Gender and Intersectionality Checklist for AMR Community Engagement Operational Researchers

Image: A community dialogue in Bangladesh

Introduction

Antimicrobial resistance (AMR) poses a significant threat to global public health, with increasing treatment failures and *related mortality* exacerbated *by complex socio-economic, cultural, and gender dynamics. Recognising the critical role of gender and related inequalities in shaping health behaviours and outcomes, this guidance document aims to provide AMR community engagement operational researchers and practitioners with a comprehensive tool to consider the intersectionality of gender and other social stratifiers in the design, implementation, and evaluation of community engagement (CE) operational research and interventions.*

Targeted monitoring and evaluating of gender and intersectionality throughout the research process can help you determine whether equality considerations have been meaningfully integrated. Consideration of these elements can also guide programme implementers through the creation of community-based interventions that are culturally sensitive and socially inclusive, thereby improving their effectiveness and sustainability. Policymakers may find this document helpful to inform the development of equitable AMR policies and programmes that address the specific needs and circumstances of diverse populations, as will academic institutions and trainers, to incorporate gender and intersectionality into educational curricula and training modules for future researchers and practitioners in community engagement and AMR.

By following this structured approach, researchers will develop a more nuanced understanding of how and whether the research process considers the different priorities and needs of women and men, and intersecting social categorisations such as age, sexuality, race, ethnicity, religion, disability, and economic status before, during and after the implementation of project activities.

This guideline is designed to provide a clear and practical roadmap for integrating gender and intersectionality into AMR community engagement research. It includes the following key components:

KEY PRINCIPLES

An overview of the core principles that underpin this guideline linked to equity, inclusivity, and respect for diversity.

RESEARCH PROCESS

Detailed steps for incorporating gender and social stratifiers into the research process, from initial design to data collection, analysis, and dissemination.

GENDER CHECKLIST

A comprehensive checklist of questions to qualitatively *assess the* extent to which *gender and social stratifiers are integrated into AMR community engagement research and interventions* and related projects*. This checklist covers areas such as participant and researcher demographics, as well as gender-specific impacts, and equity outcomes.*

CASE STUDIES

Examples that illustrate successful integration of gender and intersectionality into an AMR CE project.

TOOLS AND RESOURCES

A list of additional resources to support the application of this guidance in various contexts.

This document evolved over several iterations through team discussions and involved an extensive review of existing literature on evaluating community engagement through the project cycle, drawing heavily on existing frameworks to identify and integrate key Gender Equality and Social Inclusion *(GESI) evaluation questions into AMR operational research to ensure its relevance, accuracy, and applicability.*

It should be noted that while the research team has taken steps to make the CE approach equitable and inclusive, this guidance specifically focuses on the gendered dimensions of the CE process we undertook in rural communities in Bangladesh and Nepal, with principally binary mentions of men and women reflecting the identities of the people in the communities where the case study project, COSTAR, is being implemented. The Community Dialogues were also not able to accommodate integration of sign-language or address the additional needs of those with severe psychological disorders. The checklist is not exhaustive and *is designed to be a living document, with periodic updates based on feedback from users, and evolving evidence generation from good practice in this field.*

KEY TERMS used in this document

The terms provided draw on both definitions from existing literature and definitions developed by authors to provide clarification in this document.

COMMUNITY

A group of people who have common characteristics or interests that impact their need for and utilisation of health services. Communities can be defined by geographical location, race, ethnicity, age, gender, occupation, a shared interest, or affinity (such as religion and faith) or other common bonds, such as health need or disadvantage (e.g. refugees).[i]

EQUITY

Equity is the absence of unfair, avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically or by other dimensions of inequality (e.g. sex, gender, ethnicity, disability, or sexual orientation). Health is a fundamental human right. **Health equity is achieved when everyone can attain their full potential for health and well-being.**[ii]

Ensuring adults identifying as members of a geographic community get the support they need to benefit from, and to attend and actively participate in the community engagement and decision-making processes regardless of age, ability, gender, socio-economic status, religion, or political views.

GENDER

This refers to the socially constructed roles, behaviours, activities, attributes and opportunities that any society considers appropriate for men and women, boys and girls" and people with non-binary identities. [iii]

INTERSECTIONALITY

Intersectionality is an analytical lens that examines how different social stratifiers (such as gender, class, 'race', education, ethnicity, age, geographic location, religion, migration status, ability, disability, sexuality, etc.) interact to create different experiences of privilege, vulnerability and/or mariginalisation.[iv]

INCLUSION ENSURING THAT ALL (REGARDLESS OF IDENTITY) CAN FULLY PARTICIPATE, ARE VALUED, AND WELCOME.

