VIOLENCE AGAINST WOMEN AND GIRLS

A Compendium of Monitoring and Evaluation Indicators

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A Compendium of Monitoring and Evaluation Indicators

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Table of Contents

Preface

This compendium was developed with the help of many individuals. At the request of the USAID East Africa Regional Mission with the Inter-agency Gender Working Group (USAID), MEASURE Evaluation developed this compendium in collaboration with a technical advisory group (TAG) of experts. The goal was to develop a set of monitoring and evaluation indicators for program managers, organizations, and policy makers who are working to address violence against women and girls (VAW/G) at the individual, community, district/provincial and national levels in developing countries. An extensive literature review was undertaken to document any indicators in the field that were already being used. A steering committee of experts met over a period of several months to select members of the TAG, develop a framework for the compendium and generate an initial list of indicators for wider input from the TAG. The members of the steering committee were:

- Vathani Amirthanayagam, East Africa Regional Office, USAID
- Michal Avni, Inter-Agency Gender Working Group, USAID
- Mary Ellsberg, PATH;
- Ann McCauley, East Africa Regional Office, USAID;
- Suzanne Maman, School of Public Health, University of North Carolina at Chapel Hill
- Claudia Garcia-Moreno, Department of Gender, Women and Health, World Health Organization; Saba Moussavi, UNAIDS
- Judith Polsky, UNAIDS
- Diana Prieto, Inter-Agency Gender Working Group, USAID;
- Beth Vann, Independent Consultant on Humanitarian Emergencies
- Jeanne Ward, Global Consultant on Gender-based Violence

The TAG meeting was held in Washington, DC, September 5-7, 2007. In a series of work sessions, TAG members identified the indicators to be included in the compendium as well as the overall structure of the compendium. Following the TAG meeting, the draft structure and chapters were sent out to TAG members for review. The following experts comprised the TAG:

- Joan Allison, UNHCR
- Vathani Amirthanayagam, East Africa Regional Office, USAID
- Ian Askew, Population Council, Nairobi
- Michal Avni, Inter-Agency Gender Working Group, USAID;
- Shelah S. Bloom, MEASURE Evaluation
- Sian Curtis, MEASURE Evaluation
- Anupa Deshpande, MEASURE Evaluation
- Mary Ellsberg, PATH
- Nomi Fuchs-Montgomery, Office of the US Global AIDS Co-ordinator
- Mary Goodwin, Centers for Disease Control
- Alessandra Guedes, Independent Consultant on Gender-based violence
- Michelle Hynes, Independent Consultant
- Liz Kelly, London Metropolitan University
- Erin Kenny, UNFPA
- Sunita Kishor, Macro International (MEASURE DHS)
- Heidi Lehmann, International Rescue Committee
- Anju Malhotra, International Center for the Research on Women
- Jessie Mbwambo, Muhimbili University College of Health Sciences
- Ann McCauley, East Africa Regional Office, USAID
- Claudia Garcia-Moreno, Department of Gender, Women and Health, World Health Organization
- Diana Prieto, Inter-Agency Gender Working Group, USAID
- Ilene Speizer, MEASURE Evaluation
- Beth Vann, Independent Consultant on Humanitarian Emergencies

Among the other individuals who contributed to this work, Chiho Suzuki made a significant contribution to its development leading up to the TAG meeting. Leah Gordon and Joni Bowling worked to coordinate TAG members and ensured that the TAG meeting ran smoothly. Catherine Cozzarelli reviewed the TIP section. Special thanks go to Miriam Schreier, whose work as an editor for the draft and final versions of the compendium was invaluable to ensure its quality and consistency.

Acronyms

AIDS	Acquired Immunodeficiency Syndrome
BCC	Behavior Change Communication
FGC/M	Female Genital Cutting/Mutilation
HIV	Human Immunodeficiency Virus
GBV	Gender-based violence
GEM Scale	Gender Equitable Men Scale
IEC	Information and Education Campaign
IGWG	Interagency Gender Working Group, USAID
IPV	Intimate Partner Violence
M&E	Monitoring and Evaluation
MDGs	Millennium Development Goals
OGAC	Office of the United States Global AIDS Coordinator
PEP	Post-exposure prophylaxis
PEPFAR	The United States President's Emergency Fund for AIDS Relief
SEA	Sexual Exploitation and Abuse
STIS	Sexually Transmitted Infections
TAG	Technical Advisory Group
TIP	Trafficking in Persons
UN	United Nations General Secretariat
UNAIDS	The United Nations Joint Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
USAID	United States Agency for International Development
WHO	World Health Organization
VAW/G	Violence against women and girls

Chapter 1: Introduction

The tireless work and effort of grassroots organizers, researchers, policy-makers and advocates over the past two decades have put violence against women and girls (VAW/G) on the map as a critical issue to be addressed in the international arena. Donor organizations such as USAID, WHO, UNFPA, UNHCR, UNAIDS and international initiatives such as PEPFAR have dedicated funds and provide technical assistance for research and programmatic efforts aimed at preventing and responding to VAW/G. This has resulted in many VAW/G programmatic initiatives taking place around the world. However, the dearth of rigorous evaluations has resulted in a lack of data to support recommendations for best practices in the field. Most of these programs also lack quality systems designed to monitor and evaluate their progress in attaining their stated objectives.

One reason for the lack of information is the difficulty involved in obtaining reliable data to measure the outcomes of interest associated with VAW/G. There is also a lack of consensus regarding what constitutes standard indicators to monitor and evaluate the progress and impact of programs aimed at prevention and response. The need to address this gap has been asserted by USAID,[1] and the UN.[2] In the past year, two UN initiatives were undertaken to provide a basic set of indicators at the country level, including the State response to VAW/G.[3]

1 IGWG of USAID. 2006. *Addressing gender-based violence through USAID's health programs: A guide for health sector program officers*. Washington, DC.

2 UN General Assembly. 2006. In-depth study on all forms of violence against women. Sixty-first session. Item 60 of the preliminary list, A/61/122/Add.1.

3 UN Division for the Advancement of Women (UNDAW), UN Economic Commission for Europe (UNECE) and UN Statistical Division. 2008. Indicators to measure violence against women. Report of the Expert Group Meeting, 8 to 10 October 2007, Geneva, Switzerland; UN Human Rights Council. 2008. Report of the Special Rapporteur on violence against women, its causes and consequences by Yakin Ertürk. Indicators on violence against women and State response. Advance edited version (28 January 2008).

At the request of the USAID East Africa Regional Mission in collaboration with the IGWG, MEASURE Evaluation developed this compendium of indicators which focuses on VAW/G program monitoring and evaluation. Leading experts from around the world who work in the various fields of VAW/G represented in this guide were consulted during all stages of the development process. The group of experts (listed in the preface) worked collaboratively with MEASURE Evaluation to identify relevant indicators, come to consensus on definitions, and resolve issues pertaining to the scope and focus of the compendium.

An extensive literature review was conducted as part of the development process. Citations which appear as footnotes were used only for direct quotes, such as in questions taken verbatim from published surveys to be used for measuring some indicators, and for references to specific guides and manuals. Otherwise, all literature that was cited to support information presented in both the introductory and indicator chapters appear in a "References Cited" list at the end of each chapter in which they were used. The "References Consulted" list that appears at the end of the compendium includes those sources which were helpful in developing the compendium, but which were not used directly to support information presented.

This guide was developed for managers, organizations, and policy makers working in the field of VAW/G program implementation and evaluation in developing countries, and for people who provide technical assistance to those individuals and organizations. The indicators can also be used by programs that may not specifically focus on VAW/G, but include reducing levels of VAW/G as part of their aims. The indicators have been designed to be used by people who need information that can be assessed with quantitative methods on program performance at the community, regional and national levels. Indicators were included only if they conformed to the criteria describing good indicators in Chapter 2. While almost all the indicators have been used in the field, they have not necessarily been tested in multiple settings.

Some areas of VAW/G monitoring and evaluation should be captured through qualitative, rather than quantitative assessment. For example, the coordination of services for violence prevention activi-

ties by multisectorial networks at the community level is critical for influencing a real change in a community. A strong multisectorial network will build support and broaden awareness and concern within a range of community sectors. A full description of the effectiveness of multisectorial networks in the field of intimate partner violence can be found in Phase III of the Raising Voices guide. [4] However, assessing whether such a network exists and how well it functions is beyond the scope of a quantitative indicator. A good assessment would include interviews with organizations, community leaders and key informants. Ellsberg and Heise[5] developed a comprehensive guide on conducting research on violence against women, which includes a discussion on when and how to conduct qualitative research in this area.

Each indicator includes a description of what it measures, the tools needed to gather the data, and the calculations involved in producing the measure. While individual indicators are presented with the information needed to allow them to be used independently, in most cases, groups of indicators should be used together in order to provide enough overall information to program managers or policy makers. Any considerations regarding measurement or other issues have also been noted. The proposed UN indicators have been incorporated when they fall within the scope of this aim.

The indicators cover the following areas of VAW/G:

1. The magnitude and characteristics of five types of VAW/G — skewed sex ratios, intimate partner violence, violence from someone other than an intimate partner, female genital cutting/mutilation, and child marriage

4 Michau, Lori and Dipak Naker. 2003. Mobilizing communities to prevent domestic violence: a resource guide for organizations in East and Southern Africa. Raising Voices. Available at: www.raisingvoices.org/publications.php

5 Ellsberg, Mary Carroll & Heise, Lori. 2005. Researching Violence Against Women: A Practical Guide for Researchers and Activists. Washington, D.C: World Health Organization, PATH. www.path.org/files/GBV_rvaw_complete.pdf

2. Four VAW/G programmatic sectors — health, education, justice/security, social welfare
3. Under documented forms of VAW/G and emerging areas — humanitarian emergencies, femicide
4. Prevention programs in three areas — youth, community mobilization, working with men and boys

Violence Against Women and Girls

VAW/G causes pain, disability and death to an untold number of individuals every day, in every country in the world. VAW/G was declared to be a violation of human rights by the United Nations (UN) General Assembly in 1993, in its Declaration on the Elimination of Violence Against Women. The UN Declaration defined VAW/G as including physical, sexual and psychological violence occurring in the family and general community, which is perpetrated or condoned by the State, and includes traditional practices such as child marriage and female genital cutting/mutilation (FGC/M). VAW/G takes place in a multitude of contexts, including homes, schools, and the workplace. In unstable situations such as armed conflict and its aftermath, or human trafficking, the incidence rates of VAW/G escalate sharply.

The most common type of violence that women experience worldwide is intimate partner violence (IPV). The WHO multi-country study observed that lifetime prevalence of physical or sexual violence from an intimate partner was reported by 15-71% of women from 15 sites in ten countries. Women who reported being abused at least once in their lifetime were also more likely to experience a range of poor physical and mental health outcomes than those who had never been abused. Sexual, psychological and emotional violence inflicted by an intimate partner is also widespread. It is estimated that at least one in three women are subjected to some type of IPV over their lifetime.

Other types of VAW/G are localized in particular areas of the world. Female infanticide and sex selective abortion in parts of Asia are so prevalent that sex ratios have been notably altered. FGC/M affects millions of girls in parts of Africa and elsewhere. Other forms of vio-

lence, such as sexual harassment and coercion are common in the workplace and schools world wide. In situations of international and civil strife, rape is used as a tool of war to terrorize the population. Trafficking displaces and permanently alters the lives of thousands of girls and young women each year, many of whom are sold into sexual slavery.

All types of VAW/G stem from unequal power relations between women and men. VAW/G is used as a means of controlling and curbing women's autonomy and sexual behavior, and is perpetuated by gender norms that mediate expectations regarding the roles women and men are supposed to play in the family, community and society at large. Gender norms also define the parameters of acceptable behavior between boys and girls and men and women in the family, community and society within a given culture. In situations of conflict, violence against women is often employed as a tool of war to humiliate and demoralize the enemy.

The past two decades have seen an increase in both international attention and programmatic efforts towards developing interventions to prevent and respond to VAW/G. Reducing violence against women is addressed specifically by one of the Millennium Development Goals (MDGs) which all 191 Member States have pledged to achieve by 2015. Reducing VAW/G will also contribute to the achievement of all of the MDGs since it contributes to the full range of health and development outcomes covered.

Strategies to prevent and respond to VAW/G have been launched by agencies around the world based in a range of sectors, including governmental and non-governmental organizations. The multisectorial nature of prevention and response efforts is critical to the ultimate success of programs. Political will and commitment on the part of States leads to the development of policies and laws that provide the legal environment in which all other programs must operate. However, laws in and of themselves are not enough. On a community level, services in the justice/security, health, social welfare and educational sectors must be both accessible and user-friendly to affected girls and women. Finally, the primary prevention of VAW/G must take place in all of these sectors, focusing on both the underly-

ing causes such as gender norms and inequality, as well as the more immediate determinants such as behavior change.

Gender-based violence definitions

Gender-based violence (GBV) is the general term used to capture violence that occurs as a result of the normative role expectations associated with each gender, along with the unequal power relationships between the two genders, within the context of a specific society. VAW/G constitutes a part of GBV. Men and boys can also be victims of GBV. For example, homosexuality in many communities is considered an aberration from the expectations of how men should behave. Men who have sex with men in these communities experience everything from discrimination in the health and legal sectors to physical attacks in the community because they are deviating from expectations around masculinity. Men may also experience GBV from their intimate partners, other family members as children, and peers.

Except in cases of child sexual abuse, the strategies employed for the prevention and response to gender-based violence experienced by men and boys necessarily differ from those directed towards helping women and girls, due to the context in which this violence takes place. Apart from in situations such as humanitarian emergencies or human trafficking, the greatest proportion of violence women experience is most likely to be perpetrated by a husband, intimate partner, or relative. This contrasts violence enacted against men, which is far more likely to be perpetrated by a stranger or acquaintance.

The scope of this compendium is limited to VAW/G and does not address the types of GBV that are not perpetrated on women. Thus, the indicators presented are directed towards programs aimed at the prevention of and response to VAW/G only. As such, the only indicators targeted towards men are those oriented towards measuring programmatic outputs and outcomes associated with attitudes, beliefs and behaviors that are associated with the prevention of VAW/G. Many of the other indicators could be adapted for use among men and boys.

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Chapter 2: Monitoring and evaluation of VAW/G programs

Ethical considerations in the M&E of VAW/G

Many of the indicators in this guide rely on women's self-reports through the use of population-based and other surveys since gathering this information from other sources is usually not possible in developing country settings. Most countries do not have violence surveillance systems in place, and service statistics in the health, legal and other sectors are of poor quality. In places where these service-based data are reliable, these statistics will only represent those women and girls who approach these sectors after experiencing violence. Service statistics in humanitarian emergencies are even less available. This means that in order to measure these indicators, women are asked directly to report their experience with physical and sexual violence.

Collecting self-reported information within the context of VAW/G involves several concerns, related to both the way this information is obtained as well as to how results are interpreted. Even after adhering to the ethical guidelines and providing a safe, sensitive setting for completing interviews, there will always be a proportion of women who will not disclose this type of information. This means that prevalence and other estimates will likely be lower than the actual level of violence which has taken place in the population. Under reporting may occur for many reasons, including cultural contexts where some types of violence perpetrated by intimate partners is viewed as normal, where a woman fears reprisal upon disclosure, or where the level of stigma around such violence in the given society is high.

Therefore, estimated levels of physical violence and the patterns associated with factors such as education and socio-economic status should be interpreted with caution. In addition, obtaining information from girls (anyone under the age of 18) is problematic because of the legal necessity of obtaining parental consent for the interview.

For example, parents may pressure the child to reveal what they answered in an interview, or if the father is one of the perpetrators, the child could be put at risk if she participates.

While all research protocols involving human subjects require that investigators put mechanisms in place to protect the confidentiality and safety of their research subjects, research in the area of VAW/G involves special consideration due to the level of potential risk involved for these women. Women's psychological health can be endangered if interviewers are not specifically trained on how to elicit potentially hurtful information from women in a sensitive manner. Further, there are ethical issues pertaining to what actions should be taken or not taken if women reveal that they are in an abusive relationship, or are in danger. Women's physical safety could be at stake if her partner finds out that she revealed information about their relationship. Thus, data collection methods must ensure that the confidentiality of women's identities and the information they reveal is protected.

Two documents have been developed by the WHO that provide ethical and safety recommendations for doing this type of research on intimate partner violence[6] and on sexual violence in humanitarian emergencies.[7] The list of recommendations is presented here as a start for thinking about these issues, but the full documents (which are available online or as hard copies by contacting the WHO) should be consulted when measurement of these indicators is being considered.

- The safety and security of research subjects and the research team is paramount and should guide all research decisions.
- When documenting VAW/G, the potential benefits to the respondents or targeted communities must be greater than the

6 World Health Organization (WHO). 2001. Putting women first: Ethical and safety recommendations for research on domestic violence against women. Geneva: WHO. WHO/FCH/GWH/01.1 www.who.int/gender/documents/vawethics/en/index.html

7 WHO. 2007. WHO Ethical and Safety Recommendations for Researching, Documenting and Monitoring Sexual Violence in Emergencies. Geneva, Switzerland: World Health Organization. www.who.int/hac/network/interagency/news/ethical_and_safety_recommendations/en/index.html

risks involved to them.

- Information gathering and documentation must be done in a manner that presents the least risk to respondents, is methodologically sound, and builds on current experiences and good practice.
- Before conducting research, the local availability of care and support services for survivors/victims must be ascertained; if services are not available in the community or cannot be made available by the research team then research should not be undertaken.
- The confidentiality of individuals and the information they reveal must be protected at all times.
- Informed consent must be given by anyone participating in research on VAW/G.
- All members of the data collection team must be carefully selected and trained for this research, as well as receive ongoing support through the research process.
- If children (anyone under 18) will be research subjects, special safeguards must be put into place.

Throughout the compendium, the need for attending to the ethical and safety issues involved in this type of data gathering are mentioned in the considerations sections.

Program Monitoring and Evaluation (M&E)

M&E is the process by which data are collected and analyzed in order to provide information to program managers, policy makers and others about the progress and results of program implementation. The goal of M&E is to assess and improve the implementation of programs, as well as to demonstrate the effectiveness of those programs. The way a program collects, analyzes and reports data is systematically described in a document called an M&E plan. A good M&E plan will help keep VAW/G programs (or VAW/G components of more general programs) on track, guide the process needed to achieve their stated objectives, and describe how they will demonstrate the effectiveness of their strategies.

Program Monitoring: Monitoring is the routine tracking of program progress using data that are collected on a regular basis to show that activities are taking place as planned. Monitoring is the tracking system that program managers use to understand how well programs are running on a daily, weekly, monthly or quarterly basis, and where any bottlenecks may exist in overall implementation. Monitoring shows that the program inputs are being used effectively and whether they are leading to expected program outputs. For example, a program designed to raise awareness and decrease stigmatization about IPV in a community will want to keep track of (or monitor) the level of inputs such as funding, staff time, and material development as well as outputs such as how many times workers went out to speak at community meetings. Changes detected in the expected performance levels in these inputs and outputs will alert program managers to possible problems.

Program Evaluation: Evaluation is used to demonstrate how effective programs have been in achieving their targets and results. The data used for program evaluation will be drawn from a number of different sources, such as program indicators, periodic data collection from surveys, or special studies. The information from program evaluations can be used to revise program practices, to achieve better desired outcomes, as well as to report to donors. Program evaluations require funding, planning and time. Because they rely on quality data to measure key indicators, the M&E system that the program uses must be sound.

Process evaluations measure the quality and integrity of the program by demonstrating how well the program has been implemented as planned. Process evaluations focus on program implementation and assess coverage, rather than desired results or outcomes. The information from a process evaluation can be used to make mid-course corrections in a program to improve its effectiveness. In order to be useful, process evaluations must be planned to occur at frequent enough periods to allow for changes to be made, but after a long enough time to demonstrate what is needed. Process evaluation is generally easier than measuring results or outcomes. For example, a community awareness program may count how many people attended the community meetings.

Outcome evaluations measure whether or not the desired change or result has been attained. The outcome evaluation will focus on demonstrating whether or not program objectives have been reached. Data used for this type of evaluation usually come through a special study and are collected periodically, not on a routine basis. The goal of an outcome evaluation is to show that the changes observed in the target population occurred as a result of the program being implemented. Outcome evaluations are used to assess changes in knowledge, behavior, skills, community norms, utilization of services, and health status indicators in the population, such as the prevalence of IPV. In order to measure change, baseline data from the target population, in other words, data collected before the program was implemented, must be available to compare with data collected after the program took place. This is why planning is so important to a strong evaluation design. Often, data are not collected before a program begins. In these cases, an evaluation is limited to utilizing a different type of design that compares a community which has been exposed to the program with one that has not, but these are less desirable because it may be hard to find comparable communities who have truly not been exposed to the program in question. Comprehensive evaluation designs will combine comparisons between baseline with post-program exposure data in program areas and comparison areas.

Impact evaluations show how much of the change can be attributed to the program. These evaluations are harder to conduct and require very specific study designs to measure the extent of the observed change in the desired VAW/G outcome that can be attributed to the program. These evaluations often require the technical assistance of someone who specializes in their design and analyses.

Why M&E Matters to VAW/G Programs: M&E is critical to VAW/G programs and the field in general for several reasons. Program managers need information in order to facilitate day-to-day implementation, plan for the future, and report results to donors and policymakers. Information from outcome and impact evaluations will demonstrate promising strategies for prevention and response that can be implemented in other settings. The information provided by programs may also be used to feed into a larger M&E

system in a country or internationally. Information reported at this level is likely to garner enough attention and support to influence international policy and sustained funding.

What makes a good indicator

An indicator is a variable that measures a specific aspect of a program or project. Indicators should reflect the stated goals and objectives of a program. They are used to show that activities were implemented as planned, or that the program has influenced a change in a desired outcome. The specific program aspect measured by an indicator can be an input, output, or expected outcome. Several criteria describe a good indicator. Indicators must be valid, reliable, comparable (over time or between settings), non-directional, precise, measurable, and programmatically important.

Valid: Indicators should measure the aspects of the program that they are intended to measure.
Specific: Indicators should only measure the aspect of the program that they are intended to measure.
Reliable: Indicators should minimize measurement error and should produce the same results consistently over time, regardless of the observer or respondent.
Comparable: Indicators should use comparable units and denominators that will enable an increased understanding of impact or effectiveness across different population groups or program approaches.
Non-directional: Indicators should be developed to allow change in any direction, and not specify a direction in their wording (for example: an indicator should be worded as "the level of awareness" instead of "an increased awareness").
Precise: Indicators should have clear, well-specified definitions.
Feasible: It must be possible to measure an indicator using available tools and methods.
Programmatically relevant: Indicators should be specifically linked to a programmatic input, output or outcome.

Indicators are only as good as the quality of the data used to mea-

sure them. Data quality begins with careful protocols guiding data collection, but it can be affected at any point afterwards, including the way it is entered on forms (computerized or not), tallied at higher levels, and analyzed to calculate specific indicators. Many factors contribute to poor data quality. Some of these include:

- Double (or over) counting, when a person, service or other programmatic aspect is counted more than once
- Lack of coverage to assure representation of the targeted population or services to be included in the indicator; the accuracy with which records are created and reported to a higher system
- Precision used to record the data; whether or not the data reflect current information (timeliness)
- Integrity with which the data are recorded (do people have an interest in not reporting accurately?).

People collecting and processing the data need to be trained to understand how important data quality is to the success of the program, as well as empowered with the skills they need in order to preserve it. Data quality should be addressed in the M&E Plan by describing the standards used for collection, storage, analysis and reporting.

Where to go for more information on M&E

The information in this section provides an introduction to the rationale behind monitoring and evaluation (M&E), and basic definitions of its core concepts. More detailed information on M&E can be found on the MEASURE Evaluation website (www.cpc.unc.edu/measure) which includes on-line courses, and links to publications and other websites pertaining to specific aspects of the field.

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Chapter 3: List of Indicators

5.1.3	Proportion of health units that have clinical commodities for the clinical management of VAW/G	91
5.1.4	Proportion of health units with at least one service provider trained to care for and refer VAW/G survivors	93
5.1.5	Number of service providers trained to identify, refer, and care for VAW/G survivors	95
5.1.6	Number of health providers trained in FGC/M management and counseling	96
5.1.7	Proportion of women who were asked about physical and sexual violence during a visit to a health unit	97
5.1.8	Proportion of women who reported physical and/or sexual violence	100
5.1.9	Proportion of VAW/G survivors who received appropriate care	102
5.1.10	Proportion of rape survivors who received comprehensive care	104
5.2 – Education		
5.2.1	Percent of schools that have procedures to take action on reported cases of sexual abuse	106
5.2.2	Number of teacher training programs that include sexual and physical VAW/G in their curriculums	108
5.2.3	Percent of schools that train their staff on sexual and physical VAW/G issues	110
5.2.4	Proportion of nursing and medical schools that include VAW/G as part of their core curriculum	112
5.3 – Justice and Security		
5.3.1	Proportion of law enforcement units following a nationally established protocol for VAW/G complaints	114

6.1.1	Protocols that are aligned with international standards have been established for the clinical management of sexual violence survivors within the emergency area at all levels of the health system	148
6.1.2	A coordinated rapid situational analysis, which includes a security assessment, has been conducted and documented in the emergency area	151
6.1.3	The proportion of sexual violence cases in the emergency area for which legal action has been taken	153
6.1.4	Proportion of reported sexual exploitation and abuse incidents in the emergency area that resulted in prosecution and/or termination of humanitarian staff	155
6.1.5	Coordination mechanisms established and partners orientated in the emergency area	157
6.1.6	Number of women/girls reporting incidents of sexual violence per 10,000 population in the emergency area	159
6.1.7	Percent of rape survivors in the emergency area who report to health facilities/workers within 72 hours and receive appropriate medical care	162
6.1.8	Proportion of sexual violence survivors in the emergency area who report 72 hours or more after the incident and receive a basic set of psychosocial and medical services	164
6.1.9	Number of activities in the emergency area initiated by the community targeted at the prevention of and response to sexual violence of women and girls	167
6.1.10	Proportion of women and girls in the emergency area who demonstrate knowledge of available services, why and when they would be accessed	169
6.2 – Trafficking in Persons		

7.1.7	Proportion of girls who believe that girls are not to blame for sexual harassment by a male teacher or student	200
7.2 – Community Mobilization and Individual Behavior Change		
7.2.1	Proportion of individuals who know any of the legal rights of women	202
7.2.2	Proportion of individuals who know any of the legal sanctions for VAW/G	204
7.2.3	Proportion of people who have been exposed to VAW/G prevention messages	206
7.2.4	Proportion of people who say that wife beating is an acceptable way for husbands to discipline their wives	208
7.2.5	Proportion of people who would assist a woman being beaten by her husband or partner	210
7.2.6	Proportion of people who say that men cannot be held responsible for controlling their sexual behavior	212
7.2.7	Proportion of people who agree that a woman has a right to refuse sex	214
7.2.8	Proportion of people who agree that rape can take place between a man and woman who are married	216
7.2.9	Proportion of target audience who has been exposed to communication messages recommending the discontinuation of FGC/M	218
7.2.10	Proportion of people who believe that FGC/M should be stopped	220
7.2.11	Proportion of women who do not intend to have any of their daughters undergo FGC/M	222
7.2.12	Proportion of people who believe child marriage should be stopped	224
7.2.13	Proportion of women who do not intend to marry their daughters before the age of 18	226

7.3 – Working with Men and Boys		
7.3.1	Number of programs implemented for men and boys that include examining gender and culture norms related to VAW/G	228
7.3.2	Proportion of men and boys who agree that women should have the same rights as men	230
7.3.3	Proportion of men and boys with gender-related norms that put women and girls at risk for physical and sexual violence	232
7.3.4	Proportion of men and boys who believe that men can prevent physical and sexual violence against women and girls	234

Chapter 4: Magnitude and Characteristics of Different Forms of VAW/G

Introduction

The indicators included in this section are designed to measure outcomes related to five types of violence against women and girls that occur in a country, region or a more locally defined community such as an urban area or rural district. The types of violence covered include skewed sex ratios, IPV, violence from someone other than an intimate partner, female genital cutting/mutilation (FGC/M), and child marriage. The measures in 4.2, 4.3 and 4.4 depend on women's self-reports of their own (or their daughters') experience. This section is oriented towards measuring prevalence among household populations in non-emergency settings. Measures focused on women in situations such as humanitarian emergencies and human trafficking appear in Chapter 6.

