Monitoring, Evaluation, Accountability and Learning (MEAL)

Advocacy Indicators

Methodology Handbook
The Methodology Handbook is only one tool of a set that White Ribbon Alliance will use to implement its new monitoring, evaluation, accountability and learning (MEAL) processes. These processes will help White Ribbon Alliance to articulate its collective as well as individual alliance results, hold ourselves accountable to the 2018–2022 Strategic Framework and adapt our approaches to make the best use of limited resources and ensure the greatest amount of impact.

The Methodology Handbook contains a menu of White Ribbon Alliance’s standardized indicators, as well as captures a ‘methodology card’ for each of the approximate 26 indicators. Each card provides relevant background, including:

- Important definitions and concepts for each indicator
- Each indicators’ relationship to White Ribbon Alliance’s theory of change
- Degree of difficult or priority tier for each indicator
- Any necessary disaggregation and frequency of collection for each indicator
- How each indicator is measured

In conjunction with each National Alliances’ (NA) strategic plan, the Methodology Handbook should be used to help NAs select which indicators to measure. Thereafter, it serves as a valuable reference guide throughout data collection and reporting.

For more information, contact your point person or White Ribbon Alliance’s Senior Business and Organizational Development Officer, Katy Bumpus, kbumpus@whiteribbonalliance.org.

Good luck and happy selecting, collecting and reporting!

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1. This number is subject to change. More indicators may be added to the menu overtime.
2. Adapted from the 2018–2022 Strategic Framework.

**MEAL AND THE THEORY OF CHANGE**

White Ribbon Alliance’s MEAL processes build upon the theory of change (ToC) described within the 2018-2022 Strategic Framework. Each indicator corresponds to a specific result within the various levels of the ToC (e.g. foundation, strategy or outcome).

Not every National Alliance will collect on all indicators. Indicators are sorted into tiers. Tier one indicators are the simplest to collect, while tier two and three indicators require more complex measurement strategies and resources.

All National Alliances will collect tier one indicators, which primarily relate to the ToC’s foundation level.
**OUR VISION:** All girls and women realize their right to quality health and well-being

**IMPACT**
- Maternal and newborn mortality and morbidity and stillbirths are reduced and universal access to sexual and reproductive health services achieved (SDG3)
- Right to health and participation upheld for all

**OUTCOMES**
- Increased utilization of reproductive maternal and newborn health services
- Greater accountability of governments to people
- Improved quality, equity and dignity in reproductive, maternal and newborn services
- New or improved policies and practices that are driven by women’s needs
- Increased resources (financial, human and material) for RMN programs

**OUR STRATEGY**
- Educate and empower people about health and rights
- Directly influence decision makers; support decision makers to respond
- Collect and use evidence for advocacy
- Play a crucial role in the feedback loop between people, government and global bodies
- Convene and catalyze action to drive change
- Use media and champions to amplify voices

**FOUNDATION**
- Resilient secretariats
- Engaged members and partners
- Effective governance at all levels
- Sufficient and diverse funding base
- Robust monitoring, evaluation, accountability and learning

*QUALITY, EQUITY AND DIGNITY  **AMPLIFYING CITIZEN VOICES TO DEMAND HEALTH AND RIGHTS*
1. Percentage of target population in target geographies who make use of target RMN health programs and services / Page 1
2. Number of target RMN health commitment benchmarks that are on track and/or fulfilled / Page 2
3a. Percentage of target population that believes community-raised RMN health grievances are being addressed by decision-makers and/or duty-bearers (geography) / Page 3
3b. Percentage of target population that believes community-raised RMN health grievances are being addressed by decision-makers and/or duty-bearers (events) / Page 3
4. Percentage of target facilities that are meeting select QED standards / Page 5
5. Number of RMN health recommendations included in target policies and programs / Page 7
6. Number of target RMN health policies that advanced / Page 8
7. Percentage coverage of target RMN health programs and services in target geographies / Page 9
8. Percentage of target budget for RMN health in comparison with total budget / Page 10
9a. Percentage of target funding released / Page 11
9b. Percentage of target funding disbursed, nationally and/or in target geographies / Page 11
10. Number of target healthcare workers in target facilities / Page 13
11. Percentage of target facilities that have stock outs of 3 or more tracer drugs in previous six months / Page 15
12. Percentage of target facilities that lack or have 3 or more non-functioning tracer equipment in previous six months / Page 17
13. Percentage of target facilities that lack or have 3 or more non-functioning amenities in the previous six months / Page 19
14a. Percentage of target population who demonstrate understanding of rights and responsibilities related to RMN health (geography) / Page 21
14b. Percentage of target population who demonstrate understanding of rights and responsibilities related to RMN health (events) / Page 21
15a. Percentage of target population reporting that they participated in an activity to demand RMN health and rights in the past one year (geography) / Page 23
15b. Number of target population participating in a WRA organized activity to demand RMN health and rights (events) / Page 23
16a. Percentage of target population reporting increased confidence in voicing issues of concerns to decision-makers and duty-bearers (geography) / Page 25
16b. Percentage of target population reporting increased confidence in voicing issues of concerns to decision-makers and duty-bearers (events) / Page 25
17. Number of target decision-makers taking increasing action in support of RMN health and rights / Page 27
18. Number of WRA-packaged evidence referenced in target government documents and/or decision-maker statements / Page 29
19. Number of actions taken jointly by at least 75% of target partners to influence decision-makers and duty-bearers actions / Page 30
20. Number of target champions taking increasing action in support of RMN health and rights / Page 31
21. Percentage change in coverage of RMN health, rights, and accountability by target media / Page 32
22. Number of alliance members / Page 33
23. Percentage of benchmarks achieved according to governance scorecard / Page 34
24. Number of donors approached and/or proposals submitted / Page 35
25. Total amount of funds mobilized / Page 37
26. Number of adjustments made to strategy based on MEAL / Page 38
Target population: Refers to the specific population you are aiming to impact. For example, it may be adolescent girls 15 to 19 or expectant mothers.

Target geographies: Refers to the specific catchment area in which WRA is aiming to influence. It may refer to communities, villages, parishes, districts, counties, local government areas, provinces, states, or countries, among others. It will vary depending on the program of work and/or a country's governance structure.

Target RMN health programs and services: Specific programs and services will be listed in the Programs and Services tab in the tracking tool. NAs will select which of these programs and services they are targeting or indicate if it is other.

