI.

Use inclusive data collection methods:

- Implement data collection techniques that are accessible and utilise diverse communication methods.
- Involve women, people of diverse genders and people with disabilities in data collection design, collection, and analysis to strengthen the quality of data collected, and model inclusive practices.
- Integrate ethical and safety considerations into monitoring processes.

Ensure GEDSI expertise and adequate funding is available to support MEL processes:

- Allocate clear responsibility, sufficient funding and GEDSI expertise for collection and analysis of data. For example, technical specialists and engagement of women’s rights organisations, organisations of persons with disabilities (OPDs), or other representative organisations.

Regularly analyse and report GEDSI data and ensure its visibility in program reporting:

- Analyse GEDSI data regularly to track progress, identify inequities, check for unintended consequences (positive and negative), and adapt program implementation.
- Present and mainstream progress on GEDSI alongside other data and detail in reports and presentations, highlighting achievements and challenges.
- Include a specific GEDSI section in reporting.
- Monitor and analyse progress on changes in social norms that contribute to GEDSI outcomes and use the information to drive improvements and learning.

Engage stakeholders to provide insights and inform learning:

- Engage diverse stakeholders, including people of diverse genders, people with disabilities, and other groups experiencing social disadvantage and health inequities, in interpreting GEDSI data and insights.
- Where relevant, engage government counterparts responsible for gender, disability and social development.
- Incorporate stakeholder feedback, including from government counterparts, into program decision-making, fostering continuous learning and improvement. This includes working with counterparts to understand barriers and enablers to advancing GEDSI.

WHAT GEDSI INFORMATION TO INCLUDE IN REPORTING

GEDSI reporting goes beyond data collection. Effective GEDSI reporting highlights achievements, identifies gaps, and signals areas for improvement. This allows stakeholders to make informed decisions and allocate resources effectively. GEDSI reporting contributes to broader dialogue on health inequities, influencing policy, funding priorities and supporting sustainable impacts. Structuring your report using the following questions will support comprehensive GEDSI reporting.

Note, the underlined questions below identify the criteria for assessing performance in DFATs Annual Investment Monitoring Reporting process (with some adaptations to broaden scope of these questions). They should be included in health program reporting as a minimum standard.

What progress has been made in integrating GEDSI across the program?

This level of reporting is essentially the first step in the reporting process, focused on the output level. It provides an opportunity to reflect on progress, challenges and risks. It should address some of the following points:

- To what extent has the GEDSI strategy or GEDSI components of the program been implemented?
- Have there been any challenges to implementation?
- Is the GEDSI strategy still appropriate and effective?
- Are there GEDSI related risks that are being realised? Has the risk profile with respect to GEDSI related risks changed?
- What barriers may be hindering progress, and is there anything that can be done to address them?
- Have any new opportunities to promote GEDSI emerged during implementation?

This section should report progress and achievements related to GEDSI mainstreaming activities and targeted GEDSI interventions.

What GEDSI results have been achieved?

- What progress has been made towards the achievement of GEDSI IOs and EOPOs included in the program logic and GEDSI strategy?
- Where positive or negative GEDSI results have been identified, what caused or contributed to these results? For example, what are the key features of your GEDSI strategy or approach that have contributed to the achievement of positive GEDSI results?

What processes and factors helped to achieve GEDSI results?

- How has GEDSI analysis informed the program design and implementation?
- How has the program actively involved people with disabilities and/or organisations of persons with disabilities and other representative groups in planning, implementation and monitoring and evaluation?
- How has the program identified and addressed barriers to inclusion and opportunities for participation for people with disabilities, women and girls in all their diversity and other groups who experience social disadvantage to enable them to benefit equally from the program?
- What resources (technical and financial) are in place to support implementation of GEDSI work? Are these sufficient?
- To what extent has GEDSI been integrated into monitoring systems and processes?
- How are GEDSI risks being monitored and mitigated?
- What has been done to ensure partner ownership of GEDSI, and to build partner capacity? What evidence is there of increased partner institutionalisation and ownership of GEDSI?

WHAT GEDSI INFORMATION TO INCLUDE IN REVIEWS AND EVALUATIONS

Program reviews and evaluations must assess performance on GEDSI and identify learnings. The following guidance and questions provide a starting point for integrating GEDSI into reviews and evaluations.