Skewed sex ratios: Section 4.1 presents two measures based on sex ratios. The sex ratio reflects the number of males relative to the number of females in a population, and is fairly consistent, particularly at birth and young ages. A ratio that is altered or skewed from the norm in a given region reflects the effects of a social, rather than a biological, influence on the sex composition of a population. Cultural norms such as son preference will result in sex ratios that are notably skewed from the observed constants. In societies with strong son preference, such as in South and East Asia, demographers have long noted the problem of "missing girls and women" at birth and later ages. Calculations to derive these estimates, which range in the millions, are based on sex ratios and population figures.

The reasons for missing girls at birth reflect practices such as sex-selective abortions and female infanticide. At later ages, research has shown that the systematic neglect of female children, or preferential treatment of male children with regard to nutrition and health care has resulted in higher female infant and child mortality. These skewed ratios persist despite socioeconomic status, and have been

observed to be more pronounced in places where fertility has declined. Good estimates of the sex ratio can be easily derived using census data, which are available in most countries.

Intimate Partner Violence and violence from someone other than an intimate partner: Section 4.2 on IPV includes measures to examine self-reported physical and sexual violence perpetrated by a male intimate partner. This section does not include aspects of IPV such as emotional abuse because measures in this area have been largely untested. Indicators pertaining to physical and sexual violence perpetrated by any person other than an intimate partner are presented in 4.3. The sexual and physical violence covered in these sections occurs everywhere in the world and contributes significantly to women's ill health. Programs designed to prevent IPV and other violence and programs that seek to ameliorate their effects are critical resources for improving women's overall health and well-being anywhere. If measured in a carefully conducted research protocol, the indicators suggested in these sections will yield good estimates.

Important Considerations Pertaining to Indicators in Sections 4.2 and 4.3

While it is useful to measure the prevalence of any form of IPV (physical or sexual) and violence perpetrated by someone other than an intimate partner, there are several concerns to consider related to both the way this information is obtained as well as to how the results are interpreted. A woman who experiences IPV or other violence may be endangered by participating in a study if her partner or another perpetrator discovers that she disclosed this information. The interview also needs to be conducted in a sensitive manner in order to protect the woman as much as possible from experiencing distress if she discloses her experiences.

The difficulties inherent in measuring these two types of violence that women experience should be seriously considered before undertaking such an endeavor. All research in this area should adhere

to the WHO ethical and safety guidelines[8] which were established as standards to maintain women's safety and confidentiality. In addition, data based on women's self-reports can be biased by any number of factors.

Even after adhering to the ethical guidelines and providing a good setting in which to conduct interviews, there will always be some women who will not disclose this information. This means that estimates will likely be lower than the actual level of violence which has taken place in the surveyed population. Under reporting may occur for many reasons, including cultural contexts where some types of violence perpetrated by intimate partners is viewed as normal, when a woman fears reprisal upon disclosure, or where the level of stigma around such violence in the given society is high. Therefore, estimated levels of IPV and other violence and the patterns associated with factors such as education and socio-economic status should be interpreted with caution.

For indicators in these sections that measure recent experiences with violence (e.g., within the past year), trends can be obtained if a survey with this question is repeated every few years. A change in the recent prevalence of IPV or other sexual violence may reflect changes in the level of violence over time. However, a change in either direction may also reflect a change in the way women are reporting violence over time rather than a true change in the proportion of women affected from one survey period to the next. For example, if a program has been implemented to raise awareness about IPV and counter community stigma, women may be more likely to report their experiences in the next survey. An increase in prevalence would logically indicate a worsening situation for women in that community, but if there had been no true change, the increase may indicate a good programmatic outcome since women felt safer about disclosing their IPV experiences.

8 Watts, C et al. 2001. Putting women first: Ethical and safety recommendations for research on domestic violence against women. Geneva, World Health Organization (document WHO/EIP/GPE/01.1, available at: http://whqlibdoc.who.int/hq/2001/WHO_FCH_GWH_01.1.pdf; WHO. 2007. WHO Ethical and safety recommendations for researching, documenting and monitoring sexual violence in emergencies. Geneva: WHO.

For all these reasons, collecting and interpreting the data to measure the indicators in these two sections must be done with care. The cultural, socio-political and programmatic context in which these indicators are measured should constitute part of study design and the subsequent presentation of its results. In most cases, the technical expertise of people familiar with studies on VAW/G should be elicited.

Female Genital Cutting/Mutilation: FGC/M is an important type of violence inflicted on girls and young women in Africa, the Middle East, and more recently among immigrant populations from these areas living in Europe and elsewhere. Indicators to measure the levels and types of FGC/M and the circumstances under which procedures were performed are described in Section 4.3. Research on the social context of FGC/M has shown that the practice is difficult to eradicate or change, though many programs have been implemented in this area. Measuring the prevalence of recent procedures is one way of assessing how successful these efforts have been. Other programmatic outcomes in this area relate to societal attitudes and intentions regarding FGC/M, and the skills of health practitioners to mitigate its consequences among affected women and girls. Indicators in these two areas are described in sections 5.1 and 7.2.

Child Marriage: Several studies have shown that child marriage is associated with increased risk of sexual and/or physical abuse, early pregnancy, and STIs. Girls who marry before the age of 18 are also less likely to be enrolled in school. Child marriage is documented as a violation of human rights in the Universal Declaration of Human Rights since a child is unable to make informed decisions about a life partner and enter into a marriage with free and full consent. Girls and women who are married before age 18 are also more likely to experience violence and abuse. Section 4.4 provides one indicator designed to measure the prevalence of recent child marriage and serves as a point of reference for programs addressing this type of violence against women and girls.

4.1 SKEWED SEX RATIOS

4.1.1 – Sex ratio at birth

Definition: The number of female births per 100 male births.

Numerator: Number of female births recorded at a specified point in time.

Denominator: Number of male births recorded at a specified point in time.

Calculation: Divide the numerator by the denominator and multiply the result by 100.

Disaggregate by: Geographic region.

What It Measures: This is a ratio of the number of females per males born in a population. The normal sex ratio at birth is close to 95 females born per 100 males, with little variance. The sex ratio is usually expressed as the number of males per females, but in areas where son preference is strong, the ratio is expressed as the number of females per 100 males. In North India, numbers as low as 75 females born per 100 males have been recorded. This type of skewed sex ratio at birth is indicative of practices that prevent females from being born (sex-selective abortion) or surviving after a live birth (female infanticide).

Measurement Tool: Both the numerator and denominator are available in a census, which is normally conducted in countries every ten years. This means that information may not be current, but trends over time can be tracked because these data are readily available. Measuring the ratio between the census years would necessitate using vital registration records or conducting a special study, such as a demographic survey.

How to Measure It: In a census, both the numerator and denominator are readily available. These numbers are usually available by district and region. Divide the number of female births by the number of male births recorded in the census, and multiply the result by 100 to derive the ratio. A special survey of births during a specified period would likely focus on a small region in the country. Collecting demographic data of this type is typically done based on a representative sample. This would not be a population sex ratio, but the resulting ratio would be representative of the sampled population if the sample was drawn using probability methods.

Considerations: While vital registration systems can provide the relevant information, these systems in most developing countries are typically of poor quality. Using these data to derive the sex ratio may result in biased estimates, since many births (especially of females) may not be reported. A special study, such as a population-based survey has the advantage of offering an estimate between the census years. The resulting estimate will not be a true sex ratio, but will be representative of the population sampled.

4.1.2 – Excess female infant and child mortality (sex ratios up to age 1 and under 5)

Definition: The number of females per 100 males at two points in time — age 0-1 for excess infant mortality, and age 0-4 years for excess child mortality.

Excess female infant mortality:
Numerator: Number of females aged 0-1 year at a specified point in time.
Denominator: Number of males aged 0-1 year at the same specified point in time.

Excess female child mortality:
Numerator: Number of females aged 0-4 years at a specified point in time.
Denominator: Number of males aged 0-4 years at the same specified point in time.

Calculation for either ratio: Divide the numerator by the denominator, then multiply the result by 100.

Disaggregate by: Geographic region.

What It Measures: These ratios measure the number of female infants (aged 0-1 year) and children under 5 (aged 0-4 years) per male infants and children in a population. The sex ratio is usually expressed as the number of males per females, but in areas where son preference is strong, the ratio is expressed as the number of females per 100 males. Unlike a skewed sex ratio at birth, which reflects practices that discriminate against unborn (or just born) females, skewed sex ratios at older ages reflect discriminatory practices against female babies and children. Studies have observed systematic neglect through undernutrition and underutilization of necessary preventive and treatment-oriented health care.

Measurement Tool: Both the numerator and denominator are available in a census, which is normally conducted in countries ev-

ery ten years. This means that information may not be current, but trends over time can be tracked because these data are readily available. Another way of measuring excess female mortality at both ages would be to calculate age-specific mortality rates for females and males for the same age ranges. Measuring the ratio between the census years would necessitate using vital registration records (births or death records), or conducting a special study, such as a demographic survey.

How to Measure It: In a census, both the numerator and denominator are readily available. These numbers are usually available by district and region. Divide the number of females aged 0-1 year by the number of males in the same age group recorded in the census, and multiply the result by 100 to derive the infant ratio. The child ratio is derived in the same way, only using females and males aged 0-4 years. Collecting demographic data of this type is typically done based on a representative sample. This would not be a population sex ratio, but the resulting ratio would be representative of the sampled population if the sample was drawn using probability methods. Mortality rates can also be calculated using the census, or a representative population-based survey that recorded children born within the last 5 years.

Considerations: Data available from vital registration systems in most developing countries is typically of poor quality. Using these data to derive the sex ratio or mortality rates may result in biased estimates, since many births and deaths (especially of girls) may not be reported. A special study, such as a population-based survey has the advantage of offering an estimate between the census years. The resulting estimate will not be a true sex ratio, but will be a representative of the population sampled.

4.2 INTIMATE PARTNER VIOLENCE

4.2.1 – Proportion of women aged 15-49 who ever experienced physical violence from an intimate partner

Definition: The proportion of women surveyed who report experiencing physical violence from a male intimate partner at any point during their lifetime. An intimate partner is defined as a cohabiting partner (either currently or in the past), whether or not they had been married at the time. The violence could have occurred after they had separated.

Numerator: Women aged 15-49 who currently have or ever had an intimate partner and report ever experiencing physical violence by an intimate partner (based on the checklist[9] below).

The woman is included in the numerator if she reports that a current or past intimate partner ever:

- Slapped her or threw something at her that could hurt her
- Pushed her or shoved her
- Twisted her arm or pulled her hair
- Hit her with a fist or something else that could hurt
- Kicked, dragged, or beat her up
- Choked or burnt her
- Threatened her with, or actually used a gun, knife or other weapon against her

Denominator: Total number of women surveyed aged 15-49 who currently have or ever had an intimate partner.

9 Checklist based on: World Health Organization. WHO Multi-country Study on Women's Health and Domestic Violence Against Women: Summary Report of Initial Results on Prevalence, Health Outcomes and Women's Responses. Geneva, Switzerland: World Health Organization; 2005 & Macro International, DHS Domestic Violence Module. *Note: In some countries, additional items may need to be included.*

Disaggregate by: Age, region, ethnicity or other appropriate group.

What It Measures: This indicator measures the prevalence of lifetime physical intimate partner violence (IPV) experienced by women of reproductive age who have ever had an intimate partner at the time of the survey. The indicator only includes relationships in which the couple resided together at some point. The violence could have happened recently or any number of years ago, with a current or past partner. If this is measured in a survey using a probability sample, this estimate can be generalized back to the target population (e.g., women of reproductive age who have ever had an intimate partner living in a particular region or country). The indicator does not measure the frequency or duration of the violence.

Measurement Tool: A population-based survey. A population-based survey can be a general health survey which includes a module on violence against women, or one which is focused on this topic alone. The latter is recommended because focused surveys have revealed higher prevalence estimates (and likely less under reporting) than national surveys designed to measure other health outcomes in addition to violence. The question order in a survey on IPV is also important. Sensitive questions should not be asked at the beginning of the survey because participants need time to feel comfortable with the interviewer. Ideally, the sample of women in the survey is selected using probability methods in the target population (whether in a region, city, or country) so that the results will represent all women of reproductive age in the geographic area covered by the survey.

How to Measure It: A question is included in a survey which asks women whether they ever experienced any type of violence on the checklist from an intimate partner, past or present. If a woman answers yes to any of the items, she is included in the numerator. The numerator is then divided by the denominator.

Considerations: For special considerations on the collection and interpretation of information needed to measure this indicator, please see, "Important Considerations Pertaining to Indicators in Sections 4.2 and 4.3," on p. 36.

4.2.2 – Proportion of women aged 15-49 who experienced physical violence from an intimate partner in the past 12 months

Definition: The proportion of women surveyed who report experiencing physical violence from a male intimate partner during the past 12 months. An intimate partner is defined as a cohabiting partner, whether or not they had been married at the time. The violence could have occurred after they had separated.

Numerator: Women aged 15-49 who currently have or ever had an intimate partner, who report experiencing physical violence by at least one of these partners (based on the checklist[10] below) in the past 12 months.

The woman is included in the numerator if she reports that in the past 12 months, a current or past intimate partner:

- Slapped her or threw something at her that could hurt her
- Pushed her or shoved her
- Twisted her arm or pulled her hair
- Hit her with a fist or something else that could hurt
- Kicked, dragged, or beat her up
- Choked or burnt her
- Threatened her with, or actually used a gun, knife or other weapon against her

Denominator: Total women surveyed aged 15-49 who currently have or ever had an intimate partner.

What It Measures: This indicator measures the prevalence of recent physical intimate partner violence (during the past 12 months) experienced by women of reproductive age who had ever had an intimate partner at the time of the survey. The violence could have happened anytime during the past year, with a current or past part-

10 Checklist from: World Health Organization. WHO Multi-country Study on Women's Health and Domestic Violence Against Women: Summary Report of Initial Results on Prevalence, Health Outcomes and Women's Responses. Geneva, Switzerland: World Health Organization; 2005 & Macro International, DHS Domestic Violence Module.

ner. If this is measured in a survey using a probability sample, this estimate can be generalized back to the target population (e.g., women of reproductive age living in a particular region or country). The indicator does not measure the frequency or duration of the violence. If the indicator is measured in more than one survey conducted at different points in time (e.g., every five years), it may reflect changes in the prevalence of physical IPV over time (see Considerations for cautions relating to this interpretation).

Measurement Tool: A population-based survey. The survey can be a general health survey which includes a module on violence against women, or one which is focused on this topic alone. The latter is recommended because focused surveys have revealed higher prevalence estimates (and likely less under reporting) than national surveys designed to measure other health outcomes in addition to violence. The question order in a survey on IPV is also important. Sensitive questions should not be asked at the beginning of the survey because participants need time to feel comfortable with the interviewer. Ideally, the sample of women in the survey is selected using probability methods in the target population (whether in a region, city, or country) so that the results will represent all women of reproductive age in the geographic area covered by the survey.

How to Measure It: Women are asked if they experienced each type of violence in the last year from an intimate partner, past or current. If a woman answers yes to any of the questions on violence in the last year, she is included in the numerator. The numerator is then divided by the denominator.

Considerations: For special considerations on the collection and interpretation of information needed to measure this indicator, please see, "Important Considerations Pertaining to Indicators in Sections 4.2 and 4.3," on p. 36.

4.2.3 – 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

Definition: The proportion of women surveyed who experienced physical violence from a male intimate partner during the past 12 months and who were injured as a result of the violence, during the same time period. An intimate partner is defined as a cohabiting partner, whether or not they had been married. The violence and resulting injury could have occurred after they had separated.

Numerator: Women aged 15-49 who currently have or ever had an intimate partner, who report experiencing physical violence (based on the checklist in Indicators 4.2.1 and 4.2.2) in the past 12 months and being injured as a result of that violence (based on the checklist[11] below).

The woman is included in the numerator if she experienced violence in the past 12 months, and as a result of what her partner did to her, she had:

- Cuts, bruises or aches
- Eye injuries, sprains, dislocations or burns
- Deep wounds, broken bones, broken teeth or other serious injuries

Denominator: Total women surveyed aged 15-49 who currently have or ever had an intimate partner, and who reported any type of physical IPV during the past 12 months.

Disaggregate by: Age, region, ethnicity or other appropriate group.

What It Measures: This indicator is a general measure of the severity of physical IPV experienced by women in the past 12 months,

11 Checklist from: World Health Organization. WHO Multi-country Study on Women's Health and Domestic Violence Against Women: Summary Report of Initial Results on Prevalence, Health Outcomes and Women's Responses. Geneva, Switzerland: World Health Organization; 2005 & Macro International, DHS Domestic Violence Module.

among women who have experienced IPV during the same time period. The injury could have resulted from IPV anytime during the past year with a current or past partner. If this is measured in a survey using a probability sample, this estimate can be generalized back to the target population (e.g., women of reproductive age living in a particular region or country). The indicator does not measure the frequency or the severity of the injury. If the indicator is measured in more than one survey conducted at different points in time (e.g., every five years), it may reflect changes in the prevalence of physical IPV or changes in the severity of associated physical violence over time (see considerations for cautions relating to this interpretation).

Measurement Tool: A population-based survey. The survey can be a general health survey which includes a module on violence against women, or one which is focused on this topic alone. The latter is recommended because focused surveys have revealed higher prevalence estimates (and likely less under reporting) than national surveys designed to measure other health outcomes in addition to violence. The question order in a survey on IPV is also important. Sensitive questions should not be asked at the beginning of the survey because participants need time to feel comfortable with the interviewer. Ideally, the sample of women in the survey is selected using probability methods in the target population (whether in a region, city, or country) so that the results will represent all women of reproductive age in the geographic area covered by the survey.

How to Measure It: A question is included in a survey which asks women who have experienced IPV in the past 12 months whether they have experienced any of the types of injury as a result. If a woman answers yes to any of the items, she is included in the numerator. The numerator is then divided by the denominator.

Considerations: For special considerations on the collection and interpretation of information needed to measure this indicator, please see, "Important Considerations Pertaining to Indicators in Sections 4.2 and 4.3," on p. 36.

4.2.4 – Proportion of women aged 15-49 who ever experienced sexual violence from an intimate partner

Definition: The proportion of women surveyed who report experiencing sexual violence from a male intimate partner at any point during their lifetime. An intimate partner is defined as a cohabiting partner, whether or not they had been married at the time. The sexual violence could have occurred after they had separated.

Numerator: Women aged 15-49 who currently have or ever had an intimate partner, who report ever experiencing sexual violence by at least one partner (based on the checklist[12] below).

The woman is included in the numerator if she reports that a current or past intimate partner ever:

- Physically forced her to have sexual intercourse against her will
- Made her afraid of what her partner would do if she did not have sexual intercourse
- Forced her to do something sexual she found degrading or humiliating

Denominator: Total women surveyed aged 15-49 who currently have an intimate partner or ever had one.

Disaggregate by: Age, region, ethnicity or other appropriate group.

What It Measures: This indicator measures the prevalence of lifetime sexual IPV experienced by women of reproductive age at the time of the survey. The sexual violence could have happened recently or any number of years ago, with a current or past partner. If this is measured in a survey using a probability sample, this estimate can be generalized back to the target population (e.g., women of

12 Checklist from: World Health Organization. WHO Multi-country Study on Women's Health and Domestic Violence Against Women: Summary Report of Initial Results on Prevalence, Health Outcomes and Women's Responses. Geneva, Switzerland: World Health Organization; 2005 & Macro International, DHS Domestic Violence Module.

reproductive age living in a particular region or country). The indicator does not measure the frequency or duration of the sexual violence.

Measurement Tool: A population-based survey. The survey can be a general health survey which includes a module on violence against women, or one which is focused on this topic alone. The latter is recommended because focused surveys have revealed higher prevalence estimates (and likely less under reporting) than national surveys designed to measure other health outcomes in addition to violence. The question order in a survey on IPV is also important. Sensitive questions should not be asked at the beginning of the survey because participants need time to feel comfortable with the interviewer. Ideally, the sample of women in the survey is selected using probability methods in the target population (whether in a region, city, or country) so that the results will represent all women of reproductive age in the geographic area covered by the survey.

How to Measure It: A question is included in a survey which asks women whether they ever experienced any type of sexual violence from an intimate partner, past or present. If a woman answers yes to any of the items, she is included in the numerator. The numerator is then divided by the denominator.

Considerations: For special considerations on the collection and interpretation of information needed to measure this indicator, please see, "Important Considerations Pertaining to Indicators in Sections 4.2 and 4.3," on p. 36.

4.2.5 – Proportion of women aged 15-49 who experienced sexual violence from an intimate partner in the past 12 months

Definition: The proportion of women surveyed who report experiencing sexual violence from a male intimate partner during the past 12 months. An intimate partner is defined as a cohabiting partner, whether or not they had been married at the time. The violence could have occurred after they had separated.

Numerator: Women aged 15-49 who currently have or ever had an intimate partner and who report experiencing sexual violence (based on the checklist[13] below) by at least one partner in the past 12 months.

The woman is included in the numerator if she reports that in the past 12 months, a current or past intimate partner:

- Physically forced her to have sexual intercourse against her will
- Made her afraid of what her partner would do if she did not have sexual intercourse
- Forced her to do something sexual she found degrading or humiliating

Denominator: Total women surveyed aged 15-49 who currently have or ever had an intimate partner.

Disaggregate by: Age, region, ethnicity or other appropriate group.

What It Measures: This indicator measures the prevalence of recent sexual IPV (during the past 12 months) experienced by women of reproductive age at the time of the survey. The violence could have happened anytime during the past year, with a current or past partner. If this is measured in a survey using a probability sample,

13 Checklist from: World Health Organization. WHO Multi-country Study on Women's Health and Domestic Violence Against Women: Summary Report of Initial Results on Prevalence, Health Outcomes and Women's Responses. Geneva, Switzerland: World Health Organization; 2005 & Macro International, DHS Domestic Violence Module.

this estimate can be generalized back to the target population (e.g., women of reproductive age living in a particular region or country). The indicator does not measure the frequency or duration of the sexual violence. If the indicator is measured in more than one survey conducted at different points in time (e.g., every five years), it may reflect changes in the prevalence of physical IPV over time (see Considerations for cautions relating to this interpretation).

Measurement Tool: A population-based survey. The survey can be a general health survey which includes a module on violence against women, or one which is focused on this topic alone. The latter is recommended because focused surveys have revealed higher prevalence estimates (and likely less under reporting) than national surveys designed to measure other health outcomes in addition to violence. The question order in a survey on IPV is also important. Sensitive questions should not be asked at the beginning of the survey because participants need time to feel comfortable with the interviewer. Ideally, the sample of women in the survey is selected using probability methods in the target population (whether in a region, city, or country) so that the results will represent all women of reproductive age in the geographic area covered by the survey.

How to Measure It: Women are asked whether they experienced any type of sexual violence during the past 12 months from an intimate partner, past or present. If a woman answers yes to any of the items, she is included in the numerator. The numerator is then divided by the denominator.

Considerations: For special considerations on the collection and interpretation of information needed to measure this indicator, please see, "Important Considerations Pertaining to Indicators in Sections 4.2 and 4.3," on p. 36.

4.3 VIOLENCE FROM SOMEONE OTHER THAN AN INTIMATE PARTNER

4.3.1 – Proportion of women aged 15-49 who ever experienced physical violence from someone other than an intimate partner

Definition: The proportion of women surveyed who report ever experiencing sexual violence from anyone other than an intimate partner, including when they were a child. The perpetrator could have been a family member, friend (including a non-cohabiting boyfriend), acquaintance or stranger.

Numerator: Women aged 15-49 who have ever experienced physical violence (based on the checklist[14] below) by someone other than an intimate partner.

The woman is included in the numerator if she reports that anyone has ever:

- Slapped her or threw something at her that could hurt her
- Pushed her or shoved her
- Twisted her arm or pulled her hair
- Hit her with a fist or something else that could hurt
- Kicked, dragged, or beat her up
- Choked or burnt her
- Threatened her with, or actually used a gun, knife or other weapon against her

Denominator: Total number of women surveyed aged 15-49.

Disaggregate by: Age, region, ethnicity or other appropriate group.

14 Checklist based on: World Health Organization. WHO Multi-country Study on Women's Health and Domestic Violence Against Women: Summary Report of Initial Results on Prevalence, Health Outcomes and Women's Responses. Geneva, Switzerland: World Health Organization; 2005 & Macro International, DHS Domestic Violence Module. *Note: In some countries, additional items may need to be included.*

What It Measures: This indicator measures the prevalence of lifetime physical violence perpetrated by someone other than an intimate partner that was experienced by women of reproductive age at the time of the survey. The violence could have happened recently or any number of years ago, with anyone other than an intimate partner. If this is measured in a survey using a probability sample, this estimate can be generalized back to the target population (e.g., women of reproductive age living in a particular region or country). The indicator does not measure the frequency or duration of the violence.

Measurement Tool: A population-based survey. The survey can be a general health survey which includes a module on violence against women, or one which is focused on this topic alone. The latter is recommended because focused surveys have revealed higher prevalence estimates (and likely less under reporting) than national surveys designed to measure other health outcomes in addition to violence. The question order in a survey asking about VAW/G is also important. Sensitive questions should not be asked at the beginning of the survey because participants need time to feel comfortable with the interviewer. Ideally, the sample of women in the survey is selected using probability methods in the target population (whether in a region, city, or country) so that the results will represent all women of reproductive age in the geographic area covered by the survey.

How to Measure It: A question is included in a survey which asks women whether they ever experienced any type of violence on the checklist from anyone other than an intimate partner, past or present. If a woman answers yes to any of the items, she is included in the numerator. he numerator is then divided by the denominator.

Considerations: For special considerations on the collection and interpretation of information needed to measure this indicator, please see, "Important Considerations Pertaining to Indicators in Sections 4.2 and 4.3," on p. 36.

4.3.2 – Proportion of women aged 15-49 who experienced physical violence from someone other than an intimate partner in the past 12 months

Definition: The proportion of women surveyed who report experiencing sexual violence from anyone other than an intimate partner during the past 12 months. The perpetrator could have been a family member, friend (including a non-cohabiting boyfriend), acquaintance or stranger.

Numerator: Women aged 15-49 who report experiencing physical violence (based on the checklist[15] below) by someone other than an intimate partner in the past 12 months.

The woman is included in the numerator if she reports that in the past 12 months, a current or past intimate partner:

- Slapped her or threw something at her that could hurt her
- Pushed her or shoved her
- Twisted her arm or pulled her hair
- Hit her with a fist or something else that could hurt
- Kicked, dragged, or beat her up
- Choked or burnt her
- Threatened her with, or actually used a gun, knife or other weapon against her

Denominator: Total women surveyed aged 15-49.

Disaggregate by: Age, region, ethnicity or other appropriate group.

What It Measures: This indicator measures the prevalence of lifetime physical violence perpetrated by someone other than an intimate partner that was experienced by women of reproductive age during the 12 months preceding the survey. If this is measured in a survey using a probability sample, this estimate can be

15 Checklist from: World Health Organization. WHO Multi-country Study on Women's Health and Domestic Violence Against Women: Summary Report of Initial Results on Prevalence, Health Outcomes and Women's Responses. Geneva, Switzerland: World Health Organization; 2005 & Macro International, DHS Domestic Violence Module.

generalized back to the target population (e.g., women of reproductive age living in a particular region or country). The indicator does not measure the frequency or duration of the violence.

Measurement Tool: A population-based survey. The survey can be a general health survey which includes a module on violence against women, or one which is focused on this topic alone. The latter is recommended because focused surveys have revealed higher prevalence estimates (and likely less under reporting) than national surveys designed to measure other health outcomes in addition to violence. The question order in a survey asking about VAW/G is also important. Sensitive questions should not be asked at the beginning of the survey because participants need time to feel comfortable with the interviewer. Ideally, the sample of women in the survey is selected using probability methods in the target population (whether in a region, city, or country) so that the results will represent all women of reproductive age in the geographic area covered by the survey.

How to Measure It: A question is included in a survey which asks women whether they ever experienced any type of violence on the checklist from anyone other than an intimate partner, past or present, in the past 12 months. If a woman answers yes to any of the items, she is included in the numerator. The numerator is then divided by the denominator.

Considerations: For special considerations on the collection and interpretation of information needed to measure this indicator, please see, "Important Considerations Pertaining to Indicators in Sections 4.2 and 4.3," on p. 36.

4.3.3 – Proportion of women aged 15-49 who ever experienced sexual violence from someone other than an intimate partner

Definition: The proportion of women surveyed who report ever experiencing sexual violence from anyone other than an intimate partner, including when they were a child. The perpetrator could have been a family member, friend (including a non-cohabiting boyfriend), acquaintance or stranger.

Numerator: Women aged 15-49 who report ever experiencing sexual violence (based on the checklist[16] below) perpetrated by someone other than an intimate partner.

