

ACCELERATING EVIDENCE-INFORMED ADVOCACY AND POLICY-MAKING EFFORTS TO ELIMINATE VIOLENCE AGAINST WOMEN AND GIRLS AND HARMFUL PRACTICES IN AFRICA

Toolkit to Guide Collection and Use of Harmonized and
Standardized Data and Indicators on Violence Against
Women and Girls, Harmful Practices and Sexual and
Reproductive Health and Reproductive Rights

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Foreword

The persistence of Violence Against Women and Girls (VAWG) across the continent exacerbates gender inequalities placing women and girls at greater risk with more than 50 million girls under the age of 14 years in Africa at risk of Female Genital Mutilation (FGM), while more than 115 million women, were married as girls. Now more than ever, the importance of access to and use of VAWG data to inform policies and programmes have been re-emphasized. Not more than 5% of African countries can generate and use vital statistics from their civil registration systems or routine administrative records related to VAWG, Harmful Practices (HP), and Sexual Reproductive Health and Reproductive Rights (SRH&RR).

Measuring progress in achieving Sustainable Development Goal (SDG 5) significantly contributes to the efforts in ensuring gender equality and women empowerment including eliminating all forms of VAWG. As a result, the African Union Commission (AUC) in partnership with UNDP, and the African Population and Health Research Center (APHRC), within the framework of the Spotlight Initiative Africa Regional Programme (SIARP), have developed a toolkit to guide the collection and use of data on VAWG, HP, and SRH&RR. The Toolkit will strengthen the capacity of regional partners and civil society organizations (CSOs) to ensure that relevant harmonized and standardized data collection tools on VAWG, HP, and SRH&RR are produced and utilized to inform policy, evidence-based decision-making, and advocacy.

It, therefore, gives me great pleasure to introduce the Toolkit to Guide Collection and Use of Harmonized and Standardized Data and Indicators on VAWG, HP, and SRH&RR. The toolkit is a useful resource to guide users on methodologies for collecting and generating harmonized and standardized indicators on VAWG, including HPs and related SRH&RR outcomes. It brings together relevant approaches, methodologies, and indicators in resources, to ease their access and utilization. It helps in generating comparable data on VAWG, HP, and SRH&RR by putting in place harmonized and standardized data collection processes.

The toolkit also comprehensively addresses a range of diverse indicators including social norms, reproductive coercion, masculinity, online violence, and gender-based workplace unsafety and insecurity. Overall, it will enable policymakers, regional partners, research institutions, and CSOs to evaluate efforts on ending VAWG and improve policy.

I believe that the full implementation of this capacity-building initiative will enhance the knowledge and skills of regional partners and CSOs to better measure progress made in achieving SDG 5 and Agenda 2063, which both seek to achieve gender equality and empower all women and girls including specific targets on eliminating all forms of VAWG.

Prudence Ngwenya,
Director of Women, Gender, and Youth Directorate
African Union Commission (AUC)

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List of abbreviations

APHRC	African Population and Health Research Center
CDC	Centers for Disease Control and Prevention
CSOs	Civil Society Organizations
DHS	Demographic and Health Surveys
EANNASO	Eastern Africa National Networks of AIDS and Health Service Organizations
FGM	Female genital mutilation
GATE	Institute for Gender and the Economy
GBV	Gender-based violence
GDP	Gross Domestic Product
GSHS	Global School-based Student Health Survey
HIV/AIDS	Human immunodeficiency virus / Acquired immunodeficiency syndrome
HPs	Harmful practices
ILO	International Labour Organization
IMAGES	International Men and Gender Equality Survey
IPV	Intimate partner violence
MICS	Multiple Cluster Indicator Surveys
OHCHR	United Nations Office of the High Commissioner for Human Rights
PC-Kenya	Population Council-Kenya
PMA	Performance Monitoring for Action
RC	Reproductive coercion
SDG	Sustainable Development Goals
SGBV	Sexual- and gender-based violence
SIAP	Statistical Institute for Asia and the Pacific
SIARP	Spotlight Initiative Africa Regional Programme
SRH&RR	Sexual and reproductive health and reproductive rights
STIs	Sexually transmitted infections
UN	United Nations
UNDP	United Nations Development Programme
UN Women	United Nations Entity for Gender Equality and the Empowerment of Women
UNECA	United Nations Economic Commission for Africa
UNECE	United Nations Economic Commission for Europe
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNJP	United Nations Joint Programme
USAID	United States Agency for International Development
VACs	Violence against Children Surveys
VAW	Violence against women
VAWG	Violence against women and girls
WHO	World Health Organization

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1. Background

Violence against women and girls (VAWG) is a pervasive global public health and socio-economic problem and a human rights issue. According to the United Nations Entity for Gender Equality and the Empowerment of Women (UN Women), about one in three women globally has experienced intimate partner violence (IPV) and/or non-partner sexual violence^{1,2}. At least 200 million women and girls aged 15 – 49 years have undergone female genital mutilation (FGM) in 31 countries where the practice is concentrated. In 2019, one in five women aged 20–24 years was married before 18. Violence against women and girls, including sexual and gender-based violence (SGBV) and harmful practices (HPs) such as FGM and child marriages, prevent many girls from achieving their full potential.

The effect of violence on women's and girls' health and welfare, their families, and communities is substantial. The high rates of violence expose women and girls to severe health and social challenges, including HIV, unintended pregnancy, unsafe abortion, maternal morbidity, and deaths^{3,4}. VAWG also poses broader socio-economic challenges^{5,6}, including limited educational opportunities and economic disempowerment. The pervasive nature of VAWG demands urgent action to promote and facilitate its elimination as articulated in Sustainable Development Goal (SDG 5)—achieve gender equality and empower all women and girls—that includes specific targets on eliminating all forms of VAWG. However, to achieve the SDG 5 targets, there is a need for well-defined indicators that can be monitored consistently across different contexts. Further, where programmes and interventions are being implemented there is a need to measure and understand their impacts. These measures include quantitative estimates of what progress has been made towards ending VAWG, as well as qualitative and quantitative data that document the reasons why and the pathways through which these changes have occurred.

A desk review of the literature and two capacity needs assessment surveys that explored methodologies, approaches and publicly available data collection tools for capturing data on VAWG/SGBV, HPs and sexual and reproductive health and reproductive rights (SRH&RR) revealed the existence of defined indicators and tools that can be used to measure progress achieved in eliminating VAWG. However, the indicators and tools were developed for use in specific surveys such as Demographic and Health Surveys (DHS), the Multiple Indicator Cluster Survey (MICS), and the Violence against Children Surveys (VACs) among others, and therefore, varied by definition. The desk review and the capacity needs assessment surveys underscored the need to develop a toolkit to guide users on methodologies for collecting and generating harmonized and standardized indicators on VAWG, HP, and SRH&RR.

¹ UN Women, *Facts and figures: Ending violence against women*, <https://www.unwomen.org/en/what-we-do/ending-violence-against-women/facts-and-figures>.

² World Health Organization, *Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence* (2013).

³ Ibid.

⁴ Ibid.

⁵ Devries KM., Mak JY., Bacchus LJ., Child JC., Falder G., Petzold M., *Intimate partner violence and incident depressive symptoms and suicide attempts: a systematic review of longitudinal studies* (2013).

⁶ Alhusen JL., Ray E., Sharps P., Bullock L., *Intimate partner violence during pregnancy: maternal and neonatal outcomes*. *Journal of women's health* (2015).

2. Toolkit for harmonized and standardized data collection approaches and indicators on VAWG/HP and SRH&RR

This section describes how the toolkit was developed and what is captured in the toolkit. It describes the rationale for harmonized and standardized data collection tools and indicators, the purpose and scope of the toolkit, and when, where, and how the toolkit can be used.

2.1. Purpose and scope of the harmonized and standardized toolkit

To produce comparable data on VAWG, and related SRH&RR outcomes, there is a need for harmonized and standardized indicators, definitions, and approaches to data collection. This toolkit highlights key indicators used to measure VAWG and related SRH&RR outcomes. The toolkit also provides a reference to publicly available data collection tools that users can adapt for surveys to generate data on VAWG.

2.2. Who, when, and where the harmonized and standardized toolkit can be used

This toolkit is developed for general use by civil society organizations, government agencies, women's rights organizations, academic and research institutions, and individuals who are conducting research or monitoring and/or evaluating programmes focused on VAWG. The toolkit serves as a guide or a resource when collecting data on VAWG. While the toolkit can be used across all settings, it responds to data needs identified within the African region.

This toolkit provides a collection of indicators, approaches, and research questions that can be used to measure progress and indicators on VAWG. Additionally, in contexts where comprehensive action on ending VAWG has not yet advanced, there remains an urgent need for evidence to pinpoint priority areas for investments in policy development and programming. The toolkit helps facilitate the use of harmonized indicators to track progress.

2.3. How the toolkit is structured

First, users are introduced to VAWG with a focus on key terminologies, gender, and power concepts in relation to VAWG as a health and development issue. Second, users are guided on ethical and other considerations when collecting data on VAWG. Third, methodologies and approaches used to collect data on VAWG are discussed. Fourth, indicators used to measure different forms of VAWG including HPs and related SRH&RR outcomes are described and lastly, other existing resources on VAWG are incorporated.

3. Understanding violence against women and girls

In this section, key terminologies used to define components and concepts about VAWG are described. This section also summarizes gender and power concepts in relation to VAWG and describes why VAWG is a health and development issue.

3.1. VAWG: Concepts, terminologies, and definitions

Violence against women and girls is a form of SGBV—an umbrella term referring to harmful acts against people based on their gender⁷. According to the United Nations, VAWG is defined as “any act of gender-based violence that results in or is likely to result in, physical, sexual, or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life” (Declaration on the elimination of violence against women, 1993). Article 2 of the 1993 declaration on the elimination of violence against women further states that VAWG encompasses:

- Physical, sexual, and psychological violence that occurs in a family setting, including battering, sexual abuse of female children in the household, violence related to dowry, marital rape, female genital mutilation, breast ironing, and other traditional practices harmful to women, non-spousal violence and violence related to exploitation and abuse.
- Physical, sexual, and psychological violence occurs within the community. This includes rape, sexual abuse, sexual harassment and intimidation at work, in educational institutions, and elsewhere, trafficking in women, and forced prostitution.
- Physical, sexual, and psychological violence that is perpetrated or condoned by the State or government, wherever it occurs.

The UN Women⁷ and the World Health Organization (WHO)⁸ (2021) define the following terminologies as forms of VAWG:

- **Intimate partner violence** refers to acts by a current intimate partner or former partner that causes physical, sexual, or psychological harm. It includes physical aggression, sexual coercion, psychological abuse, and controlling behaviors⁸.
- **Sexual violence** refers to “any sexual act, attempt to obtain a sexual act, or other act directed against a person using coercion, by any person regardless of their relationship to the victim, in any setting”⁸.
- **Economic violence** refers to acts geared towards making a person financially dependent by maintaining absolute control and ownership over financial resources while at the same time withholding access to money, and/or forbidding any means of self-improvement that would enable the victim to earn their income such attendance of school or employment⁷.

⁷ <https://www.unwomen.org/en/what-we-do/ending-violence-against-women/faqs/types-of-violence>

⁸ https://apps.who.int/iris/bitstream/handle/10665/77432/WHO_RHR_12.36_eng.pdf

- **Psychological or emotional violence** involves “causing fear by intimidation; threatening physical harm to self, partner or children; destruction of pets and property; “mind games”; or forcing isolation from friends, family, school and/or work”⁷. It also includes “undermining a person’s sense of self-worth through constant criticism; belittling one’s abilities; name-calling or other verbal abuse; damaging a partner’s relationship with the children, or not letting a partner see friends and family”⁷.
- **Physical violence** involves causing physical harm to a partner by hitting, kicking, burning, grabbing, pinching, shoving, slapping, hair-pulling, biting, or using other means of physical force⁷.
- **Sexual harassment** involves acts including inappropriate and unwelcome jokes, suggestive comments, leering, unwelcome touch/kisses, intrusive comments about their physical appearance, unwanted sexually explicit comments, or people indecently exposing themselves to them.

It is important for users of this toolkit to understand the differences between these terms and to consider how different forms of violence can be measured.

3.2. Gender and power in relation to VAWG

The root cause of VAWG is unequal power relationships between men and women, and deeply rooted gender norms that are accepting of VAWG⁹. People with less power such as children and women have fewer choices as compared to those with more power and are more vulnerable to abuse¹¹. Gender norms carve the unequal power relations that exist between men and women. This is because gender norms determine the roles and responsibilities of girls and boys as well as their “do’s” and “don’ts” in society¹⁰. Power imbalance often favors men in many patriarchal cultures/societies around the world. This has contributed significantly to understanding why more women and girls’ survivors of GBV are as compared to men¹⁰.

Gender norms are taught, displayed, and reinforced by society and by both men and women from a very young age¹¹. This implies that if the gender norms that are taught are accepting of VAWG, the young boys and girls grow up to think that VAWG is normal and may end up being perpetrators or survivors. Gender norms can be changed overtime and across cultures by a society, a community, a family, or an individual¹¹. This provides room for changing those gender norms that are retrogressive such as those that encourage VAWG.

⁹ <https://www.who.int/news-room/fact-sheets/detail/violence-against-women>

¹⁰ <https://blogs.worldbank.org/developmenttalk/gender-based-violence-power-and-norms>

¹¹ <https://www.unhcr.org/583577ed4.pdf>

3.3. Factors that put women and girls at risk of violence

Factors that increase the risk of violence exist at multiple levels¹². At the individual level, for example, low levels of education, drug or alcohol abuse, or one's attitudes toward violence can increase the risk of experiencing violence. At the interpersonal level, marital discord or instance of child maltreatment can increase the likelihood of violence. At the community level, diminished economic opportunities, low levels of community participation, and high social disorganization can increase the likelihood that women and girls will experience violence. Finally, at the policy level, weak laws against VAWG or poor enforcement of laws may increase the risk of violence as perpetrators know that there are few repercussions.

It is important to recognize that certain groups of women and girls may be at greater risk of violence. These groups include adolescent girls, women living with disabilities, migrant women and girls, women who are incarcerated, pregnant women, and domestic workers. These women and girls may also not be represented in many research studies or programmes.

3.4. VAWG as a health, human rights, and development issue

The World Health Organization⁹ acknowledges that VAWG, including SRH&RR-related violence, is not only a health and human rights issue but also a development issue. Violence against women and girls has serious short- and long-term physical, psychosocial, behavioral, and socio-economic consequences for women and girls, their families, and society. Some of the consequences are:

Physical and psychosocial consequences

- It may lead to death;
- It leads to injuries that sometime might leave the victim paralyzed;
- It may lead to unintended pregnancies, induced abortions, gynecological problems, and sexually transmitted infections, including HIV/AIDS;
- It increases the probability of having a miscarriage, stillbirth, pre-term delivery, and low birth weight babies;
- It may lead to depression, post-traumatic stress, and other anxiety disorders sleep difficulties, eating disorders, and suicide attempts; and
- It may cause headaches, back pain, abdominal pain, chronic pelvic pain, gastrointestinal disorders, limited mobility, and poor health.

¹² Heise L., *Violence against Women: An Integrated, Ecological Framework. Violence against Women* (1998).

Behavioral consequences

- When sexual violence, a type of VAWG happens particularly during childhood, it can lead to increased smoking, substance use, and risky sexual behavior. It can also lead to men being perpetrators of violence while women are survivors of abuse.

Social and economic consequences

- Child marriages place girls at increased risk of experiencing domestic violence;
- Child marriages may lead to the social isolation of the girls from family, friends, and participating in their communities which may affect their physical and psychological well-being;
- It may make women be unable to work effectively which leads to low labor productivity and hence inefficiency in the production of goods and services;
- It may cause some women to stop working completely. This may lead to a reduction in the proportion of the workforce who contribute to the country's Gross Domestic Product (GDP) hence causing low-income generation for the respective countries;
- It may lead to loss of wages when these women stop working hence can push them into poverty;
- It may contribute to income inequality between men and women since women might quit their jobs because they experience violence, very often men will continue working and earning income hence causing income disparities between men and women;
- It may lead to economic costs associated with prevention and response measures to VAWG; and
- Child marriages lead to interrupted schooling and limited opportunities for career advancement, which affects the girl's economic empowerment.

Additional resources

1. <https://www.who.int/news-room/fact-sheets/detail/violence-against-women>
2. <https://www.ohchr.org/en/professionalinterest/pages/violenceagainstwomen.aspx>
3. <https://www.ohchr.org/documents/professionalinterest/cedaw.pdf>
4. <https://www.ohchr.org/documents/professionalinterest/crc.pdf>
5. [https://www.un.org/womenwatch/daw/csw/csw57/CSW57_Agreed_Conclusions_\(CSW_report_excerpt\).pdf](https://www.un.org/womenwatch/daw/csw/csw57/CSW57_Agreed_Conclusions_(CSW_report_excerpt).pdf)
6. https://www.unfpa.org/sites/default/files/event-pdf/PoA_en.pdf
7. <https://www.who.int/publications/i/item/9789241564625>
8. <https://www.unhcr.org/583577ed4.pdf>
9. <https://www.who.int/publications/i/item/9789240022256>
10. <https://www.unwomen.org/en/what-we-do/ending-violence-against-women/faqs/types-of-violence>
11. <https://apps.who.int/violence-info/>
12. <https://blogs.worldbank.org/developmenttalk/gender-based-violence-power-and-norms>

4. Ethical and safety considerations while collecting VAWG data

Collecting data on VAWG requires careful consideration of ethical and safety issues because it is a very sensitive issue. While the section focuses on research ethics, the information provided here guides any data collection exercises including for programme monitoring and evaluation purposes. Those collecting data should ensure that they have adequate resources to ensure the safety of those collecting the data as well as research participants.

Research ethics refers to rules or principles that govern the conduct of research. It encompasses the obligations of researchers as well as participants' rights and welfare. Research ethics is important for ensuring that research findings are credible and are of value to inform policies or programmes that improve the well-being of those who provide information. Part of the ethical conduct of research is ensuring that research findings are shared as widely as possible with end-users to increase their utility. In addition, research findings should be fed back to participants and the study communities.

This section describes the rationale for research ethics, fundamental research ethics principles, key ethical and safety considerations in VAWG research, and the role of research ethics committees.

4.1. History of research ethics

Research ethics was necessitated by a history of abuse on research participants. There are different examples of abuse of research participants in different contexts but key examples that stand out globally include:

- **Tuskegee Syphilis Trials (1932 – 1972):** This was a study on African American men with syphilis to observe the effects of the disease when untreated. Participants were not informed about their diagnosis and were given placebos as a treatment for bad blood.
- **Nazi War Camps, Germany (1939 – 1945):** Prisoners were forced to participate in experiments to help design strategies for combat situations, develop new weapons, and recovery of injured military personnel.

4.2. Key developments following the history of abuse of research subjects

As a result of abuses of research participants, there were key developments that informed the development of research ethics. These include:

- **Nuremberg Code (1946):** A key highlight of the Nuremberg Code was that voluntary informed consent is absolutely important before participation in research.
- **Declaration of Helsinki (1964/2000):** Participants' well-being takes precedence over research objectives.
- **Belmont Report (1978),** which outlines three fundamental ethics principles that are described in detail in the next section.

