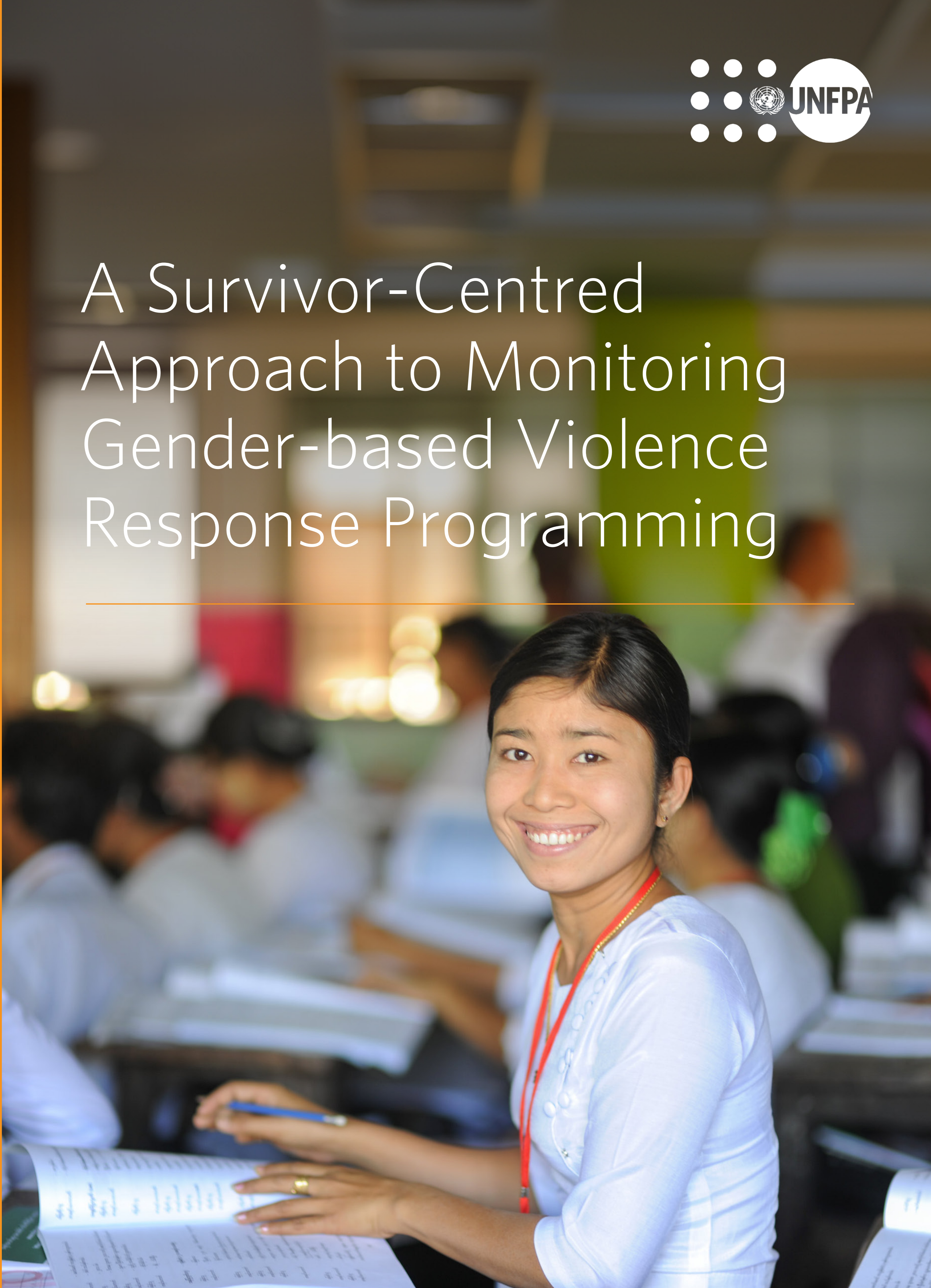
A Survivor-Centred Approach to Monitoring Gender-based Violence Response Programming



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A Survivor-Centred Approach to Monitoring Gender-based Violence Response Programming

Key Principles and Practices for Survivor Data

- Services must be available to gender-based violence (GBV) survivors if data are to be gathered from them (See Interagency Minimum Standards for GBV in Emergencies Programming (2019))
- Data from survivors may only be collected when the benefits of data collection outweigh the risks
- Sharing survivor data for any purpose without informed consent is a violation of GBV guiding principles
- Identifiable case information is only shared within the context of a referral based on the survivor's consent
- Survivor/incident data must be collected in a way that limits identification, and, if shared for analytical/reporting purposes, must be non-identifiable* and obtained through informed consent
- Before data are shared, an agreement must be established in collaboration with service providers to determine how data will be shared, protected, stored, used, for what purpose* and in what format
- Client data must be protected at all times and only shared with those who are authorized*
- Setting targets or constructing monitoring indicators for the number of GBV survivors/cases is not appropriate for any sector or service provider
- Data collected regarding use or delivery of GBV services does not represent GBV prevalence

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* See InterAgency Minimum Standards for GBV in Emergencies Programming (2019)

Purpose

> "Monitoring is the systematic and continuous process of collecting, analysing and using information to track a programme's progress towards reaching its objectives and to guide management decisions.[1]"

This note is intended to support personnel with guidance on the selection of safe and meaningful indicators and measures for monitoring GBV response programming and reporting progress to stakeholders. These measures and indicators must be designed to follow the "do no harm" approach, uphold GBV guiding principles (safety, confidentiality, respect, and non-discrimination, along with informed consent) and avoid providing any basis for survivor identification or staff endangerment, while still ensuring effective monitoring of programmes.