The woman is included in the numerator if she reports someone (other than an intimate partner) ever:

- Physically forced her to have sexual intercourse against her will
- Made her afraid of what he would do if she did not have sexual intercourse with him
- Forced her to do something sexual she found degrading or humiliating

Denominator: Total women surveyed aged 15-49.

Disaggregate by: Age, region, ethnicity or other appropriate group, and perpetrator.

In order to disaggregate this indicator by perpetrator, ask all women who respond affirmatively to any of the three probes above: "Who did this to you?"

Suggested categories: male member of immediate family, male member of extended family, friend, someone she knew, stranger.

16 Checklist from: World Health Organization. WHO Multi-country Study on Women's Health and Domestic Violence Against Women: Summary Report of Initial Results on Prevalence, Health Outcomes and Women's Responses. Geneva, Switzerland: World Health Organization.

What It Measures: This indicator measures the prevalence of lifetime sexual violence perpetrated by anyone other than an intimate partner experienced by women of reproductive age at the time of the survey. The sexual violence could have happened recently or any number of years ago. If this is measured in a survey using a probability sample, this estimate can be generalized back to the target population (e.g., women of reproductive age living in a particular region or country). The indicator does not measure the frequency or duration of the sexual violence. Measurement of sexual violence in humanitarian emergencies is described in Section 6.1, and within the context of human trafficking in Section 6.2.

Measurement Tool: A population-based survey. The survey can be a general health survey which includes a module on violence against women, or one which is focused on this topic alone. The latter is recommended because focused surveys have revealed higher prevalence estimates (and likely less under reporting) than national surveys designed to measure other health outcomes in addition to violence. The question order in a survey on VAW/G is also important. Sensitive questions should not be asked at the beginning of the survey because participants need time to feel comfortable with the interviewer. Ideally, the sample of women in the survey is selected using probability methods in the target population (whether in a region, city, or country) so that the results will represent all women of reproductive age in the geographic area covered by the survey.

How to Measure It: Women are asked whether they experienced any type of sexual violence during the past 12 months from someone other than an intimate partner. If a woman answers yes to any of the items, she is included in the numerator. The numerator is then divided by the denominator.

Considerations: For special considerations on the collection and interpretation of information needed to measure this indicator, please see, "Important Considerations Pertaining to Indicators in Sections 4.2 and 4.3," on p. 36.

4.3.4 – Proportion of women aged 15-49 who experienced sexual violence from someone other than an intimate partner in the past 12 months

Definition: The proportion of women surveyed who report experiencing sexual violence during the past 12 months from anyone other than an intimate partner, which can include a family member, friend (including a non-cohabiting boyfriend), acquaintance or stranger.

Numerator: Women aged 15-49 who report experiencing sexual violence (based on the checklist[17] below) from someone other than an intimate partner during the past 12 months.

The woman is included in the numerator if she reports that in the past 12 months, someone other than an intimate partner:

- Physically forced her to have sexual intercourse against her will
- Made her afraid of what he would do if she did not have sexual intercourse
- Forced her to do something sexual she found degrading or humiliating

Denominator: Total women surveyed aged 15-49.

Disaggregate by: Age, region, ethnicity or other appropriate group, and perpetrator.

In order to disaggregate this indicator by perpetrator, ask all women who respond affirmatively to any of the three probes above: "Who did this to you?"

Suggested categories: male member of immediate family, male member of extended family, friend, someone she knew, stranger.

17 Checklist from: World Health Organization. WHO Multi-country Study on Women's Health and Domestic Violence Against Women: Summary Report of Initial Results on Prevalence, Health Outcomes and Women's Responses. Geneva, Switzerland: World Health Organization; 2005 & Macro International, DHS Domestic Violence Module.

What It Measures: This indicator measures recent sexual violence, perpetrated by someone other than an intimate partner, experienced by women of reproductive age in the target population at the time of the survey. The sexual violence could have happened anytime during the past 12 months. If this is measured in a probability survey, this estimate can be generalized back to the target population (e.g., women of reproductive age living in a particular region or country). The indicator does not measure the frequency or duration of the sexual violence.

Measurement Tool: This indicator is measured in a survey. The survey can be a general health survey which includes a module on violence against women, or one which is focused on this topic alone. The latter is recommended because focused surveys have revealed higher prevalence estimates (and likely less under reporting) than national surveys designed to measure other health outcomes in addition to violence. Ideally, the sample of women in the survey is selected using probability methods in the target population (whether in a region, city, or country) so that the results represent all women of reproductive age in the geographic area covered by the survey.

How to Measure It: Women are asked whether they experienced any type of sexual violence during the past 12 months from someone other than an intimate partner. If a woman answers yes to any of the items, she is included in the numerator. The numerator is then divided by the denominator.

Considerations: For special considerations on the collection and interpretation of information needed to measure this indicator, please see, "Important Considerations Pertaining to Indicators in Sections 4.2 and 4.3," on p. 36.

4.3.5 – Proportion of women aged 15-49 who report sexual violence below age 15

Definition: The proportion of women surveyed who report experiencing sexual violence at age 14 or below from anyone other than an intimate partner, which can include a family member, friend, acquaintance or stranger. This indicator captures child sexual abuse, as well as sexual violence perpetrated by a stranger.

Numerator: Women aged 15-49 who report experiencing sexual violence when they were 14 years old or younger (based on the checklist[18] below).

The woman is included in the numerator if she reports that below age 15 someone:

- Physically forced her to have sexual intercourse against her will
- Made her afraid of what he would do if she did not have sexual intercourse
- Forced her to do something sexual she found degrading or humiliating

Denominator: Total women surveyed aged 15-49.

Disaggregate by: Age, region, ethnicity or other appropriate group, and perpetrator.

In order to disaggregate this indicator by perpetrator, ask all women who respond affirmatively to any of the three probes above: "Who did this to you?"

Suggested categories: male member of immediate family, male member of extended family, friend, someone she knew, stranger.

18 Checklist from: World Health Organization. WHO Multi-country Study on Women's Health and Domestic Violence Against Women: Summary Report of Initial Results on Prevalence, Health Outcomes and Women's Responses. Geneva, Switzerland: World Health Organization.

What It Measures: This indicator is a measure of the past prevalence of sexual violence among girls, as reported by women, that was perpetrated by someone other than an intimate partner. The sexual violence could have happened anytime up until they turned 15 years old. Among women in the oldest age categories, the violence would have occurred many years before the time of the survey. If this is measured in a probability survey, this estimate can be generalized back to the target population (e.g., women of reproductive age living in a particular region or country). The indicator does not measure current sexual violence among children, or the frequency or duration of the sexual violence.

Measurement Tool: This indicator is measured in a survey. The survey can be a general health survey which includes a module on violence against women, or one which is focused on this topic alone. The latter is recommended because focused surveys have revealed higher prevalence estimates (and likely less under reporting) than national surveys designed to measure other health outcomes in addition to violence. Ideally, the sample of women in the survey is selected using probability methods in the target population (whether in a region, city, or country) so that the results represent all women of reproductive age in the geographic area covered by the survey.

How to Measure It: Women are asked whether they experienced any type of sexual violence from anyone other than an intimate partner when they were aged 14 or younger. If a woman answers yes to any of the items, she is included in the numerator. The numerator is then divided by the denominator.

Considerations: Since women are being asked about an event that could have occurred many years ago, estimates can be influenced by recall bias. Women may not remember exactly how old they were when the event occurred, which means the act could have taken place prior to or after age 15. A change in the past prevalence of childhood sexual violence as reported by women may reflect changes in the level of violence over time. This change could be examined within one survey, comparing the responses of older age groups of women to those in younger categories. Several explanations could account for an observed change (either up or down). For example,

older women may be more (or less) reluctant to report these events from their childhood when compared with younger women.

Trends over time can also be obtained if a survey with this question is repeated at a later time and the youngest age groups of women are compared between one survey period and the next. However, it could also reflect a change in the way women are reporting sexual violence over time, and not a true change in the proportion of women affected from one survey period to the next. For example, if a program has been implemented to raise awareness about childhood sexual violence within the community and counter stigma associated with it, women may be more likely to report their experiences in the next survey. Even though the increase in prevalence would indicate a worsening situation for women in that community, there may have been no true change, and the increase may indicate a good programmatic outcome since women felt safer disclosing their experience.

Women who report sexual violence below the age of 15 will also be captured in Indicator 4.3.3, which measures lifetime prevalence of sexual violence from someone other than an intimate partner. However, the current indicator will only capture those women who experienced sexual violence as a child aged 14 and below, while 4.3.3 includes women who experienced this type of violence at any time during their life.

Considerations: For special considerations on the collection and interpretation of information needed to measure this indicator, please see, "Important Considerations Pertaining to Indicators in Sections 4.2 and 4.3", on p. 36.

4.4 FEMALE GENITAL CUTTING/MUTILATION (FGC/M)

4.4.1 – Proportion of women aged 15-19 who have undergone female genital cutting/mutilation

Definition: Proportion of women aged 15-19 years old who have undergone female genital cutting/mutilation (FGC/M) at the time of the survey.

Numerator: Number of surveyed women aged 15-19 who have undergone FGC/M.

Denominator: Total number of women aged 15-19 in the survey.

Disaggregate by: Region, ethnicity, religion.

What It Measures: This indicator measures the prevalence of FGC/M among young women in a given area at the time of the survey, based on self-reported status. The indicator provides a measure of the effectiveness of programs and initiatives that aim to reduce the practice of FGC/M. While the programs are targeted at all age groups, change in the prevalence is most easily detected by focusing on the 15-19 year old age group. In countries and societies where the practice is prevalent, girls undergo the procedure before or around puberty. Therefore, a reduction in the practice of FGC/M would be observed first among this age group when this measure is repeated over time.

Measurement Tool: A population-based survey (e.g., Demographic and Health Survey's FGC/M module[19])

19 Macro International. Demographic and Health Surveys, female genital cutting module, accessed 1/2008 at: www.measuredhs.com/pubs/pdf/DHSQM/DHS5_Module_Female_Genital_Cutting.pdf

How to Measure It: This indicator is measured by asking if women have ever undergone a practice in which their genitals were cut. It is important to use locally adapted wording to identify FGC/M. All women aged15-19 who report that they have undergone FGC/M (any type) are included in the numerator. This is divided by the denominator, which includes the entire survey population of women in the same age group.

Considerations: The measurement of this indicator relies on self-report, which may or may not be valid. Research has shown that the validity of the response varies by context. Several researchers have reported that FGC/M is under reported, but many of these studies refer to specific types of FGC/M rather than ever having undergone an FGC/M procedure or not. In some countries such as Ghana, where FGC/M has been legally banned, women may be likely to avoid reporting that they are cut due to fear of legal ramifications. In areas where there have been campaigns to reduce the practice, women may be reluctant to report having undergone FGC/M due to a perceived stigma associated with the practice.

In some regions, where FGC/M is widely practiced, socially accepted, and few interventions are in place to prompt people to question its acceptability and legality, the self-reported responses tend to be valid. In other regions, self-reported responses should be interpreted with caution.

When measured over time, this indicator can be used to track changes in the practice of FGC/M, which can be further analyzed by education levels, geographic location, religion, and other variables to identify factors associated with change. This information can be used to improve programs aimed to eliminate FGC/M.

It should also be noted that in countries where the DHS sample is limited to married women, interpretation of the findings needs to be treated with caution. This is because women who marry as teenagers tend to be cut more often than those who marry later. In order to accurately estimate the prevalence of FGC/M, a representative sample of all women 15-19 years old should be included.

Evaluation of FGC/M interventions require a long-term period of observation because the questions are asked about something which occurred many years earlier. Since FGC/M tends to be performed over a wide range of age groups, short-term evaluations may detect a delay in age at cutting rather than incidences of cutting averted.

4.4.2 – Among cut women aged 15-19, the nature of procedure performed

Definition: Among cut women aged 15-19, the proportions of women who underwent each of three defined types of cutting. Three different measures are obtained to capture this information.

Numerator: Cut women who report undergoing one of the following procedures:

- Genital area was nicked, but no flesh removed
- Any flesh was removed from the genital area
- The genital area was sewn closed

Denominator: All cut women aged 15-19 in the survey.

Disaggregate by: Age, region, ethnicity, religion.

What It Measures: The indicator measures the prevalence of each type of cutting, per the physical descriptions of cutting given, in the survey area. Researchers have found that using a traditional classification system (e.g., the WHO classification system of Types I, II and III) led to low reliability of estimates among women. The descriptive classification listed ensures higher reliability in women's reports.

Measurement Tool: A population-based survey (e.g., Demographic and Health Survey's FGC/M module[20])

How to Measure It: This indicator is measured by asking cut women what type of procedure was performed on them. It is important to use locally adapted wording to identify each of the three descriptions. Three different proportions will result, unless one or two types are not reported at all in a given area. The three proportions added together should cover all cut women, but some women may fall into two categories (those who had flesh removed and those whose genital area was sewn closed, since the latter procedure includes the former). Each numerator includes cut women who report that

20 Macro International. Demographic and Health Surveys, female genital cutting module, accessed 1/2008 at: www.measuredhs.com/pubs/pdf/DHSQM/DHS5_Module_Female_Genital_Cutting.pdf

they have undergone a particular procedure. Each numerator is divided by the same denominator, which is the entire survey population of cut women.

Considerations: The denominator of this indicator relies on self-reported FGC/M status, which may or may not be valid. The numerator also depends on women being able and willing to describe the procedure performed on them. Research has shown that the validity of the response varies by context. Several researchers have reported that FGC/M is under reported, but many of these studies refer to specific types of FGC/M rather than ever having undergone an FGC/M procedure or not. In some countries such as Ghana, where FGC/M has been legally banned, women may be likely to avoid reporting that they are cut due to fear of legal ramifications. In areas where there have been campaigns to reduce the practice, women may be reluctant to report having undergone FGC/M due to a perceived stigma associated with the practice. In regions where FGC/M is widely practiced, socially accepted, and few interventions are in place to prompt people to question its acceptability and legality, the self-reported responses tend to be valid. In other regions, self-reported responses should be interpreted with caution.

4.4.3 – Among cut women aged 15-19, proportion who had it performed by a medical practitioner

Definition: Among cut women aged 15-19, the proportion of women who had the procedure done by a health professional.

Numerator: The number of cut women aged 15-19 who state that a health professional (either a doctor, or trained nurse or midwife) performed their procedure.

Denominator: All cut women aged 15-19 in the survey.

Disaggregate by: Age, region, ethnicity, religion.

What It Measures: This measures the percent of cut women who had their procedure performed by a health professional. If the procedure was performed by another type of practitioner, the likelihood of infection and other medical complications is high.

Measurement Tool: A population-based survey (e.g., Demographic and Health Survey's FGC/M module[21])

How to Measure It: This indicator is measured by asking cut women who performed their procedure. Two basic categories are used:

- Traditional practitioners which can include a traditional circumciser, traditional birth attendant (TBA), or other person
- Health professionals which can include a doctor, nurse, or school-trained midwife (as opposed to a TBA who has gone through a short training program).

It is important to use locally adapted wording to identify traditional practitioners. The numerator includes women who report being cut by a health professional, which is divided by the denominator that includes all cut women in the survey.

21 Macro International. Demographic and Health Surveys, female genital cutting module, accessed 1/2008 at: www.measuredhs.com/pubs/pdf/DHSQM/DHS5_Module_Female_Genital_Cutting.pdf

Considerations: There are many negative effects that can follow a female cutting procedure. Some of these effects depend on how the procedure itself was performed. For example, the chance of infection would be greatly reduced if performed within a clinical environment, and if anesthesia were used within this environment, pain during the procedure would also be reduced. However, having the procedure performed by a health professional may do little to ameliorate the psychological effects of cutting, which have been widely reported in the literature. Further, female genital cutting/mutilation is located within the social context of patriarchal social control over women and their sexuality. Some researchers therefore consider that having the procedure done by a health professional represents progress in the wrong direction: rather than working towards the eventual elimination of the practice altogether, moving it within the clinical context lends credibility to the practice. In addition, if women were very young when they had the cutting performed, they may not remember or know who did it and what their qualifications were. One alternative would be asking women whether or not the cutting was performed in a health facility. This indicator should be interpreted with caution.

4.4.4 – Proportion of mothers aged 15-49 who have at least one daughter who is cut

Definition: Among mothers aged 15-49 who have at least one daughter, the proportion with one or more who is/are cut.

Numerator: The number of mothers with one or more daughters who have been cut.

Denominator: All surveyed mothers with at least one daughter who is age X (culturally appropriate minimum age at which girls are cut) or older.

Disaggregate by: Age of the mother, region, ethnicity, religion.

What It Measures: This indicator provides a measure of prevalence of female cutting in a geographic area at the time of the survey. This may reflect recent patterns in the case of women with young daughters, or patterns from many years before if the daughters are older.

Measurement Tool: Population-based survey (e.g., Demographic Health Survey's FGC/M module)

How to Measure It: This indicator is measured by asking women with at least one daughter who is old enough to be cut if they have any cut daughters. This should include women who have daughters who are old enough to be cut in that particular cultural context. It will be important to determine the minimum and maximum age at which girls are cut in the particular place where this is being measured. The numerator includes women with at least one cut daughter, which is divided by the denominator that includes all women in the survey with daughters of the same minimum age as women in the numerator.

Considerations: The measurement of this indicator relies on the willingness of women to report that their daughters have been cut, which may or may not be valid. In countries where FGC/M has

been legally banned, women may be likely to avoid reporting that their daughters are cut due to fear of legal ramifications. In areas where there have been campaigns to reduce the practice, women may be reluctant to report having had their daughters cut due to a perceived stigma associated with the practice. In regions where FGC/M is widely practiced, socially accepted, and few interventions are in place to prompt people to question its acceptability and legality, women's responses will tend to be valid. In other regions, responses should be interpreted with caution.

When measured over time, this indicator can be used to track changes, which can be further analyzed by education levels, geographic location, religion, and other variables to identify factors associated with change. This information can be used to improve programs aimed to eliminate FGC/M. A way of making this indicator reflect only recent prevalence would be to limit the age of the daughters to a range that would mean that procedures had taken place in the past five years, or limit women's responses to daughters who have been cut in the past five years. This would make the interpretation of a change in patterns more reliable, with the same caveats on interpreting women's reports with caution as detailed above.

4.4.5. – Among mothers aged 15-49 with at least one cut daughter, proportion of the most recently cut daughters who had it performed by a medical practitioner

Definition: Among mothers with cut daughters, the proportion of those whose most recently cut daughter had the procedure done by a health professional.

Numerator: The number of women with one or more cut daughters who state that a health professional (either a doctor, or trained nurse or midwife) performed the procedure on the one most recently cut.

Denominator: All women with at least one cut daughter in the survey.

Disaggregate by: Age, region, ethnicity, religion.

What It Measures: This measures the pattern of recent practitioner use for female genital cutting/mutilation. By asking about the most recently cut daughter, recall bias is minimized, and answers will reflect more recent patterns than if all daughters, or other daughters were included in this measure. If the procedure was performed by another type of practitioner, the likelihood of infection and other medical complications is high.

Measurement Tool: A population-based survey with a series of questions to identify the most recently cut daughter and the type of person who cut her (e.g., Demographic Health Survey's FGC/M module[22])

How to Measure It: This indicator is measured by asking women with cut daughters who performed the procedure on their most recently cut daughter. Two basic categories of practitioners are used:

22 Macro International. Demographic and Health Surveys, female genital cutting module, accessed 1/2008 at: www.measuredhs.com/pubs/pdf/DHSQM/DHS5_Module_Female_Genital_Cutting.pdf

- Traditional practitioners which can include a traditional circumciser, traditional birth attendant (TBA), or other person
- Health professionals which can include a doctor, nurse, or school-trained midwife (as opposed to a TBA who has gone through a short training program).

It is important to use locally adapted wording to identify traditional practitioners. The numerator includes women whose most recently cut daughter had the procedure done by a health professional, which is divided by the denominator that includes all women with cut daughters in the survey.

Considerations: There are many negative effects that can follow a female cutting procedure. Some of these effects depend on how the procedure itself was performed. For example, the chance of infection would be greatly reduced if performed within a clinical environment, and if anesthesia were used within this environment, pain during the procedure would also be reduced. However, having the procedure performed by a health professional may do little to ameliorate the psychological effects of cutting, which have been widely reported in the literature. Further, female genital cutting is located within the social context of patriarchal social control over women and their sexuality. Some researchers therefore consider that having the procedure done by a health professional represents progress in the wrong direction: rather than working towards the eventual elimination of the practice altogether, moving it within the clinical context lends credibility to the practice. Therefore, this indicator should be interpreted with caution.

4.5 CHILD MARRIAGE

4.5.1 – Proportion of women aged 18-24 who were married before age 18

Definition: The proportion of women surveyed who were married when they were younger than the age of 18.

Numerator: Number of women aged 18-24 who report that they were married below the age of 18.

Denominator: Total number of women surveyed, aged 18-24.

Disaggregate by: Age group, region/area, ethnicity, religion

What It Measures: This indicator provides a measure of the prevalence of recent child marriage in a given country or region during a specified period. The measure is limited to younger women in order to measure child marriage which has taken place within the past several years. Policy makers, program managers and evaluators in countries that are discouraging child marriage may be interested in monitoring the change in the proportion of girls who are married below age 18, which can be done by using this indicator in more than one survey implemented at least 3-5 years apart.

Measurement Tool: A population-based survey (e.g., Demographic Health Surveys (DHS) and Multiple Indicator Cluster Surveys (MICS)).

How to Measure It: A question regarding age at first marriage is included in population-based surveys such as DHS or MICS. The indicator is calculated by dividing the number of women aged 18-24 who say they were married at any time before their 18th birthday, by the total number of women in the survey aged 18 through 24, at the time of the survey.

Considerations: Measurement of this indicator by itself is not sufficient to determine whether legal actions and interventions aimed at discouraging early marriage are having the intended effect. Although the indicator measures recent child marriage, some of the older women included in this measure will be answering about marriages which took place up to 10 or 12 years before the survey. The impact of a recent change in law, policy or programmatic intervention would not be demonstrated by this indicator until several years elapsed.

In many countries, vital registration information is not complete or accurate, which is why this information is best gathered retrospectively in a survey. In some regions of the world (e.g., South Asia), girls are married at a young age (e.g., age 12), but do not start living with their spouses until an older age. In such instances the numerator for "age at first marriage" could be locally defined as the age at which the woman began living with her first spouse/partner. However, regardless of when women begin living with their spouse, being married as a child is a violation of human rights. Therefore, the definition of marriage being used for this indicator should be carefully considered.

In some countries, the legal age of marriage is under 18 years, and some countries have lower legal ages for girls than for boys. However, international organizations such as UNICEF and the United Nations Population Fund have suggested that 18 should be considered the minimum age of marriage. This indicator is meant to measure the instance of child marriage based on this recommendation.

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Chapter 5: Programs addressing VAW/G by sector

Introduction

Health: Physical and sexual violence are associated with negative health consequences and mortality among affected women and children. Research has shown that women who report experiencing physical or sexual violence are more likely to suffer reproductive and maternal morbidity as well as ill health in general. Studies around the world have documented that physical abuse occurs in approximately 4% to 15% of pregnancies and is associated with negative outcomes for mothers and infants. HIV infection is also associated with VAW/G. HIV positive women are more at risk for IPV, especially at the time of status disclosure to their partners. Women who experience IPV and other sexual violence are at greater risk for becoming infected with HIV as a result of this violence.

Therefore, health service delivery programs are key in the prevention and response to VAW/G. Every clinic visit made by a woman presents an opportunity to address and ameliorate the effects of violence as well as help prevent future incidents. In order to take advantage of these opportunities, health facilities and providers need to be prepared to deliver appropriate services, including identification of survivors, necessary health services, counseling and referrals to community-based resources such as legal aid, safe shelter and social services.

Section 5.1 presents indicators pertaining to the readiness, breadth and coverage of VAW/G service delivery. Please note that indicators 6.1.7, 6.1.8, and 6.1.10 which refer to humanitarian emergencies can be used in this section as well.

Education: Growing evidence demonstrates that sexual abuse and other forms of violence against women and girls are prevalent in educational settings. Violence against women and girls adversely affects school enrollment, attendance, abandonment, and is asso-

ciated with increased risk of early pregnancy and STIS. The education sector in many countries still lacks policies, protocols, and systematic channels to promote zero tolerance for sexual abuse. In many countries, schools ignore female students' complaints. Fearing reprisals from teachers and because they believe nothing will be done, most girls choose not to complain. Sexual abuse takes place in schools in many countries, but school administrators, the larger community, and ministries of education remain indifferent.

Integrating curriculum about violence against women into teacher and other school staff training illustrates the education sector's systematic commitment to preventing sexual violence in schools. Initiatives to enable students to report incidents safely and anonymously are also in place, as well as initiatives to implement zero tolerance among staff members and others. These efforts increase awareness of the issue and sensitize educators on how to address incidents, should they arise. Policy makers, program managers and evaluators in countries that are trying to promote gender equality and women's empowerment within the context of girls' education may be interested in monitoring the development and inclusion of VAW/G curricula in sector-wide activities. This may also encourage parents, who may keep girls out of school because they fear for their safety, to allow higher enrollment of girls in school as well as keeping girls in school through graduation. A higher level of education among women is associated with a range of positive reproductive and other health outcomes (e.g., child survival and well being and lower teen fertility).

Section 5.2 provides indicators that address VAW/G in educational settings. The indicators help gauge the existence of protocols for addressing reported sexual abuse at the institutional level. They also address the systematic provision of capacity building efforts to increase awareness of the issue at the institutional, regional and national levels, as well as drawing the attention of schools to the problem.

Justice and Security: The UN Declaration on the Elimination of Violence Against Women asks States to exercise due diligence to prevent, investigate and punish acts of violence against women,

whether perpetrated by the state or private persons. To comply with the UN Declaration, States must establish a functioning police and legal system to properly handle the reporting and prosecution of VAW/G incidents. The first step to achieving such a system is to ensure that appropriate laws exist. Then, a national protocol for how to handle complaints of VAW/G to the police should be established. Such a protocol should include how and where survivors are confidentially interviewed and the type of investigation that should take place following the report. However, existence of a protocol is not sufficient; law enforcement professionals must also be properly trained in the protocol and its implementation.

Although national protocols are in place in many countries, they do not guarantee the reporting and proper handling of VAW/G cases. Women are unlikely to report VAW/G to the police in the first place because of stigma, fear, and the threat of losing their children. When women do report VAW/G-related incidents to the police, the cases are often classified as assault, robbery or rape. This means that it is very difficult to use these records to investigate how VAW/G cases are followed within the legal system. A special classification that distinguishes VAW/G-related reports from other violence should be made in police records. Police in much of the world are not trained to handle cases of VAW/G and frequently blame the victim. Personal biases based on cultural norms around the status of women also interfere with justice. Police and legal systems are often ill equipped to properly manage victims, document incidents and prosecute cases. Although States are called upon to protect women, in reality, there is a lack of support for this premise. All these factors point to the importance of measuring the ability of police and legal systems to respond to VAW/G.

The indicators in section 5.3 are a starting point to assess the extent to which law enforcement and legal systems are able to respond to VAW/G.

Social Welfare: Women and children who experience violence in the home or elsewhere need help in a number of areas not specifically addressed by health, educational, or legal programs. Social welfare programs comprise a range of activities which include pro-

vision of or referral to a safe space, or shelters for women and children, crisis hotlines for intimate partner and sexual violence, mental health counseling, support groups, safety planning, support during legal proceedings, child welfare, recreational programs for abused girls, and crisis intervention skills including training, income generation, and self defense. Some or all of these activities would ideally be included in comprehensive case management programs for affected women and children. However, in most areas, social-welfare based services for VAW/G survivors are scarce. Therefore, monitoring and evaluating each of these services separately may be the best strategy. Section 5.4 includes basic indicators to assess the extent to which these programs are available, and how accessible they are to women and children in need.

5.1 HEALTH

5.1.1 – Proportion of health units that have documented & adopted a protocol for the clinical management of VAW/G survivors

Definition: The percent of health facilities that have a protocol in place for the clinical management of VAW/G survivors that has been both documented and adopted.

Numerator: Number of health facilities in the geographic region of study (e.g., country, region, community) reporting that they have both documented and adopted a protocol for the clinical management of VAW/G survivors.

Ask: Are there written policies and procedures (a protocol) in this clinic to identify victims of VAW/G? May I see a copy?

Denominator: Total number of health units surveyed.

Disaggregate by: Type of health unit, geographic area surveyed (region, province, urban or rural area)

What It Measures: This indicator measures whether or not a health unit has a standard protocol to guide the identification, service provision and referral mechanism for VAW/G survivors. The protocol should describe the elements of care that should be provided, and the way in which it should take place. The protocol should be displayed or be otherwise accessible to health facility staff.

