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Considerations for indicators on sexual and other forms of violence against women and girls

Prepared for the Small Arms Survey

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Background

In the last decade, violence against women has increasingly been addressed in the international agenda. However, responses remain inadequate worldwide. As described below, there is a growing recognition and awareness of the impact and costs of sexual violence and other forms of gender-based violence on the lives, health and wellbeing of women, their children, families and on society overall. In conflict and other humanitarian settings, the risk of such violence may increase, response and prevention mechanisms are weakened and access to services may be disrupted.

This recognition of violence as both a major public health problem and a human rights violation has led to an increasing demand for better data on the magnitude, nature and scope of this violence, its causes and consequences, and on what are effective interventions to both prevent and respond to it. The demand for data and indicators with which to monitor progress at the global level has come from the Task Force on the Millenium Development Goal (MDG) 3 on gender equality and women's empowerment[1], from the HIV/AIDS community, and more recently from UN Security Council Resolutions 1820 and 1888, specifically on data related to sexual violence in conflict.[2] Policy makers, programmes planners and advocates also need indicators with which to monitor progress.

Numerous initiatives to develop indicators to measure violence against women, in particular its scope, scale and distribution, have started in the last few years and several proposed lists of indicators exist which can be used as the basis for further work in this area. However, the challenge of how best to collect data for these indicators in a systematic, ethical and sustainable manner and the need to build capacity for this remains large. It is critical to address this challenge, particularly in low- and middle-income countries for indicators to be useful.

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* the views expressed are those of the author and do not necessarily represent policy of the World Health Organization

[1] Grown C, Rao Gupta G, Kes A (2005) Taking action: achieving gender equality and empowering women. UN Millenium Project Task Force on Education and Gender Equality. London: Earthscan.

[2] United Nations Security Council. Resolution 1820, adopted by the SC on 19 June 2008. See http://www.ifuw.org/advocacy/docs/UN_SC_Resolution1820.pdf(2008) and United Nations Security Council Resolution 1888, adopted by the SC on 30 September 2009. See http://www.peacewomen.org/un/sc/SCR1888.pdf

This paper therefore rather than propose new indicators, summarizes some of the ongoing work on development of indicators. It proposes some principles to guide the development and adoption of indicators and discusses some of the challenges and opportunities around data collection. There are many forms of 'gender-based violence' (i.e., violence against women and girls that is fuelled by gender inequality) or violence against women, ranging from sexual abuse of girls, intimate partner violence, rape and other forms of sexual assault to trafficking, harmful practices such as female genital mutilation, and murders of women. This paper focuses on the two most common forms: intimate partner violence (physical, sexual and emotional) and sexual violence by non partners, while touching on a few others.

Violence against women: prevalence and consequences

Available data show that violence against women (VAW) (i.e., both adolescents and adults) is a substantial public health problem worldwide. Physical or sexual violence by an intimate partner was reported by at least 40% of women in 10 sites participating in the WHO multi-country study on women's health and violence (Garcia-Moreno et al, 2005). Rape and other forms of sexual violence, including forced or coerced first sex, are also common for many women. **I**n conflict and other humanitarian settings, while not much good data exist we know that the risks are increased, particularly for sexual violence.

The health consequences of this violence are numerous. It affects women's' sexual and reproductive health (e.g. unintended pregnancy, unsafe abortion, gynecological problems, sexually transmitted infections, including HIV, fistulae), physical health (e.g. chronic pain syndromes, gastro-intestinal problems, hypertension) and their mental health (anxiety disorders, depression, suicide, post traumatic stress). Violence during pregnancy is associated with low birth weight, miscarriage and premature birth and infant mortality, among other things. Violence against women also interacts with HIV/AIDS in complex ways. Rape by an infected person can lead directly to HIV transmission, but more important is women's lack of ability to negotiate condom use and safe sex in the context of a violent relationship. Partner violence or fear of it can also be a barrier to testing and thus to access to prevention, treatment and care.

Sexual abuse during childhood has been associated with high-risk behaviours such as alcohol and substance misuse, early and unprotected sex and multiple partners, thus increasing the risk for other health problems. Although the negative effects of violence are felt by all, violence also disproportionately affects the development of low- and middle-income countries.(Global Burden of Disease, 2004).