4.3. Fundamental research ethics principles

The overall guiding principle of research ethics is that research must be conducted in a way that **respects the rights** and **protects the welfare** of the individuals participating in the research. There are three fundamental research ethics principles:

- **Respect for persons:** this principle pertains to the respect of participants' autonomy and recognizes that individuals are capable of making their own choices. It also emphasizes the need for additional protection of participants with diminished autonomy such as children and prisoners. Respect for participants also requires that anyone providing the information must provide informed consent before participating in the data collection activity. It is important to ensure that informed consent documents can easily be understood by those participating in the research or data collection exercise. Some groups of participants will require additional protections. For example, those collecting data from children must get consent from children's parents or guardians, in addition, to getting assent from the children themselves. Even if a parent or guardian has given consent, the child depending on their age may still have to assent in participating in the data collection exercise. Those collecting data should be aware that certain socio-cultural norms may affect the consenting process. For example, in some cultures, men cannot interview women, or men will expect to be allowed to listen in on an interview with their wives. It is important for those collecting data to be well-trained to be respectful of community norms, but to ensure that individual's rights to privacy are not violated.
- **Do no harm (beneficence):** this principle requires researchers to take steps to minimize all forms of harm – physical, psychological, social – to participants and to maximize benefits that accrue from the research to participants. Before collecting any data, it is important to consider the potential risks that participants may experience as a result of the research, as well as the potential benefits. For example, women and girls who participate in a survey on violence may experience trauma as they recount some of their personal experiences. Those collecting data must also consider the benefits of the research and ensure that these benefits outweigh the risks of conducting the research. For example, data on the prevalence of VAWG can lead to programmes to reduce its prevalence.
- **Justice:** pertains to a fair distribution of risks and benefits resulting from the research by ensuring that research does not pose a greater risk to one group compared to the other or that it does not benefit one group more than the other. For example, it would be against the principle of justice to conduct research with institutionalized and people in low-income settlements simply because of their greater accessibility.

4.4. Key ethics and safety considerations in VAWG research

The sensitive nature of violence requires researchers to consider a number of ethical and safety measures to protect participants and the research team from possible harm in addition to protecting the integrity of the research. These include:

- **Safety of participants:** those collecting data should consider threats to the safety of women and girls at risk of violence, especially from perpetrators who may learn that they are taking part in the research and may reveal their deeds. One way of ensuring the safety of participants is to introduce the research using safe terms during recruitment. For example, rather than labeling a survey as a survey on violence against women, it would be preferable to label it as a survey on women's health or well-being. The same would apply to research on violence against children. Interviews should also be conducted in private and cues should be developed for abruptly ending the interview if it is interrupted by the presence of a third party. Researchers can also use different sets of questionnaires. For example, general questions about the household should be administered to the household head, and core questions administered to women and girls in order to avoid raising suspicion among household decision-makers regarding the real aim of the research. In addition, interviewing only one person per household may be important for safety reasons.
- **Safety and well-being of interviewers:** research on violence may have a negative impact on the emotional well-being and physical safety of interviewers. Those collecting data need to anticipate, detect and respond to the emotional impact of questions on violence on interviewers. For example, there could be regular debriefings and counseling. In addition, unsafe neighborhoods or threats to safety arising from asking questions about violence require escorts, emergency phone numbers, and other security measures for ensuring the safety of interviewers.
- **Confidentiality and anonymity:** interviewers and field supervisors working on research on violence should sign a pledge to keep the information provided by participants confidential. Interviewers ideally should not conduct interviews in their community. Interviews should also be conducted in private and participants informed about procedures for ensuring confidentiality and anonymity during the consenting process. In situations when privacy may be violated, interviewers should be trained to politely stop the interview or to request to interview in an alternate safe, and private space. No personal identifying information should be captured in the questionnaires and any personal identifiers should be kept separate and destroyed after the completion of interviews. Completed questionnaires should be securely kept with restricted access, and data shared with researchers should not contain participant-identifying information. Ensuring confidentiality should also extend to the identification of victims of violence and any referrals for additional support in instances where participants have to be referred for additional care.

- **Consent and voluntary participation:** informed consent should be reiterated throughout the interview by emphasizing the voluntary nature of participation. Where signed consent forms could lead to a breach of confidentiality or privacy and pose risks to participants, the obligation of the participant to sign a consent form could be waived. It may be important for a third party to confirm that informed consent has been obtained even when signed consent is waived. The interviewer or the person obtaining informed consent also needs may also be required to provide a signed statement confirming that the participant was not coerced into giving consent, and the consent was given freely and voluntarily.
- **Minimizing and responding to emotional distress:** interviewers should be trained to refer participants in distress to sources of support in the local community. Referral information should be given to all participants in a manner that does not put them at risk of harm.
- **Ethical conduct of researchers:** it is the responsibility of researchers to produce good quality data and reliable results to inform policy and programme decisions. Researchers should take cognizance of the fact that poor quality data produce unreliable results that could lead to decisions that harm community efforts to respond to violence. Researchers should ensure that results are correctly interpreted and widely disseminated to a variety of audiences in a manner that aids in decision-making.

The following ethical and safety considerations should be taken into account when collecting information on sexual violence in emergencies:¹³

1. The benefits to respondents or communities of documenting sexual violence must be greater than the risks to respondents and communities.
2. Information gathering and documentation must be done in a manner that presents the least risk to respondents, is methodologically sound, and builds on current experience and good practice.
3. Basic care and support for survivors must be available locally before commencing any activity that may involve individuals disclosing information about their experiences of sexual violence.
4. The safety and security of all those involved in information gathering about sexual violence is of paramount concern and in emergency settings in particular should be continuously monitored.
5. The confidentiality of individuals who provide information about sexual violence must be protected at all times.
6. Anyone providing information about sexual violence must give informed consent before participating in the data gathering activity.
7. All members of the data collection team must be carefully selected and receive relevant and sufficient specialized training and ongoing support.
8. Additional safeguards must be put into place if children (i.e., those under 18 years) are to be the subject of information gathering.

¹³ World Health Organization (WHO), *WHO Ethical and Safety Recommendations for Researching, Documenting and Monitoring Sexual Violence in Emergencies*. https://www.who.int/gender/documents/OMS_Ethics&Safety10Aug07.pdf (2007).

4.5. Ethics review committee

Some of the users of this toolkit will be collecting research data that are collected through systematic approaches to contribute to wider knowledge about VAWG. Projects or programmes should seek approval from an ethics review committee before they undertake any research study or conduct an evaluation where the findings will be shared beyond the project team for wider knowledge¹⁴. For projects or programmes that collect data that will only be utilized by the project or programme team, ethical approval is not needed. In the next sub-section, we describe the role of the ethics review committee.

4.6. Role of research ethics committees

Research ethics committees go by various names in different contexts; for example, ethics review boards, institutional review boards, ethics review committees, and scientific and ethics review committees. Research ethics committees are independent of researchers in order to provide unbiased decisions without conflict of interest. The primary responsibility of research ethics committees is to protect potential participants in research by balancing potential risks to participants and benefits of the research to the community where it is conducted. Key roles of research ethics committees include:

- Reviewing proposed studies to ensure they conform to international and local ethical guidelines.
- Monitoring implementation of studies to ensure they conform to approved procedures and protocols.
- Taking part in follow-up action and review after the end of the research.

Most academic institutions will have an ethics review committee. Alternatively, ministries of health and gender may have ethical review committees. For non-researchers who are collecting research data, partnering with an academic or research institution may be useful. It is important to contact the ethics review committee to understand the procedures and documents required for ethical review and approval. The documents typically required are a study protocol that describes the study design, data collection approaches, data collection tools, ethical considerations, and consent forms. The ethics review committee must approve before any data are collected. Those collecting research data should incorporate the time to develop the protocol and obtain approval into their work plan. They should also ensure that adequate resources are available for any ethics review fees, as well as ethical and safety measures required (for example, psychosocial support).

For individuals or organizations collecting non-research data on VAWG, it may still be useful to engage external experts to review the data collection methods to ensure that they are rigorous and that appropriate protections are provided for those who participate in the data collection exercise.

¹⁴ The Global Women's Institute, George Washington University, *Gender-Based Violence Research, Monitoring, and Evaluation with Refugee and Conflict-Affected Populations. A Manual and Toolkit for Researchers and Practitioners* (2017). <https://globalwomensinstitute.gwu.edu/sites/g/files/zaxdzs1356/f/downloads/Manual%20and%20Toolkit%20-%20Website.pdf>

Additional resources

1. United Nations Department for Economic and Social Affairs Statistics Division. 2014. *Guidelines for Producing Statistics on Violence against Women —Statistical Surveys*. https://unstats.un.org/unsd/gender/docs/guidelines_statistics_vaw.pdf
2. United Nations Office on Drugs and Crime and United Nations Economic Commission for Europe. 2010. *Manual on Victimization Surveys*. https://www.unodc.org/documents/data-and-analysis/Crime-statistics/Manual_on_Victimization_surveys_2009_web.pdf
3. World Health Organization (WHO). 2007. *WHO Ethical and Safety Recommendations for Researching, Documenting and Monitoring Sexual Violence in Emergencies*. https://www.who.int/gender/documents/OMS_Ethics&Safety10Aug07.pdf
4. World Health Organization. 2009. *Research Ethics Committees: Basic Concepts for Capacity-building*. https://www.who.int/ethics/Ethics_basic_concepts_ENG.pdf
5. World Health Organization. 2021. Ethical Considerations in Research on Female Genital Mutilation. <https://apps.who.int/iris/rest/bitstreams/1403571/retrieve>

5. Approaches and methodologies used in collecting data

Data on violence against women and girls can be obtained from various sources. This section describes the major sources of data on VAWG/SGBV/HP and SRH&RR in Sub-Saharan Africa. It also describes the various forms of population-based surveys on VAWG, which are the most readily available sources of data in the region that policy makers and practitioners can use to inform decisions aimed at eliminating VAWG.

5.1. Data sources

Major sources of data on VAWG and SRH&RR in Sub-Saharan Africa include:

- (i) Nationally-representative population-based surveys, e.g., the Demographic and Health Survey (DHS), Multiple Indicator Cluster Survey (MICS), Multi-Country Study on Women's Health and Violence against Women (VAW), and Violence Against Children Surveys (VACS).
- (ii) Specialized surveys focusing on specific sub-groups of the population or geographic areas, e.g., Performance Monitoring for Action (PMA), the Global School-based Student Health Survey (GSHS), and small-scale quantitative and qualitative studies.
- (iii) Administrative records, including health facility records (e.g., on the number of women and girls seeking GBV-related services), justice and legal systems (e.g., on GBV-related cases), relevant government ministries (e.g., gender, women's or children's affairs), and structures for reporting GBV cases (e.g., helplines and community structures).
- (iv) Other secondary sources of data, include the [World Bank gender portal](#), [WHO Global Health Observatory](#), [UN Women data portal](#), [Global Database on Violence Against Women](#), [United Nations Statistics Division](#), [UNICEF State of the World's Children](#), published articles, and unpublished reports, theses or dissertations.

5.2. Population-based surveys on VAWG

There are two major forms of population-based surveys on VAWG including dedicated VAWG surveys and surveys with add-on GBV modules.

- (i) Dedicated VAWG surveys include
 - WHO Multi-Country Study on Women's Health and Violence against Women: This study was initially conducted in 15 sites in 10 countries (3 of which were in Africa – Ethiopia, Namibia, and Tanzania) between 2000 and 2003 and later replicated in 6 other countries (none of which was in Africa).
 - Violence against Children Surveys (VACS): VACS has been conducted in nearly 20 low-and middle-income countries since 2007 (13 of which are in Africa). It targets female and male children and young people aged 13-24 years and captures information on childhood violence (physical, sexual, and emotional), child labor, and child neglect.

(ii) Surveys with optional add-on VAWG modules include:

- Demographic and Health Surveys (DHS): DHS has been conducted in over 90 countries since the mid-1980s, with nearly half of them in Africa. It has modules on domestic violence and female genital mutilation (FGM), which were introduced as optional modules in the early 1990s.
- Multiple Indicator Cluster Surveys (MICS): MICS has been conducted in over 118 countries since the mid-1990s. It has questions on child labor (introduced in MICS 2 module for children), gender-based violence and violent child discipline (introduced in MICS 3 as an optional module), and FGM (introduced in mid-2000s).
- Performance Monitoring for Action (PMA): PMA introduced questions to capture physical and sexual violence in Phase 2 beginning 2019. Phase 1 of the surveys, which did not have questions on GBV, was implemented between 2013 and 2018.

5.3. Gaps in data sources and opportunities to address them

Table 1 Gaps in existing data sources

Gap	Opportunity to address gap
• Limited information on root causes and underlying drivers of VAWG	• Qualitative studies can be conducted to shed light on the root causes and underlying drivers of VAWG
• Routinely conducted population-based surveys such as DHS and MICS have optional GBV modules	• Consumers of information on VAWG should actively advocate for the inclusion of the GBV module each time population-based surveys are conducted in their countries
• Experiences of certain sub-groups that are vulnerable to violence (e.g., children under 5 years, and older or elderly persons 50 years or older) are not captured in existing data sources	• Appropriate approaches and methodologies for capturing the experiences of these sub-groups could include expanding the age groups targeted by dedicated VAWG surveys, conducting specialized surveys focusing on the sub-groups, and strengthening information capture and reporting through administrative records
• Lack of coordination and harmonization of administrative data	• One information management system for capturing administrative data on VAWG from different sectors and ministries of government can improve the coordination and harmonization of data

5.4. Skills and Training for VAWG Data Collection

It is important that when training interviewers on VAWG data collection, the following broad components should be covered:

- (i) **Basic training:** This component should focus on equipping interviewers with skills to fully understand the purpose and structure of the survey, effectively and correctly conduct an interview, develop rapport and manage relationships with participants, understand their role in the data collection process, and accurately capture information.
- (ii) **Sensitivity training:** This component should focus on equipping interviewers with skills to pose very delicate questions about experiences of violence respectfully, accurately assess the feelings or reactions of participants in a variety of situations, and respond appropriately.
- (iii) **Response plan:** This component should focus on equipping interviewers with skills on how to respond to participants who identify during the interview that they are at risk or have experienced violence, including procedures for identifying and referring participants in distress for appropriate help.
- (iv) **Community entry:** This component should focus on equipping interviewers with skills to safely navigate through the community, including processes for engaging with community leadership, introducing the research in the community, and managing their security while in the field.

6. VAWG/HP and SRH&RR Indicators

This section describes in detail the key indicators of different forms of VAWG and SRH&RR. Major sources of data, and where applicable, strengths and limitations of such data sources are described. Additionally, research questions and a detailed description of the methodologies and approaches that could be used under each set of indicators will be provided. It is important to note that SRH&RR indicators in regard to VAWG/SGBV/HP are not described as stand-alone indicators but are presented in different sections of the toolkit.

6.1. Violence against women and girls

6.1.1. Intimate partner violence and non-intimate partner violence

An intimate partner refers to a current or former spouse, cohabiting, or dating partner¹⁵. It includes relationships in which the couple resided together at some point. According to the WHO¹⁶, intimate partner violence (IPV) is any behavior, within an intimate relationship that causes physical, psychological, or sexual harm to those in the union. Non-intimate partner violence is perpetrated by individuals other than an intimate partner, including strangers, or by a person with whom the victim has some relationship. Both forms of violence constitute a violation of a person's human rights.

Intimate partner violence is among the most common forms of violence against women and girls globally. It is a pervasive form of violence that cuts across all socioeconomic statuses, gender, ethnicity, race, and settings. Its consequences are lifelong and far-reaching, affecting survivor's physical and mental health and wellbeing.

FORMS OF INTIMATE PARTNER VIOLENCE¹⁷

While attention is often centered on three primary forms of violence: physical, emotional, and sexual violence, IPV also encompasses stalking and economic violence.

¹⁵ Centers for Disease Control and Prevention, *Preventing Intimate Partner Violence Factsheet*. https://www.cdc.gov/violenceprevention/pdf/ipv/IPV-factsheet_2021.pdf (2021).

¹⁶ World Health Organization, *Understanding and addressing violence against women: Intimate partner violence* (No. WHO/RHR/12.36). (2012).

¹⁷ <https://eige.europa.eu/thesaurus/terms/1096>

Table 2 Forms of intimate partner violence

Forms of intimate partner violence	Description
Physical violence	Any acts of pushing, punching, strangling, slapping, hitting, kicking, stabbing, or throwing objects at one's partner.
Sexual violence	Any sexual acts or attempts to obtain sexual acts without consent or with force or coercion.
Emotional violence / psychological abuse	Any act directed at one's partner to insult, belittle, humiliate, intimidate and threaten.
Economic violence	Any acts of or attempts to make someone economically dependent by maintaining total control over financial resources (e.g., taking away the earnings of the victim, not allowing them to have a separate income, denying one's partner access to financial resources, education, or labor market, not complying with economic responsibilities, such as alimony and property damage).
Stalking	The act or crime of willfully and repeatedly following or harassing another person in circumstances that would cause a reasonable person to fear injury or death especially because of express or implied threats ¹⁸ .

KEY RESEARCH QUESTIONS ON INTIMATE PARTNER VIOLENCE

1. What is the prevalence of intimate partner violence among men and women over a particular period (past year or lifetime)?
2. What are the factors that predispose someone to intimate partner violence?
3. What is the extent and pattern of reporting and help-seeking among survivors of intimate partner violence?
4. What services and care exist for survivors in a particular setting and what is the quality of this service?
5. What are the barriers hindering survivors from seeking care?
6. In what ways does violence impact the survivors' physical, mental and socioeconomic wellbeing?
7. What promising interventions can effectively prevent and respond to survivors of intimate partner violence?

INDICATORS FOR MEASURING INTIMATE AND NON-INTIMATE PARTNER VIOLENCE

Common indicators for measuring intimate partner violence and non-intimate partner violence in nationally representative surveys are presented in Table 3.

¹⁸ <https://www.stalkingawareness.org/wp-content/uploads/2018/11/Stalking-IPV-Fact-Sheet.pdf>

Table 3 Indicators for measuring intimate partner violence*

Intimate partner violence	Numerator	Denominator	
Proportion of women aged 15-49 who ever experienced physical violence from an intimate partner	Total women surveyed who report having ever experienced physical violence, as described in Table 2, from a male intimate partner at any point during their lifetime	Total women surveyed aged 15-49 who currently have or ever had an intimate partner	Results can be disaggregated by age (five-year age category), severity, place of residence, education, wealth status, marital status, ethnicity, region, and perpetrators of violence at the time of data analysis
Proportion of women aged 15-49 who experienced physical violence from an intimate partner in the past 12 months	Total women surveyed reporting having experienced physical violence in the past year as included as numerator	Total women surveyed aged 15-49 who currently have or ever had an intimate partner	
Proportion of women aged 15-49 who experienced physical violence from an intimate partner in the past 12 months who were injured as a result of the violence	Total women who experienced physical violence in past year who had injuries among	Total women surveyed reporting having experienced physical violence in the past year as included as a denominator	
Proportion of women aged 15-49 who ever experienced sexual violence from an intimate partner	Total women surveyed reporting any experience of sexual violence	Total women surveyed aged 15-49 who currently have or ever had an intimate partner	
Proportion of women aged 15-49 who experienced sexual violence from an intimate partner in the past 12 months	Total women surveyed reporting having experienced sexual violence in the past year	Total women surveyed aged 15-49 who currently have or ever had an intimate partner	
Proportion of women aged 15-49 who ever experienced emotional violence from an intimate partner	Total women surveyed reporting any experience of emotional violence	Total women surveyed aged 15-49 who currently have or ever had an intimate partner	

Intimate partner violence	Numerator	Denominator	
Proportion of women aged 15-49 who experienced emotional violence from an intimate partner in the past 12 months	Total women surveyed reporting having experienced emotional violence in the past year	Total women surveyed aged 15-49 who currently have or ever had an intimate partner	Results can be disaggregated by age (five-year age category), severity, place of residence, education, wealth status, marital status, ethnicity, region, and perpetrators of violence at the time of data analysis
Proportion of women aged 15-49 who ever experienced any forms of violence (emotional, physical and sexual) from an intimate partner	Total women surveyed who report any experience of emotional, physical and sexual violence	Total women surveyed aged 15-49 who currently have or ever had an intimate partner	
Proportion of women aged 15-49 who experienced any forms of violence (emotional, physical and sexual) from an intimate partner in the past 12 months	Total women surveyed reporting past year experience of any emotional, physical and sexual violence	Total women surveyed aged 15-49 who currently have or ever had an intimate partner	
Proportion of women aged 15-49 who ever experienced economic violence from an intimate partner	Number of women surveyed who report having ever suffered economic violence	Total women surveyed aged 15-49	
Proportion of women aged 15-49 who experienced economic violence from an intimate partner in the past 12 months	Number of women in the survey who reported past year experience of economic violence	Total women surveyed aged 15-49 who currently have or ever had an intimate partner	
Proportion of women aged 15-49 who ever experienced stalking from an intimate partner	Number of women in the survey who report any experience of stalking?	Total women surveyed aged 15-49 who currently have or ever had an intimate partner	
Proportion of women aged 15-49 who experienced stalking from an intimate partner in the past 12 months	Number of women surveyed reporting past year experience of stalking	Total women surveyed aged 15-49 who currently have or ever had an intimate partner	

Note: Existing indicators on IPV focus on women of reproductive age. In some contexts, girls aged 15 years are in unions or romantic/sexual relationships. While most surveys included women and girls aged 15 to 49, women age over 49 years can also be included in VAWGs surveys and using these indicators. Disaggregating data by widowhood and disability is possible if such data are captured in the survey.