Measurement Tool: A survey of health units. The survey would ideally be part of a specific study on readiness of health units, using a tool such as the IPPF assessment.[23] The survey could be part of a

23 International Planned Parenthood Federation. 2004. Improving the health sector response to gender-based violence: A resource manual for health care professionals in developing countries. IPPF/WHR Tools/02/September 2004. www.

more general study of health units and service provision. Either way, a probability sample of health units should be selected in order to assess the situation in the geographic area of interest.

How to Measure It: In order to be included in the numerator, the answer to both questions must be "yes". Health units (at any level: primary, referral or tertiary care) must be able to show a documented protocol outlining the procedures to be used for identifying, providing care for and referring VAW/G survivors who present to the unit. Health unit staff should be able to state where they can access the protocol when they need to refer to it (e.g., it is posted somewhere, or kept in a place readily accessible to staff). "Documented" means that staff should be able to show the protocol during an assessment. "Adopted" means that the health unit reports that they use it to guide practice. Units would be asked about the specific elements of clinical management, such as identification of affected women and girls, services to be provided, etc, as outlined in standard assessments such as IPPF, UNFPA,[24] and SVRI.[25] All health units that can answer the question affirmatively about policies and procedures and show a corresponding document are entered into the numerator. This number is then divided by the denominator, which includes all health units surveyed.

Considerations: Ideally we would want to measure how the protocol is implemented, but this would involve a complex assessment. The IPPF, UNFPA and SVRI documents include examples of such an assessment of health unit readiness to deliver services to VAW/G survivors, which includes questions pertaining to a protocol. This indicator should be considered as a single part of the other indicators in this section on how prepared health units are to deliver services.

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ippfwhr.org/atf/cf/%7B4FA48DB8-CE54-4CD3-B335-553F8BE1C230%7D/gbv_guide_en.pdf

24 Stevens, L. 2002. 'A practical approach to gender-based violence: A programme guide for health care providers and managers' developed by the UN Population Fund. Int. J of Gyn & Obstet. 78 (Suppl. 1): S111-S117.

25 Sexual Violence Research Initiative. 2008. Assessment Instruments Used to Study Healthcare-Based Interventions for Women Who Have Experienced Sexual Violence. Available at: http://www.svri.org/evaluation.htm

5.1.2 – Proportion of health units that have done a readiness assessment for the delivery of VAW/G services

Definition: The proportion of health units which have gone through a process to assess their readiness to deliver appropriate services to VAW/G survivors, at a specific point in time in the geographic area of interest.

Numerator: Number of health facilities in the geographic region of study (nation, province, state, community) reporting that they have undergone a readiness assessment and can produce documentation that the assessment took place.

The readiness assessment would include asking questions about areas defined in the IPPF assessment, including provider knowledge, beliefs and practices, clinic resources, VAW/G training experience of staff, clinic protocol, and a quality of care assessment for clients.[26]

Denominator: Total number of health facilities surveyed in the geographic region of study (nation, province, state, community).

Disaggregate by: Type of health unit, region or province (if national study), urban or rural area

What It Measures: This measures a health unit's efforts to provide a basic level of service that can be expected to be delivered to VAW/G survivors. If there is a low proportion of facilities who have done such an assessment, it would indicate that the services being provided may be of variable quality. Once a readiness assessment is completed, health units will be in a position to look at their strengths and rectify the gaps in VAW/G service provision.

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

Measurement Tool: A survey of health units. The survey would ideally be part of a specific study on VAW/G service delivery. The survey could also be part of a more general study of health units and service provision. Either way, a probability sample of health units should be selected in order to assess the situation in the geographic area of interest.

How to Measure It: The health unit should be able to show documentation of the assessment that took place, including the areas examined. All health units that can produce such documentation are entered into the numerator. This number is then divided by the denominator, which includes all health units surveyed.

Considerations: The team measuring this indicator should decide what an acceptable readiness assessment would entail. Also, the same type of assessment may not be appropriate for a primary health care unit in a rural area that would be appropriate for a larger unit at a higher level of the health system. Thought should go into how comprehensive an assessment would need to be in order to be counted in the numerator.

5.1.3 – Proportion of health units that have commodities for the clinical management of VAW/G

Definition: The proportion of health units who have the clinical commodities needed for the clinical management of VAW/G, at a specific point in time in the geographic area of interest.

Numerator: Number of health facilities in the geographic region of study (nation, province, state, community) reporting that they have all of the relevant clinical commodities for the management of VAW/G.

Necessary commodities may include the following resources within the unit itself, or in the referral system to ensure women's access to the following resources in the community:

- Private area for exam/interview
- Supplies for STI and HIV testing
- Supplies for HIV post-exposure prophylaxis
- Rape kit and supplies for collecting forensic evidence
- Staff trained to identify, counsel, carry out needed clinical procedures, and refer
- Emergency contraception
- Safe abortion

Denominator: Total number of health units surveyed in the geographic region of study (nation, province, state, community).

Disaggregate by: Type of health unit, region or province (if national study), urban or rural area

What It Measures: This is a measure of readiness for health units to provide VAW/G services. If the necessary commodities are not present in the health unit, presumably, VAW/G services cannot be provided at an acceptable level. The indicator does not measure the service quality with which these commodities are delivered.

Measurement Tool: A survey of health units to assess what each has in terms of human and physical resources. The survey would ideally be part of a specific study on VAW/G service delivery. The survey could also be part of a more general study of health units and service provision. Either way, a probability sample of health units should be selected in order to assess the situation in the geographic area of interest.

How to Measure It: The elements on the checklist should be developed to reflect what is appropriate for the level of care (e.g., whether the unit should have access to STI testing itself or referral to a higher level clinic to provide access). Those units that can answer yes to all of the resources determined to be appropriate would count in the numerator. This number is then divided by the denominator, which includes all surveyed units.

Considerations: Although the list of necessary components of care should reflect what women need, there are constraints on what will be available in health units. For example, in places where abortion is illegal, even when the pregnancy is a result of sexual violence, including access to safe abortion in the checklist will mean that none of the health units will be included in the numerator. Thought should be put into what the most important elements are in terms of survivor's needs and what is feasible within a given context. It may be beneficial to include only those elements that are legally possible within any context to assess readiness for service provision for other VAW/G services.

5.1.4 – Proportion of health units with at least one service provider trained to care for and refer VAW/G survivors

Definition: The percent of health facilities with at least one provider who has been trained within the past three years in the identification, care and support of VAW/G survivors in the geographic area of interest.

Numerator: Number of health facilities in the geographic region of study (nation, province, state, community) reporting that at least one provider has been trained in the past three years.

Providers in health units would be asked if and when they participated in a training focused on VAW/G, such as the module that appears in the IPPF assessment[27]. If there is at least one provider who was trained within three years of the time of interview, the facility would be included in the numerator.

Denominator: Total number of health facilities in the geographic region of study (nation, province, state, community).

Disaggregate by: Type of health unit, region or province (if national study), urban or rural area

What It Measures: This is an indicator of readiness for health units to provide VAW/G services. If staff have undergone no specific training, the provision of such services could be done in an inappropriate or detrimental manner. This indicator reflects training, but not the quality of the training, or how well the staff member integrated what they learned into practice.

Measurement Tool: A survey of health units, with a query about staff participation in training on the provision of VAW/G services.

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

The survey would ideally be part of a specific study on VAW/G service delivery, such as the IPPF assessment. The survey could also be part of a more general study of health units and service provision. Either way, a probability sample of health units should be selected in order to assess the situation in the geographic area of interest.

How to Measure It: When health units are visited, a manager is asked if they have any staff who have participated in a training on the service provision for VAW/G survivors including identification, within the past three years. Facilities with at least one staff member who has undergone such training are counted in the numerator. That number is then divided by the denominator, which includes all units surveyed.

Considerations: It may be difficult to get accurate information on the participation of staff in training programs without interviewing each one. Even if the staff replies affirmatively, without knowing anything about the curriculum of the program, how intensive or long it was, this indicator may not tell us very much. It might be better to query staff about their own readiness to deliver services based on their training experience, which could be done using the module for the provider interview included in the IPPF Knowledge, Attitude and Practices Survey. In addition, the number of total providers in a facility should be considered, when interpreting this indicator. For example, one provider trained in a small facility with only five total providers would be a good ratio. If the facility was large and had only one provider trained out of 20, this would be only slightly better than no providers trained since a woman would have little chance of being seen by that provider. In addition, there would be no way to know if affected women and girls were actually referred to that provider.

5.1.5 – Number of service providers trained to identify, refer, and care for VAW/G survivors

Definition: The number of health service providers trained in a VAW/G training program during a specific time period.

Count: Number of health providers trained in the past year or other period (the length of time would depend on how often the program holds trainings).

Disaggregate by: Type of provider, region or province, area in which they work (urban or rural).

What It Measures: This indicator is an output measure for a program designed to provide training to health service providers in VAW/G service provision. This will provide a measure of coverage of trained personnel per geographic area of interest, and will help monitor whether or not a program is attaining its target number of providers trained.

Measurement Tool: Records of the training program that reflect training program participants among current staff. The record should reflect, at minimum, what type of provider the participant was and where they practice.

How to Measure It: A review of records reflecting program participation during the past year or other specific period. The number of providers trained is counted, and disaggregated by practitioner type and location where they practice in the country (if it is a national program), region or community.

Considerations: This indicator will provide a count of providers trained, but not how well they integrate the information disseminated or how well they use it later in their own practice. Presumably, if they are allowed to participate in the training program, there is a level of support in the health unit in which they practice for service provision to VAW/G survivors. This is one among several factors that may influence overall care provided in any place by any one provider.

5.1.6 – Number of health providers trained in FGC/M management and counseling

Definition: The number of health providers who have been trained to manage the complications resulting from FGC/M procedures, including OB/GYN related, as well as psycho-social, in a specific time period in a geographic area of interest.

Count: Number of health providers trained in the management of FGC/M complications in the selected time period (the length of time would depend on how often the program holds trainings).

Disaggregate by: Type of provider, region or province, area in which they work (urban or rural)

What It Measures: This indicator is an output measure for a program designed to provide training to health service providers in the management of complications, both physical and psychosocial, resulting from FGC/M procedures. This will provide a measure of coverage of trained personnel per geographic area of interest, and will help monitor whether or not a program is attaining its target number of providers trained.

Measurement Tool: Records of the training program that monitor characteristics of training program participants. The record should reflect, at minimum, what type of provider the participant was and where they practice.

How to Measure It: A review of records reflecting program participation during the past year or other specific period. The number of providers trained is counted, and disaggregated by practitioner type and location where they practice in the country (if it is a national program), region or community.

Considerations: This indicator will only be measured in regions where FGC/M occurs. The type of training provided will also depend on what type of FGC/M takes place. The measure will provide a count of providers trained, but not how well they integrate the information disseminated or how well they use it in their own practice.

5.1.7 – Proportion of women who were asked about physical and sexual violence during a visit to a health unit

Definition: The proportion of women who presented to the clinic for any reason who were asked about physical or sexual violence, during a specific period of time (e.g., during the past 12 months)
.
Numerator: Number of women who were asked, during the course of their service provision at the unit, about any violence that had ever occurred, either physical or sexual, in the geographic area of study (nation, province, state, community).

If this is being measured with a medical record review, all women's charts which noted that they were asked if they experienced any physical and sexual violence by a provider would be entered into the numerator.

If this is being measured in a survey of women based on exit interviews from the health unit, all women leaving the clinic would be asked if a provider asked them if they had ever experienced any physical or sexual violence. All women answering yes would be entered into the numerator.

Denominator:
If the indicator is measured through a record review, this is the number of women's records that were reviewed at the health unit.

If the indicator is being measured through an exit interview, this is the total number of women interviewed.

Disaggregate by: Type of health unit, geographic area (region, province, urban or other community).

What It Measures: The number of women presenting for any type of care at health units who are asked about experiencing any physical or sexual violence that may have occurred, ever. The count can be determined per health unit, or per area of interest.

Measurement Tool: Medical record review at a health unit, or in a survey using exit interviews at health units.

How to Measure It: If using a record review to report this indicator: The records should have a space that records whether or not women were asked about any experience of physical or sexual violence. If this is not part of the record, a review of the narrative recorded for each visit will have to be reviewed, but this narrative would have to note whether or not women have been asked about any experience of physical or sexual violence. All women's records which noted that they were asked about any experience of physical or sexual violence would be entered into the numerator, which would then be divided by the denominator, which is the total number of women's records reviewed.

Totals at different units within the same community can be summed together to get an aggregate number of women asked about experiences of physical or sexual violence for a given area, based on either a sample of health units, or a census of all health units within a given area.

In an exit interview study, all women answering that they were asked about experiences of physical or sexual violence would be entered into the numerator, which is then divided by the denominator that includes all women interviewed.

Considerations: If this indicator is measured using a record review, the resulting numbers will only be as accurate as the data sources. Measurement of this indicator relies on records maintained at health units which include information about whether a woman was asked about experiences of physical or sexual violence. This information may not be consistently recorded by different providers, which may lead to over- or underestimates in counting women as part of the numerator. Whether or not women are asked about physical or sexual violence could be added as a check box to medical records to ensure that these records are properly counted.

If an exit interview survey is used, care needs to be used to ensure that women are interviewed in a private area and in a sensitive

manner. Even though they are not being asked to report violence at the interview (they will be asked if they were asked about it), a study of this type needs to adhere to the same ethical standards that apply to asking women about experiences with violence, as outlined by the WHO[28].

Ideally, all women should be asked about experiences with physical or sexual violence, regardless of the type of visit. However, health units may have protocols around which type of visits include this type of interview. For example, only women presenting for reproductive health services may be questioned. Therefore, the denominator for this measure should only include the type of visit specified by the protocol, whether done by medical record review or by an exit interview. If no such protocol exists, then the denominator would be defined as described above.

28 Watts, C et al. 2001. Putting women first: Ethical and safety recommendations for research on domestic violence against women. Geneva, World Health Organization (document WHO/EIP/GPE/01.1, available at: http://whqlibdoc.who.int/hq/2001/WHO_FCH_GWH_01.1.pdf

5.1.8 – Proportion of women who reported physical and/or sexual violence

Definition: The percent of women per health unit who reported physical and/or sexual violence to a health provider during a specified period (e.g., during the past 12 months).

Numerator: Number of women who reported experiencing recent physical and/or sexual violence to a health provider, during a certain period of time preceding the survey (e.g., past year).

Denominator: Number of women asked about physical or sexual violence at the health unit, during the same time period.

Disaggregate by: Age of survivor and region, source of referral, type of violence reported (physical or sexual).

What It Measures: This output indicator provides a measure of service utilization by VAW/G survivors who disclose their experience to health providers.

Measurement Tool: Medical record review at a health unit.

How to Measure It: The records should have a space that documents whether or not women were asked about physical or sexual violence and whether or not women reported such violence. If this is not part of the record, a review of the narrative recorded for each visit will have to be done, but this narrative would have to note whether or not women have been asked about any experience of physical or sexual violence. Women who disclose that they have experienced recent physical and or sexual violence will be entered into the numerator. This number is then divided by the denominator, which includes all women who were asked about physical or sexual violence at the health unit. This proportion can be extended to include multiple health units in an area/country, by adding the numerators and denominators together to get an overall proportion of women who disclosed.

Considerations: Measurement of this indicator relies on records maintained at health units which include information on a provider questioning about physical or sexual violence, and disclosure. This information may not be consistently recorded by different providers, which may lead to errors in counting women as part of either the numerator or denominator. Even if the data sources are of good quality, measurement of this indicator should be interpreted with caution. A change in the proportion of women disclosing violence may indicate a number of things: a true rise in prevalence, or more likely, a rise in the number of affected women who are willing to disclose or report their experience. An increase could also mean a better service delivery environment which makes women feel more comfortable about disclosure. Therefore, this indicator should be used in conjunction with the other indicators in this section to obtain a clear picture of what is taking place at the health unit. For example, if a number of providers have recently gone through training and sensitization for VAW/G service provision, rates of disclosure would likely rise.

5.1.9 – Proportion of VAW/G survivors who received appropriate care

Definition: The percent of women/girls who have experienced and disclosed recent violence, per health unit, who were appropriately cared for within a specific time period (e.g., during the past 12 months).

Numerator: Number of women/girls who reported experiencing recent physical and/or sexual violence, who also received appropriate care, during a certain period of time preceding the survey (e.g., past year).

Appropriate care, depending on the type of violence experienced, may include:

- STI screening and treatment
- HIV counseling and testing
- Emergency contraception (rape survivors presenting within 72 hours)
- Access to safe abortion
- Psycho-social counseling
- Referrals to legal and other community (safe shelter) services

Denominator: Number of women/girls who disclosed physical and/or sexual violence at the health unit, during the same time period.

Disaggregate by: age of survivor and region, source of referral.

What It Measures: This output indicator provides a measure of adequate service delivery to VAW/G survivors who disclose their experience to health providers. This does not assess the quality of service delivery.

Measurement Tool: Medical record review at a health unit.

How to Measure It: Women who disclose that they have experienced recent physical and/or sexual violence and who have received appropriate elements of care, which correlates to a checklist

like the one above, will be entered into the numerator. This number is then divided by the denominator, which includes all women who disclosed recent violence at the health unit. This proportion can be extended to include multiple health units in an area/country, by adding the numerators and denominators together to get an overall proportion of women who disclosed and were cared for appropriately.

Considerations: Measurement of this indicator relies on records maintained at health units which include details on the type of violence disclosed and the care/referrals which followed. This information may not be consistently recorded by different providers, which may lead to errors in counting women as part of either the numerator or denominator. If the data sources are of reasonable quality, this indicator will show how well affected women and children are cared for, with regard to the elements of care received.

5.1.10 – Proportion of rape survivors who received comprehensive care

Definition: Proportion of rape survivors presenting at health services who received comprehensive care, during a specified period of time (e.g., during the past 12 months).

Numerator: 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).

Comprehensive care includes:

- STI screening and treatment
- HIV counseling and testing, and PEP (within 72 hours of the incident)
- Psycho-social services
- Access to legal abortion
- Collection of forensic evidence using a Rape Kit
- Access to emergency contraception (within 72 hours of the incident)

Denominator: Total number of rape survivors seeking care at facilities included in the survey.

Disaggregate by: Age of survivor and region, element of care, and the number of elements received.

What It Measures: This output indicator provides a measure of adequate service delivery to rape survivors who present at health units. This does not assess the quality of service delivered.

Measurement Tool: Medical record review at a health unit.

How to Measure It: Women who disclose that they have been raped and who have received appropriate elements of care, which correlates to a checklist like the one above, will be entered into the numerator. This number is then divided by the denominator, which includes all women who presented at the health unit and disclosed

being raped. This proportion can be extended to include multiple health units in an area/country, by adding the numerators and denominators together to get an overall proportion of women who were raped and who received the appropriate elements of care.

Considerations: Measurement of this indicator relies on records maintained at health units which include details on sexual violence, how soon the woman presented to the facility, and the care/referrals which followed. This information may not be consistently recorded by different providers, which may lead to errors in counting women as part of either the numerator or denominator. If the data sources are of reasonable quality, this indicator will show whether affected women and children receive appropriate care. However, the quality of care delivered may range from excellent to inadequate.

5.2 EDUCATION

5.2.1 – Percent of schools that have procedures to take action on reported cases of sexual abuse

Definition: The percent of schools in a country or region that have established procedures to take action on reported cases of sexual abuse.

Numerator: Number of schools that have procedures to take action on reported cases of sexual abuse among students

In order to be included in the numerator, a school must have procedures in place to take action on reports. In addition, a school's protocols should be current (revised within 5 years), formally documented and readily available. The procedures should align with the National Teachers' Code of Conduct and/or any Ministry of Education policies or protocols for sexual abuse cases. If there are none in place at the country level, this indicator cannot be measured.

Denominator: Total number of schools surveyed

Disaggregate by: Level of school (i.e. primary, secondary, vocational, university); type (e.g., English-medium, religious focus, all-girls, co-ed, etc); geographic area (e.g., country/region, urban/rural); public-/private-funded

What It Measures: This indicator measures the percent of schools in which procedures exist which promote an established means of redress if women or girls are subjected to sexual violence. The existence of these procedures at the institutional level discourages instances of sexual harassment, intimidation or violence in schools.

Measurement Tool: A survey of schools, based on a probability sample of schools in a region or country. The survey could be specifically focused on gathering information about VAW/G in school

(e.g., USAID interview guide for school-based information[29]), or could be part of a more general study of schools.

How to Measure It: The indicator is calculated by asking schools for documentation of procedures to take action on reported acts of violence perpetrated against female students. Schools that can produce this documentation comprise the numerator, which is then divided by the total number of schools in the survey.

Considerations: Each institution's commitment to ensuring a safe environment should be clearly expressed through a set of formally documented procedures to implement in order to take action on reported cases of sexual abuse among students. The documented procedures should clearly define sexual harassment, abuse, intimidation and violence, as well as detail protocols to report violations, while protecting the confidentiality of the person filing the report. Procedures should also outline steps for investigating cases while maintaining a safe environment for plaintiffs. Many countries currently do not have a National Teachers' Code of Conduct or other policy that explicitly addresses teacher-student relations in the context of sexual abuse, harassment, intimidation, or violence. Even if such a policy exists, countries may not have formalized procedures or channels for victims in schools to report instances of sexual abuse and seek redress. In addition, individual educators may or may not be aware of national codes or policies in place, and/or the issues connected to sexual abuse (including harassment, intimidation, and violence) in the school setting. These individual attitudes are important to note, and could be part of a larger study on schools, but do not apply to the current indicator.

Measurement of this indicator by itself does not determine the level of awareness or an institution's capacity to carry out the documented procedures. Nor does it measure how safe a woman or girl feels reporting sexual abuse to the school authorities. This indicator should be considered in conjunction with others in this chapter to present a more complete picture on a school system's readiness and commitment to act on reports of sexual abuse.

29 USAID. 2006. Safe Schools Program Quantitative Research Instrument to Measure School-Related Gender-Based Violence

5.2.2 – Number of teacher training programs that include sexual and physical VAW/G in their curriculums

Definition: The number of training programs for teachers in a country or region that have curricula that include components focused on sexual and physical violence against women. In order to be counted, these components should address how VAW/G is related to various factors such as power, coercion and gender.

Count: A simple count of training programs conforming to the defined criteria, in the area targeted for monitoring.

Disaggregate by: Program topic (e.g., HIV/AIDS, professional development), VAW/G topic included (e.g., power, coercion or gender).

What It Measures: Teachers at all levels are engaged in various training opportunities throughout their career. Teacher trainings range from pre-certification coursework and professional development to seminars addressing specific topics for their school community (e.g., HIV/AIDS awareness and prevention, first aid, vocational or career guidance for youth, etc). Teacher attitudes are influenced by cultural norms which may promote gender inequity or sexual harassment. Attitudes can be changed within the context of professional training. Implementing training programs for teachers that include a focus on VAW/G, its effects and why its prevention is critical can lay the foundation for providing a safe environment for girls and young women in educational institutions.

This indicator captures the number of teacher training programs offered in a country or region that include components on sexual and physical VAW/G in their curriculums. These VAW/G components should address topics specifically related to sexual and physical violence against women and girls, such as power, coercion, and gender.

Measurement Tool: This indicator is measured in a survey of teacher training programs in a region or country. The survey could

be specifically focused on gathering information about VAW/G in teacher training programs, or could be part of a more general study of teacher training curricula.

How to Measure It: "Teacher training program" should be defined in terms of acceptable length and content in advance of trying to measure this indicator, and only those programs conforming to the definition should be included in the count. In order to track progress, the same type of program would have to be used over time to observe whether the number of countable training programs increased over time.

Considerations: Many countries do not have a National Teachers' Code of Conduct that explicitly addresses teacher-student relations in the context of sexual abuse, harassment, intimidation, or violence. Implementing training programs on VAW/G in these countries is still possible and this indicator can be measured in these instances. However, if there are no formalized procedures or channels for victims in schools to report instances of sexual abuse and seek redress, these programs may change attitudes but will not assure a safe atmosphere for girls and women.

This indicator is hard to measure because of the broad definitions of "teacher training program," and "sexual and physical VAW/G curricula". The definitions to be used in measuring this indicator need to be carefully considered, since progress over time can only be measured by using the same definition. The definition should be as specific as possible, and include components that would align with high standards, such as outlined in the USAID document on safe schools.

5.2.3 – Percent of schools that train their staff on sexual and physical VAW/G issues

Definition: The percent of schools in a country or region that conduct trainings on sexual and physical VAW/G issues for school staff, at least once every two years. School staff includes teachers, administrators, and other people who work within schools.

Numerator: Number of schools that conduct trainings on VAW/G at least once every two years.

Schools included in the numerator must have training programs for school staff that have curricula including components focused on sexual and physical violence against women and girls. Schools can be included if they only train one type of school staff (e.g., teachers), but this should be clearly noted in the interpretation.

Denominator: Total number of schools surveyed

Disaggregate by: Type of staff trained, level of school (i.e. primary, secondary, vocational, university); type (e.g., English-medium, religious focus, all-girls, co-ed, etc); geographic area (e.g., country/region, urban/rural); public-/private-funded.

What It Measures: The percent of schools that train their staff (not limited to teachers) on sexual and physical VAW/G issues (e.g. power, coercion and gender).

Measurement Tool: This indicator is measured in a survey of schools, based on a probability sample of schools in a region or country. The survey could be specifically focused on gathering information about VAW/G in school (e.g., USAID interview guide for school-based information[30]), or could be part of a more general study of schools.

30 USAID. 2006. Safe Schools Program Quantitative Research Instrument to Measure School-Related Gender-Based Violence

How to Measure It: The indicator is calculated by asking school administrators for documentation of trainings on VAW/G that have taken place for staff. Schools that can produce this documentation comprise the numerator, which is then divided by the total number of schools in the survey.

Considerations: Measurement of this indicator by itself does not determine the level of awareness about VAW/G among staff. Nor does it measure how safe a woman or girl feels reporting sexual abuse to the school. This indicator should be considered in conjunction with others in this chapter to present a more complete picture on a school system's readiness and commitment to act on reports of sexual abuse.

5.2.4 – Proportion of nursing and medical schools that include VAW/G as part of their core curriculum

Definition: The proportion of nursing and medical schools in a region or country that include a module on VAW/G as part of their core curriculum. This means that all students studying for a nursing or medical degree will have been exposed to this curriculum module which is directed at training service providers to identify VAW/G survivors, and provide appropriate care and support.

Numerator: The number of nursing and medical schools that include a module on VAW/G as part of the core curriculum for the end degree. The module includes the following elements:

- Identifying women who may have experienced VAW/G based on signs of injury and an interview protocol asking about experience with physical or sexual violence
- Appropriate response, including care and support

Denominator: Total number of schools surveyed.

Disaggregate by: Type of school (nursing or medical), region

What It Measures: The proportion of schools that train future nurses and doctors that has integrated VAW/G as a topic on which basic training is needed. This demonstrates a commitment on the part of the school to ensure that once providing care, nurses and doctors will be able to appropriately identify VAW/G and provide care and support.

Measurement Tool: A survey of nursing and medical schools. Depending on the context, this could be based on a probability sample of such schools (in a country with many nursing and medical schools) or it could include all in a region or country.

How to Measure It: The indicator is calculated by asking nursing and medical schools about units that comprise their core curriculums. If VAW/G is included as a unit, the school may be counted in

the numerator. The number of schools that include a VAW/G unit will then be divided by the denominator, which includes all schools surveyed.

Considerations: Measurement of this indicator by itself does not determine the quality or particular content of the VAW/G curriculum.

5.3 JUSTICE AND SECURITY

5.3.1 – Proportion of law enforcement units following a nationally established protocol for VAW/G complaints

Definition: The proportion of law enforcement units that adhere to nationally established protocols pertaining to the management of VAW/G complaints.

Numerator: Number of law enforcement units in a region or country that follow a nationally established VAW/G protocol when handling complaints.

If there is no national protocol pertaining to the management of VAW/G cases, this indicator cannot be measured. The protocol should cover the following areas:

- How and where VAW/G survivors should be interviewed
- How confidentiality is ensured
- Type of investigation and follow-up that should take place following a report
- How women and girls are protected following a complaint

Denominator: Total number of law enforcement units surveyed

Disaggregate by: Area in city, region; province, depending on how large of an area is being surveyed.

What It Measures: This indicator measures the number of law enforcement units that handle VAW/G complaints using a protocol which is in compliance with nationally established standards.

Measurement Tool: A survey of law enforcement units.