How to measure (collected annually):

You will first need to define your target geographies and target population in those geographies on the Indicator Tracking Form: Tab—Geographies.

It will be challenging to interview your entire target population. Therefore, you should create a sample, using the Sampling Guidelines.

Next, refer to the Indicator Tracking Form: Tab—Programs and Services to identify potential programs and services to track. This is not an exhaustive list; you may want to include other programs and services more relevant for your context. It is suggested that you track no more than 3–5 programs and services for ease of use. Include those you want to track on the Individual Survey Tool.

Create a baseline by surveying your sample target population utilizing the relevant survey questions in the Individual Survey Tool. The questions are identified as "Indicator 1."

Enter this baseline on the Indicator Tracking Form: Tab 1—Use in the column labeled 'Baseline.'

On an annual basis, you will return and use the Individual Survey Tool to determine changes in use. You will input the results into the Indicator Tracking Form: Tab 1—Use.

All completed Individual Survey Tool responses should be retained for at least one year.
**Target RMN health commitment**: A target commitment is a formal high-level declaration or pledge that you intend to influence the government to implement. Can be written or verbal. Not to be confused with individual decision-makers voicing support for an issue.

**On track and/or fulfilled**: Interpretation depends on the specific commitment, but generally refers to benchmarks laid out in the commitment being met and on time.

**DISAGGREGATION**

Disaggregated by global, regional, national, or sub-national level

**HOW TO MEASURE (COLLECTED QUARTERLY)**

List the specific commitments you are intending to target and their associated benchmarks in the [Indicator Tracking Form: Tab 2—Health Commitment](#).

More commitments are not necessarily better, there is room to track up to 10 commitments, but we recommend no more than 3–5.

For the baseline, indicate the current status of the benchmark.

On a quarterly basis, enter whether the benchmark is off track, partially on track, completely on track, or fulfilled and a short explanation as to why into the [Indicator Tracking Form: Tab 2—Health Commitment](#).

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Target population: Refers to the specific population you are aiming to impact. For example, it may be adolescent girls 15 to 19 or expectant mothers.

Community-raised grievance: These are general concerns that the community has voiced to responsible persons and for which they expect improvement. It is important to note that this measurement is a perception-based indicator. You will be measuring if individuals have raised grievances and if that individual perceives whether that grievance has or will be addressed. You will not measure whether that grievance has or has not been actually addressed.

Decision-makers: Individuals with the formal power or authority to make policy, take action, or vote on issues of importance. May include, but not limited to: parliamentarians, ministers and permanent secretaries, administrators and deputy administrators, local governors and councilors, chief administrative officers, district health management teams.

Duty-bearers: Actors who have a particular obligation or responsibility to respect, promote and uphold RMN health rights. Includes decision-makers but also encompasses those without authority to make official decisions, such service providers and other program and policy implementers.

Events: For this indicator these events primarily relate to citizen-hearings, community meetings or other social accountability-related events. These events should include at least 25 people.
You will first need to define your target geographies and target population in those geographies on the **Indicator Tracking Form: Tab—Geographies**. If you have done this for a previous indicator, it will carry over. If you have not, refer to Indicator 1 methodology card for more instructions.

It will be challenging to interview your entire target population. Therefore, you should create a sample, using the **Sampling Guidelines**.

Create a baseline by surveying your sample target population utilizing the relevant survey questions in the **Individual Survey Tool**. The questions are identified as "Indicator 3."

You will enter this baseline on the **Indicator Tracking Form: Tab 3A—Community Grievance—Geo** in the column labeled ‘Baseline.’

On an annual basis, you will return and use the **Individual Survey Tool** to determine changes in perception of grievances raised. You will input the results into the **Indicator Tracking Form: Tab 3A—Community Grievance—Geo**.

All completed **Individual Survey Tool** responses should be retained for at least one year.

If you choose 3B methodology, you will first need to define your events, location, number of participants, etc. on the **Indicator Tracking Form: Tab—WRA Events**.

You will use the questions under Indicator 3 of the **Individual Survey Tool** to survey those who participate in WRA-sponsored event. You will then administer the tool to all individuals in attendance at the event to assess whether community-raised grievances have been addressed. You will not use a sampling methodology at the event(s). At the first WRA-sponsored event, you will establish your baseline and enter it into **Indicator Tracking Form: Tab 3B—Community Grievance—Events**.

If collecting this indicator, you should generally expect to organize an event(s) on a quarterly basis, reaching a minimum of 125 people, in a specific catchment area.

All completed **Individual Survey Tool** responses should be retained for at least one year.

**NOTES:**
**Target facilities:** A designated building in which general health services are offered. Target facilities are facilities in which you intend to improve services and conditions. It could include, but is not limited to, district or referral hospitals, clinics, health posts, health centers, outpatient care centers, and specialized care centers, such as birthing centers. It does not include mobile service delivery points and non-formal services, such as traditional healers. District and national databases often provide the number of public facilities, often by type (such as hospital, health center, health post, dispensary).

**Select QED standards:** The WHO has developed eight standards of care to improve maternal and newborn quality of care in facilities. Select standards are the ones from that list you are interested in tracking. Refer to the Indicator Tracking Form: QED Standards to inform your selection.

Your country or context may have a related or specific set of standards you are more interested in tracking against (e.g. Primary Healthcare Under One Roof in Nigeria). You can use those standards in place of the WHO QED standards—it will need to be noted in the form.

**DISAGGREGATION**

Public/Private, Urban/Rural, Type of Facility
You will first need to define your target facilities and their associated geographies on the Indicator Tracking Form: Tab—Facilities. The geographies will be prepopulated in a drop-down menu, pulling from the Indicator Tracking Form: Tab—Geographies. If you have not completed this tab, refer to Indicator 1 methodology card for directions. You will also need to disaggregate the facilities, directions for how to do this is found on the facilities tab.

You will next need to identify which QED standards you want to track that facilities are meeting. Refer to Indicator Tracking Form: Tab—QED Standards to review each WHO QED standard, its overall aim and its shorthand descriptor to help inform your selection. We recommend no more than 3–5 standards. WRA is particularly interested in standards related to Respect & Dignity; Competent, Motivated Staff; and Working Facilities, however the standards you choose may differ on country and project context.

If you intend to influence standards that are not the WHO QED standards, but are more relevant for your country context, you will need to add these to the Indicator Tracking Form: Tab—QED Standards.

You are tracking the same standards across all facilities.

It will be challenging to assess all facilities in your target geography. Therefore, you should create a sample, using the Sampling Guidelines. Before conducting your baseline, you should calculate your sample size.