Violence is a major cause of injuries among women and also leads to death, including from femicide, suicide, and AIDS. Injuries are among the ten leading causes of death for women in many regions.[3] In Asia burns is the third leading cause of death for women aged 15-45 years and a significant proportion of these are related to gender-based

[3] These data however include both intentional and non intentional (e.g. road traffic injuries) making it difficult to ascertain the role of violence. Furthermore, injuries from intimate partner violence are poorly captured in most hospital statistics.

violence. Murders in the name of honour still go on in some regions of the world and a growing number of femicides (often accompanied with sexual violence) is documented in several parts of Latin America. The Global Burden of Disease 2004 estimated that 115,000 of 600,000 murders are among females.[4] While the number of women murdered is lower than that of men, we know that women are more likely to be murdered by intimate partners (married and non married) or former partners than by strangers. In the USA, approximately 30% of murdered women (42% of those with a known perpetrator) are killed by an intimate partner compared to 5.5% of men killed by an intimate partner.[5] According to the United States Bureau of Justice Statistics (2004) women are murdered by partners or ex partners 9 times more often than by a stranger.[5]

Definitions and scope

There are a large number of definitions and terms used that refer to violence against women generally and to intimate partner violence (which includes physical, sexual and emotional violence), and sexual violence. Definitions used in public health sometimes do not coincide with those used by the legal sector.

Violence against women has also been called gender-based violence (GBV), because much of the violence that women experience has its roots in gender inequality and discrimination. However, GBV is now being used to encompass other forms of violence such as homophobic violence and violence against men in conflict, thereby making the use of the term confusing. Intimate partner violence is also called domestic violence (although this can also include child abuse and elderly abuse in the family), wife or spousal abuse, wife or spousal battering. Some include physical, sexual and emotional violence and others just physical and sexual. Terms used for sexual violence include rape, sexual assault, coerced sex., forced sex. All of these, however, have slightly different meaning and encompass different sets of acts. A recent study commissioned by the World Health Organization and the CDC on sexual violence in conflict identified over ten different definitions of sexual violence.[6]

A discussion of all definitional issues is beyond the scope of this paper, but for the purposes of indicators and data collection it is necessary to have clearly defined operational definitions for each of the different forms of violence that are being measured. There is general agreement that in data collection, particularly surveys, it is best to ask respondents about specific acts of physical, sexual or emotional abuse and avoid the use of words like ‘violence’, ‘abuse’, ‘rape’ which are open to interpretation. How questions are framed is also important. Crime surveys, for example, may underestimate instances of intimate partner violence or sexual violence by friends and acquaintances, which respondents may not think of as crimes. Similarly when questions

[4] Global Burden of Disease, 2004.
www.who.int/.../**global_burden_disease**/GBD_report_**2004**update_full.pdf
[5] In Campbell J, Glass N, Sharps S et al (2007). Intimate partner homicide. Review and implications of research and policy. Trauma, violence and abuse 8(3):246-269
[6] Sami S for WHO and CDC. Sexual violence in conflicts: Recommended minimum and expanded data elements (Draft paper under revision).

about acts are framed in the context of conflict as instances of intimate partner violence may not always take place in the context of conflict.

Annex 1 provides examples of operational definitions from the WHO Multi-country Study on Women's Health and Violence.[7] While there is general agreement on the measures for physical violence, work is ongoing on the operational definitions of sexual violence and what acts of sexual violence to include (e.g. ranging from being physically forced to have sex against one's will, being coerced or intimidated, to issues such as forced pregnancies, sterilizations or abortions). Some work has gone into defining emotional abuse in the context of intimate partner violence, but again there is no universal agreement about what counts towards prevalence (is it any act or specific combinations of number of acts, frequency and severity of the acts). Without a clear definition and agreement on what is to be measured for each indicator it is difficult to compare across countries.

What is an indicator?

Indicators are summary (usually quantitative) measures that provide information on complex issues. They can be used for different purposes: for programme evaluation and improvement, for monitoring progress towards specific outcomes and for advocacy, whether at global, national or local levels. In general, indicators need to be reliable (easy to measure and interpret), representative, comparable, and based upon easily available data. Ideally they should be collected at regular intervals and be comparable over time and provide information of whether the situation has improved, worsened or stay the same. For global monitoring purposes they should be comparable between settings and countries.