How to Measure It: There must be a national set of standards established for the management of VAW/G complaints within the

security sector in order for this indicator to be measured. Police stations and other law enforcement units at the local, district and regional levels should have a protocol documented that outlines how VAW/G complaints are handled. This protocol should be in alignment with a national standard which has information on the above four criteria in the indicator definition. A checklist or outline detailing key steps in adhering to the national protocol guidelines should be part of the documentation available at the unit.

Police and other law enforcement units are selected into a probability (ideally) or other sample that may cover one or more urban areas, regions, or the entire country. Units are then surveyed to investigate whether or not the unit has the described documentation affirming that they follow a standard protocol in managing their VAW/G complaints. Only units who can show this documentation are counted in the numerator. This number is then divided by the denominator, which includes all units surveyed.

Considerations: The area being surveyed needs to be taken into account when interpreting this indicator. For example, the results of a survey in the capital city in which large police units are selected into the sample will and should differ from a survey in a rural area which goes to small outposts, since the resources available in each of these situations differs considerably. This indicator measures the standards set for dealing with VAW/G complaints on local levels and will yield a snapshot of whether or not the security sectors in a given area are maintaining a standard protocol. However, this does not ensure the proper management of VAW/G complaints. Even though a protocol exists, individual law enforcement personnel or units themselves may not actually follow it. Also, this indicator cannot be measured if there is no nationally established protocol. Despite these limitations, this indicator can be used to monitor progress within the security sector because proper management of complaints is very unlikely if no protocol exists in a law enforcement unit.

5.3.2 – Number of law enforcement professionals trained to respond to incidents of VAW/G according to an established protocol

Definition: Total number of law enforcement professionals trained to respond to incidents of VAW/G according to an established protocol, over a period of time (e.g., one year). If there is no established protocol pertaining to the management of VAW/G cases, this indicator cannot be measured.

Count: Number of law enforcement professionals, including police officers, investigators, and others, who are trained.

Count the law enforcement employee if he/she has been listed as participating in a training program that included information on how to respond to VAW/G incidents. The program curriculum may vary by context, but must include information on managing the response to VAW/G incidents in accordance with an established protocol. The protocol for response may be regional or national.

Disaggregate by: Law enforcement unit (e.g. police sub-station), region/province/district, or type of trainee/professional.

What It Measures: This output indicator tracks the number of law enforcement professionals trained to respond to VAW/G incidents using an established protocol.

Measurement Tool: This indicator is measured through records maintained by organizations responsible for training law enforcement personnel, or through records maintained by law enforcement units. When a training is held which includes components on how to respond to VAW/G complaints, records should be kept on the number of VAW/G-related training hours, the name of the professional completing the training, type of work they do in the security sector, and their place of employment. Additional information regarding the participants may be relevant, such as attendees' gender, rank, number of years in law enforcement, previous trainings attended, etc.

How to Measure It: Records kept by organizations implementing training programs on VAW/G response and law enforcement units are reviewed periodically (e.g. every 6 months or every year).

Considerations: This indicator is a crude measure of whether a program is achieving its targets or is making progress over time in terms of building the capacity of law enforcement professionals to respond to VAW/G incidents. The indicator does not measure whether the training enhanced the trainees' skills or their subsequent performance. Trainees' performance assessment requires direct observation, which may be difficult. Access to training attendance records maintained at government Ministries may also be a challenge.

5.3.3 – Number of VAW/G complaints reported to the police

Definition: The number of complaints pertaining to some act of VAW/G that was reported to the police, in a community, region or country, during a specific time period (e.g. the past 12 months).

Count: The number of complaints that are identified as pertaining to VAW/G during the specified time period.

Disaggregate by: Type of violence, age, community; region; province.

What It Measures: This indicator measures how many VAW/G complaints were made to and recorded by the police during a specified time period.

Measurement Tool: A confidential review of police records.

How to Measure It: Police records will be reviewed to count reported cases that pertained to VAW/G. Ideally, the police will classify these cases as a separate crime category, or in addition to another category. However, as data collected by police are usually collected by crime type, with VAW/G case reports being classified as assault, robbery, or rape, a careful review of the description of the crime will often be needed. If this type of review is to take place, a list of criteria should be generated to describe what is considered a report pertaining to VAW/G. Examples of case report classifications to examine, in addition to those listed above, would be injury, family disputes, type of violence, and whether or not children were involved. Information pertaining to the sex and age of the victim and perpetrator, as well as the victim's relationship to the perpetrator will also help determine whether or not the case can be considered to be counted as VAW/G.

Considerations: This indicator is collected through police records and the measure will only be as good as the data recorded in the records. In many places, records are not kept in an orderly fashion,

and the extent of detail in descriptions of cases may vary so much that it may be impossible to ascertain if the report can be classified as pertaining to VAW/G or not. The advantage of using records is that they are free from recall or social desirability biases, but this indicator will not be feasible to collect in places where the information on police records lacks sufficient detail to correctly classify the cases into the count.

The number of VAW/G complaints is likely not reflective of the number of incidents that occur in a given place. Women are unlikely to report violence to police because of stigma, fear, the threat of losing their children, or lack of available services. Additionally, police in many parts of the world are not trained to deal with VAW/G. Personal biases and lack of sensitivity interfere with the protection of the woman, thus making her less likely to report to the police.

5.3.4 – Proportion of VAW/G cases that were investigated by the police

Definition: The proportion of VAW/G complaints that were investigated by the police, during a specific time period (e.g. the past 12 months).

Numerator: The number of VAW/G complaints that were investigated during a specific time period. This includes reports that had confirmed police investigations.

Denominator: The total number of VAW/G police reports made during the same time period

Disaggregate by: Community; region; province.

What It Measures: This indicator measures the proportion of VAW/G cases that were followed up with a police investigation, during a specified time period. The denominator of this indicator is the count collected in 5.3.3.

Measurement Tool: A confidential review of police records.

How to Measure It: Police records will be reviewed to count reported cases that pertained to violence against women and girls, noting when those cases were followed up with an investigation. This indicator should be collected at the same time as 5.3.3, since the same records will be reviewed for the information needed for the numerator. In this case, only those cases in which an investigation can be verified will be counted in the numerator. This number will then be divided by the denominator, which will be all VAW/G cases reported, or the count provided by indicator 5.3.3.

Considerations: This indicator is collected through police records and the measure will only be as good as the data recorded in the records. In many places, records are not kept in an orderly fashion, and the extent of detail in descriptions of cases may vary so much that it may be impossible to ascertain if the report can be classified

as pertaining to VAW/G or not. The advantage of using records is that they are free from recall or social desirability biases, but this indicator will not be feasible to collect in places where the information on police records lacks sufficient detail to correctly classify the cases into the count.

This indicator does not capture the timeliness or thoroughness of the investigation. In order to provide protection and prevent further assault, VAW/G cases need to be investigated as soon as possible. Information regarding the result of the police investigation is also not captured in this measure.

5.3.5 – Proportion of VAW/G cases that were prosecuted by law

Definition: The proportion of reported VAW/G cases that were prosecuted by law, during a specific time period (e.g., the past 12 months).

Numerator: Number of VAW/G cases that were prosecuted during the specified time period.

Denominator: Total number of VAW/G cases reported to the police, during the same time period.

Disaggregate by: community; region; province

What It Measures: This indicator measures the effectiveness of the legal system by tracking the proportion of reported VAW/G cases that were prosecuted.

Measurement Tool: A confidential review of both police and court records.

How to Measure It: Police records will be reviewed to count reported cases that pertained to violence against women and girls. This indicator should be collected at the same time as 5.3.3 since some of the same records will be reviewed for the information needed for both the numerator and denominator. In addition to police records, court records will also have to be reviewed, since police records may not reflect whether or not a case made it to the level of prosecution. Only those cases in which a court prosecution took place will be counted in the numerator. This number will then be divided by the denominator, which will be all VAW/G cases reported, or the count provided by indicator 5.3.3.

Considerations: This indicator does not measure how many cases were prosecuted successfully and thus does not fully measure the legal climate surrounding VAW/G. This can however be determined if the researchers note and measure the number of convictions that resulted from prosecutions.

Like the previous indicators, this one is based on records in both the police and court systems and the measure will only be as good as the data recorded in these records. In many places, such records are not kept in an orderly fashion and accessing this data may be very difficult.

Under the United Nations Declaration on the Elimination of Violence Against Women, states are required to exercise due diligence to prevent, investigate and punish acts of violence against women, whether perpetrated by the state or private persons. However, in many countries, cases are not brought to trial due to biases against victims of VAW/G crimes in both the police and court systems.

5.3.6 – Proportion of prosecuted VAW/G cases that resulted in a conviction

Definition: The proportion of prosecuted VAW/G cases that resulted in a conviction, during a specific time period (e.g., the past 12 months).

Numerator: Number of VAW/G cases that were prosecuted and resulted in a conviction, during the specified time period.

Denominator: Total number of VAW/G cases that were prosecuted, during the same time period.

Disaggregate by: Community; region; province.

What It Measures: This indicator measures the effectiveness of the legal system by tracking the proportion of reported VAW/G cases that were both prosecuted and resulted in an actual conviction.

Measurement Tool: A confidential review of both police and court records.

How to Measure It: This would be conducted through a special study. The time period selected should reflect the average amount of time that such cases take in court in the particular country. If there is a relatively short time that a case spends in the court system, one year can be selected as the period of review. Judicial records will be reviewed to count VAW/G cases that were prosecuted. This indicator should be collected at the same time as 5.3.5, since some of the same records will be reviewed for the information needed for both the numerator and denominator. Only those cases in which a court prosecution led to an actual conviction will be counted in the numerator. This number will then be divided by the denominator, which will be all VAW/G cases that were prosecuted.

Considerations: This indicator provides a measure of the legal climate surrounding VAW/G. Like the previous indicators, this one is based on records in the judicial system and the measure will only

be as good as the data recorded in these records. In many places, such records are not kept in an orderly fashion and accessing this data may be very difficult. In addition, in many countries, cases may be prosecuted over very long time periods (more than a year). In these cases, this indicator may not be possible to measure. However, this in of itself would reflect a very poor legal climate surrounding VAW/G, and should be noted.

Under the United Nations Declaration on the Elimination of Violence Against Women, states are required to exercise due diligence to prevent, investigate and punish acts of violence against women, whether perpetrated by the state or private persons. However, in many countries, cases are not brought to trial due to biases against victims of VAW/G crimes in both the police and court systems. This indicator will provide a measure of how effective the legal system is in VAW/G-related cases.

5.3.7 – Number of legal aid service organizations for VAW/G survivors

Definition: Number of service organizations providing legal aid to VAW/G survivors in a country, state or community

Count: Number of organizations providing legal aid or services to VAW/G survivors.

If several different organizations are in existence, categorize them by:

- Government vs. non-governmental organizations
- Type of legal services provided
- Free vs. with service fee
- Region/Province/District

What It Measures: VAW/G survivors need legal advice and advocacy, covering issues such as how to register a legal complaint against assault, protection from perpetrators, divorce, child custody and protection. This is an output indicator which measures whether legal services are available for VAW/G survivors in a country, province or community.

Measurement Tool: A survey of organizations and agencies in a particular area to investigate what types of services they provide. These organizations should include all legal-action based governmental and non-governmental organizations that may provide services to VAW/G survivors. If organizations do not provide services themselves but have information on organizations that do, these listed organizations should be surveyed as well to ascertain the type of services they provide.

How to Measure It: Unless a good record exists of organizations providing legal services to VAW/G survivors, a mapping exercise would have to be conducted in order to identify legal-aid based services. Then these organizations would be surveyed to investigate what, if any, services they provide specifically to VAW/G survivors. If records pertaining to such organizations are available at community,

regional or national levels, they should be reviewed and validated with a visit or other contact with the organization in question.

Considerations: This indicator will be difficult to measure reliably, since organizations providing such services may not be officially registered as governmental or non-governmental organizations, meaning that they may be hard to find. This could result in an under-estimate of such organizations. Also, services provided by organizations that are surveyed may not be specifically targeted at VAW/G survivors, but those women and children may still benefit from services provided. Relying on records maintained at government ministries for a list of legal service organizations for VAW/G survivors in a country is problematic in countries where the records are not maintained well or updated on a regular basis. Organizations on record may not be functional, which is why all information from records needs to be validated by contacting or visiting the organization in question.

Measurement of this indicator by itself does not provide an assessment of the quality of the legal services provided for survivors of VAW/G, nor the extent to which these services are utilized by survivors.

When disaggregating the measurement by public vs. private organizations, it should be noted that while the actual services may be provided by civil society organizations or non-governmental organizations, financial support may be provided by the government or international donor organizations.

5.3.8 – Proportion of women who know of a local organization that provides legal aid to VAW/G survivors

Definition: Proportion of women who know of an organization that provides legal assistance to VAW/G survivors.

Numerator: Number of women surveyed who know of at least one local organization that provides legal aid or services to VAW/G survivors.

Women are asked if they know of and can specifically name a local organization that provides such services for women and children, and if they know where it is or how to access it (this could be a phone call, depending on the context). Women are counted if both criteria are met.

Denominator: Total number of women surveyed.

Disaggregate by: Community; region; country.

What It Measures: This indicator measures the proportion of women who are aware of an organization that provides legal support to VAW/G survivors. Women may not need to know the specific organization, but should know enough about it to be able to access services if needed.

Measurement Tool: A survey of women in the geographical area of interest. Questions could be added to a planned survey of households on other issues. A representative (probability) sample of women should be drawn in order to understand access to legal services in a given area among the target population of women (e.g., of reproductive age).

How to Measure It: Women who meet both the criteria listed under the definition are counted in the numerator, which is then divided by the denominator that includes all women surveyed. "Local" can be defined as within the same community, town, city or region. If

the survey is representative of the population of interest, it can be generalized back to the geographic area of interest.

Considerations: This indicator provides information regarding women's awareness of legal assistance for VAW/G. However, the fact that women are aware of such organizations does not necessarily mean that they utilize them or feel able to do so. The WHO multi-country study noted that very few women told staff of formal services or authorities that they were abused. Even in countries where resources for VAW/G victims are abundant, many women are afraid to seek help because of stigma, fear and the threat of losing their children. Additionally, victim blaming attitudes on the part of the legal systems in many countries force women to remain silent about their experiences. Lack of training and personal biases on the part of law enforcement and legal staff create additional barriers for women seeking services.

5.4 SOCIAL WELFARE

5.4.1 – Availability of social services within an accessible distance

Definition: The number and type of organizations in a community that provide social-welfare based services pertaining to the prevention and response to VAW/G, at one point in time.

Social-welfare based services include but are not limited to:

- Safe space, or shelters, for women and children
- Crisis hotlines for intimate partner and sexual violence
- Case management services including counseling, support groups, safety planning, legal aid/support, child welfare, recreational programs for abused girls
- Crisis intervention skills including training, income generation, and self defense
- Perpetrator programs, and reintegration

Accessibility needs to be locally defined, depending on the geographic area and the modes of transportation and communication that are readily available to most of the population.

Count: Number of organizations that provide any social-welfare services directed at the prevention of and response to VAW/G in a specified geographic area (community, province, region).

Disaggregate by: Type of services provided, per checklist above.

What It Measures: This output indicator measures whether there are social services and what type of social-welfare services, directed towards the prevention of and response to VAW/G, are available in a community.

Measurement Tool: Generating a list from resources within the targeted area, depending on what is available. In places where

agencies providing services might use websites or telephone directories (e.g., in urban centers of South-east Asia), a list should be compiled from these information sources. A list should also be generated by checking governmental offices, such as women's ministries or departments of social welfare, as well as non-governmental organizations in the geographic area of interest. In many places, consulting informally with key informants in the community, or running a mapping exercise such as the second step of the MEASURE Evaluation PLACE[31] protocol will be needed to generate a list. The list of service organizations should be verified by either calling or visiting the agencies to ascertain what types of, if any, services are provided to VAW/G survivors.

How to Measure It: Count the resources listed and disaggregate by type of social welfare-based services provided. If one or more organizations provides comprehensive services (and thus multiple types), the organization would be classified under a category called "integrated services", noting which actual services are provided.

Considerations: Generating a comprehensive list of organizations may be difficult, and some organizations may be missed, depending on the methods used. Unless organizations are listed accurately, double-counting could occur. If organizations are missed at one count, and included in the next count, the increase in the number of organizations will not reflect growing service availability in social welfare. A true increase in organizations over time may reflect a number of things, including more need (a growing population of affected individuals), increased funding and focus on the problem, or increased attention and awareness within communities.

31 MEASURE Evaluation Project. 2005. PLACE: Priorities for local AIDS control efforts, a manual for implementing the PLACE method. USAID & MEASURE Evaluation, MS-05-13

5.4.2 – Proportion of women who demonstrate knowledge of available social welfare-based VAW/G services

Definition: The proportion of women who know about available social welfare-based services in the community for VAW/G survivors, such as shelters, hotlines, and counseling services, and know their purpose (why and when they would be accessed).

Numerator: Number of women spontaneously naming at least one available resource (the list of available community resources can be used from measuring 5.4.1), or upon probing for their awareness ("do you know about the organization located at such and such a market?"), and specifying why and when this service would be used, without probing.

Denominator: All women surveyed.

Disaggregate by: Age, education, socio-economic status.

What It Measures: This measures true access to available community resources that provide social welfare-based services to women and girls affected by VAW/G. Availability of resources by itself will not mean much if women are not aware of them, and if they do not know why or when they would access them.

Measurement Tool: A probability survey. The questions around community resources can be one module that is part of a larger assessment, such as a Demographic and Health Survey. A probability sample of women should be drawn, so the estimate can be generalized back to the population of women in the community, region or country.

How to Measure It: Women will be asked to name at least one VAW/G social welfare service available in the community. If she cannot name a service, she can be probed further by asking her about specific organizations in a list with their location (such as the one generated by 5.4.1). If probing is used, the interviewer should

take care to not mention the purpose of these organizations, but only describe them using location or a general description. In order to be counted in the numerator, she also needs to specify why and when these services would be accessed. This number would then be divided by the total number of women surveyed.

Considerations: This indicator provides information regarding women's awareness of social services for VAW/G. However, the fact that women are aware of such organizations and understand why and how they would be accessed does not necessarily mean that they are utilizing them. A multi-country study of women by the World Health Organization revealed that very few women told staff of formal services or authorities that they were abused. Even in countries where resources for VAW/G victims are abundant, many women are afraid to seek help because of stigma, fear, and the threat of losing their children. Alternately, not knowing about an organization does not necessarily reflect access, as it may mean that services are not needed.

5.4.3 – Number of women and children using VAW/G social welfare services

Definition: The number of women and children who used VAW/G services during a specified time period (e.g., during the past 12 months).

Social-welfare based services include but are not limited to:

- Safe space, or shelters, for women and children
- Crisis hotlines for intimate partner and sexual violence
- Case management services including counseling, support groups, safety planning, legal aid/support, child welfare, recreational programs for abused girls
- Crisis intervention skills including training, income generation, and self defense

Count: Number of women and children who used VAW/G social welfare-based services during a specified time period

Disaggregate by: Type of social service, per the above list.

What It Measures: This output indicator provides a crude utilization measure of VAW/G social welfare-based services.

Measurement Tool: A record review at all organizations providing social welfare services in a given area.

How to Measure It: This indicator should be measured in conjunction with 5.4.1, since the organizations identified in that count would constitute those whose records would be reviewed. Reviewing the records and compiling the count at individual organizations will yield a figure disaggregated by organization. The counts can then be added together to get a total figure representing utilization within the given geographic area. The disaggregated count by type is calculated by grouping together organizations by the type of services they provide, and then tallying those totals together per type. In this instance, case management services should note the specific type of services listed in that category. If one or more organizations

provides comprehensive services (and thus multiple types), the organization would be classified under a category called "integrated services," noting which actual services are provided.

Considerations: Measurement of this indicator relies on records maintained at organizations that provide services for VAW/G survivors. The data collected will only be as good as the original records. If identifiers are not used in the records, double counting of individuals can occur when one person is using more than one service organization. A true increase in the number of individuals using these organizations over time may reflect a number of things, including more need (a growing population of affected individuals), increased funding and focus on the problem, or increased attention and awareness within communities.

5.4.4 – Number of VAW/G hotlines available within a specified geographic area

Definition: The number of hotlines serving VAW/G survivors in a specified geographic area, at one point in time. A hotline is a telephone number which affected women and girls can call to receive support and/or referral to other needed services. The hotline may be available 24 hours a day, 7 days a week, or only during certain hours/days.

Count: Number of hotlines serving VAW/G survivors in a specified geographic area of interest

Disaggregate by: Geographic area, types of services and referrals.

What It Measures: This indicator measures the availability of crisis intervention services for survivors of VAW/G in a geographic area of interest, at the time measured.

Measurement Tool: This indicator is measured by asking organizations in the area of VAW/G about the availability of hotlines in the geographic area of interest. Hotlines may also be listed from phone or web-directories, if available in the targeted area. Hotlines should be verified by calling them, to be sure they are still in operation and to ask about particular services provided.

How to Measure It: A count of the number of hotlines available for survivors of VAW/G in the targeted community, region or country.

Considerations: Hotlines are often nationally run and headquartered in capital cities, due to the cost of staffing the hotline relative to the coverage area. A hotline will only be a useful resource to survivors of VAW/G in countries where phones — either landlines or mobile — are available to a large proportion of the population. In rural areas, this indicator may not be feasible to measure.

This indicator only measures the presence of a telephone hotline, however, it does not capture when the hotline is available or the

quality of the advice and/or referrals or services made by the hotline employees. The indicator does not measure whether calling the hotline is free of charge or not. If there is a cost to place the telephone call, it may limit women from using the hotline. If the charge appeared on a telephone bill, this could later endanger women who experience intimate partner violence, since the partner may find out about the call.

5.4.5 – Number of calls per VAW/G hotline within a specified geographic area

Definition: The number of calls per VAW/G hotline in a specific geographic area, during a specific time period. A hotline is a telephone number which affected women and girls can call to receive support and/or referral to other needed services. The hotline may be available 24 hours a day, 7 days a week, or only during certain hours/days.

Count: Number of calls per hotline serving VAW/G survivors in a specified geographic area of interest.

What It Measures: This indicator is a count of how many calls are placed per hotline during a specified period of time in a geographic area of interest.

Measurement Tool: A review of records kept on calls placed to each hotline within the geographic area.

How to Measure It: This indicator is measured by reviewing the records kept at organizations that run telephone hotlines. This may be a logbook, a tally of calls, or some other record that is kept prospectively on each phone call received by the hotline. Data collected during the call can include the reason why the caller has contacted the hotline, the range of services offered to the caller, and any referrals made by the hotline operator to the caller.

Considerations: Hotlines are often nationally run and headquartered in capital cities, due to the cost of staffing the hotline relative to the coverage area. A hotline will only be a useful resource to survivors of VAW/G in countries where phones — either landlines or mobile — are available to a large proportion of the population. In rural areas, this indicator may not be feasible to measure.

This indicator measures the frequency and use of the hotline by survivors of VAW/G. However, the indicator does not measure the quality of the counseling and/or referrals or services made by the

hotline employees. Records and record reviews of calls placed kept should be secure and confidential. The data collected for this indicator should not have any personal identifying information since it is a simple count of calls, and not a count of people calling. Therefore, there is no risk of double-counting, and the risk of a breach of confidentiality which might endanger women using the service will be avoided.

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Chapter 6: Under-Documented Forms of VAW/G and Emerging Areas

Introduction

In humanitarian emergencies, which refer to situations of armed conflict or disaster, women and children are particularly vulnerable. Unlike traditional warfare, which primarily involved soldiers on a battle field, civilians are often specifically targeted by combatants in the armed conflicts that have taken place from World War II onwards in order to terrorize the population. Rape and other acts of violence and exploitation are used as tools of war against unarmed women and girls. In disasters, caused by either natural occurrences such as earthquakes, or human error such as industrial accidents, normal government and societal infrastructures are often disabled. In these settings, women and girls are also vulnerable to a range of violent and exploitative acts.

Any inquiry into VAW/G in humanitarian settings must be designed and carried out with constant awareness of the nature of the emergency targeted. Emergencies are generally characterized by a disruption of normal family and community life, a breakdown of law and order, human rights abuses, public health risks, population displacement, poverty, dependence, loss of autonomy, and inadequate resources for relief and assistance. Although differences exist in the type, severity, and length, all emergencies unfold in fairly predictable phases, which are marked by periods of stability followed by recurrent violence and instability. In some emergencies populations flee, find refuge that later becomes unsafe, and are forced to flee again to another location. This cycle can repeat itself multiple times throughout an emergency.[32]

All of these aspects pertaining to emergencies will influence when and how information can be collected in order to monitor and evaluate efforts to prevent and respond to VAW/G. Certain information is critical to collect during the crisis stages and the immediate

32 Beth Vann, personal contact

aftermath in order to prevent further violence. Section 6.1 addresses specific considerations for humanitarian actors, but indicators in other chapters may also apply, such as the physical and sexual violence indicators in sections 4.2 and 4.3.

Newer Emergent Areas – Trafficking in Persons (TIP) and Femicide: The indicators presented in sections 6.2 and 6.3 pertain to areas of VAW/G in which research on sound measurement is still very much in process. While the same can be said about humanitarian emergencies, considerably more work has been done in that area within the context of developing countries. The indicators presented in 6.2 and 6.3 are less likely to have been tested in the field and are meant to be examples of the best of what we know thus far. Other important emergent areas not addressed in this compendium include stalking, controlling behavior and emotional abuse, and sexual harassment in the work place and schools. Developing measures in these areas necessitates more research in developing countries.

Programs and studies pertaining to TIP are relatively recent, as this important issue has begun to draw international attention and concern. Most studies on TIP have focused on the characteristics, health, social and other factors which affect trafficked persons in countries where they have been either forced or manipulated into going. These are referred to as destination countries. Studies have observed that affected women and children in destination countries suffer from a range of reproductive health and psycho-social problems. These women and children are also more likely to experience different forms of VAW/G than resident populations in their country of origin and in destination countries. Some work has taken place on affected communities of origin, and the Demographic and Health Surveys have just added a module to the household survey oriented towards TIP, which was used for the first time in the Ukraine in 2007.[33]

The same inherent difficulties that pertain to sampling hard-to-reach

33 Macro International 2007. Demographic and Health Survey, Ukraine, www.measuredhs.com/aboutsurveys/search/listmodules_main.cfm

populations also affect measures relating to TIP. Affected populations in any stage of trafficking are hard to identify and include in a study. Accurately estimating the numbers of individuals affected in this type of covert and illegal operation is unrealistic in most situations. While it would be useful to be able to estimate the size and nature of the trafficking problem, the ability to do so using reliable measures is minimal. What is known is that trafficking is a serious problem affecting large numbers of individuals and almost all countries. The three indicators in section 6.2 focus on what will be useful to TIP programs rather than attempting to count the number of affected individuals or arrests in a country, which cannot be reliably estimated at this time.

The gravest violence against women is murder. Femicide is the murder of a woman, simply because she is a woman. Femicide occurs everywhere. Most commonly, women die at the hands of an intimate partner. Other forms of Femicide include dowry-related deaths, "honor" crimes, and sexual violence . Measuring Femicide is problematic for a number of reasons related to the data available. If the murder is recorded in the criminal justice system it may be impossible to tell why or how it took place. Section 6.3 presents a general female homicide indicator as well as an indicator for Femicide. Both of these indicators are recommended by the two latest UN endeavors on measuring violence against women.[34]

34 UNDAW, UNECE and UN Statistical Division. 2008. Indicators to measure violence against women. Report of the Expert Group Meeting, 8 to 10 October 2007, Geneva, Switzerland. www.un.org/womenwatch/daw/egm/IndicatorsVAW/IndicatorsVAW_EGM_report.pdf. UNHRC. 2008. Report of the Special Rapporteur on violence against women, its causes and consequences by Yakin Ertürk. Indicators on violence against women and State response. Advance edited version (28 January 2008). www2.ohchr.org/english/bodies/hrcouncil/7session/reports.htm (A/HRC/7/6)

6.1 MEASURING VAW/G IN HUMANITARIAN EMERGENCIES

6.1.1 – Protocols that are aligned with international standards have been established for the clinical management of sexual violence survivors within the emergency area at all levels of the health system

Definition: The clinical management of sexual violence survivors is complex, involving multiple aspects of care and support. In order to ensure that women receive appropriate care, a protocol that is aligned with international standards should exist at all levels of the health system within the emergency area.

Yes: A protocol for the clinical management of sexual violence survivors exists at all levels of the defined health system within the given emergency area. This protocol is also aligned with international standards, such as the Minimum Initial Service Package (MISP)[35] and the WHO protocol on the clinical management of rape survivors.[36]

No: A protocol does not exist at all, or exists at some levels of the health system but not all, or exists at all levels but is not aligned with international standards

What It Measures: This indicator measures whether or not there is a sound clinical protocol in place to ensure that sexual violence survivors are cared for appropriately within the health system of an emergency area. However, it does not measure adherence within the health units.