For the baseline, survey the facilities using your Facility Assessment Tool. Enter results in the Indicator Tracking Form: Tab 4—QED Standards.

On a bi-annual basis, you will return and utilize the Facility Assessment Tool to determine changes in standards. You will update your tracking tool and input the results into the Indicator Tracking Form: Tab 4—QED Standards.

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**Target recommendations**: These are suggestions or provisions that you want to see included in target policies and/or programs.

**Target policies and programs**: Policies are formal governing or guidance documents reflecting plans, programs or actions that inform and/or administer health services. A target policy is one you specifically intend to influence with recommendations. May include, but not limited to laws, regulations, strategies, frameworks, plans, guidelines, essential medicines list, executive orders, applications to multi-laterals for support such as country investment cases.

Programs include an initiative or planned, integrated set of activities or services. Target programs include initiatives or set of services you specifically intend to influence with recommendations.

As currently written, this indicator focuses on public sector policies and programs.

**How to measure (collected quarterly)**

First you identify which policies and programs you are targeting. Then you define the recommendations you are making for each policy or program. Include both the policy or program and the related recommendations in the Indicator Tracking Form: Tab 5—Recommendations in Policy.

There is no baseline.

On a quarterly basis, determine whether the recommendation is not included, included in draft version, or included in final version. Enter the quarterly findings into the Indicator Tracking Form: Tab 5—Recommendations in Policy.

**Notes:**
Target policies: Policies are formal governing or guidance documents reflecting plans, programs or actions that inform and/or administer health services. A target policy is one you specifically intend to influence its passage. May include, but not limited to laws, regulations, strategies, frameworks, plans, guidelines, essential medicines list, executive orders, applications to multilaterals for support such as country investment cases.

HOW TO MEASURE (COLLECTED QUARTERLY)

First you identify which policies you are targeting and input them in the Indicator Tracking Form: Tab—6 Policy Process.

Then you determine the baseline by identifying the specific status of the policy (e.g. first draft, in front of committee). The specific status varies depending on the type of policy you are targeting.

On a quarterly basis, determine the status of the policy by identifying from the drop-down if it has advanced or not advanced. You will provide a brief explanation of the status. Enter the quarterly findings into the Indicator Tracking Form: Tab—6 Policy Process.
### Target RMN health programs and services

Specific programs and services will be listed in the Programs and Services tab in the tracking tool. NAs will select which of these programs and services they are targeting or indicate if it is other.

### Target geographies

Refers to the specific catchment area in which WRA is aiming to influence. It may refer to communities, villages, parishes, districts, counties, local government areas, provinces, states, or countries, among others. It will vary depending on the program of work and/or a country’s governance structure.

### HOW TO MEASURE (COLLECTED BI-ANNUALLY)

First, refer to the Indicator Tracking Form: Tab—Programs and Services to identify potential programs and services to track. This is not an exhaustive list; you may want to include other programs and services more relevant for your context. It is suggested that you track no more than 3–5 programs and services for ease of use. Include those you want to track on the Facility Assessment Tool under Indicator 7—Coverage heading and in Indicator Tracking Form: Tab 7—Coverage.

You should track these programs and services in the facilities you previously defined in the Indicator Tracking Form: Tab—Facilities using the Sampling Guidelines.

If you have not already identified the target facilities, refer to the directions provided in Indicator 4 methodology card.

You are tracking the same programs and services across all facilities. You should be mindful that the programs and services you are tracking are appropriate and should be available across all such facilities.

For the baseline, survey the facilities using your Facility Assessment Tool under Indicator 7—Coverage heading. You will need to add the total number of facilities that you tracked that are offering the program or service and enter results in the Indicator Tracking Form: Tab 7—Coverage.

On a bi-annual basis, you will return and utilize the Facility Assessment Tool to determine changes in coverage of programs and services. You will update your tracking form and input the results into the Indicator Tracking Form: Tab 7—Coverage.
**Target budget:** The *target* budget are the line items in national or subnational budgets that the NA intends to influence for increase.

**Total budget:** The total amount of money included in the account the NA is comparing against.

An example is a family planning line item (target budget) drawing from the RMNCH account (total budget).

### HOW TO MEASURE (COLLECTED ANNUALLY)

You will first need to identify which budget line items you are targeting for increase in the **Indicator Tracking Form: Tab 8—Budget Allocated**. You will then need to define the total budget. You will also identify the geography and financial or funding authority.

For the baseline, you will provide the level of funding for the target line item and the total budget for the current fiscal year.

On an annual basis, you will identify allocations to the targeted budget line items and the total budget. You will input the results into the **Indicator Tracking Form: Tab 8—Budget Allocated**.
**Target funding:** The target funding are the line items in national or subnational budgets that the you intend to influence for release (9A)/disbursement (9B). May or may not be the same budget line items you are targeting for increase under indicator 8 or release in indicator 9A.

**Released:** (9A) Funding has been transferred from the treasury to the relevant government authority for spending. Depending on the line item the transfer may occur within or across levels of governance.

**Disbursed:** (9B) Funding budgeted has been disbursed when cash is withdrawn from the national or sub-national treasury for the payment of budgetary transactions.

**Target geographies:** Refers to the specific catchment area in which WRA is aiming to influence. It may refer to communities, villages, parishes, districts, counties, local government areas, provinces, states, or countries, among others. It will vary depending on the program of work and/or a country’s governance structure.

**Disaggregation**

Disaggregated by financial or funding authority
**9A: HOW TO MEASURE (COLLECTED ANNUALLY)**

You will first need to identify the funding allocation (line item) you will track on the **Indicator Tracking Form: Tab—9A Budget Released**. You will then identify the authority or agency where the funding is originating, and subsequently where the authority or agency where the funding should be transferred.

For your baseline, you will examine government records to identify the budget for the funding allocation and the amount that was released in the previous year. If the funding allocation did not exist in the previous year, your baseline is 0.

On an annual basis you will examine government records to determine total released for the fiscal year. You will input the results into the **Indicator Tracking Form: Tab—9A Budget Released**.

**9B: HOW TO MEASURE (COLLECTED ANNUALLY)**

You will first need to identify the funding allocation (line item) you will track on the **Indicator Tracking Form: Tab—9B Budget Disbursed**. You will then identify the financial or funding authority that is authorized to spend the funds.