The demographic diversity of communities (e.g. ethnocultural; educational; socioeconomic, beliefs, language, age, gender, values and health status) are recognised and respected while social norms perpetuating inequalities are acknowledged and discussed.

PARTICIPATION

A range of processes through which people with different gendered / social-economic backgrounds are involved and play a role in the planning, implementation and quality control of the project.

Creating 'working Definitions'

While the above definitions can act as a useful tool for discussion, particularly at the beginning of a research project, research teams could consider developing a set of working definitions where appropriate. Teams might want to consider interrogating commonly understood terms during the early stages of planning; terms such as 'community', 'equity', and 'gender' can often be contested in different settings and are considered to change over time. Multidisciplinary research teams could start by removing assumptions on the applicability of generic (western) definitions of such terms in all contexts and dedicate time to considering how these terms might be better defined for their context/project.

For example, in the work of the COSTAR project, researchers developed a working definition of the term 'community' that better suited the needs of the project:

WORKING DEFINITION

For the purposes of the COSTAR project (see below), the team began with a working definition of a community as advised by gatekeepers and community consultants, primarily based on geographic location. Within the geographic parameters of a given community, facilitators and individuals self-identify community via their own parameters and organise/attend CD sessions in accordance.

Examples from a community engagement operational research project

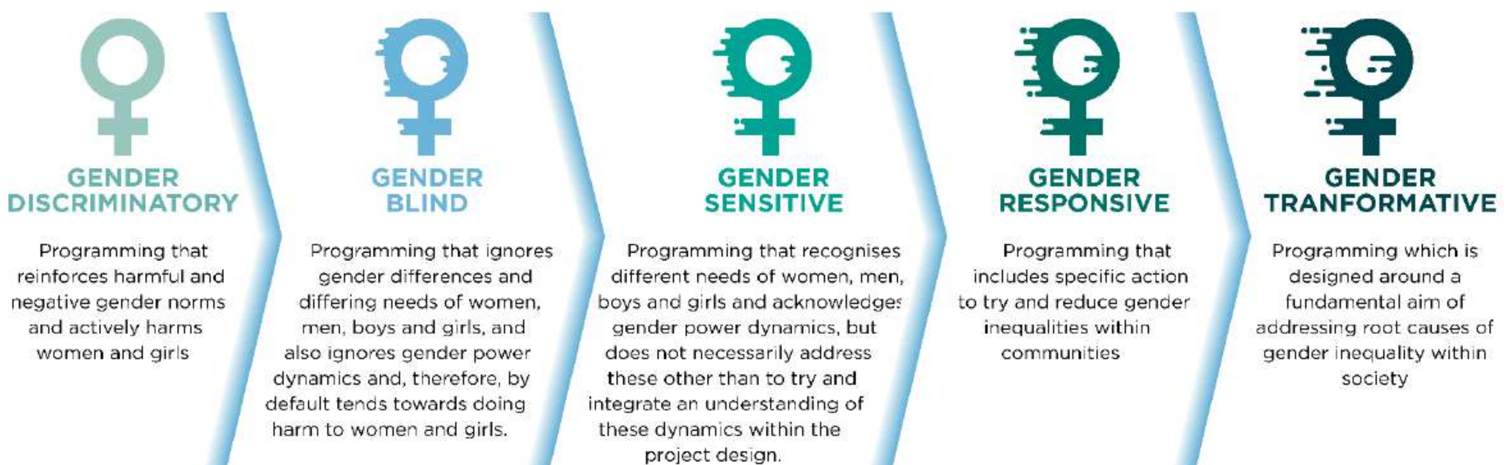
Photo: Women creating a map of their community in a community dialogue, Cumilla, Bangladesh.

Community-Led Solutions to Antimicrobial Resistance (*COSTAR*) is a three-year operational research project comprising a randomised control trial (RCT) in Bangladesh, and a feasibility study in Nepal that aims to co-create, embed in governmental structures and robustly evaluate an innovative a One Health Community Engagement intervention. Community members in Cumilla district, Bangladesh, and Kapilvastu, Nepal, are learning about Participatory Video and the Community Dialogue Approach and are engaging members of

their communities in participatory community dialogues about antimicrobial resistance (AMR).