35 RHRC. 2006. Minimum initial services package (MISP). www.rhrc.org/rhr_basics/misp.html

36 WHO. 2004. Clinical management of rape survivors: Developing protocols for use with refugees and internally displaced persons. Revised Edition. www.who.int/reproductive-health/publications/clinical_mngt_rapesurvivors/clinical_mngt_rapesurvivors.pdf

Measurement Tool: A health service delivery point survey. This is an inclusive measure, not one based on a probability survey. As such all health service delivery posts and clinics would be surveyed to see whether or not there is an internationally aligned protocol in place for the clinical management of sexual violence survivors. This survey should cover all levels of the available health system within the emergency area. This could also be measured as part of a larger situational analysis conducted in the emergency area. This indicator is a simple yes or no for the entire emergency area, meaning that all health units must have such a protocol.

How to Measure It: A listing of all health service delivery points and their locations within the defined emergency area is created. A question addressing whether or not a standard protocol for the clinical management of sexual violence survivors should be asked first. The established protocol should be shown to the person conducting the survey. This indicator can be integrated into a larger survey to examine other aspects of health service delivery within the emergency area.

The definition of a health system in an emergency situation will vary between contexts. Depending on the extent of societal disarray in a place at the time this indicator is measured, a health system may mean anything ranging from a well connected set of facilities that includes an integrated referral mechanism, to a disparate set of services being offered by relief organizations. The health system should be defined within the respective emergency area being evaluated, and this protocol for clinical management should exist at all levels of the operative health system.

The definition of the emergency area will also vary. This indicator can be used within a camp for displaced persons, a region of an affected country, at the country level itself, or any defined emergency area; the smaller the area, the easier it will be to measure.

International standards for the clinical management of sexual violence survivors in humanitarian emergencies have been defined within the MISP of reproductive health in emergency situations and as part of the Inter-Agency Standing Committee (IASC) Guidelines

Considerations: It is very important to have an established, standardized protocol for the clinical management of sexual violence survivors to ensure appropriate care and referrals for other needed services. This needs to happen at each level of the health system in order to ensure agreement among all players, and to facilitate referrals. However, the feasibility of getting to all health service delivery points may be low if the emergency area is defined as a large region or a country. Including all levels of the health system in an assessment within a camp area would be very different than doing the same within a country. A country's health system is likely to be much more complex, and the difficulty of surveying all levels may be insurmountable. In a camp or much smaller defined emergency area, the "health system" may be comprised of only several service delivery points, making it easier to know that all levels of the system are being included in the assessment[37].

In addition to developing a protocol that is aligned with international standards, it is important that providers understand the protocol and are trained to implement it. This indicator only measures whether or not a protocol exists, not how it is being used or the preparedness of health providers to implement it.

37 Women's Commission for Refugee Women and Children. 2002. UNHCR policy on refugee women and guidelines on their protection: An assessment of ten years of implementation. New York: Women's Commission for Refugee Women and Children. www.womenscommission.org; Interagency Standing Committee (IASC) Task Force on gender and Humanitarian Assistance. 2005. Guidelines for Gender-based Violence Interventions in Humanitarian Settings: Focusing on Prevention of and Response to Sexual Violence in Emergencies www.humanitarianinfo.org/iasc/content/products/docs/tfgender_GBVGuidelines2005.pdf

6.1.2 – A coordinated rapid situational analysis, which includes a security assessment, has been conducted and documented in the emergency area

Definition: A situational analysis designed to rapidly collect information about the extent of sexual violence experienced by a community, including a security assessment, has been conducted and documented for use in prevention and response.

Yes: A rapid situation analysis has been undertaken and documented and has:

- Used established field-tested tools (RHRC 2003, UNHCR 2003, WHO 2000) as a guide to collect & compile information related to VAW/G
- Used a field tested tool for a security assessment (e.g., UNICEF 2006b).
- Collected information in accordance with guiding principles for safety, confidentiality, respect, and non-discrimination (WHO 2007)
- Documented the findings of the situational analysis disseminated the report to key humanitarian actors (to be defined within the context of the emergency)

The situational analysis can be based on the existing tools mentioned, or parts of them, as is appropriate for the specific emergency area and phase.

No: The situational analysis has not been conducted, or some of the criteria have not been met.

What It Measures: This indicator measures whether a situational analysis aimed at the prevention and response of VAW/G has been completed for a given emergency area, using internationally validated tools. The choice of tools and how much of each to be incorporated is up to the coordinated body undertaking the assessment and depends on the context of the situation.

Measurement Tool: The UNICEF GBV camp safety audit[38] stands as an example of a security assessment which is directed at community members, camp authorities, and camp management personnel. The form is designed to be implemented by section, or in its entirety. Assessment tools for other aspects of the situational analysis are available from the RHRC,[39] UNHCR,[40] and WHO.[41]

How to Measure It: A VAW/G working group should be in charge of carrying out the assessment. Using the mentioned tools, an assessment which is appropriate for the context of the emergency should be developed by this team. The team would implement the tool and produce the report based on the findings. If the assessment and report conform to all four criteria listed, the indicator is classified as a yes. If one or more of the criteria are not met, the indicator is classified as a no.

Considerations: It might be difficult to assess all four criteria by looking at the report. In some situations, one or more of the referenced field manuals (i.e., UNICEF, RHRC or UNHCR) may be more or less appropriate, and this should be taken into consideration when measuring this indicator.

38 UNICEF 2006b. Uganda IDP camp GBV safety audit tool.

39 Reproductive Health for Refugees Consortium. 2003. Gender-based violence tools manual: For assessment, program design, monitoring and evaluation in conflict-affected settings. Available at: www.rhrc.org/resources/gbv/gbv_tools/manual_toc.html

40 UNHCR. 2003. Sexual and gender-based violence against refugees, returnees and internally displaced persons: Guidelines for prevention and response. UNHCR. www.rhrc.org/pdf/gl_sgbv03.pdf

41 WHO. 2000. Reproductive health during conflict and displacement. A guide for program managers.Geneva: WHO. www.who.int/reproductivehealth/publications

6.1.3 – The proportion of sexual violence cases in the emergency area for which legal action has been taken

Definition: The proportion of reported sexual violence cases within the emergency area for which any legal action was taken during a specific time period.

Numerator: Number of reported sexual violence cases within the emergency area for which any legal action was taken during a specified time period.

The minimum available legal action, as evidenced by legal record in the security sector, was taken for a reported incident of sexual violence. This could be on a local, regional, or national level depending on the nature of the emergency and the legal system available to address these cases.

Denominator: Number of reported cases of sexual violence in the emergency area during the same time period.

What It Measures: This indicator measures the extent to which legal recourse is taken for reported cases of sexual violence. If there is a very low proportion of cases that have had the minimum legal action defined as acceptable, this would indicate that the legal structure in the emergency area is not adequate. A high proportion of reported cases for which legal action was taken would indicate a legal system functioning at a high level of protection for women and children within the area.

Measurement Tool: A review of records during the time period defined (e.g., the past month or several months) to assess the number of cases reported to various sectors within the emergency area that serve sexual violence survivors. This record review would include records in any unit providing services to sexual violence survivors (e.g., legal/security, health, social welfare, etc.). A list of reported cases will be generated. For all cases, the type (if any) of legal action taken would be noted by security or legal sector records.

How to Measure It: Legal action can be defined by a range of activities. These would start with a formal investigation following an incident report, and continue through to prosecution of the perpetrator to the fullest extent of the law. The types of legal action which can take place will depend on the availability of legal resources within the emergency area. At minimum, there should be a mechanism of legal follow up after a confidential report of a sexual violence incident. This follow-up should include a protection plan for the survivor. The availability of legal recourse within an emergency area will change over time, so it is important to note the minimum availability during the time period included in this measure.

The numerator would include only those cases for which the minimum (or more) legal action available took place. The numerator is divided by the denominator, which includes all reported cases of sexual violence.

Considerations: This indicator may be very difficult to measure depending on the nature of the emergency area. If the emergency area is a camp, or small regional area, the full review of records should not be difficult. If the emergency area is defined as a larger region or country, measuring this indicator may not be feasible.

It is very important to keep all records resulting from a review of reports and subsequent actions in a secure location where no one outside of the investigative team would have access to them. Women and children could be endangered if their confidential reports were exposed. Further, any breach of confidentiality would discourage women from coming forward to file a report. Thus, the record review should adhere to the same ethical guidelines and protections employed for collecting information for confidential reporting of incidents.

Since multiple sources of records may be used (e.g., legal/security, health, social welfare, etc.), the researcher must take care not to double count incidents that may be recorded in multiple locations when calculating the denominator.

6.1.4 – Proportion of reported sexual exploitation and abuse incidents in the emergency area that resulted in prosecution and/or termination of humanitarian staff

Definition: Among sexual exploitation and abuse (SEA) incidents in which the perpetrator works within the humanitarian organizations responding to the emergency, the proportion of reports which result in the prosecution of the perpetrator and termination of their position. This includes all UN personnel including peacekeepers, as well as those who work in governmental or non-governmental organizations.

Numerator: The number of reported SEA incidents involving a humanitarian staff serving the emergency area, that are both investigated and prosecuted, and result in the prosecution and/or termination of this perpetrator's position.

Denominator: The total number of reported SEA incidents that involve humanitarian workers.

What It Measures: This indicator measures an adherence to the minimum prevention and response protocol pertaining to the conduct of humanitarian staff. Many studies have noted that numerous SEA incidents in emergency areas are perpetrated by the very people who are employed to protect the victims of humanitarian emergencies. A demonstrated zero tolerance for such incidents means that once reported and confirmed persons responsible will be prosecuted to the full extent of the law, or at minimum, terminated from their position to protect the women and girls under their care.

Measurement Tool: There must be a monitoring system for all SEA complaints that would be used to track complaints made against humanitarian staff (and their affiliations). These records would be matched to staff terminations or any legal proceedings in SEA cases.

How to Measure It: The numerator is all of the terminations and/or legal prosecutions enacted against humanitarian personnel who were the identified perpetrator in reported SEA cases. Humanitarian personnel would include anyone who is working in the area as a result of the crisis that is taking place or just occurred. This includes UN personnel, those working for non-governmental emergency-aid organizations, and international and national governmental organizations. This number is divided by the denominator, which is all SEA complaints registered that identified a humanitarian worker as the perpetrator.

Considerations: There must be clear and transparent procedures in place for receiving and following up on all SEA complaints. The process must also protect the confidentiality of the person reporting the incident, as well as the victim involved (if not the same person reporting). This monitoring system can be used to match prosecuted cases and terminations of humanitarian staff positions, if there is a record of why the person was terminated.

This indicator is very difficult to measure. An accurate denominator would depend on a very good monitoring system with enough information to identify who perpetrators were and if they worked for a humanitarian organization. This would be easier to measure within a very defined emergency area such as a camp, but may not be feasible for a larger region or country.

6.1.5 Coordination mechanisms established and partners orientated in the emergency area

Definition: Among the group of organizations responsible for humanitarian coordination in a defined emergency area, mechanisms have been established to coordinate efforts undertaken by these organizations, the partners contributing to the relief effort. At a minimum, this includes health and social services actors, legal, human rights and security sectors.

Yes: Coordinating mechanisms have been established, orientation of partners has been done, and the following criteria have been met:

- There is a multisectorial approach to establish mechanisms to coordinate actors in the health and social services, and in the legal, human rights and security sectors of the community with regard to VAW/G. There is one agency responsible for tracking this coordination.
- Methods for communication and coordination between working groups at different levels (national, regional etc.) have been established.
- All sector groups have defined their respective responsibilities regarding prevention and response to sexual violence.
- All actors agree to adhere to a common set of guiding principles that minimize harm to survivors and maximize efficiency of prevention and response.
- All actors have been oriented to the multisectorial approach.
- A list of organizations, focal points and services for prevention and response has been compiled.

No: These criteria have not been met.

What It Measures: This indicator measures whether or not multiple agencies involved in the response to an emergency are working together with respect to the prevention and response to sexual exploitation and abuse. The criteria listed can be taken as a minimum list of what should be done with respect to coordination and orientation of partners.

Measurement Tool: A survey of organizations involved in the response which includes descriptive responses.

How to Measure It: The results of the survey are matched against the list of criteria. If all have been met, then establishment and coordination has taken place.

Considerations: This indicator must be assessed somewhat subjectively. The minimum extent of coordination and orientation will have to be defined. The survey must be comprised of questions with open ended responses, in order to understand the type of coordination and orientation that has taken place. The minimum criteria should be documented as part of a monitoring and evaluation plan.

According to the IASC Guidelines,[42] a resource list of organizations, focal points and services for the prevention and response to VAW/G should be complied. This list could be used as a source for the survey.

42 Guidelines for Gender-based Violence Interventions in Humanitarian Settings: Focusing on Prevention of and Response to Sexual Violence in Emergencies www.humanitarianinfo.org/iasc/content/products/docs/tfgender_GBVGuidelines2005.pdf

6.1.6 – Number of women/girls reporting incidents of sexual violence per 10,000 population in the emergency area

Definition: Reported incidents of sexual violence over a specific period of time (to be defined within the context of the emergency situation).

Numerator: Number of incidents of sexual violence reported by women and girls in the specified period.

Denominator: The total camp/area/country population during the same time period.

Calculation: Divide the numerator by the denominator and multiply the result by 10,000.

Disaggregate by: Age (under 15, 15-20, 20+), geographic location

What It Measures: This estimates the number of reported sexual violence incidents per a standard number of people. Using this standardization will allow for a comparison to be made across time in the same location, or between locations.

Measurement Tool: The numerator would be derived through a review of records during the time period defined (e.g., the past month or several months) to assess the number of cases reported to various sectors within the emergency area that serve sexual violence survivors. This record review would include records in any unit providing services to sexual violence survivors (e.g., legal/security, health, social welfare, etc.). A list of reported cases will be generated. The denominator can be estimated using camp/area censes conducted by organizations such as UNHCR and others who track the number of refugees/IDPs in a given area.

How to Measure It: Identify the sources to be used in gathering the number of reports. Reports can be collected prospectively, tracking

reports weekly as they come in. Once there is a reporting system in place, this indicator can be collected periodically to monitor patterns and trends. Population shifts in the emergency area should be taken into account if this indicator is measured over time. The denominator, which includes a count of the total emergency/camp population, is measured during the same period as the numerator.

Considerations:

Definition of "report": This refers primarily to survivors or those close to them coming forward to seek care or support, and thus reporting an incident. While official reports to local authorities are important to track, the vast majority of incidents are not officially reported and are thus less important for this indicator.

Time period: This will depend on the nature of the emergency. In an acute or post-acute stage, a short period such as three months would be appropriate. A longer period, such as a year, would be appropriate for situations ongoing for several years, such as what is taking place in Darfur. Some sources define it as 6 months, but this appears to be too long a period for acute situations. Therefore, the period should be defined per the specific emergency.

Geographic area: This would depend on the program reach and the situation being targeted. A national program in a country with ongoing civil/international strife might strive to capture as much of the country's population as possible. In this instance, disaggregating by location would be helpful in order to track areas of need. If there are a number of refugee camps within a given geographic zone, it would be important to track this indicator by camp.

Data Sources: Noting data sources used in calculating this indicator is essential because it could account for variance over time as well as between geographical areas within the same emergency. For example, if the first time the indicator was measured only health-post reports were used, and in subsequent times reports from groups were used in addition, an increase may not reflect an actual increase but only an increase of sources used to gather reports. Considering the consistency of reporting sources needs to be balanced with the need to use new (and perhaps better) sources of reports.

Interpretation of trends: Related to the above, there are many reasons for increases or decreases in trends over time or between places. A marked increase in reports might mirror the scale up of activities directed towards sexual violence, when women feel safer about reporting; the same trend might also mean a marked increase in incidents. This indicator needs to be interpreted with caution and should be informed with a rich contextual knowledge of what is taking place.

6.1.7 – Percent of rape survivors in the emergency area who report to health facilities/workers within 72 hours and receive appropriate medical care

Definition: The proportion of rape survivors who present for care at a health facility within 72 hours and who receive appropriate care, within a defined time period.

Numerator: Number of rape survivors who present for care within 72 hours of the incident and who receive appropriate care within a defined time period (e.g., past three months).

Appropriate care for rape survivors who present within 72 hours includes: HIV post-exposure prophylaxis (PEP), emergency contraception, sexually transmitted infection and HIV testing, psycho-social services, information about access to legal abortion. Other elements, such as a female health worker being present for any medical exam, are outlined in detail in the UNHCR interagency field manual.[43]

Denominator: Number of rape survivors who report an incident within 72 hours, during the same defined time period.

Disaggregate by: Age (under 15, 15-20, 20+), geographic location.

What It Measures: This indicator measures whether or not health facilities provide the appropriate comprehensive care to rape survivors who present within 72 hours of the incident. If survivors present after this period, services such as PEP and emergency contraception would not be part of the care that health service delivery points should be expected to provide.

Measurement Tool: A review of medical records in health service delivery points.

How to Measure It: Medical records at all health service delivery points are reviewed and rape cases are identified. The record should

43 UNHCR. 1999. Reproductive health in refugee settings: an inter-agency field manual. Geneva: UNHCR, WHO, UNFPA.

reflect that women received each of the services that appear in the list, and in this case, these women would be counted in the numerator. If the listed services do not exist at the specific facility, in order for women to be counted, they would need to be referred to a facility that does offer these services, and would subsequently need to receive them. This would be determined by examining the record at the referral facility. This number would be divided by the denominator, which includes all rape survivors who present to any health service delivery point within 72 hours of the incident within the emergency area.

Considerations: Because women may be referred from one point to another, a possibility of double-counting for the denominator exists. Care should be taken to match records of identical women who may have been referred from one point to another. Training in research confidentiality and ethics is especially important in this type of medical record review, since women can be readily identified through their medical records. In measuring this indicator, women will ideally be assigned an anonymous identifier (and identification number), which will ensure that data records maintain confidentiality. However, if a woman has multiple records (has been referred from the first facility to another with more appropriate services), this may cause the double-counting problem as noted above. It is important to include all health service delivery points in the record review in order to estimate an accurate denominator. Therefore, data collection for this indicator is very complex, especially when women are referred to other services.

It should be noted that many women do not present within this time period, if they present to health services at all. While this indicator will show whether or not women who seek care are receiving the appropriate elements of care, it does not reflect the quality of care that women receive, apart from the specific items. Quality of care is extremely important in the case of rape survivors given the emotional nature of the incident. If women are not treated with care and sensitivity at available health facilities, they will be less likely to present in the future. This indicator does not measure how many women do not receive services because they do not present either on time, or at all. This information would be critical to assess the health and social service climate for women in the specified area.

6.1.8 — Proportion of sexual violence survivors in the emergency area who report 72 hours or more after the incident and receive a basic set of psychosocial and medical services

Definition: The proportion of sexual violence survivors, including rape survivors, who present for care at a health facility 72 hours or more after the incident, and who receive a basic set of psychosocial and medical services, within a defined time period.

Numerator: Number of sexual violence survivors, including rape survivors, who present for care 72 or more hours after the incident occurred and who receive a basic set of psychosocial and medical services, within a defined time period (e.g., past three months).

The basic set of psychosocial and medical services that should be provided to sexual violence survivors who present after 72 hours includes: sexual transmitted infection and HIV testing, psycho-social services, information about access to legal abortion. Other elements, such as a female health worker being present for any medical exam, are outlined in detail in the UNHCR interagency field manual.44

Denominator: Number of sexual violence survivors who report an incident 72 hours or more after the incident occurred, during the same defined time period.

Disaggregate by: Age (under 15, 15-20, 20+), geographic location

What It Measures: This indicator measures whether or not health facilities provide the appropriate basic psychosocial and medical care to sexual violence survivors, including rape survivors, who present to health service delivery points 72 hours or more after the incident occurred. The list of basic services can be drawn from chapter 4 of the UNHCR field manual.

44 UNHCR. 1999. Reproductive health in refugee settings: an inter-agency field manual. Geneva: UNHCR, WHO, UNFPA.

Measurement Tool: A review of medical records in health service delivery points.

How to Measure It: Medical records at all health service delivery points are reviewed and all sexual survivor cases are identified. The medical record should reflect that women received each of the services that appear in the list, and in this case, these women would be counted in the numerator. If the listed services do not exist at the specific facility, in order for women to be counted, they would have to be referred to a facility that does offer these services, and would subsequently need to receive them. This would be determined by examining the record at the referral facility. This number would be divided by the denominator, which includes all sexual violence survivors who present to any health service delivery point within the emergency area 72 hours or more after the incident.

Considerations: Because women may be referred from one point to another, a possibility of double-counting for the denominator exists. Care should be taken to match records of identical women who may have been referred from one point to another. Training in research confidentiality and ethics is especially important in this type of medical records review, since women can be readily identified through their medical records. In measuring this indicator, women will ideally be assigned an anonymous identifier (and identification number), which will ensure that data records maintain confidentiality. However, if a woman has multiple records (has been referred from the first facility to another with more appropriate services), this may cause the double-counting problem as noted above. It is important to include all health service delivery points in the record review in order to estimate an accurate denominator. Therefore, data collection for this indicator is very complex, especially when women are referred to other services.

It should be noted that many women will not present to health services after experiencing sexual violence. While this indicator will show whether or not women who seek care are receiving the appropriate elements of basic care, it does not reflect the quality of care that women receive, apart from the specific items. Quality is extremely important in the case of sexual violence survivors given the emo-

tional/psychological trauma associated with the incident. If women are not treated with care and sensitivity at available health facilities, they will be less likely to present in the future. This indicator does not measure how many women do not receive services because they do not seek care. This information would be critical to assess the health and social service climate for women in the specified area.

6.1.9 – Number of activities in the emergency area initiated by the community targeted at the prevention of and response to sexual violence of women and girls

Definition: The number of activities initiated by community members that are targeted at preventing and responding to sexual violence among women and girls.

Count: Number of activities such as:

- A safe way to collect fuel, such as organizing an escort for groups of women to collect firewood at certain times
- Organizing a committee to ensure a safe place for sexual violence survivors to go for shelter
- Making sure that latrines and their access are well lit

What It Measures: This is a measure of how involved the community is in ensuring that women and children are safe within the emergency area.

Measurement Tool: A community-level survey that collects information from community leaders, workers and others.

How to Measure It: The list of activities which could be initiated may differ between contexts. The survey will document information about the types of activities taking place related to the prevention and response to VAW/G.

Considerations: Community involvement in activities to prevent and respond to VAW/G is very important, since plans and programs enacted solely by outsiders may inadvertently disregard something critical to affected communities. It also signals community stance against violence and a commitment to restore safety. There must be strong coordination among organizations and the active involvement of communities, especially women, to ensure security-focused and gender-sensitive arrangements during an emergency.

This is only a count of activities, and does not measure the relative impact of these activities on prevention and response. Repeating this measure over time will demonstrate more or less involvement of communities over time. That said, it may be difficult to document all activities within an emergency, especially if the area is defined as a large region or country. It may also be difficult to identify which activities were initiated by communities. Activities may have been initiated by others but have high community involvement by the time this indicator is measured.

6.1.10 – Proportion of women and girls in the emergency area who demonstrate knowledge of available services, why and when they would be accessed

Definition: The proportion of women and girls who know about available community resources in the emergency setting for VAW/G survivors, such as shelters, health services and counseling services, and know their purpose (when women would access them).

Numerator: Number of women and girls spontaneously naming at least one available resource (generate list of available community resources via situational analysis) or upon probing for their awareness ("do you know about the shelter located at X") as illustrated in question 1 below. In addition, the answer to question 2 for at least one named/probed service must be correct.

Ask: Can you please name any services available to help women and girls who experience any type of violence?,

If they cannot name one, ask: Do you know about the shelter located at X (for every service on the generated list)

If the respondent knows about any of the services ask: Under what circumstances would a woman use X?

Denominator: All women surveyed in the emergency area.

Disaggregate by: Age (under 15, 15-20, 20+), education, socio-economic status.

What It Measures: This measures important aspects of access to available community resources to prevent and respond to VAW/G. Availability of resources by itself will not mean much if women are not aware of them, and if they do not know why or when they would access them. However, this does not measure whether women are able to physically get to the resources when they need them.

Measurement Tool: A probability survey. The questions around community resources can be one module that is part of a larger assessment, such as the tools introduced in the RHRC manual.[45] A probability sample of women should be drawn, so the estimate can be generalized back to the population of women and girls in the emergency area.

How to Measure It: Women will be asked to name at least one service available in the community provided for the prevention and response to VAW/G. If she cannot name a service, she can be probed further by asking her about specific services. In order to be counted in the numerator, she also needs to specify why and when these services would be accessed.

Considerations: The difficulty in measuring this indicator would be in the identification of various services within large emergency regions. The decision to either count women who only know one service or women that know about various types (such as one providing health, security, etc.) has different implications for what this indicator would show.

Since sexual violence survivors may be part of the sample of women interviewed, ethical considerations on surveying women in emergency situations[46] need to be part of the study protocol. It is possible that through asking this question, even if it is not part of a larger assessment collecting information on the prevalence of sexual violence, women may either reveal their own experience or be reminded of another woman's experience when answering this question. Interviewers should therefore be appropriately trained, and ready to make referrals to services if necessary.

45 Reproductive Health for Refugees Consortium. 2003. Gender-based violence tools manual: For assessment, program design, monitoring and evaluation in conflict-affected settings. Available at: www.rhrc.org/resources/gbv/gbv_tools/manual_toc.html

46 WHO. 2007. WHO Ethical and safety recommendations for researching, documenting and monitoring sexual violence in emergencies. Geneva: WHO.

6.2 TRAFFICKING IN PERSONS

6.2.1 – Number of specialized services provided to trafficked women and children in a targeted area of destination countries

Definition: Number of health and social services available to victims of TIP in a defined area of a destination country, at a certain point in time

Count: Number of services available at the time of the survey

Disaggregate by: Type of services (e.g. health, legal/security, social welfare, etc.)

What It Measures: This indicates the availability of services provided to women and children who have been trafficked in at-risk areas of destination countries.

Measurement Tool: A survey of NGOs and other organizations that provide programming and direct services to trafficked women and children. The survey would include questions about what type of services are provided, and where women and children are referred for other services.

How to Measure It: An area of a destination country where trafficked women and children reside is demarcated. MEASURE Evaluation's PLACE method can be adapted to identify and map these areas.[47] All organizations within the targeted area are surveyed to ascertain whether they provide services to trafficked women and children, as well as the type of services they provide. Information about referrals will ensure that all organizations that provide services to these women and children are included, even if they are not

47 MEASURE Evaluation Project. 2005. PLACE: Priorities for local AIDS control efforts, a manual for implementing the PLACE method. USAID & MEASURE Evaluation, MS-05-13

dedicated services for TIP programming.

Considerations: It may be difficult to identify and map appropriate areas or regions within destinations countries. The number of organizations serving people affected by trafficking in an area offers some information about service availability. An increase in organizations over time may reflect a number of things, including more need (a growing population of affected individuals), increased funding and focus on the problem, or increased attention and awareness within communities.

6.2.2 – Number of women and girls assisted by organizations providing specialized services to trafficked individuals, in a destination region or country

Definition: The number of women and girls affected by trafficking who are assisted by organizations dedicated to providing TIP-based services in a destination region or country, during a specified time period (e.g. the past 12 months).

Count: Number of women and girls assisted during a specified time period (e.g., the past 12 months) who:

- Are victims of human trafficking
- Have been assisted by an organization dedicated to providing services to trafficking victims

What It Measures: This measures the number of trafficked women and girls helped by organizations dedicated to servicing them, within a specified time period.

Measurement Tool: A review of records in identified organizations within the region or country.

How to Measure It: A simple count of the number of women and girls serviced by these organizations.

Considerations: Women could be served by multiple organizations, resulting in repeat counting of the same individuals. This indicator may be very difficult to obtain in a large region or country, because all organizations serving trafficked people need to be identified and visited in order to obtain the requisite information.

Trends over time can be monitored, if the indicator is measured periodically. However, an increase in the number of women and children served could mean a larger population in need as well as better services for the same size population. Under-reporting could also occur due to stigma. Trafficked women may use services but not declare that they are trafficked.

6.2.3 – Proportion of people in origin and destination communities who have been exposed to public awareness messages about TIP

Definition: Proportion of people living in destination or origin communities who have been exposed to public awareness messages about TIP. These messages could have been promoted through an Information and Education Campaign (IEC), interpersonal communication or community outreach activities during a specified period of time (e.g., past 12 months).