For your baseline, you will examine government records to identify the budget for the funding allocation and the amount that was disbursed the previous fiscal year. If the funding disbursement did not happen in the previous year, your baseline is 0.

On an annual basis you will examine government records to determine total disbursed for the fiscal year. You will input the results into the **Indicator Tracking Form: Tab—9B Budget Disbursed**.

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Target healthcare workers: A healthcare worker is someone who provides health services. May include doctors, midwives, community health workers, etc. A position is a target if the NA intends to increase the number of said workers.

Target facilities: A designated building in which general health services are offered. Target facilities are facilities in which the NA intends to improve services and conditions. It includes district or referral hospitals, clinics, health posts, health centers, outpatient care centers, and specialized care centers, such as birthing centers. It does not include mobile service delivery points and non-formal services, such as traditional healers. District and national databases often provide the number of public facilities, often by type (such as hospital, health center, health post, dispensary).

If you have not done so, you will first need to define your target facilities and their associated geographies, level etc. on the Indicator Tracking Form: Tab—Facilities. The geographies will be prepopulated in a drop-down menu, pulling from the Indicator Tracking Form: Tab—Geographies. If you have not completed this tab, refer to Indicator 1 methodology card for directions. You will also need to disaggregate the facilities, directions for how to do this is found on the facilities tab. The facilities and geographies will then auto populate in the Indicator Tracking Form: Tab 10—Healthcare Workers.

Assessing all facilities in your target geography may be feasible, depending on the size of your target geography. We suggest that if you have 50 or more facilities in your target geography, then assessing all facilities is not feasible and you should create a sample, using the Sampling Guidelines. Before conducting your baseline, calculate your sample size.

You will then need to identify which health worker positions you are targeting for increase at each facility from the drop-down menu in the Indicator Tracking Form: Tab 10—Healthcare Workers. If you are targeting an “other” health worker, select “other” from the drop-down menu and define that health worker in the space provided at the bottom of the tab.

Using the Facility Assessment Tool under Indicator 10, you will first enter the target health worker in order to assess the current number at each facility. This tool will inform your baseline which you will input into the Indicator Tracking Form: Tab 10—Healthcare Workers.

On a bi-annual basis, you will return and utilize the Facility Assessment Tool under Indicator 10 to assess the current number of target health workers. You will input the results into the Indicator Tracking Form: Tab 10—Healthcare Workers.
**Target facilities**: A designated building in which general health services are offered. *Target* facilities are facilities in which the NA intends to improve services and conditions. It includes district or referral hospitals, clinics, health posts, health centers, outpatient care centers, and specialized care centers, such as birthing centers. It does not include mobile service delivery points and non-formal services, such as traditional healers. District and national databases often provide the number of public facilities, often by type (such as hospital, health center, health post, dispensary).

**Stock outs**: Tracer drugs are not available at the facility.

**Tracer drugs**: Refers to drugs that have been selected for monitoring drug availability at facilities as a program indicator. Rather than monitoring all products, only a small subset of the full list of the products required to provide a service are selected for program level monitoring. A tracer drug should be a product whose stockout would result in cessation of important RMN services. Examples of tracer drugs include: magnesium sulphate, oxytocin, misoprostol, injectable antibiotics, antenatal corticosteroid, chlorhexidine, emergency contraception and implants. NAs can draw from this list or identify other key drugs for their specific context, such as injectable contraceptives or oral contraceptive pills, among others.
If you have not done so, you will first need to define your target facilities and their associated geographies, level etc. on the Indicator Tracking Form: Tab—Facilities. The geographies will be prepopulated in a drop-down menu, pulling from the Indicator Tracking Form: Tab—Geographies. If you have not completed this tab, refer to Indicator 1 methodology card for directions. You will also need to disaggregate the facilities, directions for how to do this is found on the facilities tab. The facilities and geographies will then auto populate in the Indicator Tracking Form: Tab 11—Drugs.

Assessing all facilities in your target geography may be feasible, depending on the size of your target geography. We suggest that if you have 50 or more facilities in your target geography, then assessing all facilities is not feasible and you should create a sample, using the Sampling Guidelines. Before conducting your baseline, you should calculate your sample size.

You will then need to identify the tracer drugs you are targeting and enter using the drop-down menu in the Indicator Tracking Form: Tab 11—Drugs. If you are targeting an “other” drug, select “other” from the drop-down menu and define that drug in the space provided at the bottom of the tab. We recommend you target 5 tracer drugs. Once you have identified your target 5 tracer drugs in the baseline period, the remaining periods will auto-populate. TO NOTE: If you are also measuring Indicators 1 or 7, the chosen program/service you are measuring must correspond with your chosen tracer drug, when appropriate.

Using the Facility Assessment Tool under Indicator 11, you will assess each facility to determine if your targeted 5 tracer drugs are available. If 3 or more tracer drugs are stocked out at the facility, then this facility will be considered stocked out. This tool will inform your baseline which you will input into the Indicator Tracking Form: Tab 11—Drugs.

On a bi-annual basis, you will return and utilize the Facility Assessment Tool to determine change in availability of tracer drugs. You will update your tracking tool and input the results into the Indicator Tracking Form: Tab 11—Drugs.

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### Important Definitions or Concepts

**Target facilities:** A designated building in which general health services are offered. Target facilities are facilities in which the NA intends to improve services and conditions. It includes district or referral hospitals, clinics, health posts, health centers, outpatient care centers, and specialized care centers, such as birthing centers. It does not include mobile service delivery points and non-formal services, such as traditional healers. District and national databases often provide the number of public facilities, often by type (such as hospital, health center, health post, dispensary).

**Non-functioning:** A tracer equipment is either not present at health facility or it is present but not working.

**Tracer Equipment:** Refers to equipment that have been selected for monitoring availability and functioning of equipment at facilities as a program indicator. Rather than monitoring all equipment, only a small subset of the full list of the products required to provide a service are selected for program level monitoring. A tracer equipment should be a product whose absence or non-functioning would result in cessation of important RMN services. Examples of tracer equipment include syphilis screening kits, uterine balloon tamponade, mucous extractor, neonatal resuscitators, and thermal care devices. NAs can draw from this list or identify other key equipment for their specific context.

### Disaggregation

Disaggregated by equipment
If you have not done so, you will first need to define your target facilities and their associated geographies, level etc. on the **Indicator Tracking Form: Tab—Facilities**. The geographies will be prepopulated in a drop-down menu, pulling from the **Indicator Tracking Form: Tab—Geographies**. If you have not completed this tab, refer to Indicator 1 methodology card for directions. You will also need to disaggregate the facilities, directions for how to do this is found on the facilities tab. The facilities and geographies will then auto populate in the **Indicator Tracking Form: Tab 12—Equipment**.