Key considerations when planning a review or evaluation

- Embed a key evaluation question that measures progress at mid-term and end of program, that links back to the expected GEDSI outcomes outlined in the program logic and MEL framework.
- Ensure the evaluation team has GEDSI expertise or, at a minimum, has a plan for how they will access it.
- Ensure evaluation tools and approaches avoid perpetuating negative social norms and attitudes, and model positive gender norms and attitudes towards disability and other groups who experience social disadvantage.
- Check that the evaluation design and data collection tools include approaches to enable full participation of diverse groups including women in all their diversity and people with disabilities. This could include, for example: participatory data collection methods; seeking input into data analysis and verification; strategic input into the evaluation process; and support in communicating evaluation findings. Supporting inclusive and meaningful participation requires attention to the accessibility of evaluation processes and activities.

The below provides example questions to support reviews and evaluations, noting these should be adapted to suit your programs intended outcomes on GEDSI:

Mid-Term Review Questions

- How has the program's implementation considered the diverse health needs of women, girls, people of diverse genders, people with disabilities, and other groups who experience social disadvantage and health inequities?
- What progress has been made in addressing barriers that affect access to health information and services?
- What progress has been made towards the achievement of GEDSI outcomes?
- How effective have the programs GEDSI-focused strategies been in strengthening health systems and supporting attention to health inequities experienced by different populations?
- Are there any unintended consequences of the program that might disproportionately affect certain genders, people with disabilities, or other groups who experience social disadvantage and health inequities?
- Are there adequate resources in place to effectively deliver GEDSI outcomes?

End-of-Program Review Questions

- To what extent were the GEDSI outcomes/results achieved? How did these outcomes contribute to the program's overall success?
- What key strategies that were effective in promoting GEDSI and achieving GEDSI related outcomes?
- How effectively were GEDSI strategies integrated into the program implementation, MEL, risk management, leadership, governance and reporting?
- What lessons have been learned about effective GEDSI strategies that can inform future health programs?

ADDITIONAL RESOURCES

- [Gender Equality in Program Design Good Practice Note](#): An operational resource to assist DFAT's partners to integrate gender equality into program designs.
- [Gender Equality in Monitoring and Evaluation Good Practice Note](#): An operational resource to assist DFAT's partners to integrate gender equality into monitoring, evaluation, and reporting.
- [Disability-Inclusive Development Guidance Note](#): Outlines DFAT's approach to disability-inclusive development and identifies main entry points for disability inclusion.
- [Partnerships for a Healthy Region GEDSI and First Nations Engagement Guidance Note](#): Outlines program guidance to support integrating GEDSI and First Nations engagement into proposals and workplans under Partnership for a Healthy Region initiative.
- [Gender Equality Program-Level Strategy Development Good Practice Note](#): Outlines key features of a good practice gender strategy for a development program.
- [Gender Equality, Disability and Social Inclusion Analysis Good Practice Note](#): Provides guidance on how to undertake high quality, evidence based GEDSI analysis to inform design.