Numerator: Number of people surveyed who answer affirmatively to either question:

- In the past (e.g., 12 months), have you heard about issues related to Human Trafficking through the radio, TV or other media like the newspaper or a poster?
- In the past (e.g., 12 months), have you discussed issues related to Human Trafficking with anyone who came to your house or neighborhood to make people aware of the problem?

Denominator: Total number of people surveyed.

Disaggregate by: Geographical area, source of message, sex of respondent.

What It Measures: In countries (or regions within countries) where communication programs related to TIP prevention are implemented using IEC techniques, interpersonal communication channels and community outreach workers, program managers and evaluators may need to know the extent to which the intended audience is exposed to the communication program. This outcome indicator measures the extent to which a population targeted by specific TIP programs and projects is exposed to TIP awareness messages through any means that they might be communicated.

Measurement Tool: Population-based survey.

How to Measure It: This indicator is measured by asking the questions in the above definition. All individuals who answer yes to either (or both) questions are counted in the numerator. This number is then divided by the denominator, which includes all people surveyed.

Considerations: It is important to find a term for Human Trafficking which will be understood by the community in which the survey is to take place. Measurement of this indicator alone does not provide a measure of how well the information was understood by the audience.

6.3 FEMICIDE

6.3.1 – Female Homicide

Definition: The number of women or girls who were murdered during a specific time period (e.g., the past 12 months)

Count: The number of women or girls who were killed by another person.

Disaggregate by: Age of the victim, circumstances of death, perpetrator, and geographic region.

What It Measures: This is a simple count of how many women or girls died during a specified time period (e.g., the past 12 months) because they were killed by another person, regardless of the circumstances, who the assailant was, or whether or not the perpetrator(s) was identified.

Measurement Tool: A special study that examines records from a number of places, including the judicial system, police reports, and/or health records from urgent care units if they record the necessary information such as cause of death.

How to Measure It: A count of female murders would be undertaken by examining records from the best sources available. These may include judicial records, medical records from urgent care units, police reports, and/or media reports. Multiple sources need to be checked because these crimes may not be reported. The names, ages, residences and any other information about the victim should be noted to avoid double-counting high profile cases.

Considerations: It may be difficult to access records, and the records may be of very poor quality. When a study is undertaken, careful reporting of the data sources and their quality should be included when presenting the measure. Double counting is a distinct

possibility due to the necessity of checking multiple records. Care should be taken to avoid duplicate counts. However, if the quality of the sources of data is not high, it is likely that the resulting count will be an underestimate, especially in places where such crimes may not be considered worth noting. For example, in many countries, the murder of women or girls due to reasons of "family honor" is legal. This indicator will also likely miss deaths due to female infanticide, since these deaths are easier to hide.

6.3.2 – Proportion of female deaths that occurred due to gender-based causes

Definition: The number of women or girls who were murdered during a specific time period (e.g., the past 12 months) for gender-based reasons. These reasons include dowry death, family honor, IPV, murder with rape, killings of prostitutes, female infanticide, and other deaths where reports confirm that the deaths occurred as a result of women or girls being targeted on the basis of gender (for example, a serial killer who has singled out women as victims).[48]

Numerator: The number of women or girls who were killed for gender-based reasons during a specific time period (e.g., the past 12 months).

Denominator: The total number of women or girls murdered during the same time period

Disaggregate by: Gender-based reason using the categories above, age of the victim, circumstances of death, perpetrator, geographic region.

What It Measures: This measures the proportion of female homicide victims who were killed specifically because of their gender, during a specified time period (e.g., the past 12 months). This is the gravest form of violence against a woman or girl.

Measurement Tool: A special study that examines records from a number of places including the judicial system, police reports, and/or health records from urgent care units as described in 6.3.1

How to Measure It: A count of female murders would be undertaken by examining records from the best sources available. These may

48 These are the categories being proposed by the UNHRC (UNHRC. 2008. Report of the Special Rapporteur on violence against women, its causes and consequences by Yakin Ertürk. Indicators on violence against women and State response. Advance edited version (28 January 2008). www2.ohchr.org/english/bodies/hrcouncil/7session/reports.htm A/HRC/7/6) to be added to homicide data systems worldwide.

include judicial records, medical records from urgent care units, police reports, and/or media reports. Multiple sources need to be checked because these crimes may not be reported. The names, ages, residences and any other information about the victim should be noted to avoid double counting of high profile cases. In addition, other methods to investigate the circumstances of death, in order to conclude that the death was due to gender-based reasons, should be undertaken. These may include methods such as verbal autopsies with neighbors or others who were close to the woman or girl and/or the examination of newspaper and media reports that may explain the circumstances of death.

Considerations: It may be difficult to access death records, and the records may be of very poor quality. When a study is undertaken, careful reporting of the data sources and their quality should be included when presenting the measure. Double counting is a distinct possibility due to the necessity of checking multiple records. Care should be taken to avoid duplicate counts. However, if the quality of the sources of data is not high, it is likely that the resulting count will be an underestimate, especially in places where such crimes may not be considered worth noting. For example, in many countries, the murder of women or girls due to reasons of "family honor" is legal. In addition, identifying whether or not the death was due to gender-based reasons will be very difficult until the classification system recommended by the UNHRC (see footnote 49 on page above) is implemented into crime statistics systems.

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Chapter 7: Programs Addressing the Prevention of VAW/G

Introduction

Primary prevention of violence against women and girls is essential in promoting women's and children's health and well being. Ultimately, prevention entails changing deep-rooted cultural norms and beliefs related to gender and what constitutes acceptable behavior between men and women. Studies of programmatic efforts aimed at social change have demonstrated that inequitable gender norms and beliefs and related behavior can be transformed over time. However, this change needs to be introduced gradually, use a range of different strategies, reach a cross-section of communities, and include activities that are sustained over time. Successful approaches to preventing VAW/G draw on support from governmental and non-governmental organizations across sectors, with coordinated efforts to implement, monitor and evaluate programs.

A range of activities may be successful in reducing the incidence of VAW/G. Programs may approach this issue by addressing women's empowerment through social training and financial independence, changing attitudes among men and women. Gender transformative programs that aim to change the cultural norms that support the acceptability of VAW/G in communities are another effective approach. Addressing gender norms with men and boys has been shown to improve reproductive health outcomes for both women and men including a reduced incidence of HIV. Programs targeted at men and boys examine men's roles in perpetuating discrimination against women and seek to involve men in improving the situation for women. Educational campaigns and small group projects focused on behavior change can help raise men's and boys' awareness about gender discrimination and the disadvantages facing women and girls.

The three areas of primary prevention of VAW/G in this section of indicators are programs aimed at youth, community mobilization

and behavior change, and working with men and boys.

The indicators in 7.1 address programs aimed at youth. Section 7.2 focuses on program coordination across sectors, exposure to IEC programs targeting attitude and behavior change, and people's beliefs pertaining to IPV, sexual violence, and FGC. The indicators in section 7.3 were developed to be used to monitor and evaluate programs that target change in gender norms and beliefs that influence the behavior of men and boys with regard to VAW/G. However, indicators in both 7.1 and 7.2 also capture outcomes that can be measured for men and boys. Indicators 7.2.4, 7.2.6, 7.2.7 and 7.2.8 are particularly relevant to Working with Men and Boys.

7.1 YOUTH

7.1.1 – Proportion of youth-serving organizations that train staff and front line people on issues of sexual and physical VAW/G

Definition: The percent of youth-serving organizations that train their staff and front line people on issues related to sexual and physical VAW/G, including power, coercion, and gender in a specific geographic area. Youth serving organizations include those in the health sector (e.g., HIV prevention programs), job training, recreation, faith-based groups, and other areas. "Front line" people would include volunteers, teachers, and peer educators who directly interact with youth.

Numerator: Number of youth-serving organizations that train any staff and others directly interacting with youths on VAW/G issues. Training curriculums should include components covering:

- Acts of VAW/G that affect youth along with the health and social consequences
- How power, coercion and gender issues place youth at risk for VAW/G
- Actions to be taken if a youth reports any act of VAW/G
- Actions to be taken if they observe a staff/front line person acting inappropriately while working with youth.

Denominator: Total number of youth serving organizations surveyed.

Disaggregate by: Area, type of organization

What It Measures: This indicator measures the awareness, sensitivity and preparedness of youth serving organizations to prevent and protect youth from acts of VAW/G. Staff and front line people who undergo training in a curriculum covering the basic elements of issues related to VAW/G will be sensitized to the issue. This is a

community-level measure of the commitment to preventing VAW/G among youth and the care of affected individuals.

Measurement Tool: A survey of youth organizations in the target area.

How to Measure It: A list of youth-serving organizations in the targeted area is generated by talking to government and non-government organizations, as well as key informants such as religious and other community leaders. If a large area is being targeted, a sample of organizations can be randomly drawn, based on a plan that would ensure representation from different types of organizations. For example, systematic selection of organizations working with youth in health, job training, social services, recreation etc. would be part of a sample selection scheme. A survey could also be implemented to cover all organizations listed, depending on the resources for the study.

Organizations would be asked if any training is provided to both staff and other workers on VAW/G issues. If they answer yes, they would be queried about what components are covered, working with a checklist that covers the topics listed above. If the training covers the required components, then the organization is counted in the numerator. That number is then divided by the denominator, which is comprised of all organizations surveyed.

Considerations: This is an important output measure that will cover people who work with both female and male youth. If staff and others associated with the organizations are trained on how VAW/G occurs and affects youth, a work culture that incorporates an awareness and sensitization of these issues will most likely be established. This will most likely also create a safer atmosphere for participating youth, and would ideally provide a place where youth could report incidents and seek help.

The measurement of this indicator depends on being able to exhaustively list organizations that work with youth in a targeted area. While this may not be difficult in a limited rural area where only several organizations exist, in a larger or urban area where there are

multiple organizations, it would be very easy to miss youth serving organizations. If organizations are missed in the listing, the resulting proportion would not accurately represent the level of organizational training that takes place in a community or area.

7.1.2 – Proportion of youth-serving organizations that include trainings for beneficiaries on sexual and physical VAW/G

Definition: The percent of organizations serving youth that train their beneficiaries on issues related to sexual and physical VAW/G, including power, coercion, and gender in a specific geographic area. Youth serving organizations include those in the health sector (e.g., HIV prevention programs), job training, recreation, faith-based groups, and other areas. Beneficiaries include any youth that these organizations serve.

Numerator: Number of youth serving organizations that train beneficiaries on VAW/G issues. Training curriculums aimed at youth should include components covering:

- Acts of VAW/G that affect youth along with the health and social consequences
- How power, coercion and gender issues place youth at risk for VAW/G
- Where and how youth can get help if they have experienced an act of VAW/G

Denominator: Total number of youth serving organizations surveyed.

Disaggregate by: Area, type of organization

What It Measures: This indicator measures the commitment of youth serving organizations to prevent and protect youth from acts of VAW/G by making youths aware of the problem as well as providing resources related to where they can go for help if needed. This is a community-level measure of the commitment among youth serving-organizations to prevent VAW/G among youth and care for affected individuals.

Measurement Tool: A survey of youth organizations in the target area.

How to Measure It: A list of youth serving organizations in the targeted area is generated by talking to government and non-government organizations, as well as key informants such as religious and other community leaders. If a large area is being targeted, a sample of organizations can be randomly drawn, based on a plan that would ensure representation from different types of organizations. For example, systematic selection of organizations working with youth in health, job training, social services, recreation etc. would be part of a sample selection scheme. A survey could also be implemented to cover all organizations listed, depending on the resources for the study.

Organizations would be asked if any VAW/G-related training is provided to youth. If they answer yes, they would be queried about what components are covered, working with a checklist that covers the topics listed above. If the training covers all of the required components, then the organization is counted in the numerator. That number is then divided by the denominator, which is comprised of all organizations surveyed.

Considerations: This is an output measure because it will demonstrate the level of commitment that youth serving organizations have to providing VAW/G awareness and referrals to the youth they serve, thus aiming for a change in the way the boys and girls will relate to each other when they become adults. If organizations train youth on how VAW/G occurs and affects them, it may influence a change in the way youths develop norms and values around the issue. The indicators in section 7.2 relate to changes in beliefs and attitudes. These types of trainings will most likely also create a safer atmosphere for participating youth, and would ideally provide a place where youth could report incidents and seek help.

The measurement of this indicator depends the ability to list all organizations that work with youth in a targeted area. While this may not be difficult in a limited rural area where only several organizations exist, in a larger or urban area it would be very easy to miss youth serving organizations. If organizations are missed in the listing, the resulting proportion would not accurately represent the level of organizational training that takes place in a community or area.

7.1.3 – Proportion of individuals who report they heard or saw a mass media message on issues related to sexual violence and youth

Definition: The proportion of individuals who say that they heard or saw a mass media message on issues related to sexual violence and youth during a specific time period (e.g., past 12 months).

Numerator: Number of individuals who state they have seen a mass media message on issues related to sexual violence and youth.

Ask: Have you seen or heard a message that talked about sexual violence and young people in the past (defined time period, e.g., 12 months)? This could have been (any of the following):

- A program or message on the radio
- A television spot or program
- A poster or billboard
- A message in a newspaper or other written media

Denominator: Total number of people surveyed.

Disaggregate by: Geographic region, age, sex.

What It Measures: This output indicator measures the proportion of people in a country, region or community reached by mass media campaigns that address sexual violence and youth. This demonstrates how many people remember hearing the message.

Measurement Tool: A population-based survey.

How to Measure It: People are asked if they have heard a message pertaining to sexual violence and youth in the past 12 months (or other time period), or other defined time period, using the checklist above as probes. The term sexual violence should be described or translated carefully, into usage that is locally recognized and acceptable. Ideally, this survey should be conducted in a probability sample which is representative of the target population. If people have heard a message, they are counted in the numerator. This

number is then divided by the denominator, which includes all people surveyed.

Considerations: This indicator measures program coverage, but not its effect. People may remember hearing a message, but may not have integrated what it means, or how they feel about it. This indicator should be coupled with those in 7.2 which pertain to attitudes and beliefs.

7.1.4 – Proportion of girls who say they would be willing to report any experience of unwanted sexual activity

Definition: The percent of girls that state they would be willing to report any unwanted sexual activity that took place at home, school or elsewhere.

Numerator: Number of girls aged 10-18 years old who state they would be willing to report an incident of unwanted sexual activity.

Ask: If someone, even a family member, had touched your private parts, would you be willing to tell someone about it?

Denominator: Total number of girls aged 10-18 years old surveyed.

Disaggregate by: Region, age group (10-14, 15-18).

What It Measures: This indicator measures the willingness of girls to report unwanted sexual activity. It may also measure the normative acceptability of talking about this subject in the particular locale.

Measurement Tool: A survey of girls in the target area. This could be done as part of a household survey such as the DHS, if girls were part of the sample (which usually includes girls aged 15 and up), or a special survey on VAW/G.

How to Measure It: A question such as the one above needs to be carefully developed to ensure that it is culturally acceptable and uses language that is understood by the target population. Ideally, this survey should be conducted in a probability sample which is representative of the target population. Girls that answer yes would be counted in the numerator. That number is then divided by the denominator, which would include all girls surveyed.

Considerations: Doing this type of research on minors requires careful consideration. Even though this is a hypothetical question, it is very likely that at least some girls surveyed will have experienced some type of unwanted sexual activity. Asking this question could create a difficult situation for these girls. Further, asking girls who have experienced unwanted sexual activity from family members or others could potentially put them at risk for violence, if their perpetrator found out that they participated in this type of survey. The ethical guidelines documented by the WHO[49] and Ellsberg & Heise[50] for doing research on violence should be followed in conducting such a study.

49 Watts, C et al. 2001. Putting women first: Ethical and safety recommendations for research on domestic violence against women. Geneva, World Health Organization (document WHO/EIP/GPE/01.1, available at: http://whqlibdoc.who.int/hq/2001/WHO_FCH_GWH_01.1.pdf

50 Ellsberg, Mary Carroll & Heise, Lori. 2005. Researching Violence Against Women: A Practical Guide for Researchers and Activists. Washington, D.C: World Health Organization, PATH Available at: www.path.org/files/GBV_rvaw_complete.pdf

7.1.5 – Proportion of girls that feel able to say no to sexual activity

Definition: Proportion of girls who state that they have a right to not have sex or engage in sexual activity if they say they do not want it, regardless of who asks them.

Numerator: Number of girls aged 10-18 years old reporting that they agree with the following two statements, adapted from the USAID Safe Schools quantitative instrument:[51]

- You have the right to say no to sex, no matter who asks you
- You have the right to say no if any male, including a teacher, family member, or friend wants to touch your thighs, buttocks or private parts

Denominator: Total number of girls aged 10-18 years old surveyed.

What It Measures: This measures girls' feeling of empowerment to speak up and try to protect themselves from unwanted sexual activity, regardless of who asks them. This does not imply that they will not be coerced or forced into having sex against their will.

Measurement Tool: A survey of girls in the target area. This can be a survey of girls in the community, in schools, or part of a general household survey with a special module on VAW/G.

How to Measure It: All girls surveyed who agree with both of the statements regarding saying no about sexual activity are counted as part of the numerator. Girls who do not agree with both statements, including girls who agree with only one statement, but not the other should not be included in the numerator. The numerator is then divided by the denominator, which includes the total number of girls surveyed. Ideally, this survey should be conducted in a probability

51 USAID. 2006. The safe schools program: Quantitative research instrument to measure school-related gender-based violence. Produced by DevTech systems, Inc. & Centre for Educational Research and Training. www.devtechsys.com/services/activities/documents/SRGBV_SafeSchoolsProgram_StudentTeacherBaselineSurveyMethodology_Dec2006_000.pdf

sample which is representative of the target population of girls in this age group.

Considerations: Doing this type of research on minors requires careful consideration. Even though this is a hypothetical question, it is very likely that at least some girls surveyed will have experienced some type of unwanted sexual activity. Asking this question could create a difficult situation for these girls. Further, asking girls who have experienced unwanted sexual activity from family members and others could potentially put them at risk for violence, if their perpetrator found out that they participated in this type of survey. The ethical guidelines documented by the WHO[52] and Ellsberg & Heise[53] for doing research on violence should be followed in conducting such a study.

52 Watts, C et al. 2001. Putting women first: Ethical and safety recommendations for research on domestic violence against women. Geneva, World Health Organization (document WHO/EIP/GPE/01.1, available at: http://whqlibdoc.who.int/hq/2001/WHO_FCH_GWH_01.1.pdf

53 Ellsberg, Mary Carroll & Heise, Lori. 2005. Researching Violence Against Women: A Practical Guide for Researchers and Activists. Washington, D.C: World Health Organization, PATH Available at: www.path.org/files/GBV_rvaw_complete.pdf

7.1.6 – Proportion of girls reporting that male teachers do not have the right to demand sex from school children

Definition: Proportion of girls who report that a teacher's authority does not include the right to demand sex from their students.

Numerator: Number of girls aged 10-18 years old reporting that they disagree with the following statement, from the USAID Safe Schools quantitative instrument:[54]

- Male teachers have the right to demand sex from school children

Denominator: Total number of girls aged 10-18 years old surveyed.

What It Measures: This measures girls' views of how far a teacher's authority extends over their students.

Measurement Tool: A survey of students in schools, such as the one presented in the USAID Safe Schools guide.

How to Measure It: All girls surveyed who disagree with the statement regarding male teacher's rights to demand sex from students are counted as part of the numerator. The numerator is then divided by the denominator, which includes the total number of girls surveyed. Ideally, this survey should be conducted in a probability sample which is representative of the target population.

Considerations: Doing this type of research on minors requires careful consideration. It is very likely that at least some girls surveyed will have experienced some type of unwanted sexual activity from their male teachers. Asking this question could create an uncomfortable situation for these girls. Further, asking girls who have experi-

54 USAID. 2006. The safe schools program: Quantitative research instrument to measure school-related gender-based violence. Produced by DevTech systems, Inc. & Centre for Educational Research and Training. www.devtechsys.com/services/activities/documents/SRGBV_SafeSchoolsProgram_StudentTeacherBaselineSurveyMethodology_Dec2006_000.pdf

enced unwanted sexual activity from teachers could potentially put them at risk for violence, if their perpetrator found out that they participated in this type of survey. The ethical guidelines documented by the WHO[55] and Ellsberg & Heise[56] for doing research on violence should be followed in conducting such a study.

55 Watts, C et al. 2001. Putting women first: Ethical and safety recommendations for research on domestic violence against women. Geneva, World Health Organization (document WHO/EIP/GPE/01.1, available at: http://whqlibdoc.who.int/hq/2001/WHO_FCH_GWH_01.1.pdf

56 Ellsberg, Mary Carroll & Heise, Lori. 2005. Researching Violence Against Women: A Practical Guide for Researchers and Activists. Washington, D.C: World Health Organization, PATH Available at: /www.path.org/files/GBV_rvaw_complete.pdf

7.1.7 – Proportion of girls who believe that girls are not to blame for sexual harassment by a male teacher or student

Definition: Proportion of girls who feel that it is not the girl's fault if she is sexually harassed* by a male teacher or student.

Numerator: Number of girls aged 10-18 years old reporting that they disagree with the following statement from the USAID Safe Schools quantitative instrument:[57]

- It is sometimes the girl's fault if a male pupil or teacher sexually harasses her

Denominator: Total number of girls aged 10-18 years old surveyed

What It Measures: This measures girls' views regarding whose responsibility it is when sexual harassment occurs. If they think they are to blame for male teachers' or fellow students' actions, they will be less likely to report the activity, seek help or even try to refuse.

Measurement Tool: A survey of students in schools, such as the one presented in the USAID Safe Schools guide.

How to Measure It: All girls surveyed who disagree with the statement regarding who is to blame are counted in the numerator. The numerator is then divided by the denominator, which includes all girls surveyed. Ideally, this survey should be conducted in a probability sample which is representative of the target population.

Considerations: Sexual harassment has to be defined carefully within the cultural context and used consistently in the study instrument. Doing this type of research on minors requires careful consideration. It is very likely that at least some girls surveyed will have

57 USAID. 2006. The safe schools program: Quantitative research instrument to measure school-related gender-based violence. Produced by DevTech systems, Inc. & Centre for Educational Research and Training. www.devtechsys.com/services/activities/documents/SRGBV_SafeSchoolsProgram_StudentTeacherBaselineSurveyMethodology_Dec2006_000.pdf

experienced some type of unwanted sexual activity from their male teachers or fellow male students. Asking this question could create an uncomfortable situation for these girls. Further, asking girls who have experienced sexual harassment from teachers or other students could potentially put them at risk for violence, if their perpetrator found out that they participated in this type of survey. The ethical guidelines documented by the WHO[58] and Ellsberg & Heise[59] for doing research on violence should be followed in conducting such a study.

58 Watts, C et al. 2001. Putting women first: Ethical and safety recommendations for research on domestic violence against women. Geneva, World Health Organization (document WHO/EIP/GPE/01.1, available at: http://whqlibdoc.who.int/hq/2001/WHO_FCH_GWH_01.1.pdf

59 Ellsberg, Mary Carroll & Heise, Lori. 2005. Researching Violence Against Women: A Practical Guide for Researchers and Activists. Washington, D.C: World Health Organization, PATH Available at: http://www.path.org/files/GBV_rvaw_complete.pdf

7.2 COMMUNITY MOBILIZATION AND INDIVIDUAL BEHAVIOR CHANGE

7.2.1 – Proportion of individuals who know any of the legal rights of women

Definition: Proportion of people who are aware of any specific constitutional and legal rights of women in a given country at a specific period in time.

Numerator: Ask individuals: Do you know that in (name of country), women have the right to (list of rights in that particular country, such as divorce, to work, to marry whom they choose)

- X (e.g., divorce)
- Y (e.g., to work)
- Etc.

Denominator: Total number of people surveyed.

Disaggregate by: Geographical area, sex of respondent

What It Measures: Knowledge of women's constitutional and legal rights remains low particularly among women in many countries. Given the situation, human rights and women's rights education programs are implemented in communities in a number of countries. Program managers and evaluators may be interested in knowing the extent to which men and women are aware of the constitutional and legal rights of women. This outcome indicator measures the extent to which the public are aware of such rights.

Measurement Tool: Population-based survey.

How to Measure It: This indicator is measured by asking a set of questions, as in the above definition, that is tailored for each country to reflect the constitutional and legal rights of that country. If a person responds yes to any of the questions, they are counted in the numerator. This number is then divided by the denominator, which

includes everyone surveyed.

Considerations: Measurement of this indicator only reflects people's awareness of a law and does not provide a measure of how well the respondents understand the constitutional and legal rights of women, and to what they are entitled. In places where there are few legal rights for women, this indicator may not be useful. However, it may be used to track changes over time as legislation begins to include more rights for women. The difference between civil and customary laws should be made clear to respondents in places where these may exist side by side.

7.2.2 –Proportion of individuals who know any of the legal sanctions for VAW/G

Definition: The proportion of people who understand what can result if an individual perpetrates an act of VAW/G which is punishable by law in the country, at a specific period of time.

Numerator: Number of people who know any of the legal sanctions which can occur after an act of VAW/G is committed.

Ask (construct list of acts and the legal recourse associated with it): Do you know that if an individual does X, then Y can result?

Denominator: Total people surveyed

Disaggregate by: Sex of respondent

What It Measures: Knowledge of the legal sanctions associated with VAW/G is low, particularly among women in many countries. If women do not know of any legal recourse, they may not seek help, thinking that nothing can be done. Program managers and evaluators may be interested in knowing the extent to which men and women are aware of the legal sanctions for acts of VAW/G that exist in a country. This outcome indicator measures the extent to which the public are aware of such sanctions.

Measurement Tool: Population-based survey.

How to Measure It: This indicator is measured by asking a set of questions as in the above definition that are tailored for each country to reflect the legal sanctions for acts of VAW/G in that country. If a person responds yes to any of the questions, they are counted in the numerator. This number is then divided by the denominator, which includes everyone surveyed.

Considerations: Measurement of this indicator only reflects people's awareness of possible legal recourse and does not provide a measure of how well the respondents understand these sanctions,

or how accessible legal recourse is for women. In order to get a fuller picture, this indicator could be used along with those in Chapter 5.3, for the Justice and Security sector.

7.2.3 – Proportion of people who have been exposed to VAW/G prevention messages

Definition: Proportion of people surveyed who have been exposed to VAW/G prevention messages that have been promoted either through an IEC campaign, interpersonal communication or community outreach activities during a specified period of time (e.g., past 12 months).

Numerator: Number of people surveyed who answer affirmatively to either question:

- In the past (e.g., 12 months), have you heard about issues related to the prevention of violence against women and girls through the radio, TV or other media like the newspaper or a poster?
- In the past (e.g., 12 months), have you discussed issues related to the prevention of violence against women and girls with anyone who came to your house or neighborhood to make people aware of the problem?

Denominator: Total number of people surveyed.

Disaggregate by: Geographical area, source of message, sex of respondent.

What It Measures: In countries (or regions within countries) where communication programs related to VAW/G prevention are implemented using IEC techniques, interpersonal communication channels and community outreach workers, program managers and evaluators may need to know the extent to which the intended audience is exposed to the communication programs. This outcome indicator measures the extent to which a population targeted by specific VAW/G programs and projects is exposed to VAW/G prevention messages through any means that they might be communicated. This indicator differs from 7.1.3 because that one focuses specifically on youth, whereas this one pertains to VAW/G in general.

Measurement Tool: Population-based survey.

How to Measure It: This indicator is measured by asking the question in the above definition. All individuals who answer yes are counted in the numerator. This number is then divided by the denominator, which includes all people surveyed.

Considerations: Measurement of this indicator alone does not provide a measure of how well the information was understood by the audience, or whether the intended audience has adopted the recommended behavior.

7.2.4 Proportion of people who say that wife beating is an acceptable way for husbands to discipline their wives

Definition: Proportion of people who consider wife beating an acceptable way for a husband to discipline his wife for any reason, at a specified period in time.

Numerator: Number of respondents in a community who respond "yes" to any of the following questions related to what justifies wife beating by husbands, as listed below.

Ask: Sometimes a husband is annoyed or angered by things that his wife does. In your opinion, is a husband justified in hitting or beating his wife:60

- If she is unfaithful to him?
- If she disobeys her husband?
- If she argues with him?
- If she refuses to have sex with him?
- If she does not do the housework adequately?

Denominator: Total number of people surveyed in the community.

Disaggregate by: Age, sex of respondent, region, number of reasons stated.

What It Measures: This outcome indicator measures the level of acceptability of wife-beating in an area (region, country, community) for any reason, at the point in time that it is measured. A high proportion would indicate that most people in the targeted population feel that wife beating is acceptable under certain conditions.