Table 4 Indicators for measuring non-intimate partner violence

Non-Intimate partner violence	Numerator	Denominator	Levels of disaggregation
Proportion of women aged 15-49 who ever experienced physical violence from someone other than an intimate partner	Number of women surveyed who experienced physical violence from males other than their intimate partners	Total women surveyed aged 15-49	Results can be disaggregated by age (five-year age category), severity, place of residence, education, wealth status, marital status, ethnicity, region and perpetrators of violence
Proportion of women aged 15-49 who experienced physical violence from someone other than an intimate partner in the past 12 months	Number of women who report having experienced physical violence from non-intimate partner violence in the past year	Total women surveyed aged 15-49	
Proportion of women aged 15-49 who ever experienced sexual violence from someone other than an intimate partner	Number of women surveyed reporting any experience of sexual violence from someone other than their intimate partner	Total women surveyed aged 15-49	
Proportion of women aged 15-49 who ever experienced physical violence during pregnancy	Number of women surveyed who report having ever being beaten or assaulted during pregnancy	Total women surveyed aged 15-49 who had ever been pregnant	
Proportion of women who experienced stalking from a non-intimate partner	Number of women surveyed who report having experienced stalking from men not their intimate partner	Total women surveyed aged 15-49	

Note: Existing indicators on non-IPV focus on women of reproductive age. In some contexts, girls aged 15 years are in unions or romantic/sexual relationships. While most surveys included women and girls aged 15 to 49, women age over 49 years can also be included in VAWGs surveys and using these indicators. Disaggregating data by widowhood and disability is possible if such data are captured in the survey.

Table 5 Indicators for reporting, help seeking behaviors and availability and quality of care

Indicators	Numerator	Denominator	Level of disaggregation
Proportion of women aged 15-49 who report sexual violence	This indicator measures the level reporting of violence to families, friends, health providers, NGOs, neighbors, priests, counselors, police, and local leaders	Total number of women who had experienced sexual violence	Results can be disaggregated by age (five-year age category), authorities cases are reported to, place of residence, education, wealth status, ethnicity, region
Proportion of women aged 15-49 who report sexual violence below age 15	Number of women aged 15-49 who report experiencing sexual violence when they were 14 years old or younger	Total women surveyed aged 15-49	Results can be disaggregated by age (five-year age category), authorities cases are reported to, severity, place of residence, education, wealth status, ethnicity, region
Proportion of health units that have documented and adopted a protocol for the clinical management of VAWG survivors	Number of health facilities in the geographic region of study reporting that they have both documented and adopted a protocol for the clinical management of VAWG survivors	Total number of health units surveyed	Type of health unit, geographic area surveyed (region, province, urban or rural area)
Proportion of health units that have done a readiness assessment for the delivery of VAWG services	Number of health facilities in the geographic region of study reporting that they have undergone a readiness assessment and can produce documentation that the assessment took place	Total number of health facilities surveyed in the geographic region of study	Type of health unit, geographic area surveyed (region, province, urban or rural area)
Proportion of health units that have commodities for the clinical management of VAWG	Number of health facilities in the geographic region of study reporting that they have all of the relevant clinical commodities for the management of VAWG	Total number of health units surveyed in the geographic region of study	Type of health unit, region or province (if national study), urban or rural area

Indicators	Numerator	Denominator	Level of disaggregation
Proportion of health units with at least one service provider trained to care for and refer VAWG survivors	Number of health facilities in the geographic region of study reporting that at least one provider has been trained in the past three years	Total number of health units surveyed in the geographic region of study	Type of health unit, region or province (if national study), urban or rural area
Number of service providers trained to identify, refer, and care for VAWG survivor	Number of health providers trained in the past year or other period (the length of time would depend on how often the programme holds trainings)	Total number of health units surveyed in the geographic region of study	Type of provider, region or province, area in which they work (urban or rural)
Proportion of rape survivors who received comprehensive care	Number of rape survivors seeking care who received any of the following elements of care at a health facility, during a specific period of time (e.g., within the past 12 months)	Total number of rape survivors seeking care at facilities included in the survey	Age of survivor and region, element of care, and the number of elements received

Note: Facility readiness assessment can be conducted using IPPF assessment tool, which measures provider knowledge, beliefs and practices, clinic resources, VAW/G training experience of staff, clinic protocol, and a quality of care assessment for clients¹⁹.

Table 6 Other indicators on intimate partner violence

Indicators	Numerator	Denominator	Level of disaggregation
Attitudes towards wife-beating	All women aged 15 to 49 responding to the question assessing their attitudes towards wife beating	Total women surveyed aged 15-49	Results can be disaggregated by age (five-year age category), severity, place of residence, education, wealth status, ethnicity, region and perpetrators of violence

¹⁹ International Planned Parenthood Federation. *Improving the health sector response to gender-based violence: A resource manual for health care professionals in developing countries*. (IPPF/WHO Tools/02/September 2004) www.ippfwho.org/atf/cf/%7B4FA48DB8-CE54-4CD3-B335-553F8BE1C230%7D/gbv_guide_en.pdf

PRIMARY SOURCES OF DISAGGREGATED DATA ON INTIMATE PARTNER VIOLENCE AND NON-INTIMATE PARTNER VIOLENCE

Nationally representative data on intimate partner violence in African countries is available from the DHS, MICS, and VACS. Also, several small-scale surveys have captured data on intimate partner violence. Other sources of intimate partner violence data include hospital records, police crime statistics, and judiciary data. In some cases, media analysis can provide an additional data source for intimate partner violence. Recent PMA surveys also include questions on sexual violence and reproductive coercion. Because the domestic violence module was introduced in the DHS after 2005 WHO's Multi-country Study on Women's Health and Domestic Violence against Women, data collected before this period do not have information on domestic violence. DHS has developed an advanced knowledge management platform—STATcompiler—that allows for the disaggregation of data on key indicators.

QUALITATIVE INDICATOR

Qualitative indicators can be captured through qualitative studies to understand various in-depth experiences around intimate partner violence, including:

1. Coping strategies and survivors lived experiences
2. Fidelity of interventions implementation and process evaluation
3. Underlying factors predisposing women and girls to violence

6.1.2. Violence against children

The World Health Organization defines violence against children (VAC) as all forms of abuse or maltreatment of people under the age of 18 years. Such abuse or maltreatment includes physical and/or emotional ill-treatment, sexual abuse, neglect or negligent treatment, or commercial or other exploitation, which results in actual or potential harm to the child's health, survival, development, or dignity in the context of a relationship of responsibility, trust or power. This is also consistent with the UN definition of VAC as “encompassing physical or mental violence, injury and abuse, neglect or negligent treatment, and maltreatment or exploitation, including sexual abuse”.²⁰ This toolkit highlights the major forms of VAC captured in existing surveys, including physical, sexual, and emotional violence, child neglect, child labor, and violent child discipline.

KEY RESEARCH QUESTIONS ON VAC

1. What is the prevalence of the various forms of VAC (physical, sexual, and emotional)?
2. What are the social construction and manifestation of other forms of VAC such as child neglect, child labor, and violent child discipline in the African context?
3. What are the drivers and underlying causes of VAC?
4. Who are the perpetrators and what factors influence the perpetration of VAC?
5. What services are available to children who experience violence in different contexts and to what extent do children access them?
6. What are the short- and long-term consequences of violence on children's health, socio-economic and psychosocial well-being?

²⁰ UNICEF, *Violence Against Children in the East Asia and Pacific: A Regional Review and Synthesis of Findings*, (2014).

SOURCES OF DATA ON VIOLENCE AGAINST CHILDREN

There are three broad sources of data on VAC that provide indicators that can be used to inform policy and programme decisions. These include:

- i. Nationally representative household surveys among individuals of reproductive age
 - Demographic and Health Surveys (DHS)
 - Multiple Indicator Cluster Surveys (MICS)
- ii. Specialized surveys among children and/or young people
 - Violence Against Children Surveys (VACS)
 - Global School-based Health Survey (GSHS)
- iii. Public records (e.g., children, justice, and/or gender departments)
 - Public records of reported cases of violence against children (Law enforcement agencies e.g., police, gendarmeries, courts/judicial reviews and reports, etc.)
- iv. Published reports (e.g., UNICEF State of the World Children and International Labor Organization)
 - Each State of the World Children report examines a particular issue affecting children, including conflict and war, child labor, early childhood development, and disability while ILO publishes reports on child labor (covered in detail in the section on forced labor)

INFORMATION ON VIOLENCE AGAINST CHILDREN CAPTURED IN VARIOUS DATA SOURCES

Existing data sources provide information on various forms of violence against children some of which require further studies to determine their relevance to the African context and the extent to which they can be reliably captured in surveys. Examples of such forms of violence include child neglect, child labor, and violent child discipline. Information on violence against children available from various sources of data includes:

Table 7 Data sources on violence against children*

Target group	Information captured
Demographic and Health Surveys	
• Adults 18-49 years • Children 15-17 years	• Physical, sexual, and psychological/emotional violence occurring prior to age 18 • Sexual violence by a non-intimate partner occurring any time during childhood • Perpetrators of violence, consequences of violence and help-seeking among survivors

Target group	Information captured
Multiple Indicator Cluster Surveys	
- Adults 18-49 years - Children 5-17 years	- Attitude towards violence against children - belief about the necessity of physical punishment in bringing up children - Violent child discipline – methods adults used to administer child discipline in the past one month - Child labor – children involved in economic activities and household chores beyond the age-specific threshold and those involved in hazardous work
Violence Against Children Surveys**	
Children and young adults 13-24 years	- Attitude toward violence against child – support for or opposition to violence against children - Lifetime experiences of childhood violence – young adults 18-24 years who experienced any form of violence before age 18 - Experiences of any form of violence in the past 12 months among children <18 years (current status measure) - Perpetrators of violence, consequences of violence and help-seeking among survivors - Child labor, child neglect by caregivers, and attitudes towards violence
Global School-based Health Survey	
Students 13-17 years	- Experience of forced sexual intercourse at any time - Intimate partner physical violence in the past 12 months - Non-intimate partner physical violence in the past 12 months
Public records	
Children and adults of all ages	- Records of violence perpetrated against children <18 years - Perpetrators and consequences of violence against children - Actions taken to prevent and/or respond to violence against children

* Where the age of experiencing violence is provided, estimates of experiences of violence prior to age 18 can be obtained, which according to the definition provided at the beginning of this section, is violence experienced during childhood.

** VAC surveys are typically conducted among 13-24 year-olds. Those aged 13-17 are asked about experiences of violence in the past 12 months and this provides a “current status” measure. Those aged 18-24 years are asked about experiences of violence prior to age 18 and this provides a measure of “lifetime experiences of childhood violence”. Both (current status and lifetime experience) are measures of childhood violence asked to different age groups.

Strengths and limitations of existing sources of information on VAC

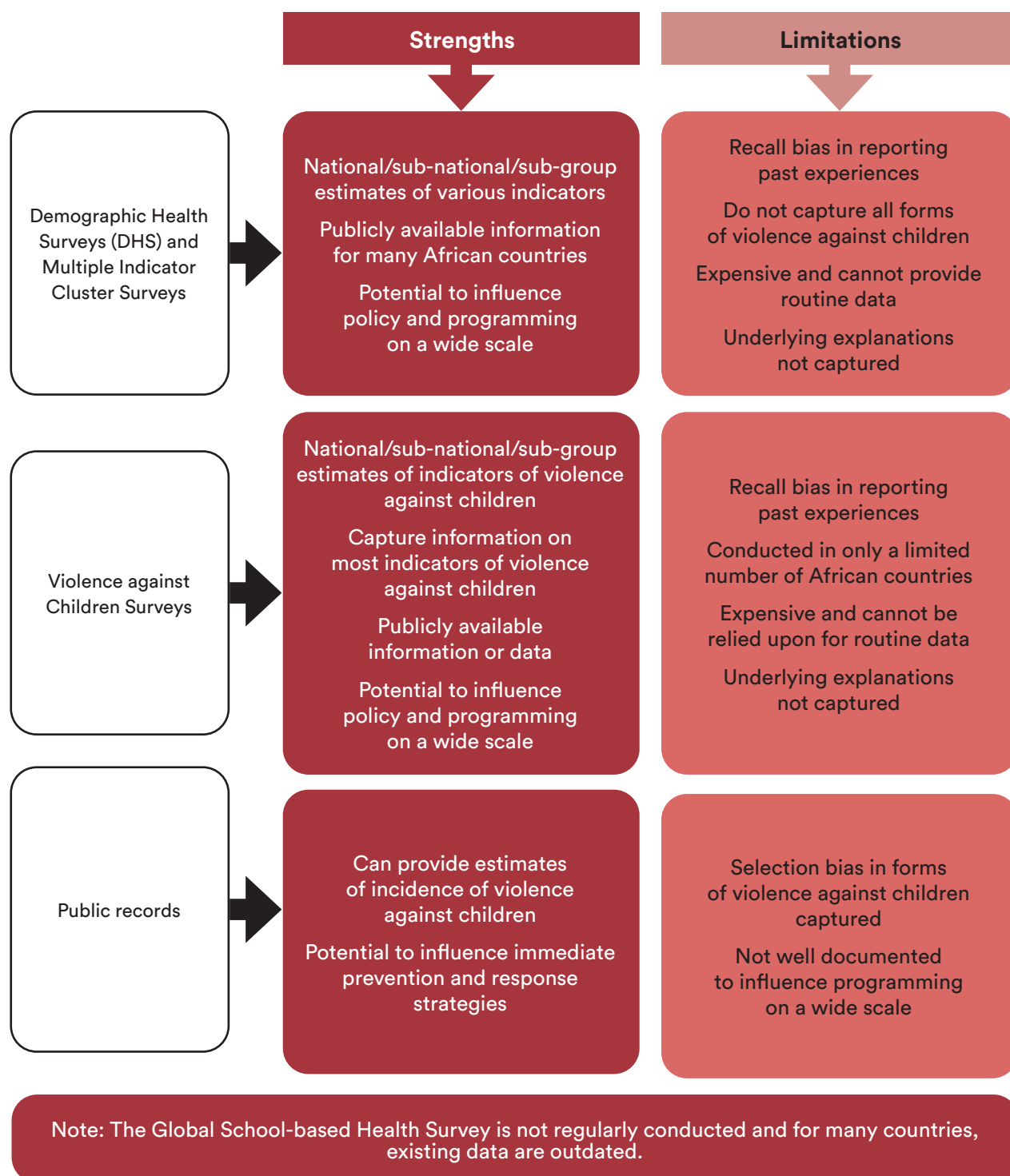


Figure 1 Strengths and limitations of existing VAC data sources

Surveys that collect information on the age at which violence occurred may provide estimates of experiences of VAC at very young ages although such estimates may be subject to under-reporting due to recall bias (if the information is provided by survey participants reporting on what happened long ago) or social desirability (if the information is provided by a caregiver who may be a perpetrator). Strengthening systems of capturing incidents of violence against children as they occur (e.g., through administrative records) can provide a more reliable picture of the extent of violence among children who are not regularly included as participants in surveys.

CORE INDICATORS ON VAC

I. QUANTITATIVE INDICATORS

Policy makers and practitioners can obtain certain core quantitative indicators on VAC from the various existing data sources, including **attitudes**, **experiences**, **perpetration**, **consequences** of violence and **help-seeking** behavior.

Table 8 Indicators for measuring VAC

Indicator	Description	Remarks
1.1. Proportion of children <18 who oppose/support violence against children	Among children aged <18 years, those who agree/disagree with specific statements about violence against children	Disaggregated by age, sex, education, household wealth status, residence and region
1.2. Proportion of adults 18+ who oppose/support violence against children	Among adults 18+ years, those who agree/disagree with specific statements about violence against children	

Prevalence of childhood violence		
Indicator	Description	Remarks
1.3. Proportion of children <18 who experienced violence (physical, sexual and/or emotional) in the past 12 months (current status)	Among children <18 years, those who experienced physical, sexual or psychological/emotional violence in the past 12 months preceding interview	Disaggregated by age, sex, education, household wealth status, residence and region
1.4. Proportion of young people aged 18-24 years who experienced life-time childhood violence (physical, sexual and/or emotional)	Among young people 18-24 years, those who experienced physical, sexual or psychological/emotional violence before age 18	
1.5. Proportion of children <18 who experience child labor	Among children <18 years, those who were involved in economic activities or household chores that were beyond the threshold for their ages or those involved in hazardous work	
1.6. Proportion of children <18 years who experienced neglect	Among children <18 years, those whose biological mother and/or father lived away from them for 6 months or more	
1.7. Proportion of young people 18-24 years who experienced child neglect	Among young people 18-24 years, those whose biological mother and/or father lived away from them for 6 months or more before age 18	
Perpetration of violence		
Indicator	Description	Remarks
1.8. Proportion of children <18 who experience violence (physical, sexual and/or psychological/emotional) by type of perpetrator	Among those who experienced any form of violence before the age of 18, the relationship of the person who perpetrated the violence to the survivor	Disaggregated by age and sex of perpetrator, and place of occurrence
1.9. Proportion of children <18 who perpetrate violence (physical, sexual and/or psychological/emotional)	Among children <18 years, those who ever perpetrated physical, sexual or psychological/emotional violence on others	Disaggregated by age, sex, education, household wealth status, residence, region, and prior experience of violence

Help-seeking for childhood violence

Indicator	Description	Remarks
1.10. Proportion of children <18 who perpetrate violence (physical, sexual and/or psychological/emotional)	Among children <18 years, those who ever perpetrated physical, sexual or psychological/emotional violence on others	Disaggregated by age, sex, education, household wealth status, residence, region, and prior experience of violence

Consequences of violence against children

Indicator	Description	Remarks
1.11. Proportion of survivors of childhood violence who experience health problems (e.g., injury, disability or depression)	Among those who experienced physical, sexual or psychological/emotional violence before the age of 18, those who experienced health problems following the violence	Disaggregated by age, sex and type of health problem
1.12 Proportion of survivors of childhood violence who experience psychosocial problems (e.g., fear, shame, guilt, or deviant behavior)	Among those who experienced physical, sexual or psychological/emotional violence before the age of 18, those who experienced psychosocial problems following the violence	Disaggregated by age, sex and type of psychosocial problem

II. QUALITATIVE INDICATORS

Quantitative indicators alone may not provide a complete picture of VAC. This requires that the indicators be supplemented with qualitative indicators that can be captured through specialized qualitative studies. Qualitative indicators can help us understand the various dynamics around violence against children, including:

1. Existence of laws and policies on violence against children and the fidelity of their implementation for the benefit of children.
2. Social construction and the manifestation of other forms of violence against children such as child neglect, child labor, and violent child discipline in the African context.
3. Underlying drivers of patterns of violence against children observed in a particular setting or across settings.
4. Nature, reach, and impact of interventions to prevent and/or respond to violence against children.