At the heart of COSTAR's ethos is an equitable and inclusive intervention development and implementation methodology. We acknowledge that not everyone starts at the same place having differing needs for resources or support to slowdown and mitigate the impact of AMR. A key aim of the COSTAR project is understanding and supporting members of under-served groups and those who lack access to health services, who are less likely to engage in the community engagement (CE) and research processes, and who may also face more barriers to practising healthy behaviours. A further aim is ensuring that stakeholders' gender does not hinder participation. Investigating how participation impacts on a particular gender or group of project participants, and whether planned activities are perpetuating harmful norms or biases, is also integral to the project evaluation and its success. In this document, you will find examples of how we used a gender-intersectional lens to deepen our understanding of our research process.

A discussion was had regarding our aspirations of impact based on the gender continuum, which stretches from 'gender blind', with no attempt to address gender, to 'gender sensitive', which accommodates gender differences, through to 'transformative programming', which seeks to transform gender relations. We knew that our research would be neither blind nor transformative, but would sit sometimes in gender sensitive, with moments of gender responsiveness where we addressed gender-based barriers to participation.



- **Gender discriminatory**: Programming that reinforces harmful and negative gender norms and actively harms women and girls.

- **Gender blind**: Programming that ignores gender differences and differing needs of women, men, boys and girls, and also ignores gender power dynamics and, therefore, by default tends towards doing harm to women and girls.

- **Gender sensitive**: Programming that recognises different needs of women, men, boys and girls and acknowledges gender power dynamics, but does not necessarily address these other than to try and integrate an understanding of these dynamics within the project design.

- **Gender responsive**: Programming that includes specific action to try and reduce gender inequalities within communities.

- **Gender transformative**: Programming which is designed around a fundamental aim of addressing root causes of gender inequality within society.

Photo: Community dialogue in Bangladesh

Evaluation of participation and gender intentionality

The checklist is grounded in five foundational principles of mainstreaming participation, gender and intersectionality, which encapsulate inclusiveness and equity to guide researchers in embedding gender and intersectional perspectives throughout their research processes. We recommend that these are each considered so that the needs and experiences of all genders and abilities can be addressed and represented throughout the research cycle. Below, we provide an evaluation of each of the principles, and how they work in practice.

1. **Leave no one behind, with a focus on understanding context and removing barriers that may prevent participation.**

We ask:

- What biases and assumptions do we have? Once recognised, we can take active steps to reduce and remove these.
- Who in the community is at risk of exclusion because of their status or identity? Why, and what barriers might they face (considering access, decision-making, norms and values, division of labour)?
- How can we identify and support people less able to attend and to engage?
- Does our approach encourage the participation of all genders and intersecting social stratisfiers in discussions about their own, and their families', health?
- How can we plan our CE approach to be inclusive, considering the local context?
- What role do different groups play in the implementation of the CE activities?

An assessment of specific needs, challenges and strengths of different ethnic, religious, age and occupation groups among others residing in the community produced some interesting findings. In communities where multiple languages are spoken, language differences can hinder effective communication and participation, especially if dialogues are conducted in a language not everyone is comfortable with. Low literacy levels were also found to limit the ability of some community members to engage fully, particularly if written materials or formal speech are heavily used in dialogues. Moreover, in communities where people work long hours or have irregular work schedules, finding suitable times for dialogue sessions that accommodate everyone can be challenging. Economic hardship was another factor identified that can limit participation, as individuals may prioritise immediate economic activities over attending dialogues, particularly, daily-wage -based workers.

Separate CD sessions were conducted for men and women by community facilitators of the same gender identity. The facilitators selected were local people belonging to the same community who had a deep understanding of their communities, i.e. local language; local norms and values; power dynamics within various groups within community; most practiced occupations; time available, etc., to increase the scope for a contextually relevant and

inclusive project. The selection of female Muslim facilitators from and for the Muslim community led to reported improved participation of Muslim women.

2. **Engage diverse stakeholders in a participatory and inclusive decision-making process. Representatives of the diverse groups of community-level stakeholders are included and able to participate in decision-making during the research process, and during the CE.**

We ask:

- Are opportunities and an enabling environment created for all gender identities and social groups to participate in a meaningful way in the process of design, decision-making and planning?
- Are the opinions of all participants equally valued and influential in decision-making?
- Will there be an impact on relationships between people of different identities because of engagement, for example, changing roles and responsibilities?
- What is the expected impact (benefits and losses) on people of different identities, both throughout the project and beyond?