Assessing all facilities in your target geography may be feasible, depending on the size of your target geography. We suggest that if you have 50 or more facilities in your target geography, then assessing all facilities is not feasible and you should create a sample, using the **Sampling Guidelines**. Before conducting your baseline, you should calculate your sample size.

You will then need to identify the tracer equipment you are targeting and enter using the drop-down menu in the **Indicator Tracking Form: Tab 12—Equipment**. If you are targeting an “other” equipment, select “other” from the drop-down menu and define that equipment in the space provided at the bottom of the tab. We recommend you target 5 tracer equipment. Once you have identified your target 5 tracer equipment in the baseline period, the remaining periods will auto-populate. **TO NOTE: If you are also measuring Indicators 1 or 7, the chosen program/service you are measuring, must correspond with your chosen tracer equipment, when appropriate.**

Using the **Facility Assessment Tool** under Indicator 12, you will assess each facility to determine if your targeted 5 tracer equipment are lacking or non-functioning. This tool will inform your baseline which you will input into the **Indicator Tracking Form: Tab 12—Equipment**.

On a bi-annual basis, you will return and utilize the **Facility Assessment Tool** to determine change in availability and functionality of the tracer equipment. You will update your tracking tool and input the results into the **Indicator Tracking Form: Tab 12—Equipment**.

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**Target facilities:** A designated building in which general health services are offered. Target facilities are facilities in which the NA intends to improve services and conditions. It includes district or referral hospitals, clinics, health posts, health centers, outpatient care centers, and specialized care centers, such as birthing centers. It does not include mobile service delivery points and non-formal services, such as traditional healers. District and national databases often provide the number of public facilities, often by type (such as hospital, health center, health post, dispensary).

**Non-functioning:** A tracer equipment is either not present at health facility or it is present but not working.

**Amenities:** WHO has identified seven tracer amenities for its Service Availability and Readiness Assessment: power, improved water source, room with privacy, adequate sanitation facilities, communication equipment, access to computer with Internet, emergency transportation. NAs can draw from this list or identify other key amenities for their specific context.

**Disaggregation**

Disaggregated by amenity

<table>
<thead>
<tr>
<th>TIER 3</th>
<th>INDICATOR</th>
<th>OUTCOME</th>
</tr>
</thead>
<tbody>
<tr>
<td>13</td>
<td>Percentage of target facilities that lack or have 3 or more non-functioning amenities in previous six months</td>
<td>Increased resources (financial, human, and material) for RMN programs</td>
</tr>
</tbody>
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If you have not done so, you will first need to define your target facilities and their associated geographies, level etc. on the Indicator Tracking Form: Tab—Facilities. The geographies will be prepopulated in a drop-down menu, pulling from the Indicator Tracking Form: Tab—Geographies. If you have not completed this tab, refer to Indicator 1 methodology card for directions. You will also need to disaggregate the facilities, directions for how to do this is found on the facilities tab. The facilities and geographies will then auto populate in the Indicator Tracking Form: Tab 13—Amenities.

Assessing all facilities in your target geography may be feasible, depending on the size of your target geography. We suggest that if you have 50 or more facilities in your target geography, then assessing all facilities is not feasible and you should create a sample, using the Sampling Guidelines. Before conducting your baseline, you should calculate your sample size.

You will then need to identify the amenities you are targeting and enter using the drop-down menu in the Indicator Tracking Form: Tab 13—Amenities. If you are targeting an “other” amenity, select “other” from the drop-down menu and define that amenity in the space provided at the bottom of the tab. We recommend you target 5 amenities. Once you have identified your target 5 amenities in the baseline period, the remaining periods will auto-populate. TO NOTE: If you are also measuring Indicators 1 or 7, the chosen program/service you are measuring must correspond with your chosen amenity, when appropriate.

Using the Facility Assessment Tool under Indicator 13, you will assess each facility to determine if your targeted 5 amenities are lacking or non-functioning. This tool will inform your baseline which you will input into the Indicator Tracking Form: Tab 13—Amenities.

On a bi-annual basis, you will return and utilize the Facility Assessment Tool to determine change in availability and functionality of the amenities. You will update your tracking tool and input the results into the Indicator Tracking Form: Tab 13—Amenities.
### IMPORTANT DEFINITIONS OR CONCEPTS

**Target population:** Refers to the specific population you are aiming to impact. For example, it may be adolescent girls 15 to 19 or expectant mothers.

**Target geographies:** Refers to the specific catchment area in which WRA is aiming to influence. It may refer to communities, villages, parishes, districts, counties, local government areas, provinces, states, or countries, among others. It will vary depending on the program of work and/or a country's governance structure.

**WRA organized events:** For this indicator these events primarily relate to citizen-hearings, community meetings or other social accountability-related events. These events should include at least 25 people.
You will first need to define your target geographies and target population in those geographies on the Indicator Tracking Form: Tab—Geographies. If you have done this for a previous indicator, it will carry over. If you have not, refer to Indicator 1 methodology card for more instructions.

It will be challenging to interview your entire target population. Therefore, you should create a sample, using the Sampling Guidelines.

You should develop 1–3 questions in the Individual Survey Tool under Indicator 14 to assess whether the interviewee understands their rights and responsibilities related to the type of information you are disseminating in the target geographies. You will then create a baseline by surveying your sample target population utilizing the questions you developed.

You will enter this baseline on the Indicator Tracking Form: Tab 14A—Rights & Resp Geography in the column labeled ‘Baseline.’

On an annual basis, you will return and use the Individual Survey Tool to determine changes in understanding. You will input the results into the Indicator Tracking Form: Tab 14A—Rights & Resp Geography.

All completed Individual Survey Tool responses should be retained for at least one year.

If you choose 14B methodology, you will survey individuals who participate in WRA sponsored events. You will first need to define your events, location, number of participants, etc. on the Indicator Tracking Form: Tab—WRA Events.

You should develop 1–3 questions in the Individual Survey Tool under Indicator 14 to assess whether the interviewee understands their rights and responsibilities related to the type of information you are disseminating in the target geographies. You will then administer the tool to all individuals in attendance at the event to assess understanding of rights and responsibilities related to RMN health. You will not use a sampling methodology at the event(s). At the first WRA-sponsored event, you will establish your baseline and enter it into Indicator Tracking Form: Tab 14B—Rights & Resp Events.