Measurement Tool: Population-based survey.

60 Checklist based on: World Health Organization. WHO Multi-country Study on Women's Health and Domestic Violence Against Women: Summary Report of Initial Results on Prevalence, Health Outcomes and Women's Responses. Geneva, Switzerland: World Health Organization; 2005 & Macro International, DHS Module A.

How to Measure It: This indicator uses a set of questions such as those listed above under the definition, which can be included in a population-based survey questionnaire. Anyone responding "yes" to any of the conditions under which wife beating might be justified is counted in the numerator. This number is then divided by the denominator, which includes everyone surveyed. Disaggregating this by the number of reasons given by people will give more information about respondents' beliefs. For example, it will be useful to programs to know if most of the people included in the numerator only cite one reason versus most people citing four or five. People living in areas where only one or two reasons were answered affirmatively may have less general acceptance for IPV than in areas where most people respond affirmatively to most or all reasons asked.

Considerations: Focus group discussions with residents of communities, key informant interviews with community leaders and women's group leaders may assess the level of tolerance for wife-beating (or more broadly, violence against women and girls) in communities. While most cases of wife beating take place in the home, most of the interventions are implemented at the community level in the form of awareness-raising activities and human rights education.

Thus, tracking the measurement of this indicator over time is of value for program managers and planners. While a direct causal relationship cannot be established, a decrease in the proportion of people who tolerate wife beating in a community may indicate that community-based awareness-raising activities and human rights education interventions are having a positive effect on norms and attitudes at the community level. However, it should be noted that the responses to the questions listed under the definition above are prone to social desirability bias. Respondents may be inclined to provide responses that they perceive to be more socially acceptable or appropriate rather than what they actually feel.

7.2.5 – Proportion of people who would assist a woman being beaten by her husband or partner

Definition: Percent of people surveyed who report that they would help a woman who was being beaten by her husband or partner, versus those who would not, for various reasons that should be noted.

Numerator: Number of people surveyed who state that they would be "willing to help" to the question:

- If you knew that a woman was being beaten by her husband, either because you heard the incident(s) or because she told you, would you be willing to help her?

Denominator: Total number of people surveyed.

Disaggregate by: Age, sex of the respondent, region/province/district.

Ask all individuals who answered no: Why wouldn't you help her?

- This type of thing is a private matter between husband and wife/partners, and I wouldn't want to interfere.
- I would not know what to do (how to help)
- The wife would be in more trouble if someone interfered
- Agrees with the husband that the wife deserves to be beaten
- Other reasons which would apply to the local context

What It Measures: Neighbors are often aware when a woman is being beaten by her husband because they can hear the incidents. Relatives (living outside the household) and friends are often told about these incidents by women. People's willingness to extend help to the woman may save the woman from the pain, disability and death associated with IPV. A low proportion of individuals stating that they are wiling to help may indicate a general acceptance of IPV in the community surveyed. Women living in such communities are at higher risk for the consequences associated with IPV, and they may have little recourse.

There are many reasons why people would not extend this help. Some include: the belief that what takes place between a husband and wife is a private matter, cultural acceptance of IPV, not being empowered enough to help, and not knowing what to do. In areas where the proportion of people willing to help is low, it is important to assess the reasons behind this in order for programs to plan activities to address these issues in the community.

Measurement Tool: Population-based survey.

How to Measure It: This indicator can be measured in the general population, or in targeted populations such as security personnel. People are asked the question in the definition, and those answering that they are willing to help are counted in the numerator. This number is then divided by the denominator, which includes all people surveyed.

To understand why people would not extend help, those who answer no should be asked why not. People can name more than one reason and results can be stratified by reason. The resulting proportions would give program managers an idea of what the main reasons within a community are for not extending help.

Considerations: Focus group discussions with residents of communities, key informant interviews with community leaders and women's group leaders may assess the level of acceptability of helping women affected by intimate partner violence in communities. Tracking the measurement of this indicator over time is of value for program managers and planners, because women may turn to neighbors, friends and relatives first for help. While a direct causal relationship cannot be established, an increase in the proportion of people who are willing to help affected women in a community may indicate that community-based awareness-raising activities and human rights education interventions are having a positive effect on norms and attitudes at the community level. However, it should be noted that the responses to the questions listed under the definition above are prone to social desirability bias. Respondents may be inclined to provide responses that they perceive to be more socially acceptable or appropriate rather than what they actually feel.

7.2.6 – Proportion of people who say that men cannot be held responsible for controlling their sexual behavior

Definition: The proportion of people who feel that when men force a woman to have sex, it can be explained by the fact that men do not have control over their sexual behavior.

Numerator: Number of people who agree with the statement:

- One reason why men force women to have sex is because sometimes men cannot control their sexual behavior.

Denominator: Total people surveyed.

Disaggregate by: Sex of respondent, age, region.

What It Measures: People who feel that men cannot control their sexual behavior (i.e., that the reason they act sexually is because of a factor outside of themselves) also feel that on some level, men cannot be held responsible for what they do sexually. This places the blame for violent sexual behavior on the victim instead of on the perpetrator.

Measurement Tool: A population-based survey.

How to Measure It: People are asked if they agree or disagree (which can be part of a 5 point Likert scale ranging from strongly agree to strongly disagree) with the statement in the definition. People who state that they agree are counted in the numerator. This number is then divided by the denominator, which includes everyone surveyed.

Considerations: Tracking the measurement of this indicator over time is of value for program managers and planners, because people need to be aware that responsibility for sexual assault lies absolutely with the perpetrator, who chooses to engage in inappropriate behavior. While a direct causal relationship cannot be established, a decrease in the proportion of people who believe that men some-

times cannot control their sexual behavior in a community may indicate that community-based awareness-raising activities and human rights education interventions are having a positive effect on norms and attitudes at the community level. However, it should be noted that the responses to the questions listed under the definition above are prone to social desirability bias. Respondents may be inclined to provide responses that they perceive to be more socially acceptable or appropriate rather than what they actually feel.

7.2.7 – Proportion of people who agree that a woman has a right to refuse sex

Definition: The proportion of people who feel that women have the right to refuse to have sex with their partner or husband.

Numerator: Number of people who agree with the statement:

It is okay for a woman to refuse to have sex with either her partner or husband if:

- He refuses to use a condom
- She does not desire it
- She is feeling ill
- She has her period
- She is pregnant
- She is nursing[61]

Denominator: Total people surveyed

Disaggregate by: Reasons, sex of respondent, age, region.

What It Measures: Cultural norms around the authority of husbands over wives may include that he has a right to have sex with his wife or partner regardless of whether or not she wants it. Alternately, there may be conditions under which it is acceptable (or not acceptable) for her to refuse. This outcome indicator measures how acceptable the idea of a woman refusing sex with her husband or partner is, and under which reasons people feel this is acceptable. In areas where there are no acceptable reasons or very low proportions of people agreeing with the reasons, women's power of sexual negotiation may be very low and could leave them at risk for violence and exposure to sexually transmitted infections including HIV.

Measurement Tool: Population based survey.

61 This list should correlate to what would constitute commonly known "acceptable" and "not acceptable" reasons within the cultural context in order to obtain an accurate estimate. The list should remain the same over time to ensure a measure of change in the same context.

How to Measure It: People are asked if they agree or disagree (which can be part of a 5 point Likert scale ranging from strongly agree to strongly disagree) with the statement under the conditions listed. A separate proportion is calculated for each reason. People who state that they agree with a particular reason are counted in the numerator. This number is then divided by the denominator, which includes everyone in the survey. This indicator can also be aggregated by placing people who agree with all the statements in the numerator (if they agree with all but one listed reason, they cannot be counted in the numerator), and all people surveyed in the denominator. This would indicate the proportion of people who feel that women have the right to refuse sex, no matter what the reason.

Considerations: Tracking the measurement of this indicator over time is of value for program managers and planners, because people need to be aware that marriage or partnership does not infer that women do not have the right to refuse sex within that context. While a direct causal relationship cannot be established, an increase in the proportion of people who believe that wives or female partners have the right to refuse sex may indicate that community-based awareness-raising activities and human rights education interventions are having a positive effect on norms and attitudes at the community level. However, it should be noted that the responses to the reasons listed under the definition above are prone to social desirability bias. Respondents may be inclined to provide responses that they perceive to be more socially acceptable or appropriate rather than what they actually feel.

7.2.8 – Proportion of people who agree that rape can take place between a man and woman who are married

Definition: The proportion of people who recognize that forced sex within the context of marriage constitutes a rape.

Numerator: Number of people who agree with the statement: When a husband forces his wife to have sex when she does not want to, he is raping her.[62]

Denominator: Total people surveyed

Disaggregate by: Sex of respondent, age, region.

What It Measures: Cultural norms around the authority of husbands over wives may include forced sexual intercourse. Marital rape may be more likely to occur in places where both women and men ascribe to this belief. This outcome indicator measures how unacceptable marital rape is in the targeted population. In areas where the proportion is very low, women may be at high risk for marital rape.

Measurement Tool: Population based survey.

How to Measure It: People are asked if they agree or disagree (which can be part of a 5 point Likert scale ranging from strongly agree to strongly disagree) with the statement in the definition. People who state that they agree are counted in the numerator. This number is then divided by the denominator, which includes everyone surveyed.

Considerations: Tracking the measurement of this indicator over time is of value for program managers and planners, because people need to be aware that marriage does not give men the right to have sex with their wives against their will. While a direct causal

62 The wording on this statement needs to be carefully developed in order to use language that conveys the meaning within the cultural context.

relationship cannot be established, an increase in the proportion of people who believe that husbands forcing their wives to have sex constitutes a rape in a community may indicate that community-based awareness-raising activities and human rights education interventions are having a positive effect on norms and attitudes at the community level. However, it should be noted that the responses to the questions listed under the definition above are prone to social desirability bias. Respondents may be inclined to provide responses that they perceive to be more socially acceptable or appropriate rather than what they actually feel.

7.2.9 – Proportion of target audience who has been exposed to communication messages recommending the discontinuation of FGC/M

Definition: Proportion of target audience that has been exposed to messages recommending the discontinuation of female genital cutting/mutilation (FGC/M), during a specified period of time (e.g., past 12 months)

Numerator: Number of people surveyed who say yes to the question: In the past (e.g., 3 months), have you seen or heard any messages related to the discontinuation of female-genital cutting?[63]

Communication messages include messages disseminated through mass media campaigns and community-based discussion forums.

Denominator: Total number of people surveyed.

Disaggregate by: Age and sex of respondents, region/province/district, type of media/forum (source), key message content

What It Measures: In countries (or regions within countries) where communication programs related to the elimination of FGC/M are implemented using mass media, program managers and evaluators may need to know the extent to which the intended audience is exposed to the communication messages. This outcome indicator measures the extent to which the public (or population targeted by specific programs and projects) remembers seeing or hearing FGC/M elimination messages through various communication channels after exposure.

Measurement Tool: Population-based survey (e.g., DHS – FGC module)

63 The term female genital cutting/mutilation (FGC/M) should be translated into the term that people will understand in the local context to cover all types of FGC/M performed in that place.

How to Measure It: This indicator is measured by asking the question mentioned under the above definition. People who reply yes are counted in the numerator, which is then divided by the denominator, which includes all people surveyed.

Considerations: In countries where communication campaigns are intensified to discourage support for the practice, this indicator can be used to track and monitor the extent to which the campaigns are reaching the intended audience and identify gaps in terms of geographical coverage of the campaigns. Measurement of this indicator alone does not provide a measure of how well the information was understood by the audience, or whether the intended audience has decided not to have their daughters undergo the procedure. This indicator should be used together with the next two, to give a fuller picture of changing attitudes and intentions.

7.2.10 – Proportion of people who believe that FGC/M should be stopped

Definition: Proportion of people surveyed who believe that the practice of FGC/M should be stopped.

Numerator: Number of people surveyed who respond "Discontinued" to the following question: Do you feel that FGC/M should be continued, or should it be discontinued?[64]

Answers: Continued, Discontinued, Depends, Don't know

Denominator: Total number of people surveyed.

Disaggregate by: Sex, age, region

What It Measures: The practice of FGC/M is deep-rooted in culture, and is supported by beliefs that are in favor of the practice. International organizations, however, recognize the practice as a violation of international standards for girls' and women's rights, and that the practice has serious health consequences. Communication campaigns and community education programs are implemented in countries where the practice is prevalent to discourage support for FGC/M. This outcome indicator measures the level of public acceptance of FGC/M within a given population.

Measurement Tool: Population-based survey (e.g., DHS – FGC module)

How to Measure It: This indicator is measured by asking the question in the above definition. Where FGC/M is prevalent, Demographic and Health Surveys include this question in the women's questionnaire, and this is sometimes asked of men as well. Those who state that the practice should be discontinued are counted in the numerator, which is then divided by the denominator, which includes all people surveyed.

64 The question comes from Yoder, DHS Female genital cutting module.

Considerations: When measured over time, this indicator can be used to track changes in the level of public acceptance of FGC/M. It can be further analyzed by education levels, geographic location, religion, and other variables to identify factors associated with change. This information can be used to improve communication programs aimed to eliminate FGC/M. However, measurement of this indicator alone is not sufficient to determine whether a communication campaign/community education program has had the intended effect of reducing the prevalence of FGC/M. Also, measurement of this indicator may be subject to social desirability bias, where the respondent answers in the way that seems acceptable to the interviewer.

7.2.11 – Proportion of women who do not intend to have any of their daughters undergo FGC/M

Definition: Proportion of women who do not intend to have any of their uncut daughters cut in the future.

Numerator: Number of women in the survey who do not intend to have any of their uncut daughters cut in the future.[65]

Ask: Do you intend to have genital cutting done to any of your uncut daughters in the future?

Denominator: Total number of women in the survey who have at least one uncut daughter.

Disaggregate by: Age, region

What It Measures: The practice of FGC/M is deep-rooted in culture, and is supported by beliefs that are in favor of the practice. International organizations, however, recognize the practice as a violation of international standards for girls' and women's rights, and that the practice has serious health consequences. Programs that aim to eliminate the practice of FGC/M will want a measure of women's intentions regarding their own daughters. This outcome indicator provides a measure of the effectiveness of programs and initiatives that aim to reduce the practice of FGC/M.

Measurement Tool: Population-based survey (e.g., DHS – FGC module)

How to Measure It: This indicator is measured by asking the question in the above definition. Women asked this question must have at least one uncut daughter. All women who answer "no" are counted in the numerator. This number is then divided by the denominator, which includes all women surveyed who have at least one uncut daughter. Where FGC/M is prevalent, the Demographic and Health Surveys include these questions in the women's questionnaire.

65 The question comes from Yoder, DHS Female genital cutting module.

Considerations: When measured over time, this indicator can be used to track changes in the level of public acceptance of FGC/M. It can be further analyzed by education levels, geographic location, religion, and other variables to identify factors associated with change. This information can be used to improve communication programs aimed to eliminate FGC/M. However, measurement of this indicator alone is not sufficient to determine whether a communication campaign/community education program has had the intended effect of reducing the prevalence of FGC/M. Also, measurement of this indicator may be subject to social desirability bias, where the respondent answers in the way that seems acceptable to the interviewer.

7.2.12 – Proportion of people who believe child marriage should be stopped

Definition: Proportion of people surveyed who believe that the practice of child marriage should be stopped. Child marriage is the marriage of anyone under the age of 18.

Numerator: Number of people surveyed who respond "Discontinued" to the following question: Do you feel that child marriage, that is, the marriage of a person who is under the age of 18, should be continued, or should it be discontinued?[66]

Answers: Continued, Discontinued, Depends, Don't know

Denominator: Total number of people surveyed.

Disaggregate by: Sex, age, region.

What It Measures: The practice of child marriage is deep-rooted in culture and is supported by beliefs and customs transmitted through the generations. International organizations, however, recognize the practice as a violation of international standards for girls' and women's rights, and that the practice can result in serious emotional and physical health consequences. Communication campaigns and community education programs are implemented in countries where the practice is prevalent to discourage support for child marriage. This outcome indicator measures the level of public acceptance of child marriage within a given population.

Measurement Tool: Population-based survey.

How to Measure It: This indicator is measured by asking the question in the above definition. Those who state that the practice should be discontinued are counted in the numerator, which is then divided by the denominator, which includes all people surveyed.

66 The question is based on Yoder, DHS Female genital cutting module.

Considerations: When measured over time, this indicator can be used to track changes in the level of public acceptance of child marriage. It can be further analyzed by education levels, geographic location, religion, and other variables to identify factors associated with change. This information can be used to improve communication programs aimed to eliminate child marriage. However, measurement of this indicator alone is not sufficient to determine whether a communication campaign/community education program has had the intended effect of reducing the prevalence of child marriage. Also, measurement of this indicator may be subject to social desirability bias, where the respondent answers in the way that seems acceptable to the interviewer.

7.2.13 – Proportion of women who do not intend to marry their daughters before the age of 18

Definition: Proportion of women who do not intend to marry their daughters before the age of 18.

Numerator: Number of women in the survey who do not intend to have any of their single daughters married before the age of 18 in the future.

Ask: Do you intend to have any of your daughters married before the age of 18 in the future?[67]

Denominator: Total number of women in the survey who have at least one unmarried daughter under the age of 18.

Disaggregate by: Age, region.

What It Measures: The practice of child marriage is deep-rooted in culture and is supported by beliefs and customs transmitted through the generations. International organizations, however, recognize the practice as a violation of international standards for girls' and women's rights, and that the practice can result in serious emotional and physical health consequences. Communication campaigns and community education programs are implemented in countries where the practice is prevalent to discourage support for child marriage. This outcome indicator provides a measure of the effectiveness of programs and initiatives that aim to reduce the practice of child marriage.

Measurement Tool: Population-based survey.

How to Measure It: This indicator is measured by asking the question in the above definition. Women asked this question must have at least one unmarried daughter under the age of 18. All women who answer "no" are counted in the numerator. This number is then divided by the denominator, which includes all women surveyed

67 The question is based on Yoder, DHS Female genital cutting module.

Considerations: When measured over time, this indicator can be used to track changes in the level of public acceptance of child marriage. It can be further analyzed by education levels, geographic location, religion, and other variables to identify factors associated with change. This information can be used to improve communication programs aimed to eliminate child marriage. However, measurement of this indicator alone is not sufficient to determine whether a communication campaign/community education program has had the intended effect of reducing the prevalence of child marriage. Also, measurement of this indicator may be subject to social desirability bias, where the respondent answers in the way that seems acceptable to the interviewer.

7.3 WORKING WITH MEN AND BOYS

7.3.1 – Number of programs implemented for men and boys that include examining gender and culture norms related to VAW/G

Definition: The number of programs implemented in a country, region or community for men and boys that include activities aimed at examining and challenging men's and boys' gender and cultural norms related to VAW/G, in a specified time period.

Programs should address the following issues, with reference to cultural context, addressed and integrated into curricula and/or activities:

- Gender and violence within the family
- Intimate partner violence
- Sexual or physical violence

Count: The number of programs aimed at men and boys that includes curricula and activities aimed at changing men's and boys' views on the cultural acceptability of VAW/G.

Disaggregate by: Program coverage (how many people participate), age, region.

What It Measures: This indicator is a measure of programmatic effort at raising awareness about, changing attitudes towards and changing behavior related to violence against women and girls. Programmatic efforts aimed at getting men and boys to be more aware of their own health issues as well as those of their partners have broadened to include the social issues underpinning those health outcomes. A good example is the Men as Partners program.[68]

68 EngenderHealth & Planned Parenthood Association of South Africa (PPASA). 2001. Men as Partners: a program for supplementing the training of life skills educators. A program developed by EngenderHealth and the PPASA. www.engenderhealth.org/files/pubs/gender/ppasamanual.pdf

Educating and listening to men and boys about masculinity and intimate partner and sexual violence combined with their participation in activities geared towards enhancing their understanding of how detrimental these issues are in their community will ideally influence changes in beliefs and actions.

Measurement Tool: A survey of organizations implementing programs aimed at men and boys.

How to Measure It: Governmental and non-governmental organizations, including donor and technical representatives in-country, such as USAID and UN offices, will be asked if they implement, or provide technical expertise or funding for programs aimed at reducing VAW/G by changing the behavior of men and boys. Once the programs in the country, region or community are identified, implementing organizations will be asked if their curricula and activities include the issues in the checklist under the definition. If they include all three issues, then they are included in the count.

Considerations: Large programmatic efforts may be fairly easy to identify, but smaller programs could be missed if they are implemented by smaller organizations. Coverage of the program is important to assess, since a large program in a country could target people in different regions and cover a larger population than several smaller programs.

7.3.2 – Proportion of men and boys who agree that women should have the same rights as men

Definition: The proportion of men and boys who agree that women should have the same rights as men.

Numerator: Number of men and boys who agree with the statement: Women should have the same legal and social rights as men.

Denominator: Total men and boys surveyed

Disaggregate by: age, region

What It Measures: Programs targeting issues related to VAW/G for men and boys try to address women's unequal status in the society by teaching men that women are entitled to the same rights. This outcome indicator measures the success of those programs on transforming men's and boys' beliefs about women's entitlement to the same rights as men.

Measurement Tool: A population-based survey. This could be a survey in a country or region to understand how men and boys feel in general, or in areas where programs have taken place to understand how attitudes change over time.

How to Measure It: People are asked if they agree or disagree (which can be part of a 5 point Likert scale ranging from strongly agree to strongly disagree) with the statement in the definition. People who state that they agree are counted in the numerator. This number is then divided by the denominator, which includes everyone surveyed.

Considerations: Tracking the measurement of this indicator over time is of value for program managers and planners, because the first step to changing the way people behave is to alter the norms that support those behaviors. While a direct causal relationship cannot be established, an increase in the proportion of people who believe that women are entitled to the same rights as men in a

community may indicate that community-based awareness-raising activities and human rights education interventions are having a positive effect on norms and attitudes at the community level. However, it should be noted that the responses to the questions listed under the definition above are prone to social desirability bias. Respondents may be inclined to provide responses that they perceive to be more socially acceptable or appropriate rather than what they actually feel.

7.3.3 – Proportion of men and boys with gender-related norms that put women and girls at risk for physical and sexual violence

Definition: The proportion of men and boys whose gender-norm related attitudes reinforce VAW/G, at a specific point in time.

Numerator: Number of men and boys who agree with one or more of the following statements:[69]

- It is the man who decides what kind of sex to have
- You don't talk about sex, you just do it
- There are times when a woman deserves to be beaten
- A woman should tolerate violence to keep her family together
- If a woman cheats on a man, it is okay for him to hit her
- It is okay for a man to hit his wife if she won't have sex with him

Response choices: agree, partially agree, and do not agree

Denominator: Total men and boys surveyed

Disaggregate by: Age, region and number of statements agreed with, comparing those who agree with none of the statements, any (at least one) of the statements, and all of the statements.

What It Measures: The Gender-Equitable Men (GEM) scale was developed to measure the impact of an intervention on changing attitudes towards gender-related norms. The five areas related to gender norms covered by the full GEM scale are: violence, sexual relationships, reproductive health and disease prevention, domestic chores and childcare, and homophobia and relationships with other men. Implementing the validated 24 item scale is a method of assessing men and boys' gender-related norms that may influence VAW/G outcomes. The items included in this indicator measure

69 These items were taken are from the GEM scale developed by Pulerwitz and Barker. For the full 24 item scale see: Pulerwitz, Julie and Gary Barker. 2008. Measuring attitudes toward gender norms among young men in Brazil: Development and psychometric evaluation of the GEM scale. Men and masculinities 10:322-338.

norms directly related to VAW/G.

Measurement Tool: A population-based survey. This could be a survey in a country or region to understand how men and boys feel in general, or in areas where programs have taken place to understand how attitudes change over time.

How to Measure It: People are asked if they agree, partially agree or disagree with each of the statements in the definition. People who state that they agree or partially agree with any of the statements are counted in the numerator. This number is then divided by the denominator, which includes all men and boys surveyed.

Considerations: The GEM scale was designed to be implemented with all 24 items. This indicator does not implement the GEM scale, but only some of items directly related to VAW/G. This offers a different snapshot of gender norms than implementing the scale in its entirety. Tracking the measurement of this indicator over time is of value for program managers and planners, because the first step to changing the way people behave is to alter the norms that support those behaviors. While a direct causal relationship cannot be established, a decrease in the proportion of men and boys with norms that support VAW/G may indicate that community-based awareness-raising activities and human rights education interventions are having a positive effect on norms and attitudes at the community level. However, it should be noted that the responses to the questions listed under the definition above are prone to social desirability bias. Respondents may be inclined to provide responses that they perceive to be more socially acceptable or appropriate rather than what they actually feel.

7.3.4 – Proportion of men and boys who believe that men can prevent physical and sexual violence against women and girls

Definition: The proportion of men and boys who believe that men can prevent physical and sexual violence against women and girls by controlling their own behavior and refusing to engage in that behavior, at a specific point in time.

Numerator: Number of men and boys who agree with the following statement: Men can control their own behavior and choose not to engage in violent physical and sexual behavior with women and girls.

Denominator: Total men and boys surveyed

Disaggregate by: Age, region

What It Measures: Programs targeting issues related to VAW/G for men and boys try to address attitudes and beliefs that are related to this behavior. This outcome indicator measures the success of those programs on transforming men's and boys' beliefs about men's responsibility in preventing violent acts against women.

Measurement Tool: A population-based survey. This could be a survey in a country or region to understand how men and boys feel in general, or in areas where programs have taken place to understand how attitudes change over time.

How to Measure It: People are asked if they agree or disagree (which can be part of a 5 point Likert scale ranging from strongly agree to strongly disagree) with the statement in the definition. People who state that they agree are counted in the numerator. This number is then divided by the denominator, which includes everyone surveyed.

Considerations: Tracking the measurement of this indicator over time is of value for program managers and planners, because the

first step to changing the way people behave is to alter the norms that support those behaviors. While a direct causal relationship cannot be established, an increase in the proportion of men and boys who believe that they can prevent violence against women and girls in a community may indicate that community-based awareness-raising activities and human rights education interventions are having a positive effect on norms and attitudes at the community level. However, it should be noted that the responses to the question listed under the definition above are prone to social desirability bias. Respondents may be inclined to provide responses that they perceive to be more socially acceptable or appropriate rather than what they actually feel.

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Appendix I: Suggested national level and policy-based indicators

A. 1	Data systems
A.1.1	Surveillance systems that collect data on VAW/G exist within the country
A.1.2	Data collected by national violence surveillance system is analyzed and disseminated
A.1.3	Data are regularly reported and disseminated in some manner
A.1.4	Current (within last 5 years) national, population-based data are available on VAW/G
A. 2	Health policy
A.2.1	Existence of national health policies that addresses VAW/G
A.2.2	Existence of policies, laws or regulations that require service providers to care for and/or refer VAW/G survivors
A.2.3	Focal person within the ministry of health is responsible for coordination of health sector response for VAW/G survivors
A.2.5	A funded line item exists in the Ministry of Health's budget to address VAW/G
A.2.6	Existence of a protocol to care for and refer VAW/G at all levels of the health system
A.3	Education
A.3.1	Existence of a national policy on sexual violence in school that specifically addresses the risks to girls and young women
A.3.2	National educational curricula that includes issues of sexual and physical VAW/G (e.g. power, coercion and gender)
A.4	Youth

A.4.1 Existence of national laws protecting confidentiality of minors (in the media)

A.4.2 Existence of national laws on sexual exploitation of minors

A.5 Multisectorial coordination

A.5.1 A national network for prevention of and response to VAW/G exists to ensure multisectorial coordination among all social actors

A.6 Justice & security

A.6.1 Existence of laws with associated criminal sanctions for perpetrators of IPV

A.6.2 Laws associated with criminal sanctions for perpetrators of IPV include marital rape

A.6.3 Existence of laws (national or state) with associated criminal sanctions for perpetrators of sexual VAW/G (not IPV)

A.6.4 Existence of laws (national or state) with associated criminal sanctions for perpetrators of sexual exploitation of women and girls (not IPV)

A.7 Child Marriage

A.7.1 Existence of national law that prohibits child marriage

A.7.2 Number of laws and legislations protecting women's rights within marriage

A.8 Female Genital Cutting/Mutilation

A.8.1 Existence of a national policy against FGC/M

A.8.2 Existence of national laws that prohibit abuse associated with traditional kinship practices

A.9 TIP

A.9.1 National government established victim-sensitive procedures and guidelines to be used by law enforcement officials to identify, interview and assist trafficked women

A.9.2 National government established standard procedures and guidelines for service providers assisting victims of trafficking

A.9.3 National government established standard procedures and guidelines to identify and prosecute traffickers

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