In Nepal, trainers who provided training to the dialogue facilitators were all local-level stakeholders, familiar with local context and language. This ensured delivery of training aligned with the local context and prevented any language barriers for facilitators belonging to diverse socio-demographic groups. A separate session on 'practical skills and approaches for making CD sessions inclusive' was delivered as a part of training of facilitators.

3. **Encourage inclusive representation in language and imagery. Using understandable language, visuals and media that reflect the diversity of the community ensure that all participants, regardless of their background, feel seen, valued and respected.**

We ask:

- Do language or images used discriminate or stereotype a group? (Consider gender, ethnicity, religion or specific social norms.)
- Is gender made visible where relevant? Are men and women made equally visible?
- Does the image value and respect the gender and cultural norms in the particular context, for example, the type of dress or other accessories used in the image of men and women.

We aimed to avoid stereotypes and biases to promote a more accurate and respectful portrayal of different groups in the CE materials, research tools and publications.

BOX.4 MATERIAL DEVELOPMENT

In Nepal, the flipbook used in the community dialogues was co-created with the community members to ensure that the messages and pictures used were culturally and linguistically appropriate for the various groups residing in the community. Narratives developed by community members were adapted into stories that were told during the sessions. Pre-testing of the material was done with the same communities before the final implementation.

In Bangladesh, care was taken to avoid gender stereotypes in flipbook images, so that both men and women were depicted in professional roles.

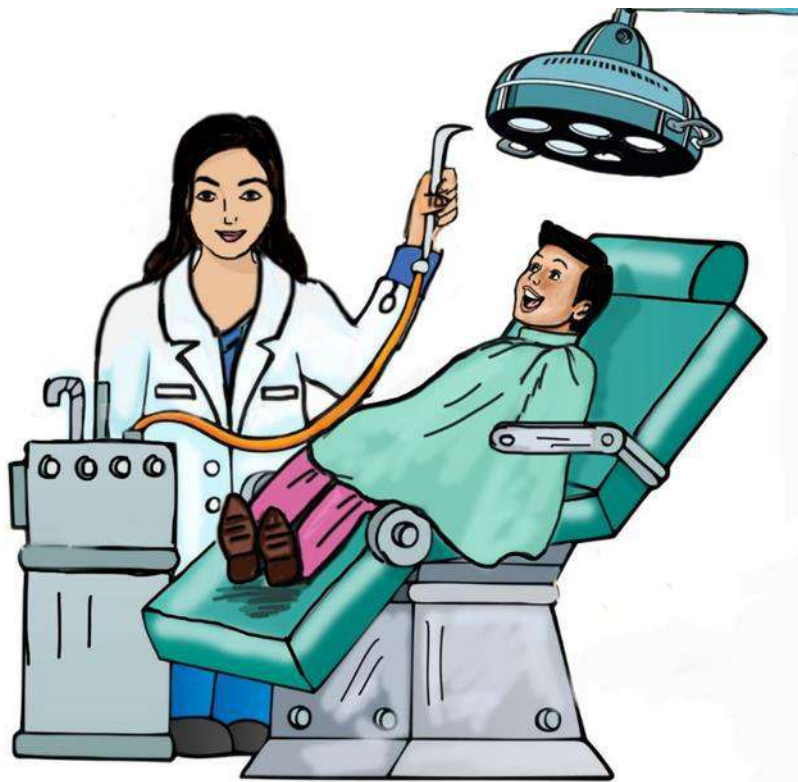


Image from the Bangladesh COSTAR flipbook

4. **Be intentional about inclusive data collection and analysis by developing and using practices that consciously include gender identities and groups who are marginalised or underrepresented in data collection tools and processes, and consider their unique experiences in data analysis.**

We ask:

- How are the data collected and analysed? Are they collected from a broad spectrum of people from different geographic locations, ages and ethnicities? Are data disaggregated by sex, gender specific and implicitly gendered?
- Have we considered data disaggregated by gender and intersectional identity in the analysis?
- How transparent are we regarding how we collect and analyse data?
- Have targets been strategically set to close gender and intersectionality gaps in data?