Additional resources

1. https://dhsprogram.com/pubs/pdf/DHSQMP/domestic_violence_module.pdf.pdf
2. <https://www.dhsprogram.com/data/available-datasets.cfm>
3. <https://www.statcompiler.com/en/>
4. <https://mics.unicef.org/tools>
5. <https://mics.unicef.org/surveys>
6. <https://mics.unicef.org/tools#analysis>
7. <https://www.togetherforgirls.org/resources-bank/>
8. <https://www.togetherforgirls.org/request-access-vacs/>
9. <https://www.togetherforgirls.org/resources-bank/>
10. <https://www.who.int/teams/noncommunicable-diseases/surveillance/systems-tools/global-school-based-student-health-survey/questionnaire>
11. <https://extranet.who.int/ncdsmicrodata/index.php/catalog/history>
12. <https://www.unicef.org/eap/media/2901/file/violence.pdf>

6.2. Other SRH&RR indicators related to VAWG/SGBV

In this section, we include important indicators not captured elsewhere in the toolkit. However, some of the indicators have not been tested/validated within the African context.

6.2.1. Covert use of family planning

Covert use of family planning is the use of contraceptives without partners' knowledge. It is a strategy women use to challenge contraceptive use without suffering from related social consequences. Often, it is a representation of how women take charge of their agency to control their fertility, even in challenging or conflicting circumstances²¹. Covert contraceptive use is more common among women experiencing intimate partner violence than those in violence-free relationships²². Concealing contraceptive use illustrates women's struggle to create meaningful lives in the face of control and points to the need for family planning programmes to support their desire to discreetly choose their own family planning methods.

MEASURING COVERT CONTRACEPTIVE USE

Covert contraceptive use is measured directly by asking women whether their husbands know they are using modern contraception (overt use) or do they hide its use from them (covert use). However, it can also be measured indirectly using couples' discordant reporting of modern contraceptive use²³. While quantitative studies are illuminating, qualitative methods could help collect in-depth data on the rationale, motivations, and consequences of covert contraceptive use.

²¹ Gibbs, A., & Hatcher, A, *Covert family planning as a symbol of agency for young, married women*, *EClinicalMedicine*, 23, (2020).

²² Silverman, J. G., Challa, S., Boyce, S. C., Averbach, S., & Raj, A, *Associations of reproductive coercion and intimate partner violence with overt and covert family planning use among married adolescent girls in Niger*, *EClinicalMedicine*, 22, 100359, (2020).

²³ Gasca NC, Becker S., *Using couples' discordant reports to estimate female covert use of modern contraception in sub-Saharan Africa*. *J Biosoc Sci*. 2018;50:326–46.

KEY RESEARCH QUESTIONS ON COVERT CONTRACEPTIVE USE

Researchers should consider asking the following questions:

1. What is the prevalence of overt and covert contraceptive use?
2. What factors are associated with covert contraceptive use?
3. Why do women covertly use contraceptives and what challenges do they experience in concealing their use?

6.2.2. Reproductive coercion

Reproductive coercion is an act that undermines women's sexual and reproductive health and reproductive rights²⁴. It reduces a woman's reproductive autonomy by directly interfering with their contraception and pregnancy. Tarzia, et al. (2021)²⁵ defined reproductive coercion as behavior intended to control a woman's reproductive choices or that which undermines women's autonomy to make decisions regarding their reproductive health, especially those related to pregnancy. Reproductive coercion is a form of violence mainly perpetrated by intimate partners and a few cases by relatives / family that interfere with a woman's efforts to prevent pregnancy, seek an abortion or continue with their pregnancy. Existing literature has associated reproductive coercion with IPV, unwanted pregnancies, mental health issues, decreased contraceptive efficacy, and increased risks of sexually transmitted infections. However, little is known about reproductive coercion behavior and measurements in low and middle-income countries. A study on reproductive coercion among intimate partners in Kenya has proven that the US-developed reproductive coercion scale could be used in low and middle-income countries' context²⁶. Reproductive coercion has mainly been manifested in three different ways that are linked to one another:

- **Contraceptive sabotage:** -intentionally interfering with a woman's use of contraception or birth control. This behavior may include hiding or destroying contraception, removing or poking holes in the condom during sex, or refusing to withdraw. These behaviors interfere with female pregnancy intentions.
- **Pregnancy coercion:** this involves a male partner forcing their female partner to act against her reproductive intention including becoming pregnant, continuing with pregnancy to term or terminating a pregnancy against her will. These behaviors may include threatening and violence against female partners to ensure they comply with intentions, blocking women's access to contraceptives, or forcing their use of contraceptive services.
- **Abortion coercion:** a woman is forced to terminate or carry a pregnancy to term against her will.

²⁴ Katz, J., Poleshuck, E. L., Beach, B., & Olin, R., *Reproductive Coercion by Male Sexual Partners: Associations With Partner Violence and College Women's Sexual Health*. *Journal of interpersonal violence*, 32 (21), 3301–3320. <https://doi.org/10.1177/0886260515597441>. (2020).

²⁵ Tarzia, L., & Hegarty, K., *A conceptual re-evaluation of reproductive coercion: centring intent, fear and control*, *Reproductive Health*, 18(1), 1-10, (2021).

²⁶ Shannon N. Wood, S. Rachel Kennedy, Irene Akumu, Catherine Tallam, Ben Asira, Zaynab Hameeduddin, John McGready, Linnea A. Zimmerman, Caitlin E. Kennedy, Nancy Glass, Michele R. Decker, 1. *Reproductive Coercion among Intimate Partner Violence Survivors in Nairobi*, <https://doi.org/10.1111/sifp.12141> (8 December 2020).

KEY RESEARCH QUESTIONS ON REPRODUCTIVE COERCION

1. What do we understand or know about reproductive coercion, its prevalence, and correlates?
2. Which strategies do women employ to preserve their reproductive health autonomy when faced with or experience reproductive coercion?
3. What interventions are most effective in addressing or decreasing reproductive coercion?

INDICATORS OF REPRODUCTION COERCION

- Proportion of women who experienced contraceptive/birth control sabotage
- Proportion of women who have been subjected to pregnancy coercion
- Proportion of women who have been subjected to abortion coercion

These indicators are assessed using a reproductive coercion scale, which has a list of items as outlined below^{26,27}.

Table 9 Reproductive coercion scale items²⁸

Pregnancy Coercion:	
Has someone you were dating, going out with, or married to ever:	
1.	Told you not to use any birth control (like the pill, shot, ring, etc.)?*
2.	Said he would leave you if you did not get pregnant?*
3.	Told you he would have a baby with someone else if you did not get pregnant?*
4.	Hurt you physically because you did not agree to get pregnant?*
5.	Tried to force or pressure you to become pregnant?
6.	Have you ever hidden birth control from a sexual partner because you were afraid he would get upset with you for using it?
Birth control sabotage:	
Has someone you were dating or going out with ever:	
1.	Taken off the condom while you were having sex so that you would get pregnant?*
2.	Put holes in the condom so you would get pregnant?*
3.	Broken a condom on purpose while you were having sex so you would get pregnant?*
4.	Taken your birth control (like pills) away from you or kept you from going to the clinic to get birth control so that you would get pregnant?*
5.	Made you have sex without a condom so that you would get pregnant?*

²⁷ McCauley HL, Silverman JG, Jones KA, Tancredi DJ, Decker MR, McCormick MC, Austin SB, Anderson HA, Miller E., *Psychometric properties and refinement of the Reproductive Coercion Scale*. *Contraception*, (2017).

²⁸ Wood, Shannon N., "He Tells You Your Work Is to Give Birth": *Reproductive Coercion and Covert Use of Contraception Among Female Intimate Partner Violence Survivors in Nairobi, Kenya*, (The Johns Hopkins University ProQuest Dissertations Publishing, 2020.28068814).

6.2.3. Female infanticide

The UN Women²⁹ defines female infanticide as the intentional killing of baby girls due to the preference for male babies and from the low value associated with the birth of females. It may occur deliberately by ways of suffocating infants or administering poison to the infants. It can also occur through forms of neglect such as starvation and lack of care when the baby gets sick³⁰. While there is a lot of evidence showing that female infanticide is more prevalent in parts of Asia, with India and China leading with high number of cases³¹, there is a high likelihood that the practice occurs in Africa as well. The preference for male children in several communities in Africa may make it possible for people to engage in this practice³². This necessitates the need to explore the occurrence of female infanticide in Africa. This also means that the indicators used to measure female infanticide will need to be validated in the African settings.

KEY RESEARCH QUESTIONS ON FEMALE INFANTICIDE

1. What is the prevalence of female infanticides?
2. What are the underlying causes of female infanticide?
3. What are the consequences of female infanticide?
4. What are the interventions that can be employed to reduce female infanticides?

INDICATORS FOR FEMALE INFANTICIDE

- Proportion of female infants are deliberately killed because of their sex.
- Proportion of female infants missing. This indicator has been widely used in Asian countries to assess female infanticide³³.

SOURCES OF DATA ON FEMALE INFANTICIDE

- Criminal records maybe a possible source of data on female infanticide.

6.2.4. Sex-selective abortion

Sex-selective abortion also known as gender-selective abortion is a form of prenatal sex discrimination that involves voluntary termination of pregnancy mainly due to the anticipated sex of the child or when particular sex is not preferred³⁴. The practice has been enhanced by the development of new sex determination technologies like ultrasound screening used in early pregnancy. Ultrasound technology has extremely been exploited especially in Asian countries with high son preference rates³⁵. Female fetuses have mainly been targeted for abortion due to unfavorable cultural norms and practices that have held male children in high regard. For example,

²⁹ UN Women, *Glossary of Terms from Programming Essentials and Monitoring and Evaluation Sections*, <https://www.endvawnow.org/en/articles/347-glossary-of-terms-from-programming-essentials-and-monitoring-and-evaluation-sections.html> (Accessed on 20 April 2022).

³⁰ European Institute for Gender Equality, *Female infanticide*, <https://eige.europa.eu/thesaurus/terms/1127> (Accessed on 19 April 2022).

³¹ BBC, *Ethics Guide: Female infanticide*, https://www.bbc.co.uk/ethics/abortion/medical/infanticide_1.shtml (Accessed on 20 April 2022).

³² Baloyi, M. E., & Manala, M. J., *Reflections on challenges of preferring the male child in an African marriage – a practical theological observation*. *Verbum et Ecclesia*, 40 (1), <https://doi.org/10.4102/VE.V40I1.1852> (2019).

³³ Allahbadia, G. N., *The 50 Million Missing Women*, *Journal of Assisted Reproduction and Genetics*, <https://doi.org/10.1023/A:1016859622724> (P., 411–416, 2002).

³⁴ Hohmann SA, Lefèvre CA, & Garenne ML., *A framework for analyzing sex-selective abortion: the example of changing sex ratios in Southern Caucasus*, (*Int J Womens Health*, 2014).

³⁵ Hesketh T, Lu L, & Xing ZW., *The consequences of son preference and sex-selective abortion in China and other Asian countries*. (CMAJ, 2011).

sex-selective abortion is prevalent in India and China, countries with cultural preferences for male children, this may be the cause of highly skewed data on sex ratios in the two countries and others. Sex-selective abortion is considered a human rights violation based on the law protecting reproductive autonomy³⁶ and has derailed efforts to revert gender inequalities and improve the status of women in society, especially in countries with cultural norms that favor male children. Among the contributing factors for sex-selective abortion are cultural norms that favor one sex over the other, and political and economic factors. In countries like India with high bridal prices for the girl's family, sex-selective abortion is practiced to limit the number of female children.

KEY RESEARCH QUESTIONS ON SEX-SELECTIVE ABORTION

1. What is the prevalence of sex-selective abortion?
 - Does the prevalence vary by gender?
2. What factors contribute to sex-selective abortion?
3. What are the consequences of sex-selective abortion?
4. What strategies can be employed to prevent/address sex-selective abortion?

INDICATORS THAT HAVE BEEN USED TO DETERMINE SEX-SELECTIVE ABORTION

The current measure of sex-selective abortion is based on assessing the imbalance between the sex ratio at birth and the natural sex-ratio. This provides an indication of number of missing fetuses^{37,38}.

- Trends in sex ratio at birth (SRB) are measured by the proportion of male-to-female live births.

DATA SOURCES ON SEX-SELECTIVE ABORTION

- World population data on sex ratio at birth.
- Health facility abortion data (induced abortion) and reporting system.
- Abortion incidence studies especially on induced abortion with data segregated by sex and reasons for termination.

³⁶ Higgins Anna, *American Reports Series Issue 11 | Sex-Selection Abortion: THE REAL WAR ON WOMEN*
https://s27589.pcdn.co/wp-content/uploads/2016/04/Higgins-Sex-Selective-Abortion-paper_April12_FINAL_April122016_-1.pdf
<https://lozierinstitute.org/sex-selection-abortion-the-real-war-on-women/> (2016).

³⁷ <https://halshs.archives-ouvertes.fr/halshs-03495964/>

³⁸ Chao, F., Gerland, P., Cook, A. R., & Alkema, L., *Systematic assessment of the sex ratio at birth for all countries and estimation of national imbalances and regional reference levels. Proceedings of the National Academy of Sciences*, (p., 9303-9311, 2019).

LIMITATIONS

Noted is the possibility of using population-level data on sex ratio to determine a sex-selective abortion. However, this data source may not be very accurate, especially in countries where the sex ratio at birth is statistically average³⁹. While studies on induced abortion would be imperative to determine the specific number of sex-selective abortions, again, access to this kind of data is often challenging, especially in countries with restrictive abortion laws. In most countries, induced abortion reporting is not mandatory. Additionally, data on abortion at the health facility level are mostly not segregated by type of abortion but often recorded as miscarriage. Whereas this study may be relevant in some African countries, determining this indicator may be challenging given that most African countries have got very restrictive abortion laws. Again, the health facility data on abortion is usually not segregated by sex and type of abortion hence it may be difficult to assess/measure indicators related to sex-selective abortion.

6.2.5. Online and ICT facilitated violence against women and girls

The internet and social media technology facilitate and amplify verbal or graphical sexual violence. According to UN Women⁴⁰, women and girls are exposed to higher levels of violence through mobile phones and smartphones, the internet, social media platforms, and email than men. Thus, technology-facilitated GBV could be defined as “action by one or more people that harms others by enforcing harmful gender norms. This action is carried out using the internet and/or mobile technology and includes stalking, bullying, sexual harassment, defamation; hate speech, and exploitation”^{41,42}.

While limited research attention is dedicated to online and technology facilitated abuse, evidence shows that some groups of women, including human rights defenders, women in politics, journalists, bloggers, women belonging to ethnic minorities, indigenous women, and women with disabilities are most affected⁴³. Often, online violence against women and girls is a manifestation of offline violence. Online threats and abuse have far-reaching real-world consequences including offline insecurity, compromised ability to do one’s job and out-rightly quitting one’s job.

³⁹ Danièle Bélanger, *Sex Selective Abortions: Short-term and Long-term Perspectives*, *Reproductive Health Matters*, (p.,194-197, 2002)

⁴⁰ UN Women, *Online and ICT-facilitated violence against women and girls during COVID-19*.

<https://www.unwomen.org/sites/default/files/Headquarters/Attachments/Sections/Library/Publications/2020/Brief-Online-and-ICT-facilitated-violence-against-women-and-girls-during-COVID-19-en.pdf> (UN WOMEN New York, USA 2020).

⁴¹ Hinson, L., Mueller, J., O’Brien-Milne, L., & Wandera, N. *Technology-Facilitated GBV: What is it, and How do we measure it?* *International Center for Research on Women*, <https://www.icrw.org/publications/technology-facilitated-genderbased-violence-what-is-it-and-how-do-we-measure-it/> (2018).

⁴² Hinson L., O’Brien-Milne L., Mueller J., Bansal V., Wandera N., and Bankar S. *Defining and measuring technology-facilitated gender-based violence*. (International Center for Research on Women (ICRW), Washington DC, 2019).

⁴³ OHCHR, *Report of the Special Rapporteur on violence against women, its causes and consequences on online violence against women and girls from a human rights perspective*, <https://www.ohchr.org/EN/> (2018).

FORMS OF ONLINE AND ICT FACILITATED ABUSE

Six different forms of online and ICT facilitated abuse were identified by Cripps (2016). These include:

1. Unauthorized fabrication or distribution of sexually explicit images of non-consensual pornography or revenge porn victims on cyberspaces;
2. Fabrication or distribution of images of sexual assault;
3. Publishing an Internet advertisement inciting someone to assault another person in vengeance;
4. Cyber sexual harassment and stalking (such as sex and degrading comments on Internet forums and chat rooms);
5. Gender-based hate speech, which includes rude and demeaning statements;
6. Virtual rape, when a person's avatar (digital representative of people) is subjected to simulated sexual violence by other avatars;
7. Cyberstalking defined as a person repeatedly pursuing electrical or internet-enabled gadgets to send unwanted electronic messages that can be menacing, frightening or coercive⁴⁴; and
8. Cyberbullying using electronic communication to bully a person, typically by sending messages of an intimidating or threatening nature.

KEY RESEARCH QUESTIONS ON ONLINE AND ICT FACILITATED VAWG

1. What proportion of female internet users have experienced verbal and graphical sexual violence online?
2. What are the risk factors for experiencing online verbal and graphical sexual violence?
3. What are the consequences of online and ICT facilitated violence against women and girls?
4. What online platforms are most susceptible to online and ICT facilitated violence against women and girls?
5. What is the legal and policy landscape on online and ICT facilitated violence against women?
6. What approaches are effective in preventing online and ICT facilitated violence against women and girls?

INDICATORS FOR ONLINE AND ICT FACILITATED VIOLENCE AGAINST WOMEN AND GIRLS

There is no consensus on tools for measuring online and ICT facilitated violence against women as this area of study is evolving. The following are proposed indicators for assessing online and ICT facilitated violence against women:

⁴⁴ Reyns BW, Henson B, & Fisher BS., *Stalking in the twilight zone: Extent of cyberstalking victimization and offending among college students*. *Deviant Behav* <https://doi.org/10.1080/01639625.2010.538364> (p.,1–25, 2012).