Indicators to measure violence against women

The focus of the work on violence against women indicators has tended to be on outcome indicators, particularly the prevalence of different forms of violence against women. To monitor changes in prevalence will require repeated surveys (every 5-10 years) which are expensive to do. While it is useful to monitor the trends of the prevalence of violence over time, it is a difficult indicator to interpret. Contrary to what would be expected, prevalence may increase initially due to increased reporting as awareness of the problem increases and more services become available. This is counterintuitive for policy makers who are seeking to show reductions in incidence and prevalence of violence. Other indicators can be built using service-based data, such as police and health service records. These data, however, tend to be incomplete, do not always capture the relationship of the victim to the perpetrator and usually underestimate the problem given the shame and stigma still associated with reporting intimate partner violence and sexual violence.

There has been relatively little attention paid to monitoring trends in intimate partner femicide. While these data are not easily available, existing data from, for example,

[7] Garcia-Moreno C, Jansen HAF, et al. (2005). WHO Multi-country Study on Women's Health and Violence. Initial results on prevalence, health consequences and women's responses. Geneva, World HealthOrganization.

mortuary and police statistics could be analysed to provide useful information on this phenomenon.

Other indicators could focus on the reduction of risk factors for violence or use of proxy measures, such as attitudes towards violence against women. Most surveys on violence against women include questions on attitudes. Other surveys like the UNICEF Multiple Indicators Cluster Survey (MICS) include questions on attitudes towards intimate partner violence against women (usually phrased as the number of women or men who believe that a husband has reason to beat his wife/partner in various situations such as leaving the home without his permission, not taking care of the children, refusal to have sex, not having food ready, among others). Tolerance of intimate partner violence could be, at least in the initial stages, a proxy measure for the likelihood of violence to occur as well as a way of tracking changes in the social norms that condone this violence.

Initiatives to develop indicators for violence against women: an overview

While several initiatives have identified indicators for violence against women, many of the indicators are difficult to measure and less attention has been paid to issues of data collection. Developing standards for data collection, building capacity on data collection and its use, and establishing sustainable systems for surveillance and data management that can be maintained by countries without or with minimum external support, are critical underpinnings for any indicators.

Some of the key initiatives are summarized below.

United Nations Statistical Commission[8]

Following the Secretary General's study on violence against women, UN General Assembly resolution 61/143 requested the United Nations Statistical Commission to develop a set of possible indicators on violence against women in order to assist States in assessing the scope, prevalence and incidence of violence against women. The Statistical Commission established a Friends of the Chair group, currently comprising representatives from 15 countries with observers from several UN technical agencies, including WHO. During 2008 the group developed an interim set of indicators to measure violence against women. In November 2009 the group met again to further elaborate the interim list.

Minimum set of VAW Indicators from the UN Statistics Commission

- Total and age-specific rate of women subjected to physical violence in the last 12 months by severity of violence, relationship to the perpetrator(s) and frequency
- Total and age-specific rate of women subjected to physical violence during lifetime by severity of violence, relationship to the perpetrator(s) and frequency
- Total and age-specific rate of women subjected to sexual violence in the last 12 months by severity of violence, relationship to the perpetrator(s) and frequency
- Total and age-specific rate of women subjected to sexual violence during lifetime by severity of violence, relationship to the perpetrator(s) and frequency

[8]UN Statistical Commission (2009) Report of the Friends of the Chair of the Statistical Comission on the indicators on violence against women.Statistical Commission Fortieth session, 24-27 February 2009

- Total and age-specific rate of women subjected to sexual and/or physical violence by current or former intimate partner in the last 12 months by frequency
- Total and age-specific rate of women subjected to sexual and/or physical violence by current or former partner during lifetime.

The list of six indicators above was agreed as core and adopted by the UN Statistical Commission as interim indicators. The Friends of the Chair meeting in November 2009, proposed additional indicators:

- Total and age specific rate of women subjected to psychological violence in the past 12 months by the intimate partner
- Total and age specific rate of women subjected to economic violence in the past 12 months by the intimate partner
- Total and age specific rate of women subjected to female genital mutilation

Indicators on early and forced marriage were also suggested.