Sex-disaggregated data were collected at all levels of data collection using both qualitative and quantitative approaches and will be considered in all levels of data analysis to measure the impact of the interventions on different genders, and how different genders responded to different research and intervention components. For the baseline and endline surveys in Bangladesh, an almost equal proportion of men and women were interviewed.

5. **Create an internal environment to support gender and intersectional mainstreaming by fostering a culture of inclusivity by implementing gender-sensitive policies, providing training on gender and intersectionality, and ensuring leadership accountability in promoting equitable practices across all levels of the project.**

We ask:

- Are multidimensional social dynamics and safeguarding requirements reflected in the research team's make-up, abilities and operational outputs?
- Is there diversity in team members, among the research team, trainers, supervisors and facilitators?
- Is there guidance in place to guide the research team to be more gender intentional?
- Have we considered our own biases and how are we mitigating these?
- Does everyone on the team have access to equal and meaningful opportunities, and career progression?
- How are decisions made and who is involved in this?

BOX.5

In Bangladesh, a mandatory safeguarding session was conducted at every level of training and for all office-based and field staff.

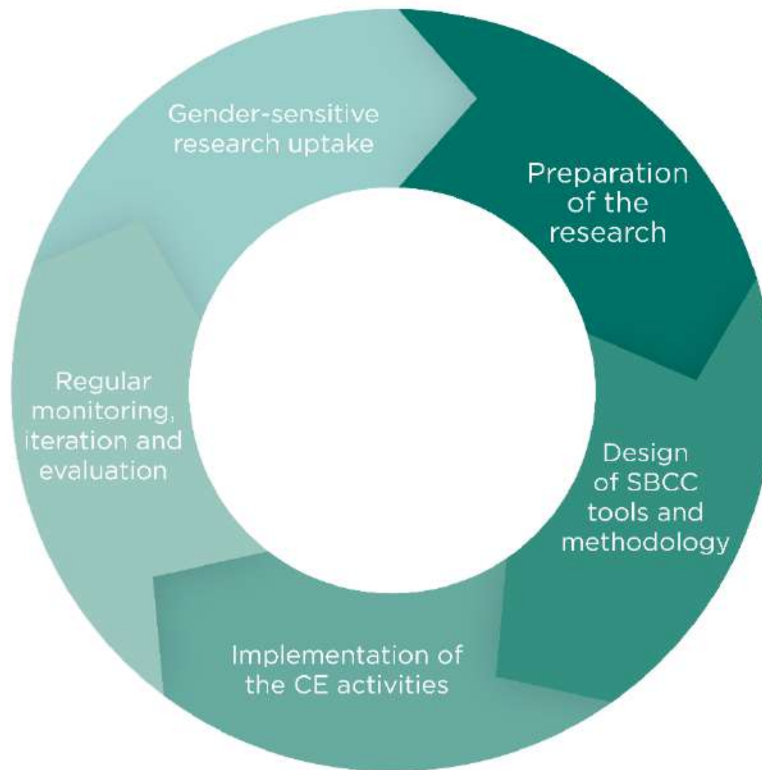
Safeguarding messages were also included in the Bangladesh flipbook and a contact number was provided to report any safeguarding issues from CD sessions. A separate reporting template was created, as well as assigning a separate individual to ensure safeguarding of all stakeholders at all levels of research and implementation.

Image: Illustration about safeguarding from the Bangladesh flipbook

Taking a gender and intersectional lens to the research cycle

Explanation of the checklist

Whereas the questions about inclusion principles above are relevant throughout the research cycle, the checklist below is organised into six sections that reflect the project cycle (Fig.1) and can be used to guide the design, implementation, and monitoring and evaluation of CE operational research to help teams understand the extent to which the CE tools and activities they are developing are inclusive. It can be adapted to projects at different levels of the gender responsiveness scale.



Section 1. Development of the research proposal and protocol

In section one, we identify the issues, needs and contextual factors affecting all stakeholder engagement in the initial planning of the research process.

Section 2. Engaging stakeholders including community members in a gender-sensitive, inclusive and consultative project design process

We aim to formulate a project with meaningful engagement with women, men and non-binary participants equally participating in the development process including social and behaviour change communication (SBCC) materials.

Section 3. Implementing project activities

In this section we look at how to ensure, where possible, that community members can access and participate in community engagement activities and decision-making processes, and equally benefit from training and capacity strengthening offered.