If collecting this indicator, you should generally expect to organize an event(s) on a quarterly basis, reaching a minimum of 125 people, in a specific catchment area. All surveys from the event should be totaled and inputted on the Indicator Tracking Form: Tab 14B—Rights & Resp—Events.

All completed Individual Survey Tool responses should be retained for at least one year.

NOTES:
**INDICATOR**

15A  
**TIER 3**  
Percentage of target population reporting participation in an activity to demand RMN health and rights in the past year (geography)  
Educate and empower people about health and rights

15B  
**TIER 1**  
Number of target population participating in a WRA organized activity to demand RMN health and rights (events)  
Educate and empower people about health and rights

**IMPORTANT DEFINITIONS OR CONCEPTS**

**Target population:** Refers to the specific population you are aiming to impact. For example, it may be adolescent girls 15 to 19 or expectant mothers.

**Target geographies:** Refers to the specific catchment area in which WRA is aiming to influence. It may refer to communities, villages, parishes, districts, counties, local government areas, provinces, states, or countries, among others. It will vary depending on the program of work and/or a country's governance structure.

**Activity to demand:** WRA supports many types of demand activities. These may vary from participating in a citizens hearing, signing a petition, attending a rally or other mobilization activity, among many others.

**DISAGGREGATION**

May be further disaggregated by age, sex, race/ethnicity, urban v. rural using the Individual Survey Tool.
You will first need to define your target geographies and target population in those geographies on the **Indicator Tracking Form: Tab—Geographies**. If you have done this for a previous indicator, it will carry over. If you have not, refer to Indicator 1 methodology card for more instructions.

It will be challenging to interview your entire target population. Therefore, you should create a sample, using the **Sampling Guidelines**.

Create a baseline by surveying your sample target population utilizing the relevant survey questions in the **Individual Survey Tool**. The questions are identified as “Indicator 15.”

You will enter this baseline on the **Indicator Tracking Form: Tab 15A—Demand Rights—Geography** in the column labeled ‘Baseline.’

On an annual basis, you will return and use the **Individual Survey Tool** to determine changes in participation. You will input the results into the **Indicator Tracking Form: Tab 15A—Demand Rights—Geography**.

All completed **Individual Survey Tool** responses should be retained for at least one year.

You will first need to define your events, location, number of participants etc. on the **Indicator Tracking Form: Tab—WRA Events**. You should be able to count the number of individuals who participated in a WRA organized activity from your project reports, after-actions, etc. (e.g. number of individuals you mobilized to participate in What Women Want).

You will then navigate to **Indicator Tracking Form: Tab 15B—Demand Rights—Events** to indicate which period the event took place. You will repeat the process on a quarterly basis.

There is no baseline.

**NOTES:**
## Important Definitions or Concepts

**Target population:** Refers to the specific population you are aiming to impact. For example, it may be adolescent girls 15 to 19 or expectant mothers.

**Target geographies:** Refers to the specific catchment area in which WRA is aiming to influence. It may refer to communities, villages, parishes, districts, counties, local government areas, provinces, states, or countries, among others. It will vary depending on the program of work and/or a country's governance structure.

**Confidence:** The feeling or belief that one has both the ability to demand action and accountability of decision-makers/duty-bearers and that good will come out of such demands.

**Decision-makers:** Individuals with the formal power or authority to make policy, take action, or vote on issues of importance. May include, but not limited to: parliamentarians, ministers and permanent secretaries, administrators and deputy administrators, local governors and councilors, chief administrative officers, district health management teams.

**Duty-bearers:** Actors who have a particular obligation or responsibility to respect, promote and uphold RMN health rights. Includes decision-makers but also encompasses those without authority to make official decisions, such service providers and other program and policy implementers.

**WRA organized events:** For this indicator these events primarily relate to citizen-hearings, community meetings or other social accountability-related events. These events should include at least 25 people.

## Disaggregation

May be further disaggregated by age, sex, race/ethnicity, urban v. rural
**16A: HOW TO MEASURE (COLLECTED ANNUALLY)**

You will first need to define your target geographies and target population in those geographies on the **Indicator Tracking Form: Tab—Geographies**. If you have done this for a previous indicator, it will carry over. If you have not, refer to Indicator 1 methodology card for more instructions.

It will be challenging to interview your entire target population. Therefore, you should create a sample, using the **Sampling Guidelines**.

Create a baseline by surveying your sample target population utilizing the relevant survey questions in the **Individual Survey Tool**. The questions are identified as "Indicator 16."

You will enter this baseline on the **Indicator Tracking Form: Tab 16A—Increased Confidence—Geo** in the column labeled 'Baseline'.

On an annual basis, you will return and use the **Individual Survey Tool** to determine changes in confidence. You will input the results into the **Indicator Tracking Form: Tab 16A—Increased Confidence—Geo**.

All completed **Individual Survey Tool** responses should be retained for at least one year.

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**16B: HOW TO MEASURE (COLLECTED QUARTERLY)**

If you choose 16B methodology, you will first need to define your events, location, number of participants, etc. on the **Indicator Tracking Form: Tab—WRA Events**.

You will use the questions under Indicator 16 of the **Individual Survey Tool**, to survey those who participate in a WRA-sponsored event. You will then administer the tool to all individuals in attendance at the event to assess their confidence in voicing issues of concern. You will not use a sampling methodology at the event(s). At the first WRA-sponsored event, you will establish your baseline and enter it into **Indicator Tracking Form: Tab 16B—Increased Confidence—Events**.

If collecting this indicator, you should generally expect to organize an event(s) on a quarterly basis, reaching a minimum of 125 people, in a specific catchment area.

All completed **Individual Survey Tool** responses should be retained for at least one year.

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**NOTES:**

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__________________________________________________________________________
Target decision-makers: Individuals with the formal power or authority to make policy, take action, or vote on issues that you are working on. Target decision-makers are those named persons who you specifically intend to influence in support of RMN health and rights. May be at the global, national, or sub-national levels. May include, but not limited to: parliamentarians, ministers and permanent secretaries, administrators and deputy administrators, local governors and councilors, chief administrative officers, district health management teams.