Table 10 Indicators for online and ICT facilitated violence against women and girls

Online and ICT facilitated violence against women and girls	Description	Remarks
Proportion of women aged 15-49 who reported having ever experienced any forms of online and ICT facilitated violence	This indicator measures the percentage women online/ with access to ICT reporting any experience of online and ICT facilitated violence	Could be disaggregated by age (five-year age category), severity place of residence, education, wealth status, region at the time of analysis, occupation (e.g journalism, and politics)
Proportion of women aged 15-49 who reported having experienced any online and ICT facilitated violence in the past 12 months	Measure of past year experience of ICT facilitated violence is important for tracking progress	
Proportion of women aged 15-49 who reported having ever experienced cyberstalking	This indicator measures percentage of women aged 15-49 who had experienced cyberstalking	
Proportion of women aged 15-49 who reported having experienced cyberstalking in the past 12 months	Measure of past year experience of cyberstalking is important for tracking progress	
Proportion of women aged 15-49 who reported having ever experienced online sexual harassment	This indicator measures the percentage of women who had experienced online-based sexual harassment	
Proportion of women aged 15-49 who reported having experienced online sexual harassment in the past 12 months	Tracking the level of reporting is important for measuring progress	
Proportion of women aged 15-49 who reported having ever experienced online verbal violence	This indicator measures the percentage of women who ever experienced any forms of verbal violence online	
Proportion of women aged 15-49 who reported having experienced online verbal violence in the past 12 months	Tracking the level of reporting is important for measuring progress	

**Note the denominator is the total number of women who have access to phones, social media and Internet*

PRIMARY SOURCES OF DISAGGREGATED DATA ON ONLINE AND ICT FACILITATED VIOLENCE AGAINST WOMEN AND GIRLS

Questions on online and ICT facilitated violence against women and girls are not included in large-scale surveys such as the DHS or MICS.

6.2.6. Discrimination based on gender

Gender discrimination refers to a form of discrimination based on perceptions of gender⁴⁵ rather than based on their abilities or skills. Gender discrimination refers to any situation where one is denied an opportunity or misjudged on the basis of their gender or sex and may also be referred to as sexism⁴⁶. Mainly, gender discrimination stems from gender norms that prescribe different roles for men/boys and women/girls in society. Gender discrimination manifests in different spaces including in the home, community, school, work, etc.

KEY RESEARCH QUESTIONS ON GENDER DISCRIMINATION

1. What are the types and drivers of gender discrimination?
2. What are the health, economic and social consequences of gender discrimination?
3. What legal frameworks are in place to promote, enforce and monitor equality and nondiscrimination on the basis of gender/sex?
4. What sets of interventions are most effective in preventing/addressing gender discrimination?

SOURCES OF DATA ON GENDER DISCRIMINATION

Data on gender discrimination can be obtained from different surveys described earlier in this toolkit. VAWG is a form of GBV committed against women because they are women⁴⁷. Thus, forms of violence such as intimate partner violence; harmful traditional practices, including female genital mutilation, female infanticide and prenatal sex selection, early marriage, forced marriage, dowry-related violence, crimes against women committed in the name of “honour”, maltreatment of widows; femicide; sexual violence by non-partners; sexual harassment and violence in the workplace, educational institutions and in sport; and trafficking in women⁴⁷ could be termed as forms of gender discrimination.

In addition, some surveys such as the Multiple Indicator Cluster Survey collect data on gender discrimination in the past 12 months using the question “In the past 12 months, have you felt discriminated against or harassed on the basis of the following grounds?” Grounds of discrimination include: ethnic or immigration origin, sex, age, religion or belief, disability, or any other reason⁴⁸. The Global Early Adolescent Study^{49,50} also has specific indicators of gender discrimination among early adolescents. Among girls and boys who have been teased or called names by someone in the last six months, the survey asks whether they thought this happened because they were a boy or a girl.

⁴⁵ de la Torre-Pérez, L., Oliver-Parra, &A., Torres, X. et al. *How do we measure gender discrimination? Proposing a construct of gender discrimination through a systematic scoping review*. <https://doi.org/10.1186/s12939-021-01581-5> (Int J Equity Health, 2022).

⁴⁶ Salvini, S. *Gender Discrimination*. In: Michalos, A.C. (eds) *Encyclopedia of Quality of Life and Well-Being Research*. https://doi.org/10.1007/978-94-007-0753-5_1126 (Springer, Dordrecht 2014).

⁴⁷ https://unece.org/fileadmin/DAM/stats/documents/ece/ces/2014/Consolidated_Gender_Report__3.2__for_CES_Consultation.pdf

⁴⁸ <https://mics.unicef.org/tools?round=mics6>

⁴⁹ https://static1.squarespace.com/static/54431bbee4b0ba652295db6e/t/5d7697464ed1ca3f4ba7d4bd/1568053063788/GEAS_Wave1_Baseline_English%281%29.pdf

⁵⁰ <https://www.geastudy.org/>

6.2.7. Gender-based workplace unsafety and insecurity

Workplace safety also often known as occupational safety and health is defined by the ILO as the prevention of work-related injuries and diseases as well as the protection and promotion of the health of workers⁵¹. On the other hand, workplace security is the provision of working conditions that are safe and that promote workers' well-being⁵². Workplace safety and security extends to addressing issues of gender-based violence and harassment at work in its various forms including bullying, verbal abuse, physical violence, sexual violence such as assault and rape, sexual harassment, threats, and intimidation, harassment around pregnancy and maternity issues and pays discrimination based on sex⁵³. While both men and women can be exposed to gender-based violence and harassment at work, women are at a higher risk of experiencing it especially sexual harassment⁵⁴. This often stems from unequal power relations between men and women in the workplace, social norms, and stereotypes that foster gender inequalities and discrimination against women⁵⁵. These forms of gender-based violence and harassment towards women in the workplace have a significant impact on their physical and mental health, well-being, and performance/productivity at work⁵⁶.

Data on workplace unsafety and insecurity remains a challenge in the African region, even as women and girls increasingly get into the labor force. A framework developed by United Nations Economic Commission for Europe indicates that studies on workplace unsafety and insecurity need to focus on the following:

- Safety and ethics of employment including safety at work, fair treatment in employment, and the absence of child and forced labor.
- Income and benefits from employment.
- Work-life balance including working hours, time arrangements, and the ability to balance work and non-working life.
- Security of employment and social protection.
- Social dialogue including the freedom to organize, strike, and collectively bargain with employers.
- Skills development and training opportunities.
- Workplace relationships and work motivation.

KEY RESEARCH QUESTIONS ON GENDER-BASED WORKPLACE UNSAFETY AND INSECURITY

1. What is the prevalence of physical violence, sexual violence, sexual harassment, verbal abuse, threats, intimidation and pay discrimination towards women at workplace?
2. What are the main causes of physical violence, sexual violence, sexual harassment, verbal abuse, threats, intimidation and pay discrimination towards women at workplace?

⁵¹ International Labour Organisation, *Occupational Safety and Health-ILO Research Guides*, <https://libguides.ilo.org/occupational-safety-and-health-en> (accessed on July 25, 2022).

⁵² International Labour Organisation, *Work Security Index: Information*, <https://www.ilo.org/sesame/SESHelp.NoteWSI> (accessed on July 25, 2022).

⁵³ Ibid.

⁵⁴ International Labour Organisation, *Gender equality at the heart of decent Work*, [http://www.genderaction.org/images/Gender Action Link - Climate Change.pdf](http://www.genderaction.org/images/Gender%20Action%20Link%20-%20Climate%20Change.pdf) (accessed on July 29, 2022).

⁵⁵ International Labour Organisation & UN Women, *Addressing violence and harassment against women in the world of work*, https://www.ilo.org/wcmsp5/groups/public/---europe/---ro-geneva/---ilo-ankara/documents/publication/wcms_731370.pdf (2019).

⁵⁶ UN Women, *Gender-Based Violence and the Workplace*, <https://www.un.org/womenwatch/osagi/ianwge2012/Executive-Summary-EGM-GBV-Workplace-Feb-21.pdf> (2011).

3. What are the consequences of physical violence, sexual violence, sexual harassment, verbal abuse, threats, intimidation and pay discrimination towards women at workplace?
4. What interventions/policies can be adopted to reduce physical violence, sexual violence, sexual harassment, verbal abuse, threats, intimidation and pay discrimination among women at workplace?
5. What organizational policies exist to prevent physical violence, sexual violence, sexual harassment, verbal abuse, threats, intimidation and pay discrimination towards women at workplace?

CORE INDICATORS FOR GENDER-BASED WORKPLACE UNSAFETY AND INSECURITY

- Proportion of women who have experienced physical violence at their workplace.
- Proportion of women who have experienced sexual harassment at their workplace.
- Proportion of women who have experienced sexual violence at their workplace.
- Proportion of women who have experienced verbal abuse, threats, and intimidation at their workplace.
- Proportion of women who have experienced harassment during pregnancy at their workplace.
- Proportion of women who have experienced pay discrimination at their workplace.

SOURCES OF DATA

- Data on gender-based workplace unsafety and insecurity can be primarily obtained from ILO surveys and reports, World Bank's gender data portal, Women, business, and law enterprise surveys, and demographic and health surveys. In some countries, national data are collected through labor force surveys.

6.2.8. Forced labor

According to the ILO Forced Labour Convention of 1930 (No. 29), forced labor refers to “all work or service that is exacted from any person under the menace of any penalty and for which the said person has not offered himself voluntarily”.⁵⁷ For purposes of measurement, ILO and Walk Free Foundation define forced labor among adults as work for which an adult person has not voluntarily offered himself or herself and which is performed under coercion. Estimates show that women comprise more than half (55%) of victims of forced labor.⁵⁸ Forced labor is a form of violence against women and girls as it curtails their safety, freedom, and autonomy.

KEY RESEARCH QUESTIONS ON FORCED LABOR INCLUDE:

1. What is the prevalence of forced labor across different age groups, sub-groups and sectors?
 - a. Does the prevalence differ by gender?
2. What are the underlying drivers of and factors perpetuating forced labor across sectors?
 - a. Do the drivers differ by gender?

⁵⁷ ILO Forced Labour Convention, https://www.ilo.org/wcmsp5/groups/public/@asia/@ro-bangkok/documents/genericdocument/wcms_346435.pdf (No. 29, 1930).

⁵⁸ <https://www.unwomen.org/en/news/stories/2016/9/speech-by-lakshmi-puri-on-economic-costs-of-violence-against-women>

3. What are the health, economic and social consequences of forced labor?
 - a. Do the consequences differ by gender?
4. What sets of interventions are most effective in preventing and responding to forced labor?
5. What laws and policies exist to prevent and respond to forced labor and what is the fidelity of their implementation?

SOURCES OF DATA ON FORCED LABOR:

Sources of data on forced labor include population-based surveys, workplace data, administrative records, and published reports. Deriving estimates of forced labor from population-based surveys, workplace data, and administrative records requires information on whether individuals voluntarily offered themselves and whether the work is performed under coercion or not. National surveys on labor force participation may not capture information on whether work is being undertaken voluntarily or not to allow the estimation of the extent of forced labor. Countries should therefore consider investing in specialized surveys focusing on forced labor in various sectors in order to provide a comprehensive picture of indicators of forced labor, including prevalence, drivers, and consequences. Such information is important for informing laws, policies, and programmes to prevent and respond to forced labor, and promote a healthy and productive working environment.

INDICATORS FOR MEASURING FORCED LABOR:

ILO and Walk Free Foundation provide estimates of forced labor for the different regions of the world in terms of the absolute number of persons affected as well as the number of persons affected per 1,000 people.⁵⁹ Specialized surveys, qualitative studies, and routine systems for capturing information should be considered in order to generate indicators on forced labor that are not available from existing data sources, including:

- Proportion of women, men, and children engaged in forced labor (disaggregated by age, sex, sector, and region).
- Social construction and the manifestation of forced labor in the African context (disaggregated by age, sex, sector, and region).
- Health, economic and social consequences of forced labor (disaggregated by age, sex, sector, and region).
- Existence, implementation, and effectiveness of laws and policies addressing forced labor.

Additional resources

1. Tarzia, L., Hegarty, K. A conceptual re-evaluation of reproductive coercion: centering intent, fear, and control. *Reprod Health* 18, 87 (2021). <https://doi.org/10.1186/s12978-021-01143-6>.
2. Grace, K. T., & Anderson, J. C. (2018). Reproductive Coercion: A Systematic Review. *Trauma, violence & abuse*, 19(4), 371–390. <https://doi.org/10.1177/1524838016663935>.
3. Katz, J., Poleshuck, E. L., Beach, B., & Olin, R. (2017). Reproductive Coercion by Male Sexual Partners: Associations With Partner Violence and College Women's Sexual Health. *Journal of interpersonal violence*, 32(21), 3301–3320. <https://doi.org/10.1177/0886260515597441>

⁵⁹ International Labour Organization and Walk Free Foundation, *Global estimates of modern slavery: Forced labour and forced marriage*, https://www.ilo.org/wcmsp5/groups/public/@dgreports/@dcomm/documents/publication/wcms_575479.pdf (2017).

4. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5577387/pdf/nihms895763.pdf>
5. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7144871/pdf/nihms-1558343.pdf>
6. http://www.futureswithoutviolence.org/userfiles/file/HealthCare/Repro_Guide.pdf
7. Office of the High Commissioner for Human Rights. 2022. Child and forced marriage, including in humanitarian settings. <https://www.ohchr.org/en/women/child-and-forced-marriage-including-humanitarian-settings>
8. International Labour Organization and Walk Free Foundation. 2017. Global estimates of modern slavery: Forced labour and forced marriage. https://www.ilo.org/wcmsp5/groups/public/@dgreports/@dcomm/documents/publication/wcms_575479.pdf

6.3. Harmful practices

According to UNICEF⁶⁰, harmful practices such as female genital mutilation (FGM) and child, early, and forced marriages (CEFM) are discriminatory practices committed regularly over long periods that communities and societies begin to consider acceptable. While both girls and boys are likely to experience some form of harmful practices, girls are at a much greater risk.

This section focuses on FGM and CEFM.

6.3.1. Female genital mutilation

Female genital mutilation refers to the practice of partially or removing the female external genitalia or causing injury to the female genital organs for non-medical reasons. The World Health Organization identifies four main types of FGM:

- Type I: **Clitoridectomy** - Partial or total removal of the clitoral glans and/or the prepuce;
- Type II: **Excision** - Partial or total removal of the clitoral glans and labia minora, with or without excision of the labia majora;
- Type III: **Infibulation** - Narrowing of the vaginal orifice by cutting and bringing together the labia minora and/or the labia majora to create a type of seal, with or without excision of the clitoris; and
- Type IV: **Other** - All other harmful procedures to the female genitalia for non-medical purposes, such as pricking, piercing, incising, scraping, and cauterization.

KEY RESEARCH QUESTIONS ON FGM

The UN Joint Programme (UNJP) on Elimination of Female Genital Mutilation, in collaboration with Population Council-Kenya, identified 10 priority research questions on FGM through a consultative process with experts from academic and research institutions, policymakers, programme implementers, and representatives of donors and UN agencies. The research questions are intended to guide the generation of evidence necessary for facilitating the elimination of FGM by 2030 in line with the Sustainable Development Goals.

⁶⁰ <https://www.unicef.org/protection/harmful-practices>

TOP FIVE RESEARCH QUESTIONS ON FGM ACCORDING TO UNJP

1. How can health care providers and the health system be effectively utilized in the prevention of FGM and the provision of services to women and girls affected by FGM?
2. How can FGM intervention activities be more effectively integrated into educational, social, and economic development programmes (e.g., programmes dealing with SRH&RR and GBV, formal and informal education avenues) for girls and boys as well as women empowerment programmes?
3. What are the valid measures of change in social and gender norms and practices that should be used in the evaluation of FGM interventions?
4. What intervention approaches are effective in preventing FGM across countries that border each other?
5. How can interventions integrate girl-centered approaches in bringing social change?

NEXT FIVE RESEARCH QUESTIONS ON FGM ACCORDING TO UNJP

1. How can other health and non-health disciplines such as mental health, social work, sexology, and psychology be incorporated to support the response and prevention of FGM?
2. How do we strengthen partnerships and collaboration with governments, UN agencies, humanitarian partners, civil society organizations (CSOs), and private partners in emergency settings to enhance prevention and support services as part of the (prevention, protection, and recovery measures) routine package of care?
3. How can men and/or boys be effectively engaged as allies of gender equality and ending FGM?
4. What lessons on the effectiveness of interventions can interventions that seek to end FGM gain from other related fields such as GBV, SRH&RR, and child marriage?
5. What context-specific factors (mechanisms) motivate communities or individuals to stop practicing FGM?

ADDITIONAL RESEARCH QUESTIONS ON FGM

In addition to the 10 priority research questions, other basic questions should be explored especially in contexts where FGM is prevalent and there is still limited evidence pertaining to the questions. These include:

1. What are the underlying drivers and root causes of FGM in different contexts?
2. What are the health, economic, and social consequences of FGM for individuals, families, and communities?
3. What interventions are most effective in changing knowledge, attitudes, beliefs, norms, and practices related to FGM?

MAJOR DATA SOURCES ON FGM

Policy makers and practitioners in Africa can obtain information on FGM from the Demographic and Health Surveys (DHS), Multiple Indicator Cluster Surveys (MICS), and administrative records. The type of information from each data source is described below.

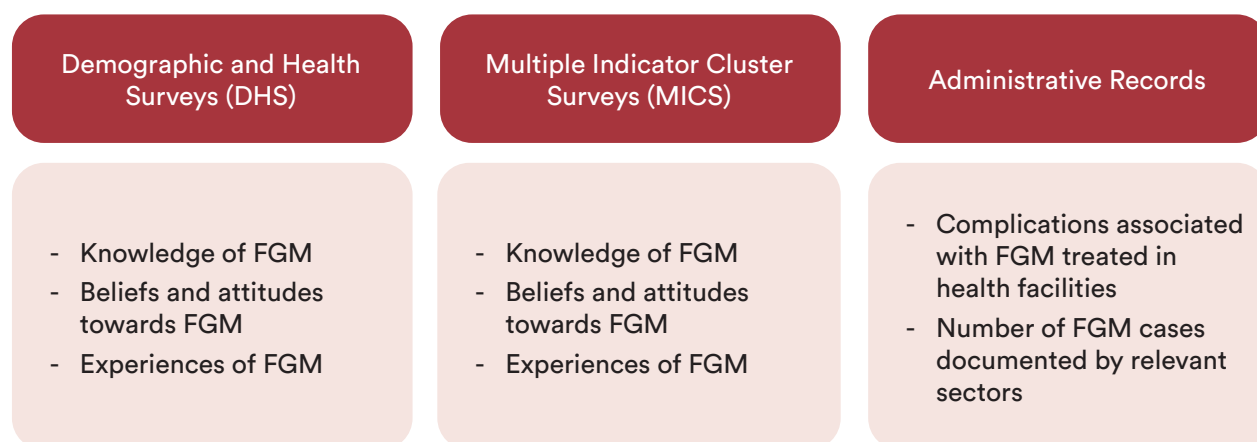


Figure 2 Major sources of data on FGM

Given that population-based surveys such as DHS and MICS are conducted at certain regular intervals (mostly five-year intervals), obtaining routine data on FGM requires strengthening administrative systems to improve the documentation of cases as they occur in order to inform immediate prevention and response efforts.