ANNEX 1: MOCK PROGRAM LOGIC - STRENGTHENING INCLUSIVE PRIMARY HEALTH CARE

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| Goal | Strengthened primary health care services that provide accessible, comprehensive and GEDSI-responsive health services for rural populations, enhancing universal health coverage | | | | | | | | |
| Objectives | Improved uptake of health services by women, girls and people with disabilities living in rural settings. | Stronger, more equitable rural health systems that meet the needs of women, girls and people with disabilities. | Enhanced communicable disease (CD) and non-communicable disease (NCD) programs that promote equitable access to and inclusion in prevention and control measures. | Equitable access to comprehensive and people-centred sexual and reproductive health (SRH) services that support realisation of SRHR for women, girls and people with disabilities. | | | | | |
| Line of Accountability | | | | | | | | | |
| EOPOs | Subnational health services have enhanced capacity to provide gender-responsive and disability-inclusive health services that meet the different needs of women, girls and people with disabilities. | | | | Women, girls and people with disabilities in rural communities have improved access to gender-responsive and disability-inclusive CD and NCD programs and SRH services. | | | | |
| IOs | Subnational health services have developed and are implementing gender-responsive and disability-inclusive policies and programs. | Subnational health services have strengthened health leadership, management and budgeting skills which foster and support gender-responsive and disability-inclusive decision-making processes. | Women and people with disabilities are engaged in health leadership and decision making roles. | Subnational health services have improved health data systems which collect, analysis and report disaggregated health information by sex, age, disability status and other aspects of social inclusion as relevant. | Women, girls, people with disabilities and groups experiencing social disadvantage have increased access to health services. | Subnational health services are using disaggregated data from disease surveillance systems to guide gender-responsive and disability-inclusive responses. | Subnational health services are implementing CD/NCD/SRHR health awareness campaigns targeted at women, girls and people with disabilities. | Rural populations have Subnational health services are integrating SRH services into primary health care services. | |
| Indicative Outputs | <ul style="list-style-type: none"> • GEDSI analysis undertaken by health sector. • Gender-sensitive and disability-inclusive health policies and programs developed. • SRHR integrated into national and subnational health strategies and programmes. • Women's groups, organisations of people with disabilities (OPDs), and local youth consulted on health policies | <ul style="list-style-type: none"> • Capacity-building initiatives for subnational health staff delivered, enhancing their skills in gender-responsive and disability-inclusive health service delivery. • Gender-responsive budgeting training delivered. • GEDSI awareness training and coaching provided for leaders and middle level managers of subnational health services. | <ul style="list-style-type: none"> • Funded health focal point positions within women's groups and organisations of persons established and provided tailored health coaching. • Women's groups and OPDs have established roles in health governance structures. • Leadership mentoring provided for women health workers (with a focus on middle managers). • Network established to connect women health workers. | <ul style="list-style-type: none"> • Data collection and tools enhanced. • Training and capacity building provided for key actors engaged in collecting, analysing and utilising data. • Health information system upgraded to support collection, secure storage and analysis of disaggregated data. • Data monitoring and quality assurance processes established. | <ul style="list-style-type: none"> • Gender-responsive and disability-inclusive community health outreach programs established. • Accessibility modifications made to health facilities. • Universal design guidelines developed for health infrastructure. • Health awareness campaigns delivered in partnership with women's groups, organisations of people with disabilities and youth groups. | <ul style="list-style-type: none"> • Gender-responsive and disability-inclusive considerations integrated into health emergency preparedness plans. • Disaggregated disease surveillance systems established to capture data and impact on different groups. | <ul style="list-style-type: none"> • Accessible disease awareness campaigns & SRHR campaigns are developed and implemented. • Interactive workshops and training sessions in communities, schools, and health facilities conducted, in partnership with women's groups, organisations of people with disabilities and youth groups. | <ul style="list-style-type: none"> • Gender-sensitive and accessible sexual and reproductive health education materials developed for use in schools, health facilities and community groups. • Community-based SRH services and referral processes established. • Health workers in primary health care facilities trained in SRH essentials and GEDSI principles. | |

ANNEX 2: SAMPLE GEDSI INDICATORS FOR HEALTH PROGRAMS

The following sample indicators offer options for measuring the progress and impact of Gender Equality, Disability Equity, and Social Inclusion (GEDSI) outcomes within health programs. These indicators are a starting point and are not meant to be applied universally. Partners should select indicators that reflect their program's unique context, objectives, and target populations; and that provide comprehensive insights into the achievements of GEDSI-related goals.

Collecting disaggregated data is essential for programs. By capturing information broken down by sex, disability status, and other relevant factors of social inclusion, programs can gain an understanding of the who benefits from or accesses the program outputs. Disaggregated data is a crucial foundation for evidence-based decision-making, enabling programs to identify health disparities tailor interventions that address the barriers hindering equitable access, participation, and outcomes.