Increasing action: WRA’s decision-maker tracker tool defines categories of action based on a scale of -1 to 7. -1=opponent; 0=uninformed neutral; 1=acknowledges problem privately or publicly, but no action taken; 2=participates in consultative meeting and/or activity in support of target policy goals; 3=publicly voices support and/or takes action to advance target policy goals; 4=consistently—at least four times a year—voices public support and/or takes action to advance target policy goals; 5=encourages other decision-makers to support and take action; 6=sponsors or participates in development of policy in support of target goal(s); 7=introduces or leads development of policy in support of target goal(s). Increasing action is defined by a decision-maker moving higher in terms of the scale.

First, identify the decision-makers (by name and position) you are targeting and list them in the Indicator Tracking Form: Tab 17—Decisionmaker Act. It is recommended you set a reasonable number of decision-makers to target your outreach. While there is space for up to 100, many times less is more. Depending on your goals, it may even be appropriate to list only one. Generally, 5 to 25 is appropriate.

To set the baseline, you will categorize each decision-maker according to the scale and include a brief description justifying the ranking.

On a quarterly basis, you will update the ranking of each decision-maker and provide a brief justification as to why in the Indicator Tracking Form: Tab 17—Decisionmaker Act.
**INDICATOR**

| 18 | Number of WRA-packaged evidence referenced in target government documents and/or decision-maker statements | Collect and use evidence for advocacy |

**TIER 2**

**IMPORTANT DEFINITIONS OR CONCEPTS**

**WRA-packaged evidence:** Evidence that you have compiled and branded to persuade decision-makers. Usually includes qualitative or quantitative data and/or citizen testimonials regarding the problem or proposed solution for your target issue. May be captured in reports, talking points, presentations, one-pagers.

**Target government documents:** Written materials that may include, but is not limited to, documentation of hearings, reports, statutes, treaties, periodicals, legislation, regulation, rules, and policies. A target document is one that you are specifically influencing to include reference to WRA evidence.

**Target decision-maker statements:** Individuals with the formal power or authority to make policy, take action, or vote on issues of importance. May include, but not limited to: parliamentarians, ministers and permanent secretaries, administrators and deputy administrators, local governors and councilors, chief administrative officers, district health management teams. Decision-maker statements may be either oral or written personal, public citations of WRA evidence by these individuals. A target statement refers to one presented by a decision-maker that you are directly influencing.

**DISAGGREGATION N/A**

**HOW TO MEASURE (COLLECTED QUARTERLY)**

You will first need to identify the packaged evidence you are using to persuade decision-makers and list that in the Indicator Tracking Form: Tab 18—WRA Evidence.

Then you will list the government document and/or decision-maker statement you are targeting.

The baseline is 0.

On a quarterly basis, you will monitor whether the target government documents and/or decision-maker statements reference the evidence. You will enter the findings into the Indicator Tracking Form: Tab 18—WRA Evidence.

**NOTES:**
**INDICATOR**

| 19 | Number of actions taken jointly by at least 75% of target partners to influence decision-makers and duty-bearers actions |

**STRATEGY**

Convene and catalyze action to drive change

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### IMPORTANT DEFINITIONS OR CONCEPTS

**Target partners:** A target partner is an organization or group that you are now or intending to work with to influence change in decision-maker or duty-bearer action. Includes official WRA members and other relevant stakeholders.

**Jointly demanding action:** This refers to advocacy activities that are undertaken together and/or in coordination. Specific actions could include a joint/shared strategy or action plan attending meetings with decision-makers together, joint convenings, issuing joint statements or press-releases, speaking with the media together or other actions voicing unified support.

**Decision-makers:** Individuals with the formal power or authority to make policy, take action, or vote on issues of importance. May include, but not limited to: parliamentarians, ministers and permanent secretaries, administrators and deputy administrators, local governors and councilors, chief administrative officers, district health management teams.

**Duty-bearers:** Actors who have a particular obligation or responsibility to respect, promote and uphold RMN health rights. Includes decision-makers but also encompasses those without authority to make official decisions, such as service providers and other program and policy implementers.

### DISAGGREGATION

Disaggregated by type of partner

### HOW TO MEASURE (COLLECTED QUARTERLY)

You will first need to identify the number and name of organizations you are targeting to partner with in the [Indicator Tracking Form: Tab 19–Partners Demand Action](#). Again, less can be more. In many instances, it’s best to have the right partners rather than a large number of partners for numbers sake.

The baseline will be the current number and name of partners working together to demand duty-bearer actions.

On a quarterly basis, you will document activity to jointly demand action and enter findings into the [Indicator Tracking Form: Tab 19–Partners Demand Action](#).

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### NOTES:
Target champion: A champion is a person who voluntarily takes extraordinary interest in the adoption, implementation, and success of a cause, policy, program, project, or product. A target champion is a person who you specifically intend to influence to take increasing action. Champions are often highly connected or well-respected individuals amongst the community of people you are trying to persuade. May occur at national, or sub-national levels. Not to be confused with someone who simply supports issue or has taken a singular action.

Increasing action: WRA’s champion tracker tool defines categories of action based on a scale of 0 to 6:

• 0= No action taken,
• 1= Participates in consultative meeting and/or activity in support of RMN health (e.g. attends a briefing, participates in a strategy meeting),
• 2= Publicly voices support and/or takes action to advance target advocacy goals (e.g. writes an op-ed or blog; makes a public statement/speech; organizes an event; initiates a sign-on letter),
• 3= Consistently—at least once a quarter for two or more quarters—voices public support and/or takes action to advance target advocacy goals (e.g. writes an op-ed or blog; makes a public statement/speech; organizes an event; initiates a sign-on letter),
• 4= Utilizes influence to make a direct ask of decision-makers to advance target advocacy goal(s), (e.g. makes a direct request through a phone call, meeting, personal note, etc.) or encourages other champions to take action,
• 5= Engages in collaborative relationship—meeting at least once a quarter—with advocates to specifically strategize on how to advance target advocacy goal(s),
• 6= Serves as a leading spokesperson to advance target advocacy goal(s), (e.g. is called upon by media as a spokesperson, is frequently requested to speak by conference or workshop organizers, parliament and other public forums to speak as expert on subject).

Increasing action is defined by a champion moving higher in terms of the scale.

How to measure (Collected Quarterly)

First, identify the champion (by name and title) you are targeting and list them in the Indicator Tracking Form: Tab 20—Champions Act. It is recommended you set a reasonable number of champions to target your outreach. While there is space for up to 100, many times less is more. Depending on your goals, it may even be appropriate to list only one. Generally, 5 to 25 is appropriate.

To set the baseline, targeting champion will categorize each champion according to the scale and include a brief description justifying the ranking.