While the indicators may measure some useful concepts, there are enormous challenges to capturing and interpreting them, especially in low and middle income countries. In settings of armed conflict or other humanitarian situations data collection is further complicated by insecurity, lack of services and stigma and other consequences of reporting.

The United Nations Statistics Division undertook a methodological overview of surveys on violence against women that were conducted in recent years. This review showed that current data on prevalence come mainly from DHS, the WHO Multi-country Study and a few national surveys, particularly from high income countries. More recently the ECE Statistics Division has led the development of a draft survey module to be field tested in 10 countries. This is useful, however, ensuring ethical and safety standards as per the WHO recommendations, is necessary and this poses particular difficulties when adding a vaw module to an existing survey. Ensuring the necessary training for interviewers, attention to quality control and provision of back up services may be less easy to guarantee. In many countries, technical assistance is needed to carry out these surveys.

There is a need to strengthen systems for collection of routine statistics (e.g. police, health, injury surveillance). A key issue here is ensuring that the relationship of the perpetrator to the victim is well documented as this is often missing. Having a standard reporting format so that data (duly anonymised) can be compiled across sectors is also important.

Compendium of violence against women and girls indicators for measuring and evaluating[9]

[9] USAID, IGWG and Measure Evaluation (2008). Violence against women and girls. A compendium of monitoring and evaluation indicators.

This initiative was implemented by Measure Evaluation/USAID and the Compendium has been finalized and published. It differs from the initiative of UN Statistical Commission (UNSC) in that it aimed to inform programme development, monitoring and evaluation, rather than global monitoring. It is targeted at programme managers and policy makers. For each indicator it includes a definition and description of the indicator, how to measure it and other considerations.

The Compendium includes most of the same indicators as the UNSC initiative above, but is more comprehensive. It includes indicators on:

a) Magnitude and characteristics of different forms of violence against women and girls (e.g. intimate partner violence, violence perpetrated by someone other than a partner, female genital mutilation, child marriage).
b) Programmes addressing violence by sector (i.e. health, education, justice/security, social welfare)
c) Under-documented forms of violence against women and girls: humanitarian emergencies, trafficking in persons, femicide
d) Programmes addressing prevention: youth, community mobilization and working with men and boys.

Box 2 provides examples of some of the indicators proposed to assess violence against women in humanitarian emergencies

Box 2. Examples of indicators to assess violence against women in humanitarian emergencies

- Protocols aligned with international standards established for clinical management of sexual violence survivors at all levels of health system
- Proportion of sexual violence cases for which legal action has been taken
- Proportion of reported sexual exploitation and abuse incidents that resulted in prosecution and/or termination of humanitarian staff
- Number of women/girls reporting incidents of sexual violence per 10,000 population in specified area
- Percent of rape survivors in the emergency area who report to health facilities/workers within 72 hours and receive appropriate medical care
- Percent of sexual violence survivors in the emergency area who report 72 hrs or more after the incident and receive basic set of psychosocial and medical services
- Proportion of women and girls in the emergency area who demonstrate knowledge of available services, why and when they should be accessed

UN Action Against Sexual Violence in Conflict (UN Action)[10]

3 UN Action unites the work of 12 UN entities with the goal of ending sexual violence in conflict. It is a concerted effort by the UN system to improve coordination and accountability, amplify programming and advocacy, and support national efforts to prevent sexual violence and respond effectively to the needs of survivors. See http://stoprapenow.org

Sexual violence in conflict and post-conflict is a serious security, health and social problem as well as a human rights violation. While there is increasing recognition of this, it is difficult to document and research this violence because of its sensitive nature. Obtaining accurate data on sexual violence in conflict presents inherent difficulties given security and logistical constraints, understandable reluctance of individuals who have suffered profound trauma to report, and lack of confidence in existence services. However, more and better data is needed to improve our understanding of the problem and of the effectiveness and benefits of different types of responses and preventive interventions. These data will allow us to develop more appropriate responses, advocate for additional resources, and monitor the impact of our interventions and strategies.

The demand for better data on the magnitude and nature of the problem is coming from many quarters (governments, UN bodies, donors, etc.), most recently Security Council Resolution (SCR) 1820[11] and SCR 1888[12].