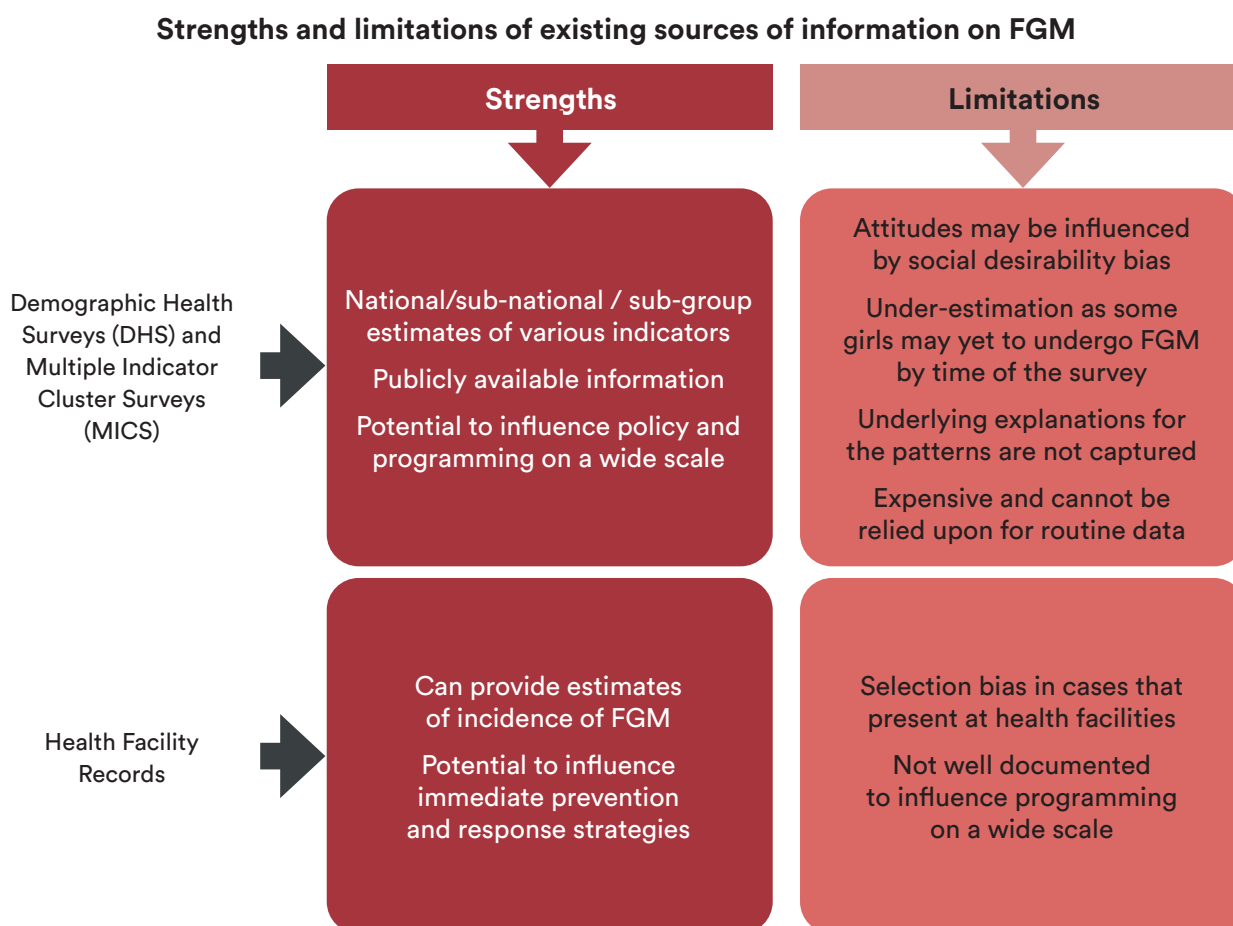


Figure 3 Strengths and limitations of existing sources of information on FGM

CORE INDICATORS ON FGM

Policy makers and practitioners can obtain specific core quantitative indicators on FGM from existing major sources of data. The indicators available from the existing sources pertain to **knowledge, beliefs and attitudes, prevalence and consequences** of FGM. The information is obtained from surveys among women and men of reproductive age (15-49 and 15-54 years, respectively). Women are further asked about the FGM status of their daughters aged 0-14 years.

Table 11 Core indicators on FGM

Knowledge		
Indicator	Description	Remarks
Proportion of women and men who have heard of FGM	Among women (15-49 years) and men (15-54 years), those who have heard of female circumcision or the practice in which a girl may have her genitals cut	Disaggregated by age, sex, education, household wealth status, residence and region
Beliefs and attitudes toward FGM		
Indicator	Description	Remarks
Proportion of women and men who believe that FGM is required by religion	Among women (15-49 years) and men (15-54 years), those who report that FGM is required by religion	Disaggregated by age, sex, education, household wealth status, residence and region
Proportion of women and men who believe that FGM is required by the community	Among women (15-49 years) and men (15-54 years), those who report that FGM is required by the community	
Proportion of women and men who believe that FGM should continue/stop	Among women (15-49 years) and men (15-54 years), those who report that FGM should continue/stop	
Prevalence of FGM		
Indicator	Description	Remarks
Proportion of women 15-49 years who have undergone FGM	Among women 15-49 years, those who report that they were circumcised/cut	Disaggregated by age of cutting, education, household wealth status, residence, region, type of FGM and the person who performed the cut
Proportion of girls 0-14 years who have undergone FGM	Among daughters 0-14 years, those whose mothers report that they were circumcised/cut	
Consequences of FGM		
Indicator	Description	Remarks
Number of women and girls with FGM-related complications	Number of women and girls treated at health facilities for FGM-related complications	Disaggregated by age, education, residence, region, type of FGM, and nature of complications

There are additional indicators on FGM that are not available from existing data sources which should be considered in order to give a comprehensive picture of the practice. The additional indicators could be generated through specialized surveys, qualitative studies, and routine systems for capturing information on the practice. The additional indicators include:

- Knowledge of the consequences of FGM among women, men, girls, and boys (disaggregated by age, sex, education, household wealth status, residence, and region).
- Knowledge, beliefs, and attitudes towards FGM among women and men aged 50 years or older (disaggregated by age, sex, education, household wealth status, residence, and region).
- Prevalence of FGM among women aged 50 years or older (disaggregated by age of cutting, education, household wealth status, residence, region, type of FGM, and the person who performed the cut).
- Economic and social consequences of FGM for individuals, families, and communities (by age, education, residence, region, type of FGM, and nature of consequences where feasible).

QUALITATIVE INDICATORS

Quantitative indicators alone may not provide a comprehensive picture of FGM where the practice is prevalent. This requires supplementing the quantitative indicators with insights from specialized qualitative studies. Qualitative studies can provide additional insights into FGM, including:

1. Existence of laws and policies on FGM and the fidelity of their implementation for the benefit of women and girls.
2. Underlying/root causes and factors contributing to continuation of FGM in different contexts where it is practiced.
3. Economic and social consequences of FGM at the individual, family and community level.
4. Nature, reach and impact of interventions to prevent and/or respond to FGM.

Additional resources

1. https://dhsprogram.com/pubs/pdf/DHSQMP/DHS6_Module_Female_Genital_Cutting_19Aug20_13_DHSQMP.pdf
2. <https://www.dhsprogram.com/data/available-datasets.cfm>
3. <https://www.statcompiler.com/en/>
4. <https://mics.unicef.org/tools>
5. <https://mics.unicef.org/surveys>
6. <https://mics.unicef.org/tools#analysis>

6.3.2. Child, early and forced marriages

I. CHILD MARRIAGES

According to the United Nations Children's Fund (UNICEF)⁶¹, child marriage refers to any formal marriage or informal union between a child under the age of 18 and an adult or another child. Early marriage encompasses child marriage but also includes unions in which one or both spouses are below the age of 18 but have attained the age of majority under the laws of a given country.

KEY RESEARCH QUESTIONS ON CHILD MARRIAGE

There are a number of research questions that should be explored depending on the context where child, early, or forced marriage is prevalent. These include:

1. What is the prevalence rate of child and early marriage?
2. What are the long-term effects of child and early marriage?
3. What are the key factors triggering and sustaining child and early marriage?
4. What role do cultural norms, traditions, and beliefs play in promoting or preventing child and early marriage?
5. What policies and laws contribute to ending child and early marriage?
6. What programmes and interventions can be employed to end child and early marriage?
7. What programmes are being implemented to address child and early marriage in different contexts?
 - How effective are these programmes?
8. What gaps in knowledge, skills, and competencies exist in institutions and among personnel involved in addressing child and early marriage?

SOURCES OF DATA ON CHILD MARRIAGE

- Demographic and Health Survey
- Multiple Indicator Cluster Survey
- VAC surveys



Capture information on marital status and age at first marriage (living together) that is used to compute the indicator for child marriage

STRENGTHS AND LIMITATIONS OF EXISTING SOURCES OF INFORMATION ON CHILD MARRIAGE

Strengths

- Ease of access and use the data since it is publicly available.
- Provides estimates on indicators of child marriage at country and regional levels.
- Provides guidance on the indicators of child marriage.

⁶¹ United Nations Children's Fund. *Child marriage*. Retrieved April 19, 2022, from <https://www.unicef.org/protection/child-marriage>

Limitations

- Lack of timely data when needed since data are collected at specific intervals.
- Limited questions to assess the issue of child and early marriage.
- Lack of specific modules on child and early marriage hence one has to extract relevant information from the marriage module.

CORE INDICATORS OF CHILD AND EARLY MARRIAGE**Quantitative indicators**

The standard indicator for capturing child marriage is the percentage of women and men aged 20-24 years who were first married or in union:

Female

- a. before age 15 (disaggregated by age, education, household wealth status, residence, and region)
- b. before age 18 (disaggregated by age, education, household wealth status, residence, and region)

Male

- c. before age 15 (disaggregated by age, education, household wealth status, residence, and region)
- d. before age 18 (disaggregated by age, education, household wealth status, residence, and region)

In contexts where the age of majority is below 18 years, estimates of early marriage should be derived as the percentage of women and men who were first married or in union before the age of the majority as set out in the laws in the specific context.

II. FORCED MARRIAGES

According to the United Nations Office of the High Commissioner for Human Rights (OHCHR), forced marriage is one in which one or both spouses have not expressed their full and free consent to enter into the union (OHCHR 2022). This definition means that child marriage is a form of forced marriage in that in many settings, laws do not consider minors to have the ability to give full and free consent. Arranged marriages for adults could also be another form of forced marriage especially if the arrangement is made by those who wield power over the couple and one or both of the concerned parties have not given full and free consent.

KEY RESEARCH QUESTIONS ON FORCED MARRIAGE INCLUDE:

1. What is the prevalence of forced marriage across different age groups and sub-groups of women and girls?
2. What are the underlying drivers and factors contributing to the practice of forced marriage?
3. What are the health, economic, and social consequences of forced marriage for women and girls?
4. What sets of interventions are most effective in preventing forced marriage?

SOURCES OF DATA ON FORCED MARRIAGE

The sources of data on child marriage as a form of forced marriage are already described in the section on child marriage. These include:

- Demographic and Health Survey
- Multiple Indicator Cluster Survey
- VAC surveys

Beyond child marriage, there is limited documentation of other forms of forced marriage in Africa. Most population-based surveys that capture data on child marriage do not collect information that allows for determining other forms of forced marriage, especially arranged marriages among adults who did not give full and free consent to the union. Some indications on the prevalence of forced marriage in Africa can be obtained from:

- Published reports, for instance, by the International Labour Organization (ILO) on the number of victims of forced marriage.
- Administrative records on the number of cases of child or arranged marriages reported to relevant authorities.
- VAC surveys: Some VAC surveys include questions on whether married participants chose each other, their marriage was arranged and they did not have a choice, or their marriage was arranged and they were asked to agree, which can be used to determine the prevalence of arranged marriage.

INDICATORS FOR MEASURING FORCED MARRIAGE

Indicators for measuring child marriage as a form of forced marriage are already described in the section on child marriage. These include:

- Percentage of women and men aged 20-49 years who were first married or in union before age 15 (disaggregated by age, sex, education, household wealth status, residence, and region).
- Percentage of women and men aged 20-49 years who were first married or in union before age 18 (disaggregated by age, sex, education, household wealth status, residence, and region).

There are other indicators for measuring forced marriage that is available from existing data sources or require specialized surveys in order to generate evidence on the existence of forms of forced marriage measured by those indicators in the African context. The indicators include:

- Number of victims: ILO and Walk Free Foundation provide estimates of forced marriage for the different regions of the world as the number of victims per 1,000 people (ILO and Walk Free Foundation 2017).
- Percentage of women and men whose marriages were arranged and one or both spouses did not consent (disaggregated by age, sex, education, household wealth status, residence, and region where feasible).

QUALITATIVE INDICATORS

Studies on CEFM should supplement the quantitative indicators with indicators obtained through qualitative research in order to provide a comprehensive picture of child, early, and forced marriage in the African context. Qualitative indicators that should be explored include:

1. Key factors triggering and sustaining child, early and forced marriage.
2. Cultural norms, traditions, and beliefs promoting or preventing child, early, and forced marriage.
3. Policies and laws contribute to ending child, early, and forced marriage.
4. Programmes and interventions to end child, early, and forced marriage.

6.4. Migration and VAWG/SGBV/HP

The International Organization of Migration (IOM)⁶² defines migration as the movement of persons away from their place of usual residence, either across an international border or within a State/country.

WHAT IS THE RELATIONSHIP BETWEEN MIGRATION AND VAWG?

- Migrant women and girls often face multiple forms of discrimination, which increases their vulnerability to violence in countries of origin, transit, destination, and return.
- Structural and gender inequalities such as lack of access to safe and regular migration pathways increase women's and girls' vulnerability to violence.
- Poverty and the inability to gain access to decent work have led some migrant women to accept risky economic opportunities rendering them more vulnerable to violence, abuse, and exploitation.
- Migration and (re)settlement involve complex processes that may sometimes include a shift in power dynamics. This may ultimately leave women vulnerable to violence.
- Women and girls migrants often face social and employment challenges during the post-migration and (re)settlement. They often end up being unemployed or underemployment and facing social isolation. This contributes to stress, family conflict, and ultimately intimate partner violence.

KEY RESEARCH QUESTIONS ON MIGRATION AND VAWG (*SEEKING TO LOOK AT VAWG THROUGHOUT THE LIFESPAN OF THE MIGRANT I.E. PRIOR TO, DURING, AND AFTER MIGRATION*)

1. What is the prevalence of VAWG among legal and illegal migrants?
2. What forms/types of VAWG are experienced by legal and illegal migrants?
3. Who are the perpetrators of VAWG among legal and illegal migrants?
4. What are the risk and protective factors of VAWG among legal and illegal migrant populations?

⁶² International Organization for Migration, *Key Migration Terms, Migration Glossary*, <https://www.iom.int/key-migration-terms> (Accessed on 19 April 2022).

5. What mechanisms exist to prevent VAWG among legal and illegal migrants?
6. What mechanisms are in place to support survivors of VAWG among legal and illegal migrants?

CORE INDICATOR FOR MIGRATION AND VAWG

- Proportion of female migrants who have experienced VAWG in their countries of origin, transit, and destination.

Additional resources

1. <https://www.unwomen.org/sites/default/files/Headquarters/Attachments/Sections/Library/Publications/2021/Policy-brief-From-evidence-to-action-Tackling-GBV-against-migrant-women-and-girls-en.pdf>
2. <https://www.migrationdataportal.org/themes/gender-and-migration>
3. <https://www.unhcr.org/583577ed4.pdf>
4. <https://www.hindawi.com/journals/nrp/2012/434592/>

6.5. Social norms change in the elimination of VAWG/SGBV/HP

Social norms are the unwritten rules guiding behavior. They guide what we do, what we think others do, and what we think others believe we should do. Norms influence behavior, and vice versa, affecting health outcomes and statuses. Unequal norms also restrict women's access to socio-economic opportunities, information, and networks. Such norms have been used to create occupational segregation relegating women to jobs that are perceived as less valuable. If normative beliefs can be changed, behavioral change can follow, and if behavior change occurs then norms can change.

In this section, we describe indicators for measuring norms change adapted from the C-Change (Communication for Change) programme⁶³. The C-Change programme has developed an online compendium of gender scales used to measure adherence to gender norms. Studies intending to measure or assess gender-related attitudes and beliefs can use these scales. The scales have been tested for their ability to measure gender attitudes and predict behaviors of interest, such as gender-based violence and partner reduction.

The identification of appropriate gender-related measures is important to inform programmes and interventions that aim to promote positive health outcomes by addressing the gender norms that affect health outcomes. The C-Change (Communication for Change) has been exploring the impact of gender on family planning and the validity of current gender scales in predicting contraceptive use⁶⁴.

⁶³ Nanda, Geeta. *Compendium of Gender Scales*, Washington, DC: FHI 360/C-Change, (2011).

⁶⁴ Ibid.

The scales, objectives, and domains/subscales items are described below:

COUPLE COMMUNICATION ON SEX SCALE

Objective: To measure the extent of sexual communication within couples.

Scale items

- Can you communicate with your partner about when to have intercourse?
- Can your partner communicate with you about when to have intercourse?
- Does your partner take into account your opinion regarding your sexual desires?
- Do you feel comfortable talking with your partner about your sexual relationship?

WOMEN'S EMPOWERMENT SCALE

Objective: To measure women's empowerment, defined as the ability to exercise agency and acquire resources within a context of gender inequality.

Three sub-scales are used:

Women's mobility subscale

- Have you ever been to the market?
- Have you ever been there alone?
- Have you ever been to the hospital/clinic/doctor?
- Have you ever gone there alone?
- Have you ever gone to the cinema?
- Have you ever gone there alone?
- Have you ever gone outside the village?
- Have you ever gone there alone?

Freedom from family domination subscale

Have any of the following happened to you in the past 12 months?

- Husband/other family member took your money when you didn't want him to.
- Husband/other family member took your land/jewelry/poultry/livestock when you didn't want him to.
- Husband/other family member prevented you from visiting your parents.
- Husband/other family member prevented you from working outside the home.

Economic security and contribution subscale

- Do you, in your name, own any land, your homestead land, or your house?
- Do you yourself own any productive assets (for example, cattle or sewing machine)?
- Do you have any cash savings?

- Have you ever used your savings for business or money-lending?
- Of your total household expenses, what proportion is met through your earnings?

GENDER BELIEFS SCALE

Objective: To measure traditional and more progressive beliefs about gender roles.

Scale items

- Men have many lovers because it is in their nature to do so.
- Men have lovers to get the energy that enables them to satisfy their primary partners.
- Women these days say that they need to have more than one sex partner.
- Men feel ashamed of their wives and want young lovers to take around to their friends.
- If men do not have lovers their friends laugh at them.
- Financially independent women do not want to commit themselves to one relationship.
- The families of young people who work do not want them to get married because they are afraid to lose their income.
- Men often force women in subtle ways to have sex with them, even if they do not want to.

GENDER EQUITABLE MEN (GEM) SCALE

Objective: To measure attitudes toward gender norms in intimate relationships or differing social expectations for men and women.

There are four sub-scales namely:

Violence domain

- There are times when a woman deserves to be beaten.
- A woman should tolerate violence to keep her family together.
- It is alright for a man to beat his wife if she is unfaithful.
- A man can hit his wife if she won't have sex with him.
- If someone insults a man, he should defend his reputation with force if he has to.
- A man using violence against his wife is a private matter that shouldn't be discussed outside the couple.

Sexual relationships domain

- It is the man who decides what type of sex to have. Men are always ready to have sex.
- Men need sex more than women do.
- A man needs other women even if things with his wife are fine.
- You don't talk about sex, you just do it.
- It disgusts me when I see a man acting like a woman.
- A woman should not initiate sex.
- A woman who has sex before she marries does not deserve respect.

Reproductive health and disease prevention domain

- Women who carry condoms on them are easy.
- Men should be outraged if their wives ask them to use a condom.
- It is a woman's responsibility to avoid getting pregnant.
- Only when a woman has a child is she a real woman.
- A real man produces a male child.