Section 4. Concurrently monitoring, collecting and responding to/adapting to feedback, and the final evaluation: Tracking and assessing progress toward goals and objectives to improve gender intentionality and intersectionality

We aim to increase accountability by ensuring the participation of local stakeholders and community structures in generating data (data collection, validation, processing and analysis), to diagnose problems with — and identify appropriate solutions for — the CE process and to AMR. This would ensure all genders equally participate in monitoring and evaluation activities and decision-making processes, and that data are collected, enabling impacts of and on gender and intersecting stratifiers to be tracked. In this way, we can assess if the project equally benefits women, men and people with non-binary identities.

Ongoing gender and intersectionality analysis should be embedded into the project, along with a MEAL framework to account for the changing situation and to enable identification of gaps.

Section 5. Research uptake

In this section, we look at how people with different intersecting identities are visible in and able to access the research outputs generated.

Section 6. Capacity strengthening

As capacity strengthening was a cross-cutting theme throughout the research cycle, we have also included this in the list.

Image: Community dialogue, Nepal 2024. HERD International

EVALUATION TOOLS COULD INCLUDE:

Methodology Document review Group interviews with key members of research team In-depth interview with government stakeholders CE participants Discussion with: • Government stakeholders • Supervisors • CE facilitators • CE participants Direct observation of community engagement activities Participatory research methods
Endline survey with CE participants

The following scale can be used to grade the performance of the research project:

0 = Not at all

1 = Somewhat

2 = Comprehensively

When looking at your answers, if you answered 0 or 1, then the research may be gender blind or gender unaware and could ignore gender and intersectional considerations.

If you answered yes, then your research is likely more gender aware.

1. **1. Gender blind** ignores gender differences and assumes policies affect everyone equally.
2. **2. Gender aware** recognises and addresses gender differences to promote equity.

Gender and intersectionality checklist

QUESTION		SCORE 0	1	2	COMMENTS
1	**Preparation of the research** Key question: Was a gendered lens used when developing research objectives, questions, hypothesis, data collection tools and analysis? Have the issues, needs and contextual factors affecting gender and intersecting inequalities in the research process been identified and analysed? Have we considered our own biases and how are we mitigating these? Has everyone had the opportunity to input into project design, including people of different genders and other intersections, from the project team, participants of the research and affected populations the project will work with?				
1.1	**Context analysis**				

	Has the project conducted a contextual analysis to gain an understanding of gender and intersecting influences in the project area? Has the team done a systematic examination of: • the differences in gender roles and gender norms; the different levels of power held; differing needs, constraints and opportunities; and the impact of these differences on people's lives? • the balance of power, leadership and management considering the gender and intersectional dimensions the range of roles in planning and in activities, influence in decision-making etc. Has the potential impact of the project on gender relationships been analysed? Has division of labour defined by gender and social norms influenced participation between different gender and intersectional groups? E.g: do women's social roles, such as family responsibility, childcare and infant feeding, affect their active and regular participation in community engagement and health promotion activities? Have potential adverse impacts or risks to equal access to, equal participation in and/or equal benefit from project activities among genders and abilities been analysed?				

1.2	Barriers to and enablers of participation				
	Did the team discuss and take the steps necessary to remove gender-related and intersectional barriers to participation in different stages of the study? Did the team identify the enablers that would increase participation? Has the project incorporated mechanisms to reflect a broad range of perspectives and balanced representation in consultations, decision-making and project activities? Who is and isn't involved in the project decision-making? Have ways to support people at risk of exclusion to attend and engage been included in the study design? When imagining solutions to the One Health AMR challenge, has the team considered which solutions are most likely to lead to more equitable changes in gender-related and intersectional stratifiers related knowledge, attitudes, beliefs, perceptions, norms, roles and behaviours as well as behaviours that reduce AMR ?				