On a quarterly basis, you will update the ranking of each champion and provide a brief justification as to why in the Indicator Tracking Form: Tab 20—Champions Act.
<table>
<thead>
<tr>
<th>INDICATOR</th>
<th>STRATEGY</th>
</tr>
</thead>
<tbody>
<tr>
<td>21</td>
<td>Percentage change in coverage of RMN health, rights, and accountability by target media</td>
</tr>
<tr>
<td>TIER 2</td>
<td>IMPORTANT DEFINITIONS OR CONCEPTS</td>
</tr>
</tbody>
</table>

**Target media:** Refers to specific means of mass communication (broadcasting, publishing or Internet). Includes traditional media (e.g. newspaper, magazines, radio, television) and new media (e.g. social media, Internet). Does not include your own communication channels.

**DISAGGREGATION N/A**

**HOW TO MEASURE (COLLECTED QUARTERLY)**

You will first need to identify and list the name of media (e.g. specific journalists, newspapers, radio stations, blogs, social media influencers) you are targeting for increased coverage in the **Indicator Tracking Form: Tab 21—Media**

For the baseline, you will monitor coverage by the specific target media for at least two days a week for one month. You will document the number of times RMN health, rights and accountability are accurately and positively mentioned by that specific target media.

For at least two days a week per month, you will monitor and document the number of times RMN health and rights are accurately and positively mentioned by each target media using the **Media Monitoring Form**. Then on a quarterly basis, you will enter the findings in the **Indicator Tracking Form: Tab 21—Media**.

The **Media Monitoring Form** should be retained for at least one year.

**NOTES:**
Members: A WRA member is an acting or contributing individual or organization, who both self-identify and are identified by the National Secretariat as engaged in the work of White Ribbon Alliance at the global, national or sub-national level. These are members in more than name only. Members, as part of our Global Alliance, use their unique talents, skills, interests, and areas of influence to catalyze action for women’s and girls’ reproductive and maternal health and rights.

Disaggregated by individual vs. organization and type of organization

HOW TO MEASURE (COLLECTED QUARTERLY)

You will first need to document the name of all current members in Indicator Tracking Form: Tab 22—Members. You will also specify if the member is an individual or an organization. If an organization, you will select from the drop-down menu the type of organization. This is your baseline.

On a quarterly basis, you will list new members in the Indicator Tracking Form: Tab 22—Members. For each quarter the indicator will roll up the total number of members from the current quarter, all previous quarters, and the baseline. This will automatically populate at the bottom of the tab and in the Indicator Tracking Form: Tab Report.

The Indicator Tracking Form only captures up to 100 members. If you anticipate tracking more, contact the Global Secretariat. As a reminder you are only tracking active and engaged members who contribute to your National Alliance. The higher the number is not necessarily better.

NOTES:
Governance Scorecard: The governance scorecard is an annual self-assessment required for WRA affiliation. It is completed by the National Alliance’s governing body. The scorecard is a roll up of four indicators which collectively determine if the governing body is executing on its responsibilities as defined in the NA Governing Body Terms of Reference. The indicators include management of the National Coordinator, ensuring financial stability, operational effectiveness and monitoring of the strategic plan.

While other indicators will be completed by the National Secretariat, this indicator will be completed by the governing body.

For your baseline, it is the percentage of benchmarks met in the previous year’s scorecard. This should be entered in the Indicator Tracking Form: Tab 23—Governance. If you did not retain this scorecard, contact the Global Secretariat and it will be provided.

On an annual basis, the governing body will select whether each benchmark was completed, is a work in progress or if there has been no action and then enter into the Indicator Tracking Form: Tab 23—Governance. They will then provide an explanation for why that status was selected. The indicator will self-tabulate the percentage of benchmarks that are either a work in progress or have been completed at the bottom of the page and in the Indicator Tracking Form: Tab Report.
**INDICATOR**

**Number of donors approached and/or proposals submitted**

**FOUNDATION**

Sufficient and diverse funding basis

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**IMPORTANT DEFINITIONS OR CONCEPTS**

**Donors approached:** Refers to specific, on-going (at least two in a quarter) cultivation conversations with target donors, in which funding for WRA is the specific focus of the dialogue.

**Proposals submitted:** Includes both concept notes and proposals that have been invited and/or in response to an open call for applications.

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**DISAGGREGATION**

Disaggregated by either invited or responding to an open call, and successful or non-successful

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**HOW TO MEASURE (COLLECTED QUARTERLY)**

You will first need to define your target donors and/or funding mechanisms in the **Indicator Tracking Form: Tab 24—Donors**.

There is no baseline for this indicator.

On a quarterly basis, for each of the listed donors in the **Indicator Tracking Form: Tab 24—Donors**, you will input 1) whether you have approached them and/or submitted a proposal, and 2) a description of the opportunity including how it came about, proposed amount, and activities under discussion.

If you approach additional donors over the year, add them to the original list.

A helpful hint in developing your target donor list – you should make sure that the requirements of a donor align well with your capacities. This will help you to ascertain if you have a reasonable chance of actually securing funds from them. Contact the Global Secretariat for specific guidance.

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**NOTES:**

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**Funds mobilized:** Funds committed by individual or institutional donors. Does not include in-kind donations. This is not about your cultivation or approaches (that is tracked in Indicator 24), rather actual funds secured.

**Disaggregation**

Disaggregated by type of funder and source

**HOW TO MEASURE (COLLECTED QUARTERLY)**

You will first need to define your target donors and/or funding mechanisms in the Indicator Tracking Form: Tab 25—Funds Mobilized. This should be the same list you created in Indicator Tracking Form: Tab 24—Donors.

There is no baseline for this indicator.

On a quarterly basis, enter the amount of money awarded per funder. If nothing has been awarded enter 0. If new donors are added to Indicator 24, those target donors should be added to this indicator as well.

**NOTES:**
### HOW TO MEASURE (COLLECTED ANNUALLY)

Each year you should conduct a MEAL review along with your strategic plan to determine what adjustments need to be made to achieve your results. You will document the stated adjustments in **Indicator Tracking Form: Tab 26—MEAL**. As appropriate, update your activity workplan and external strategic plan to reflect these adjustments. Please note, when adjusting your strategy, it may also require you to adjust your overall targets for each of your indicators.

There is no baseline for this indicator.

For this particular indicator, your number of adjustments is likely to decrease over time as your strategy will have hopefully become more effective as a result of drawing from your MEAL data.