Domestic chores and daily life domain

- Changing diapers, giving a bath, and feeding kids is the mother's responsibility.
- A woman's role is taking care of her home and family.
- The husband should decide to buy the major household items.
- A man should have the final word about decisions.

GENDER NORM ATTITUDES SCALE

Objective: To measure egalitarian beliefs about male and female gender norms.

Two sub-scales are used:

Rights and privileges of men subscale

- It is important that sons have more education than daughters.
- Daughters should be sent to school only if they are not needed to help at home.
- The most important reason that sons should be more educated than daughters is so that they can better look after their parents when they are older.
- If there is a limited amount of money to pay for tutoring, it should be spent on sons first.
- A woman should take good care of her own children and not worry about other people's affairs.
- Women should leave politics to the men.
- A woman has to have a husband or sons or some other male kinsman to protect her.
- The only thing a woman can really rely on in her old age is her sons.
- A good woman never questions her husband's opinions, even if she is not sure she agrees with them.
- When it is a question of children's health, it is best to do whatever the father wants.

Equity for girls subscale

- Daughters should be able to work outside the home after they have children if they want to.
- Daughters should have just the same chance to work outside the homes as sons.
- Daughters should be told that an important reason not to have too many children is so they can work outside the home and earn money.

- I would like my daughter to be able to work outside the home so she can support herself if necessary.

GENDER RELATIONS SCALE

Objective: To measure equity and power within intimate relationships.

Two subscales are used:

Equity subscale

- Men need sex more than women do.
- You don't talk about sex, you just do it.
- It is a woman's responsibility to avoid getting pregnant.
- A man should have the final word about decisions in his home.
- Men are always ready to have sex.
- A woman should tolerate violence to keep the family together.
- A man needs other women even if things with his wife are fine.
- A man can hit his wife if she will not have sex with him.
- A couple should decide together if they want to have children.
- Changing diapers, giving the kids a bath, and feeding the kids is a mother's responsibility.
- A woman can suggest using condoms just like a man can.
- A man should know what his partner likes during sex.
- A man and a woman should decide together what type of contraceptive to use.
- A real man produces a male child.
- Men and women should share household chores.
- A woman should not initiate sex.

Power subscale

- My partner has more say than I do about important decisions that affect us.
- I am more committed to this relationship than my partner is.
- A woman should be able to talk openly about sex with her husband.
- My partner dictates who I spend time with.
- When my partner and I disagree, he gets his way most of the time.
- I feel comfortable discussing family planning with my partner.
- I feel comfortable discussing HIV with my partner.

HOUSEHOLD DECISION-MAKING SCALE

Objective: To measure women's household decision-making, as perceived by couples, men alone, and women alone.

Scale items

- Who usually makes decisions about making major household purchases?
- Who usually makes decisions about making purchases for daily household needs?
- Who usually makes decisions about visits to family or relatives?

SEXUAL RELATIONSHIP POWER SCALE (SRPS)

Objective: To measure power within sexual relationships.

Two subscales are used:

Relationship control subscale items

- If I asked my partner to use a condom, he would get violent.
- If I asked my partner to use a condom, he would get angry.
- Most of the time, we do what my partner wants to do.
- My partner won't let me wear certain things.
- When my partner and I are together, I'm pretty quiet.
- My partner has more say than I do about important decisions that affect us.
- My partner tells me who I can spend time with.
- If I asked my partner to use a condom, he would think I'm having sex with other people.
- I feel trapped or stuck in our relationship.
- My partner does what he wants, even if I do not want him to.
- I am more committed to our relationship than my partner is.
- When my partner and I disagree, he gets his way most of the time.
- My partner gets more out of our relationship than I do.
- My partner always wants to know where I am.
- My partner might be having sex with someone else.

Decision-making dominance subscale items

- Who usually has more say about whose friends to go out with?
- Who usually has more say about whether you have sex?
- Who usually has more say about what you do together?
- Who usually has more say about how often you see one another?
- Who usually has more say about when you talk about serious things?
- In general, who do you think has more power in your relationship?
- Who usually has more say about whether you use condoms?
- Who usually has more say about what types of sexual acts you do?

Additionally, there exist specific indicators developed to measure social norms change in regard to FGM and child marriages as described below:

a) Female Genital Mutilation

Developed by UNFPA, the **ACT Framework**⁶⁵ addresses the gaps emanating from tracking social norms changes with respect to FGM using the population-level data and the monitoring and evaluation data which often do not capture community-level changes and shifts attributable to behavior-change interventions. The ACT Framework provides a macro-level framework, based on leading research in social norms that is accessible and practical for programme planners, and adaptable to local contexts.

Table 12 Indicators for measuring social norms change about FGM

Aggregated Act Measures/Indicators		
Component of the act framework	Social norms construct/concept	Aggregated measure/indicator
Assess what people know, feel and do	Know	Change over time in knowledge of FGM
	Feel	Change over time in beliefs about FGM
	Do	Change over time in intentions not to practice FGM
		Proportion of girls and women who have undergone FGM
Ascertain normative factors	Descriptive norms	Proportion of households moving along the continuum of change
		Change over time in perceived prevalence of FGM
	Injunctive norms	Change over time in the approval of FGM by self and others
	Outcome expectancies	Change over time in individuals' identification of benefits and sanctions related to FGM
		Change over time in intention to give rewards and impose sanctions related to FGM

⁶⁵ UNFPA, *The act framework: towards a new m&e model for measuring social norms change around FGM*, https://www.unfpa.org/sites/default/files/resource-pdf/ACT_FGM_Framework_for_Measuring_SN_Change.pdf

Aggregated Act Measures/Indicators		
Consider context	Empowerment	Change over time in agency Change over time in decision-making power
	Gender	Change over time in gender role beliefs Change over time in egalitarian beliefs about men and women
Collect information on social support and networks	Social Networks	Change over time in interpersonal communication about FGM Change over time in spousal communication about FGM
	Social support	Change over time in informational social support for FGM abandonment Change over time in instrumental social support for FGM abandonment
Track individual and social change over time	Individual and social change	Proportion of the intended audience participating in individual and social change communication programming on FGM abandonment
		Proportion of the intended audience exhibiting encoded exposure to individual and social change communication programming on FGM abandonment

Additional resources

1. <https://www.measureevaluation.org/our-work/gender.html>
2. <https://www.data4impactproject.org/prh/mens-health/male-engagement-in-reproductive-health-programs/attitudes-towards-gender-norms-gem-scale/>
3. <https://plan-international.org/publications/measuring-changes-social-and-gender-norms>
4. <https://www.girlsnotbrides.org/documents/882/Social-Norms-and-CMResource-Final-LR.pdf>
5. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6426797/>

b) Child marriages

Source: Recommended indicators for Girls Not Brides members working to address child marriages⁶⁶.

Table 13 Indicators for measuring social norms change about child marriages

MOBILISE FAMILIES AND COMMUNITIES			
	Indicator	Description	Remarks
Families, communities and young people are increasingly aware of the harmful impact of child marriage and alternatives available	Percentage of key stakeholders (parents, adolescents, young people, community and religious leaders, members of local government) who believe that it is harmful to get married before age 18.	These indicators are collected from a survey of individuals in the target population.	Different levels of disaggregation could include (as may be applicable): • age/age-group, • sex, sex of the parent, • marital status, • stakeholder, • region, • education, • wealth status, • religion.
	Percentage of key stakeholders (parents, adolescents, young people, community and religious leaders, members of local government) who know about the harms of child marriage, discrimination, and violence.	These indicators are collected from a survey of individuals in the target population. Survey could include questions to assess knowledge of the country's laws regarding child marriage and dowry, and the ability to correctly define child marriage, describe the legal rights of adolescent girls, and identify the main health complications associated with child marriage.	
	Percentage of community members who participated in public activities on child marriage, human rights of girls, girls' education, and violence prevention (e.g., campaigns, rallies, participatory discussions).	Reports of implementing partners and monitoring mission reports. A survey of individuals in the target community could also be used. Need to distinguish between activities organized by external stakeholders versus community-led activities.	

⁶⁶ Recommended Indicators For Girls Not Brides Members Working To Address Child Marriage A resource prepared by Aspen Planning and Evaluation Program at The Aspen Institute in collaboration with Girls Not Brides (August 2015).

MOBILISE FAMILIES AND COMMUNITIES			
	Indicator	Description	Remarks
Families, communities and young people value alternative options to child marriage	Percentage of parents of unmarried adolescent girls who say they support their daughters completing their education or returning to school.	A survey of individuals in the target population.	Different levels of disaggregation could include (as may be applicable): • age/age-group, • sex, sex of the parent, • marital status, • stakeholder, • region, • education, • wealth status, • religion.
	Percentage of parents and parents-in-law of married girls who say they support their daughters (or daughters-in-law) going back to school or participating in out-of-school life skills programmes or income-generating activities (IGAs).	A survey of individuals in the target population. Could include separate questions about returning to school, participating in out-of-school programmes, and participating in IGAs.	
	Percentage of adolescent girls who say they want to complete their education.	A survey of individuals in the target population.	
	Percentage of parents who support girls' opportunity to work outside the home. Notes: This indicator could be measured with the "equity for girls" sub-scale of the Gender Norm Attitudes Scale (GNAS). The survey questions that comprise this sub-scale are as follows: • Daughters should be able to work outside the home after they have children if they want to. • Daughters should have just the same chance to work outside the home as sons. • Daughters should be told that an important reason not to have too many children is so they can work outside the home and earn money. I would like my daughter to be able to work outside the home so she can support herself if necessary.	A survey of individuals in the target population.	

MOBILISE FAMILIES AND COMMUNITIES

	Indicator	Description	Remarks
Families and communities prefer not to marry girls as children	Percentage of individuals in the target population who support ending child marriage.	A survey of individuals in the target population.	Disaggregate by age, sex, marital status, parental status.
	Percentage of parents who say that they will not marry their sons to a girl younger than 18.	A survey of individuals in the target population.	Disaggregate by sex of parent.
	Percentage of parents who say that they will not marry their daughters before the age of 18.	A survey of individuals in the target population.	Disaggregate by sex of parent.
	Percentage of individuals who think that child marriage is uncommon (or decreasing) in their community Alternative: "Approximately how many girls are married before age 18 in your community?" (none, very few, some, many, all). Alternative: "In your opinion, has the practice of early/child marriage increased or decreased or remained the same in your community during the last five years?"	A survey of individuals in the target population. This is an indicator of a social norm, measuring perceptions of what most others in the community do (the descriptive norm). Depending on a member organization's target population, the survey could assess the perceptions of adolescents, parents, community leaders, or others at the local, regional or national level.	Different levels of disaggregation could include (as may be applicable): • age/age-group, • sex, sex of the parent, • marital status, • stakeholder, • region, • education, • wealth status, • religion.
	Percentage of individuals who think that people in their community disapprove of child marriage. Alternative: "People in my community approve of child marriage."	Survey of individuals in the target population. The indicator could be tailored to the specific target population (e.g., adolescents, parents, parents-in-law, community leaders) and the relevant reference group for that population (e.g., adolescents, parents, the community in general, and so forth). For example, variations of this indicator could be the percentage of parents who think that other parents wish to delay marriage of their daughters, or the percentage of adolescents who think that their families disapprove of child marriage.	Disaggregated by age, sex, and marital status of respondent.

KEY RESEARCH QUESTIONS ON SOCIAL NORMS CHANGE

1. What are the facilitators and barriers to social norms change?
2. What interventions are most effective in changing gender norms in different contexts?
3. How do gender norms change manifest in different contexts and population sub-groups?
4. How do changes in gender norms contribute to ending VAWG/SGBV/HPs in different contexts?
5. How do social norms influence VAWG/SGBV, HP, SRH&RR behaviors and outcomes?
6. What interventions (strategies, activities) are effective in shifting norms related to VAWG/SGBV/HPs in different contexts?

Additional resources

1. https://data.unicef.org/wp-content/uploads/2017/12/MICS6-Marriage-module_Women.pdf
2. https://data.unicef.org/wp-content/uploads/2017/12/MICS6-Marriage-module_Men.pdf
3. https://dhsprogram.com/pubs/pdf/DHSQ8/DHS8_Womans_QRE_EN_19Jun2020_DHSQ8.pdf
4. https://dhsprogram.com/pubs/pdf/DHSQ8/DHS8_Mans_QRE_EN_11Jun2020_DHSQ8.pdf
5. <https://www.unicef.org/media/104816/file/Gender-norms-technical-note-2020.pdf>
6. https://www.girlsnotbrides.org/documents/1066/GNB_Full-List-of-Indicators_August-2015_Final.pdf

6.6. Positive masculinities and male engagement to prevent VAWG and to empower women and girls

6.6.1. Masculinity

Masculinity generally refers to roles, behaviors, beliefs, and attitudes that are associated with being male⁶⁷. Such attributes are associated with both negative and positive masculine norms that are dynamic over space and time. For instance, men often dominate positions of power at household, social, economic, and political levels, leading to gender inequalities linked to VAWG. In promoting positive gender behaviors, beliefs, and attitudes associated with being male—positive masculinity—communities are likely to eliminate some forms of VAWG.

Different aspects of positive masculinity can be measured using the social norms indicators described earlier (see **Section 6.5**). In addition, the International Men and Gender Equality Survey (IMAGES)⁶⁸ provides a comprehensive tool on men's and women's attitudes and practices on a wide variety of topics related to gender equality. The IMAGES study lists key research questions that need to be considered when collecting data on masculinities and VAWG.

KER RESEARCH QUESTIONS ON POSITIVE MASCULINITIES

1. What are the manifestations of positive masculinities in different contexts?
 - a. Are men internalizing the messages and policies calling for greater equality for girls and women in education, income, and work, political participation, and health?
 - b. Are men's own lives improving as they embrace gender equality and take on more equitable, flexible, and non-violent versions of masculinity?
2. What are the facilitators and barriers to harnessing positive masculinities to end VAWG?
3. What interventions are most effective in harnessing positive masculinities to end VAWG in different contexts?

6.6.2. Male engagement

Male engagement refers to programmatic approach that involves boys and men more holistically, as clients and beneficiaries, as partners and as agents of change, in actively promoting gender equality, women's empowerment, and the transformation of inequitable definitions of masculinity. Feelings of frustration, loss of self-esteem, depression, and disaffection can all manifest in negative coping behaviors, including aggression and partner conflict whether physical, sexual, psychological, or emotional violence as men attempt to reassert themselves and their authority across different social, economic and political spheres.

Therefore, engaging men and boys is critical for promoting gender equality and improving health outcomes. Some of the key reasons that highlight why male engagement is important in eliminating VAWG include:

⁶⁷ El Feki, S., Heilman, B. and Barker, G., Eds., Understanding Masculinities: Results from the International Men and Gender Equality Survey (IMAGES) – Middle East and North Africa.

⁶⁸ Ibid.

- Men are considered the main perpetrators of VAWG;
- VAWG often emanate from gender inequalities that proscribe a higher status for men relative to women as well as male dominance over females and therefore, engaging men in narrowing the gender inequality gap is imperative;
- Ending VAWG is beneficial to both men and women, directly and indirectly. By challenging unequal gender norms, both men and women are able to experience equal social, economic, and political opportunities as well as have shared roles and responsibilities including at the household levels;
- In most patriarchal societies, men are often the gatekeepers, holding positions of power at the community level. Thus addressing issues around VAWG requires extensive engagement with the gatekeepers in both formal and informal settings;
- As husbands, partners, family members, witnesses, service providers, community leaders, and in some cases, as SGBV survivors, men, and boys are critical partners in facilitating pathways for positive social norms change; and
- As service providers or leaders, some men are engaged in service provision including facilitating access to care and social justice for women who are survivors of VAWG.

Engaging men and boys as clients and beneficiaries, as partners, and as agents of change, the approaches often used in sexual and reproductive health and reproductive rights programming. These approaches are adaptable to male engagement in eliminating VAWG as the programmatic focus is to address gender roles, norms, and power dynamics; to generate more equitable relationships; and to support women/girls' agency.

Table 14 Approaches to male engagement in eliminating VAWG

Men as clients and beneficiaries	Men as s partners	Men as agents of change
• The approach encourages men to access and use different services. • Recognizes boys and men as complex individuals with critical needs to be addressed or met. • Example: Like women and girls, boys and men also get affected by violence in their families or society that face conflicts. • A report by the WHO has also highlighted the increasing cases of homicide among young men than young women.	• Recognizes boys and men as supportive partners in GBV prevention, they care about what happens to their partners, families, and community. • Focus on the positive influence that men and boys can have on women as victims of SGBV as they play major roles in decision-making and resource allocation. • These programmes take into account gender inequalities that negatively impact women.	• To promote gender equality as a way of prevention of violence against women and girls • As agents of change in ways that intentionally challenge unequal gender and power dynamics. Actively involved in promoting gender equity, women's empowerment, and the transformation of inequitable definitions of masculinity. • The programmes are focused on addressing gender norms that put women and men at risk. • Engage men and boys to assess gender norms that negatively affect their lives and those of their partners and families and then develop healthier alternatives. • The approach is based on the assumption that more progressive norms around masculinity and gender will translate into improved GBV prevention. • Programmes are most intensive and difficult to execute as it involves asking boys and men to make progressive changes in unsupportive environment and also to engage their communities to promote gender equity, including in relation to GBV prevention.

KEY RESEARCH QUESTIONS ON MALE ENGAGEMENT

1. What are the barriers and facilitators to boys' and men's engagement in the programmes to end/prevent VAWG?
2. How can men and boys be effectively involved in the prevention of VAWG?
3. What are some of the intervention approaches that are most effective in enhancing the involvement of men and boys in programmes to end/prevent VAWG?
4. What is the impact of interventions that involve men and boys on ending VAWG?
5. What do you consider to be the responsibility of men in preventing and responding to VAWG?

CORE INDICATORS ON MALE ENGAGEMENT

Working with men and boys

- Number of programmes implemented for men and boys that include examining gender and culture norms related to GBV.
- Proportion of men and boys who agree that women should have the same rights as men.
- Proportion of men and boys with gender-related norms that put women and girls at risk for physical and sexual violence.
- Proportion of men and boys who believe that men can prevent physical and sexual violence against women and girls.

Community mobilization and individual behavior

- Proportion of people who have been exposed to VAWG prevention messages.
- Proportion of individuals who know any of the legal sanctions for VAWG and know legal rights of women.
- People who say that wife beating is an acceptable way for husbands to discipline their wives.
- Proportion of people who agree that a woman has a right to refuse sex.
- Proportion of people who agree that rape can take place between a man and woman who are married.