SCR1820 asked the Secretary General (SG) to submit a report that, inter-alia, provides "information on situations of armed conflict in which sexual violence has been widely or systematically employed against civilians; analysis of the prevalence and trends of sexual violence in situations of armed conflict; benchmarks for measuring progress in preventing and addressing sexual violence; and plans for facilitating the collection of timely, objective, accurate and reliable information on the use of sexual violence in situations of armed conflict…..".

SCR 1888 asked the SG to ensure systematic reporting on trends, emerging patterns of attack, early warning indicators (Operative Paragraphs 24 and 26). Specifically it asks the SG to report within 3 months on proposals for improved monitoring and reporting, to provide information on gaps in UN response – particularly around protection, to link with the Monitoring and Reporting Mechanisms established for the six grave violations against children in armed conflict, which include sexual violence .It requests better data to inform deliberations of sanctions committees; sexual violence relevant to designation criteria; improved reporting mechanisms [OP 10; 24; 26]

UN Action is working to respond to these requests. Three specific initiatives are underway:
a) WHO is leading an expert group to develop tools to measure prevalence and other aspects of sexual and other forms of gender-based violence in conflict and report on trends;
b) UNICEF is leading a group to develop proposals to better monitor and report on the UN's response. A set of proposed indicators is currently being discussed.

[11] United Nations Security Council. Resolution 1820, adopted by the SC on 19 June 2008. See http://www.ifuw.org/advocacy/docs/UN_SC_Resolution1820.pdf(2008).
[12] United Nations Security Council Resolution 1888, adopted by the SC on 30 September 2009. See http://www.peacewomen.org/un/sc/SCR1888.pdf

c) UNHCR, UNFPA and IRC have developed the Gender-based violence information management information system (GBVIMS) for improving the collection and analysis of service-based data on reported cases.[13]

WHO and CDC have been working together to develop a standardized survey tool for collecting data on sexual violence prevalence (also of perpetration), its nature and risk and protective factors. This would meet prevalence-related reporting requirements for both 1820 and 1612/1882 - and help inform prevention and response. WHO, with CDC has now completed a literature review and analysis of studies of sexual violence in conflict and data collection methodologies for sexual violence in conflict. Based on this and other input, a list of proposed minimum and expanded data elements for sexual violence in conflict has been developed to answer questions on: the magnitude of sexual violence, impact on individuals and communities, and factors increasing risk or protection, and draft instruments for measuring sexual violence victimization and perpetration. This work is still under development.[14]

Sexual violence research initiative

It is well recognized that research is still needed to understand better the magnitude, scope and nature of sexual and other forms of violence, factors that increase risk or conversely can protect, and effective interventions to respond. WHO, in collaboration with the Sexual Violence Research Initiative (SVRI), is developing a research agenda, building on the issues identified at the 2009 SVRI Forum[15]. Issues identified included:

- engaging the community in prevention and response, particularly addressing stigma, fear and rejection;
- the role of economic empowerment in women's recovery/prevention;
- the need for integration of mental health responses in sexual and reproductive health services;
- men as victims of sexual violence;
- children of rape; and
- perpetration and the role of command structures in it.

Challenges and opportunities for data collection

Surveys

Most of the prevalence data available at present for low and middle income countries comes from either dedicated surveys on violence against women such as the WHO Multi-country Study on Women's Health and Violence or the International Violence against Women Survey (IVAS) and other national surveys (e.g. Mexico, Albania) or from the Demographic and Health Survey, which has an optional module on violence against women that countries can choose to include.

[13] For more information on the GBVIMS contact Diana Arango of UNFPA (arangod@unfpa.org)
[14] For further information contact Claudia Garcia-Moreno (garciamorenoc@who.int)
[15] For more information on the SVRI see: http://svriforum2009.svri.org/conferencereport.pdf

Major progress has been made in developing comparable measures of prevalence particularly for physical and sexual violence, although more work is underway to expand the measures of sexual violence in order to capture better the different forms in which this takes place (from physical force, to coercion, intimidation, use of bribery or trickery, sexual exploitation, etc.), particularly in armed conflict. The measurement of emotional abuse, which is an important element of intimate partner violence, is much less well developed and more methodological and other research is needed to develop measures that can be compared across settings.