1.3	Use of secondary data				
	Did any formative assessments, reviews and lessons learnt or other exercises informing the project consider how gender-related factors impact AMR? This may include gender norms, power dynamics between men and women and other gender groups, gender-based access barriers, gender discriminatory policies, etc. Were relevant sex-disaggregated data and other gender-related information collected from primary and secondary sources and used in the problem analysis? Do the insights generated from primary and secondary research analysis include a deeper understanding of existing gender dynamics and their impact on AMR? Has the project team reviewed best, promising and emerging practices on men's engagement or women's empowerment to identify effective approaches to mainstream gender within the project? Has the project used gender-disaggregated data to explore how gender effects differ by age, socio-economic status, educational attainment, race/ethnicity and other factors?				
1.4	Sampling and research outcomes				

	Are data disaggregated by gender and other social stratifiers within the sample design? Do the research outcomes include quantifiable gender-related indicators and targets around issues that may differ by men and women? Is participation in events and activities disaggregated by gender and visible disabilities?				
1.5	**Organisational environment**				
	Project team Have equal opportunities for women and men in the management and implementation arrangements of project been considered? Is there is an unbalanced gender make-up of the research team? If yes, have steps been taken to integrate the perspective of other genders? Does the project management team have experience designing and implementing projects using a gender lens? Are visible and non-visible differing abilities catered for within the research team e.g. neurodivergence?				

	Policies and procedures Is there a policy in place, and socialised to address sexual harassment and safeguarding issues for CE facilitators, researchers and community members?				

2	**Design of the CE mechanism and tools** **Has the design process been inclusive?** **Does the approach actively promote men and women's participation, and challenge entrenched power imbalances?**				
2.1	**Development of the CE approach and activities**				
	Has there been a human centred design approach taken whereby end users have supported to shape key messaging and methodologies for dissemination?				
	Are CE activities and dialogues organised to meet the daily needs of different groups? E.g. those expressed by women, such as childcare and infant feeding or work hours.				
	Has access to dialogues been addressed/ discussed? (mobility constraints, transportation restrictions and seasonal)				

	Has the influence of gender dynamics identified during the initial stage of context analysis or formative research been considered? E.g., place to conduct CE activities, modality to conduct or engage men and women.				
	What steps or decisions have we taken to ensure the participation and engagement of different groups? (both participants and facilitators)				
	Have we offered equal opportunities for engagement in the process of the CE delivery?				
2.2	**Development of CE tools and materials**				
	Have project materials and activities been designed to meet the specific needs of different groups? (e.g. visually impaired, less spoken languages).				
	Have different groups been included in the process of design and development?				
	Have the contextual gender and intersectional dimensions been considered in the development of tools and materials/messages?				
	Have the tools and materials (pictures/messages) been pretested with different groups?				

	Have all materials and activities been reviewed by contextually appropriate stakeholders (men and women)? Have amendments been made accordingly?				
	Have stereotypes been avoided (gendered, age, caste, race) in the representation in SBCC materials? E.g. gender stereotypes, men in professional and women in domestic roles				

3	**Participation in the implementation of the CE**				
3.1	**Facilitator profiles and power dynamics between participants and CE facilitators**				
	Are men and women facilitators recognised differently?				
	Does the gender of the facilitator influence participation? How?				
	To what extent are people from different socio-cultural groups more or less likely to be CE facilitators, supervisors or trainers?				
	How does the balance impact on the project implementation?				

3.2	**Community Engagement Activity participants**				
	Are people from different groups represented in the CE activities*? Are all groups included who would like to be?*				
	Who sees these sessions as valuable, useful or relevant? How does this differ by gender, age etc.? Will sessions change, or seek to change, dynamics?				
	Are groups who lack access to health services represented by others? Who has been left out?				
	Is knowledge and information shared within the communities to reach members who are unable to participate in the activities? Who is sharing this information and by which mechanisms?				
	How does the location of the CE activities make different groups of community members more or less likely to attend?				
	Depth of engagement How much time is spent on CE related activities by different groups? Do return rates differ by age, or gender?				

	Depth of participation in CE activities How are different social groups participating in the CE activities? Whose voices are most heard and valued? Are the decisions made during sessions reflective of those participating (e.g. are men making decisions for other men? Or for different groups)? Are these decisions made in a democratic and equitable way?				
	Depth of participation in actions (post CE session) Are the actions generated in the dialogues actionable for everyone? Are they intended to be? Who will lead/implement the actions? Does anyone have to break traditional roles to complete the actions?				
	Does regular monitoring provide data about each socio-cultural group's participation and people with visible or known disabilities?				
	If monitoring data showed that only people attending are of a certain age or gender, was the CE mechanism adjusted?				
	Are there any negative messages or stereotypes being generated or perpetuated during CE sessions?				
	Has satisfaction with the CE process been analysed and broken down by participant (audience) segment?				