Additional resources

1. El Feki, S., Heilman, B. and Barker, G., Eds. (2017) Understanding Masculinities: Results from the International Men and Gender Equality Survey (IMAGES) – Middle East and North Africa. Cairo and Washington, D.C.: UN Women and Promundo-US.
2. Interventions addressing men, masculinities and gender equality in sexual and reproductive health and reproductive rights: an evidence and gap map and systematic review of reviews <https://gh.bmj.com/content/4/5/e001634>
3. Transforming gender norms, roles, and power dynamics for better health https://www.healthpolicyproject.com/pubs/381_GPMIndiaSummaryReport.pdf
4. Nanda, Geeta. 2011. Compendium of Gender Scales. Washington, DC: FHI 360/C-Change. <https://c-changeprogram.org/content/gender-scales-compendium/pdfs/4.%20GEM%20Scale,%20Gender%20Scales%20Compendium.pdf>
5. Global Early Adolescent Study: Perceptions: Perceptions of Gender Norms and Gender Attitudes <https://www.geastudy.org/download-the-measures>
6. Mahalik, J. R., Locke, B. D., Ludlow, L. H., Diemer, M. A., Scott, R. P. J., Gottfried, M., & Freitas, G. (2003). Development of the Conformity to Masculine Norms Inventory. *Psychology of Men & Masculinity*, 4, 3–25.
7. Levant RF, McDermott R, Parent MC, Alshabani N, Mahalik JR, Hammer JH. Development and evaluation of a new short form of the Conformity to Masculine Norms Inventory (CMNI-30). *J Couns Psychol*. 2020 Oct;67(5):622-636. doi: 10.1037/cou0000414. Epub 2020 Feb 3. PMID: 32011153. <https://pubmed.ncbi.nlm.nih.gov/32011153/#>

8. <https://www.alignplatform.org/4-what-and-how-male-engagement-across-key-areas>
9. https://www.icrw.org/wp-content/uploads/2018/04/ICRW_Gender-Equity-and-Male-Engagement_Full-report.pdf (ICRWs' 2018 report on Gender Equity and Male Engagement)
10. White Ribbon Campaign. (2014). Men's Engagement in Gender-Based Violence Prevention: A Critical Review of Evaluation Approaches. White Ribbon Campaign, Toronto, Ontario. March 2014
11. <https://www.measureevaluation.org/resources/newsroom/news/dataverse-network-houses-research-online.html>

7. Additional resources on data collection tools, approaches and indicators on VAWG

In this section, we will highlight some of the available resources on that are available, including collection tools and capacity building programmes.

Tools/Module	Organization	About the tool	Links
Violence Against Women module questionnaire	Economic and Social Commission for Western Asia	Wife beating justification, economic control and violence, psychological abuse, physical violence, sexual violence, injuries, victimization and perpetration, violence committed by non-partners, robbery, harassment, coerced first sex, and help-seeking.	Violence Against Women Survey Implementation Toolkit: Complete questionnaire for a stand-alone survey (unescwa.org) https://www.unescwa.org/sites/default/files/pubs/pdf/violence-against-women-survey-implementation-toolkit-english_0.pdf
DHS-domestic violence module	USAID- DHS program	Wife beating justification, physical, sexual, and emotional violence by partners, number of incidents, injuries, help-seeking behaviors and reasons for not seeking help, and non-partner violence.	NO (dhsprogram.com) https://dhsprogram.com/pubs/pdf/DHSQMP/domestic_violence_module.pdf.pdf
National Crimes Victimization Survey	US Department of Justice- Bureau of Justice Statistics	Sexual and physical violence, number of times, and reporting.	National Crime Victimization Survey (NCVS) Bureau of Justice Statistics (ojp.gov) https://bjs.ojp.gov/data-collection/ncvs#surveys-0

Tools/Module	Organization	About the tool	Links
Multiple Indicator Cluster Surveys	UNICEF	Wife beating justification, violence victimization for both men and women (defined as physically attacked, robbery, and taken or tried taking something from you, by using force or threatening to use force), discrimination based on gender, age, religion, disability, and ethnicity.	MICS Questionnaire for Individual Women (microsoft.com) https://mran.microsoft.com/web/packages/PakPMICS2018mn/vignettes/MICS6QuestionnaireforIndividualMen.pdf
Violence against women- Questionnaire for Member States	UN Women	The questionnaire is the primary tool for gathering information from Member States on measures undertaken to address violence against women.	VAW - Questionnaire to Member States (un.org) https://www.un.org/womenwatch/daw/vaw/v-q-member.htm#quest
Questionnaire - OSCE-led Survey on Violence Against Women	Organization for Security and Cooperation in Europe	The tool captures indicators like sexual harassment, conflict experiences, experiences of physician and sexual violence from partners and non-partners, repeated incidents, stalking, experiences in childhood, violence in conflict, and involvement of firearms. OSCE added to the survey several questions on norms, attitudes, and behavior related to violence and reporting experiences of abuse, in particular, to ensure comparability of its data with the EU data on gender attitudes and norms. It also captures perpetrators, the severity of incidents, impacts on physical and mental well-being, reporting, and satisfaction with responses.	FRA VAW survey draft questionnaire (osce.org) https://www.osce.org/files/f/documents/9/1/429350.pdf
Survey Module on Violence against Women	United Nations Economic Commission for Europe	It builds on WHO multi-country study on women's health and life experiences, WHO 2005. It captures economic abuse, emotional/ psychological abuse, physical and sexual violence, the impact of violence on women, the number of incidents and reporting, perpetrators, and injuries because of physical violence. It captures partner and non-partner violence.	VAW module_QxQ description _Nov 2010_ (unece.org) https://unece.org/fileadmin/DAM/stats/documents/ece/ces/ge.30/2010/mtg5/5.add.1.e.pdf

Tools/Module	Organization	About the tool	Links
The National Intimate Partner and Sexual Violence Survey	Centers for Disease Control and Prevention	The National Intimate Partner and Sexual Violence Survey (NISVS) collects comprehensive national- and state-level data on intimate partner violence, sexual violence, psychological aggression -expressive aggression and coercive control, control of reproductive and sexual health, control of reproductive and sexual health, and stalking victimization in the United States.	The National Intimate Partner and Sexual Violence Survey: 2010-2012 State Report (cdc.gov) https://www.cdc.gov/violenceprevention/pdf/NISVS-StateReportBook.pdf
Performance Monitoring for Action	Johns Hopkins Bloomberg School of Public Health and Bill & Melinda Gates Institute for Population and Reproductive Health	Captures reproductive coercion and control of reproductive and sexual health by an intimate partner, coercion at first sex, and partner and non-partner physical, emotional, and sexual violence. Five items are used to examine physical, sexual, and emotional violence. It also captures health-seeking behaviors and the number of incidents. Recent tools explore the impact of COVID-19 on exposure to these forms of violence.	Survey Methodology PMA Data https://www.pmadata.org/data/survey-methodology
UNESCO's Global Survey on Online Violence against Women Journalists	UNESCO	Captures 'intimidation, threats or abuse' online, types and sources of online violence, impacts of online violence against women, and responses to online violence against women journalists.	Online violence against women journalists: a global snapshot of incidence and impacts - UNESCO Digital Library https://unesdoc.unesco.org/ark:/48223/pf0000375136
WHO Multi-country Study on Women's Health and Domestic Violence against Women	WHO	Physical, sexual, and emotional violence by partners and non-partners, sexual abuse in childhood and forced first sexual experience, women's coping strategies and responses to physical violence by intimate partners, and impacts of violence on women's physical, reproductive, and mental health. It was conducted in ten countries, including Bangladesh, Brazil, Ethiopia, Japan, Peru, Namibia, Samoa, Serbia and Montenegro, Thailand, and the United Republic of Tanzania.	Interviewer Training in the WHO Multi-Country Study on Women's Health and Domestic Violence - Henrica A. F. M. Jansen, Charlotte Watts, Mary Ellsberg, Lori Heise, Claudia García-Moreno, 2004 (sagepub.com) https://journals.sagepub.com/doi/10.1177/1077801204265554

Tools/Module	Organization	About the tool	Links
Global School-based Health Survey (GSHS)	WHO	GSHS is a school-based survey collaborative surveillance project designed to help countries measure and assess the behavioral risk factors and protection related to the leading causes of morbidity and mortality among children and adults worldwide. The violence and unintentional injury module focus on sexual violence, dating violence, weapon carrying, physical fighting, violence (at home and in school), injuries, bullying, road safety, drinking, and driving, and knowledge, attitudes, and skills toward unintentional injuries.	GSHS survey questionnaire and methodology https://www.who.int/teams/noncommunicable-diseases/surveillance/systems-tools/global-school-based-student-health-survey
The Global Early Adolescent Survey (module on Bullying and Violence)	Johns Hopkins Bloomberg School of Public Health; The World Health Organization	The Global Early Adolescent Study (GEAS) is a worldwide investigation into how gender norms evolve and inform a spectrum of health outcomes in adolescence. The study seeks to better understand how gender socialization in early adolescence occurs around the world, and how it shapes health and wellness for individuals and their communities. The bullying and violence module focuses on exposure, victimization, and perpetration of violence in the last 6 months.	GEAS survey tools www.geastudy.org
Violence Against Children and Youth Surveys	Centers for Disease Control and Prevention	Violence Against Children and Youth Surveys measure physical, emotional, and sexual violence against children and youth up to age 24.	https://www.cdc.gov/violenceprevention/childabuseandneglect/vacs/index.html
Caring for Child Survivors of Sexual Abuse: Guidelines for health and psychosocial service providers in humanitarian settings	UNICEF; International Rescue Committee	The guidelines provide a practical approach to helping child survivors, and their families, recover and heal from the impacts of sexual abuse.	https://www.unicef.org/documents/caring-child-survivors-sexual-abuse

Tools/Module	Organization	About the tool	Links
Interagency Gender-Based Violence Case Management Guidelines	Gender-based Violence Information Management System (GBVIMS)	This resource aims to set standards for quality, compassionate care for GBV survivors in humanitarian settings, with a particular focus on the provision of case management services. It builds upon and should be used in conjunction with other GBV response resources.	https://reliefweb.int/attachments/469bf8e9-b9d6-3328-b2d1-2d8799c0bc93/interagency-gbv-case-management-guidelines_final_2017_low-res.pdf https://reliefweb.int/report/world/interagency-gender-based-violence-case-management-guidelines
Improving the health sector response to gender-based violence: A resource manual for health care professionals in developing countries	International Planned Parenthood Federation; Pan American Health Organization	This manual provides tools and guidelines that healthcare managers can use to improve the healthcare responses to gender-based violence in developing countries. It includes practical tools to determine provider attitudes to gender-based violence, legal definitions, the responsibilities of health care providers, and the quality of care.	Improving the Health Sector Response to Gender-Based Violence: A Resource Manual for Health Care Professionals in Developing Countries https://www3.paho.org/hq/index.php?option=com_content&view=article&id=4517:2010-improving-health-sector-response-gender-violence-manual&Itemid=0&lang=en#gsc.tab=0

8. Capacity building programmes/resources focused on VAWG/SGBV/HP and SRH&RR

The capacity to collect and utilize data on VAWG/SGBV, HP, and SRH&RR is important. During desk reviews and capacity needs assessments conducted by the APHRC consortium in the context of the SIARP, there emerged key gaps in the capacity of organizations to collect data on VAWG/SGBV, HP, and SRH&RR. While the SIARP, together with the APHRC consortium is developing a curriculum focused on building the capacity of CSOs to collect and utilize data on VAWG/SGBV, HP, and SRH&RR, we have highlighted other programmes that are publicly available and that could be beneficial in building the capacity of organizations and individuals to collect, analyses and utilize data on VAWG/SGBV, HP, and SRH&RR.

Table 15 Capacity-building programmes on VAWG

#	Programme	Institution	Objectives	Target audience	Type of course	Website link
1	Understanding violence against women and girls	UN Women	To provide an understanding of VAWG, its extent, drivers, and impact. To provide evidence-based guidance to better understand the key pillars for preventing and responding to VAWG.	Primary targets are the policy-makers and advocates, though general audiences would also benefit from the course.	Online course with two modules (each takes about 50 minutes) • Understanding violence against women and girls • Addressing violence against women	https://portal.trainingcentre.unwomen.org/product/understanding-violence-against-women-and-girls/
2	Measuring the prevalence of violence against women in Asia-Pacific (kNOwVAWdata)	University of Melbourne, UNFPA	To build skills in measuring the prevalence of VAWG.	Professionals involved in the measurement of VAWG.	A 4-week course with 4 subject areas. Online courses (since 2020) previously offered face-to-face.	https://knowvawdata.com/course/

#	Programme	Institution	Objectives	Target audience	Type of course	Website link
3	Gender Statistics Course	UNECA	To support the establishment of a strong foundation of knowledgeable practitioners for the development of gender statistics at the country level. To promote continued capacity building and learning by producers and users of these statistics.	Users and producers of statistics.	Online course	http://uneca.unssc.org/
4	Researching Gender-Based Violence: Methods and Meaning	London School of Hygiene and Tropical Medicine	To strengthen participants' knowledge and skills to conduct or commission technically rigorous, ethical, and policy- and service-relevant research on various forms of VAW.	Individuals who will conduct or commission research on GBV.	Online course	https://www.lshtm.ac.uk/study/courses/short-courses/gender-violence
5	Gender analytics for innovation	Institute for Gender and the Economy (GATE), University of Toronto's Rotman School of Management	Build the foundations for conducting Gender Analytics.	Data analysts.	Online course	https://www.classcentral.com/course/gender-analytics-innovation-22462
6	Gender Based Violence Information Management System (GBVIMS)	International Rescue Committee; International Medical Corps; UNHCR; UNFPA and UNICEF	Harmonize data collection on GBV in humanitarian settings. Provide a simple system for GBV project managers to collect, store and analyze their data, and to enable the safe and ethical sharing of reported GBV incident data.	Professionals involved in the data collection, data analysis and data sharing. Service providers in charge of receiving reports on GBV cases.	Online resource	https://www.gbvims.com/

#	Programme	Institution	Objectives	Target audience	Type of course	Website link
7	Gender-Based Violence Research, Monitoring, and Evaluation with Refugee and Conflict-Affected Populations	Global Women's Institute, George Washington University	Support researchers and members of the humanitarian community in conducting ethical and technically sound research, monitoring and/or evaluation (RME) on GBV within refugee and conflict-affected populations.	International humanitarian community. Academic community.	Published manual and toolkit	https://global.womensinstitute.gwu.edu/sites/g/files/zaxdzs1356/f/downloads/Manual%20and%20Toolkit%20-%20Website.pdf
8	Gender-based violence training resource pack: A standardized training tool for duty bearers, stakeholders and rights holders	UN-Kenya office, UN Women, UNFPA	Guide duty bearers and stakeholders and rights holders on the prevention of and response to GBV in Kenya.	State actors (duty bearers), partners, and rights holders.	Published toolkit	https://www.genderinkenya.org/wp-content/uploads/2019/11/GBV-Resource-Pack-13-Sept-w-3mm-bleed.pdf
9	Training curriculum onto violence against women: effective police responses	United Nations Office on Drugs and Crime	To help develop within local and national police the knowledge and skills required to respond in an effective and appropriate manner to violence against women—specifically violence within intimate relationships.	Law enforcement personnel	Published curriculum	https://www.unodc.org/pdf/criminal_justice/Training_Curriculum_on_Effective_Police_Responses_to_Violence_against_Women.pdf
10	Violence against women curriculum for healthcare students (TAKAMOL project)	Women's Centre for Legal Aid and Counselling and Juzoor for Health & Social Development	Empower and sensitize healthcare students in the medical, nursing and midwifery schools of Palestinian colleges and provide them with knowledge and skills to enable them to competently provide appropriate services to women victims of violence presenting at health care facilities.	Healthcare faculty students including medical, nursing, midwifery and community health program students.	Published curriculum	http://www.wclac.org/userfiles/Violence%20against%20Women%20Curriculum.pdf

#	Programme	Institution	Objectives	Target audience	Type of course	Website link
11	Using gender statistics: A toolkit for training data users	United Nations Economic Commission for Europe (UNECE)	Support national statistical offices in their efforts to increase the understanding and use of gender statistics by government officials and other users.	National statistical offices.	Online	https://unece.org/using-gender-statistics-toolkit-training-data-users
12	Toolkit for Monitoring and Evaluating Gender-Based Violence Interventions along the Relief to Development Continuum	USAID	Provide users with tools for the Monitoring and evaluation (M&E) of GBV-specific programming highlighting the differences and nuances required for the M&E of GBV interventions.	USAID /Professionals engaged in GBV programming. GBV coordinators and technical advisers. M&E practitioners engaged in M&E of GBV interventions.	Published/ Online resource	https://www.usaid.gov/sites/default/files/documents/2151/Toolkit%20Master%20%28FINAL%20MAY%209%29.pdf
13	Guidance to inform ethical data collection and evidence generation-on research on VAC during the COVID-19 Pandemic	UNICEF	Inform decisions related to VAC data collection and evidence generation during and after the COVID-19 crisis, and complements other resources focusing on violence against women.	Professionals involved in data collection of VAC during and after COVID-19 pandemic.	Published/ Online resource	https://data.unicef.org/resources/research-on-violence-against-children-during-the-covid-19-pandemic-guidance/
14	Reporting and Interpreting Data on Sexual Violence from Conflict-Affected Countries “do’s and don’ts”	UN Action against Sexual Violence in Conflict	Assist staff from UN Country Teams and Integrated Missions to improve data collection, analysis and reporting on sexual violence in conflict.	UN Staff and professionals involved in data collection, analysis and reporting on sexual violence in conflict areas.	Published/ Online resource	http://www.who.int/hac/global_health_cluster/guide/62_un_action_fact_sheet_sexual_violence_data.pdf

#	Programme	Institution	Objectives	Target audience	Type of course	Website link
15	WHO Ethical and safety recommendations for researching, documenting and monitoring sexual violence in emergencies	World Health Organization	Ensure that the necessary safety and ethical safeguards are in place prior to the commencement of any information gathering exercise concerning sexual violence in emergencies.	Researchers, program planners, funders, ethics review committees, ethicists, managers and staff of humanitarian and human rights organizations, all staff involved in sexual violence inquiries.	Published/ Online resource	https://www.who.int/gender/documents/OMS_Ethics&Safety10Aug07.pdf
16	Ethical and safety recommendations for intervention research on violence against women	World Health Organization and RTI International	These recommendations have been developed to help answer questions specific to conducting research on health-based interventions to prevent and respond to VAW.	This included researchers, program implementers, evaluators, activists, advocates and care providers engaged in research on health-based interventions to address VAW.	Published/ Online resource	https://apps.who.int/iris/bitstream/handle/10665/251759/9789241510189-eng.pdf
17	Gender-Transformative Approaches to End Child Marriage	UNICEF and UNFPA	Understand gender-transformative programming in the context of ending child marriage. Develop and apply practical gender-transformative strategies to end child marriage.	Staff, consultants, and partners working on the UNFPA-UNICEF Global Programme to End Child Marriage.	Online course	https://agora.unicef.org/course/info.php?id=30107

#	Programme	Institution	Objectives	Target audience	Type of course	Website link
18	Foundations of Gender-Transformative Approaches	UNICEF	Explain gender-transformative approaches and why they matter. Explain the gender continuum. Identify where a program sits within the gender continuum. Articulate the distinction between gender-responsive and gender-transformative programming. Apply an understanding of multi-sectoral interventions and the socio-ecological model for shifts in unequal power relations between genders.	UN personnel, government entities and non-governmental organizations.	Online course (45 minutes)	https://agora.unicef.org/course/info.php?id=29963
19	What is gender data and how to use it for SDG monitoring?	UN Women Statistical Institute for Asia and the Pacific (SIAP)	This is an introductory module on gender statistics.	Statisticians and other experts. Policy makers and decision makers. CSOs. Media personnel.	Published curriculum	https://data.unwomen.org/resources/gender-statistics-training-curriculum
20	The Global Health Observatory	World Health Organization	This is an online platform that provides data on various health indicators.	Users and producers of data	Published/ Online resource	https://www.who.int/data/gho/data/indicators
21	The Global Health Observatory- Statistical codes to calculate disaggregated estimates using household surveys	World Health Organization	Statistical analysis of a) estimates for health indicators disaggregated by inequality dimensions (e.g. economic status, education and urban-rural areas) and b) population subgroup sizes for each inequality dimension.	Users and producers of data	Published/ Online resource	https://www.who.int/data/gho/health-equity/statistical_codes