Similarly important work has been done on the ethical and safety dimensions of this kind of research. [16] Experience has shown that these measures can be put in place and that surveys can be done in an ethical and methodologically sound way. However capacity in countries to implement these surveys on a regular basis remains low so additional resources and capacity building will be needed to ensure data is collected on a routine basis and for improved data collection and monitoring systems.

Ensuring ethical and safety standards is one of the challenges faced with the expansion of data collection efforts. There are attempts through the Statistics Commission's efforts to integrate data collection on violence against women into routine national statistics offices. However, there is a risk that if this is not done properly and with due attention to ethical and safety standards, it could both lead to harm for some women and produce data that is not reliable. Disclosure of violence against women is highly sensitive to the approach taken and the training of interviewers to enable them to deal with the issue in a sensitive and non-judgmental manner. While there will always be some level of non-disclosure, if the appropriate measures are not taken, it is more likely there will be low rates of disclosure leading to low prevalence rates being reported which do not reflect the 'true' magnitude of the problem.

Service-based data are of limited use for most VAW indicators because women may not seek care for VAW, and if they do seek care, they might choose not to report or disclose violence to health providers because of the stigma attached to rape and other forms of violence, and the lack of support in the health system. In addition, the data is often incomplete and does not contain critical information, such as perpetrator-victim relationship. The same is true for reporting to the police. For example, in South Africa, studies have shown that reporting of rape to the police was 9 times lower than that found through surveys.[17]

Building capacity for data collection is a necessary step. The WHO/PATH Manual on Researching violence against women is a useful tool in this regard. A one week curriculum has been developed by PATH and is being implemented successfully, in

[16] See WHO (2001) Putting women first. Ethical and safety recommendations for researching domestic violence, WHO (200) WHO ethical and safety recommendations for interviewing trafficked women, WHO (2007). WHO ethical and safety recommendations for researching, monitoring and documenting sexual violence in emergencies.

[17] Department of Health, South Africa (2008). Caring for survivors. A curriculum for management of rape and sexual assault.

collaboration with local institutions in South Africa, Kenya and Ethiopia. This can be expanded to other regions.

Recommendations

1. Rather than create new indicators, new initiatives should build on those that already exist, keeping in mind the need not to overburden those who are doing the data collection in countries. A core set of indicators should be agreed at the global level, with additional indicators for specific regions/countries (e.g. on female genital mutilation, murders in the name of honour, other).

2. Initiatives to develop indicators must be accompanied with the relevant capacity building, including on ethical and safety standards for collecting, measuring or researching this violence. The WHO/PATH Researching violence against women manual and curriculum based on it, provide a useful basis for this. Support should be given to WHO and its partners to expand the use of this curriculum to regions beyond Africa.

3. Maintaining ethical and safety standards for data collection on violence against women and girls must be a non negotiable element of any data collection effort.

4. Any indicator on violence (e.g. age adjusted homicide rates, age adjusted emergency room visits due to violence, etc.) should be disaggregated by sex and age. However, the traditional indicators for violence are likely to miss out on much of the violence suffered by women, particularly where issues of stigma and shame make it unlikely that women will report violence, so specific vaw indicators will be needed as well.

5. Data on deaths and injuries should include information on the relationship between the perpetrator and the victim, in addition to the usual demographics and other information.

6. Community-based surveys will continue to be needed for monitoring of prevalence and incidence of the more common forms of vaw. Countries should be supported to do repeat surveys (using same methodology) in order to monitor trends, particularly in past year prevalence of intimate partner violence and sexual and physical violence by other perpetrators. In addition to monitoring trends in prevalence, other proxy indicators such as monitoring attitudes towards intimate partner violence, should also be monitored.

7. Specialized surveys remain the 'gold standard'. If a module is integrated into other surveys it is essential to ensure ethical and safety standards and appropriate training of interviewers to reduce non-disclosure.

8. Monitoring trends in femicide generally and in intimate partner femicide could be useful. Police and mortuary statistics data can be used, but there is a need to

improve data collection for this and ensure the relationship of perpetrator to victim is included in police and mortuary reports.

9. Routine statistics should be improved by introducing a standardized data collection form and system across services and by building capacity of those collecting the data.

10. Strengthening evaluation of programmes and interventions is critical to building up the evidence base for prevention and response.