	Are participants satisfied by their level of participation? Has this been broken down by audience segment?				
	Does the recruitment and retention of volunteers differ by gender or other social stratifiers?				
	Have feedback mechanisms been established to capture the experiences and suggestions of participants from all genders? How will these feedback loops inform improvements?				
	Are project participants aware of a safeguarding or grievance mechanism?				
	Does participation in CE increase the possibility of harm to participant/facilitator? Has the gender of the facilitator affected their safety?				
	Have community members of all genders and intersectional stratifiers been engaged in the delivery of the project as decision makers and implementers as well as CE participants?				

4	Monitoring, iteration and evaluation				
4.1	Data Collection				
	Are there gender specific targets to close gaps included in the MEAL framework? Will we identify emerging or increasing gaps through MEAL work?				
	Are stakeholders broadly represented when decisions are made about what data are collected and how performance is measured ?				
	Do stakeholders understand why these data are being collected and what happens to the data?				
	Who collects the data? And when? Is the burden of routine data collection evenly distributed across genders?				
	Do the data collectors have the capacity, time and support to effectively collect data?				
	Is there a budget to ensure activities and monitoring are done in a gender-sensitive way?				

	Have data-collection supervisors received gender mainstreaming/safeguarding training?				
4.2	**Data analysis**				
	Are gender dimensions incorporated into the analysis of data through use of variables/indicators and coding framework?				
	Will sex-disaggregated information on out-of-pocket expenditures on AMR preventative behaviours be collected? (E.g. Do the promoted behaviours incur the same out-of-pocket expenditures/ time for men and women? What is the impact on individuals and households?)				
5.0	**Reporting and dissemination of gender related research and project results**				
	Is gendered evidence included in reports and other dissemination material?				
	Are gender- and inclusion-related policy, programme and research recommendations shared with relevant stakeholders?				

	Have research recommendations been checked to confirm that they do not perpetuate existing gender inequities? (Are they informed by a gender analysis?)				
	Are gender and inclusion lessons documented and recorded and innovative gender mainstreaming practices shared?				
	Are abstracts written following the Sex and Gender Equity in Research (SAGER) guidelines?				

6	**Capacity strengthening** **Has the project ensured that the capacity strengthening process is inclusive, relevant and accessible to all genders and marginalised groups, including those with intersectional identities?**				
		0	**1**	**2**	**Comments**
6.1	Have country gender focal points been identified to lead and coordinate gender related initiatives? Do they need any support for this role?				
6.2	Has a comprehensive assessment been conducted to identify gender and inclusion related technical assistance or capacity-development needs and have these been interrogated / verified with relevant stakeholders?				
6.3	Have CE activities and capacity strengthening activities been developed to ensure equal participation opportunities for all genders taking into account different needs and potential barriers?				

6.4	Have adequate resources been earmarked specifically for gender and inclusion capacity development activities and support?				
6.5	Have the research team participated in training in gender-sensitive approaches, protection of vulnerable populations, intersectionality and gender mainstreaming?				
6.6	Have all CE staff been trained in safeguarding?				

Further reading

1. Incorporating intersectional gender analysis into research on infectious diseases of poverty - A toolkit for health researchers

   https://www.who.int/publications/i/item/9789240008458

2. A social and behavior change (SBC) quality assessment and learning tool - https://breakthroughactionandresearch.org/resource-library/gender-equality-check-in-tool/
3. Minimum Standards for Mainstreaming Gender Equality - The Gender Practitioners Collaborative - https://www.fhi360.org/wp-content/uploads/drupal/documents/minimum-standards-mainstreaming-gender-equality.pdf
4. Gender mainstreaming in the project cycle: https://www.unido.org/sites/default/files/2015-09/GM_the_project_cycle_FINAL_0.pdf
5. How to manage gender responsive evaluations https://www.unwomen.org/sites/default/files/2022-05/UN-Women-Evaluation-Handbook-2022-en.pdf#04%20Evaluation%20handbook%20YH.indd%3A.180790%3A974

References

[i] National Institute for Health and Care Excellence. 03 March 2017 Community engagement: improving health and wellbeing. Quality standard [QS148][ii] Health equity (who.int)

[iii] WHO. Gender [Internet]. 2020. Available from: https://www.who.int/health-topics/gender
[iv] Incorporating intersectional gender analysis into research on infectious diseases of poverty: a toolkit for health researchers. Geneva: World Health Organization; 2020. Licence: CC BY-NC-SA 3.0 IGO.

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