| Example GEDSI Outcome Indicators | Example GEDSI Output Indicators |
|--|--|
| <ul style="list-style-type: none"> • Percentage increase in the participation of women, people with disabilities, ethnic minority groups, diverse genders and LBGQTQ+ in community health awareness campaigns targeting CD/NCD prevention/ SRHR awareness • Availability and accessibility of gender-sensitive and disability-inclusive educational materials on CD/NCD prevention/SRHR • Percentage increase in the utilization of CD/NCD disease prevention and management services/ SRHR services among underserved communities, particularly women and people with disabilities. • Percentage increase in the utilisation of gender-sensitive and disability-inclusive sexual and reproductive health services among underserved communities, with a focus on women, people of different genders, LBGQTQ+ people and people with disabilities. • Evidence of increased representation of women, people with disabilities and ethnic minority, Indigenous persons, and LBGQTQ+ persons in decision-making bodies related to CD/NCD/SRHR response and policy development. • Evidence of reduction in CD/NCD transmission rates among women and youth and other target groups in underserved communities • Percentage increase in GEDSI awareness and knowledge among healthcare providers in CD/NCD prevention and treatment/SRHR services. • Proportion of CD/NCD/SRHR interventions that include disaggregated data collection to assess the impact on different demographic groups. • Evidence of changes in policies, systems, strategies, guidelines, procedures, road maps or practice plans for CD and NCD threats or delivery | <ul style="list-style-type: none"> • Number of community health awareness campaigns conducted with targeted GEDSI messaging on CD/NCD prevention/SRHR. • Number of healthcare facilities equipped with accessible infrastructure and resources for persons with disabilities in relation to CD/NCD prevention and treatment /SRHR services. • Number of gender-disaggregated data points collected during disease surveillance activities/SRHR activities. • Number of women and people with disabilities involved in leadership and decision-making positions in Provincial Health Offices. • Number of healthcare providers trained in providing culturally sensitive care to diverse populations affected by CD/NCD. • Quantity of GEDSI-responsive outreach programs initiated to engage hard-to-reach communities in CD/NCD prevention efforts. • Quantity of CD/NCD prevention programs that have incorporated GEDSI considerations into their design and implementation. • Number of GEDSI-focused workshops or training sessions conducted for local stakeholders involved in the CD/NCD/SRHR response. • Number of GEDSI-informed messaging included in health communication materials targeting underserved populations. • Number of accessible information and communication channels established for persons with disabilities to access disease prevention and SRHR information. • Number of SRHR awareness campaigns conducted with targeted GEDSI messaging, addressing barriers faced by underserved populations. |

| Example GEDSI Outcome Indicators | Example GEDSI Output Indicators |
|--|--|
| <p>of SRHR services that are informed by GEDSI data and analysis.</p> <ul style="list-style-type: none"> • Percentage increase in healthcare providers trained in culturally sensitive and disability-inclusive care for CD/NCD/SRHR patients. • Increase in the number of health emergency preparedness policies, plans and strategies that include a specific reference to women, girls, people with disabilities, LGBTQIA+ • Evidence of the consideration of the needs of both women and men in improvements in medical supply chains • Evidence that strengthening vector control activities includes consideration of the exposure, vulnerability and impacts on both women and men. • Evidence that interventions (such as product development, infection prevention and control activities, pathology services, emergency response plans and processes) are informed by and responsive to the needs of women from diverse backgrounds and deliver equitable results for women. • Evidence of improved partner country capacity to collect, analyse and use sex disaggregated data and data on gender equality, that could be used to ensure gender and social inequities are considered in health finance and planning decisions. • Evidence of improved capacity of surveillance systems to collect and disaggregate data by gender and to equally assess the needs of women and men. • Evidence of balanced and active participation of women and men in the development of policies, systems, strategies, guidelines, procedures, road maps or practice plans for infectious disease threats. | <ul style="list-style-type: none"> • Number of product profiles that include due consideration for end-users with disabilities. • The number and type of communications for prevention and control that are developed in a range of formats to ensure accessibility. • Number of non-communicable disease prevention programs that actively involve community leaders, women, and persons with disabilities in program planning and decision-making. • Proportion of CD/NCD/SRHR interventions that have undergone GEDSI analysis and incorporated tailored strategies. • Percentage of interventions (such as product development, infection prevention and control activities, pathology services, emergency response plans and processes) informed by GEDSI needs assessment. • Percentage increase in the number of surveillance data points that are GEDSI disaggregated. • Percentage of medical supply chain improvements that are informed by a GEDSI needs assessment. |