GBV coordination systems bring together agencies and organizations involved in GBV response and prevention to collaborate in maximizing impact and reach, reducing inefficiencies, and agreeing on standards for service provision. In humanitarian settings, GBV coordination bodies must establish "common criteria and indicators for evaluating progress in the response to GBV" and establish a "common and credible basis for funding appeals."[2] In development settings, coordination partners are called on to set standards for response and accountability, and to analyze outcomes of their coordinated actions.[3] This note will therefore also include examples of inter-agency indicators that can be used for safe and ethical monitoring of joint action on GBV response.

Sensitive Data

A range of data will be collected in the process of implementing and monitoring GBV response. Within that volume of data, some is considered sensitive because of the likelihood that its disclosure could do harm to an individual, service provider, community, or to public perception of GBV prevalence. Sensitive data includes survivor information, case details, demographic and socioeconomic data, support service utilization and research and statistical data. For instance:

- data from an individual survivor's case records, including directly identifying data (name, phone number, address, etc.), as well as other data components (locations, occupation, relationship to perpetrator, referrals accepted, type of GBV, etc.), that, taken together, can indirectly identify an individual. This includes factors that apply to a smaller group of individuals (diverse gender identities, minority ethnic or religious groups, people with disabilities, etc.) who could more easily be identified if such factors are shared.

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[1] COFEM (Coalition of Feminists for Social Change), 2017a. Finding the balance between scientific and social change goals, approaches and methods | COFEM Feminist Perspectives on Addressing Violence Against Women and Girls Series, Paper No. 3.

[2] GBV Area of Responsibility, 2019. Handbook for Coordinating Gender-based Violence Interventions in Emergencies

[3] UN Women, UNFPA, WHO,UNDP and UNODC, 2015. Essential Services Package for Women and Girls Subject to Violence. Module 5, Standard 6.1

- data that is likely to be misunderstood or misconstrued by those without GBV expertise, thereby complicating funding decisions, policy making, and community mobilization.
- data that exposes local GBV survivors or service providers to intimidation, harm, or extrajudicial penalties.

Types of Gender-based Violence Data

Assessment Data	Service (or administrative) Data	Monitoring Data	Evaluation Data	Prevalence Data
What is the nature of the problem?	*Where, how often, and to whom are services being provided/ activities conducted?*	*Are the services meeting expected quantity/ quality standards?*	*What works and what doesn't work?*	*What proportion of a population is affected?*

Assessment Data

What is the nature of the problem?[4]

Assessments are carried out to determine the need for intervention in a location or situation – what is happening and why. They may be done to justify creation, continuation, or discontinuation of programs and initiatives. When assessments are undertaken, information on GBV may only be collected (1) when existing data from secondary sources is not sufficient (2) when it is possible to do so under conditions of privacy and confidentiality, and (3) when support services are available to respond to disclosures of GBV.[5]

Service (or "administrative") Data

Where, how often, and to whom are services being provided and activities being conducted?

This information is used by programme teams to oversee the level, frequency, and types of activities being carried out. Service data provides a basis for identifying adjustments that may

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[4] MEASURE Evaluation, 2010. M&E of Gender-Based Violence (GBV) Prevention and Mitigation Programs

[5] It is crucial to note that Inter Agency Standing Committee guidance specifies that "all humanitarian personnel ought to assume GBV is occurring and threatening affected populations; treat it as a serious and life-threatening problem; and take actions ...regardless of the presence or absence of concrete "evidence." IASC, 2015a

be necessary to carry out programme activities more efficiently, e.g. distributing personnel and resources to meet demand, or identifying whether particular components of service are being delivered on schedule. Service data can be sensitive (e.g. number of survivors receiving a referral to health services) or non-sensitive (e.g. number of participants attending information sessions at the Women's Center). In the latter example, both survivors and women who have not experienced or not disclosed violence would be included, without disaggregation by this status, so the number of survivors would remain protected. Sensitive service data should be shared on a "need to know" basis, released only in aggregated formats configured to reduce risk, and used to improve programme quality. See table in Use of Sensitive Data section for examples.

Monitoring Data

Are the services meeting expected quantity/quality standards?

Monitoring data is not entirely separate from service data, as monitoring indicators are typically constructed using service data (sometimes along with other data gathered through administration of surveys, checklists, facility audits, etc). Monitoring indicators are pre-determined measures of activities and outputs, tracking progress defined through a programme logic that outlines how the programme's goals and objectives will be achieved. Indicators should be designed to measure not simply the quantity of services but accessibility, inclusiveness, timeliness, and quality standards.

Evaluation Data

What works and what doesn't work?[6]

Evaluation data makes use of monitoring data and may involve collection of additional data in order to support a systematic analysis of an intervention. Good quality evaluations, when based on accurate monitoring data, provide credible, reliable evidence that is used for accountability, learning, and informing implementation.[7] Commonly, evaluations are conducted at the closing of a programme/project; however formative evaluations at the start of a programme/project and mid-term evaluations are also useful in assessing the design, including M&E frameworks, and in determining whether it is necessary to make programmatic adjustments during implementation. This data supports decision-making about whether the strategy for the programming was relevant (addressed the diverse needs of beneficiaries), effective (made the intended difference to the baseline conditions), efficient, coherent (complementarity and added value) and if results were sustainable.[8]

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[6] MEASURE, 2010

[7] For a useful overview of types of evaluations used in programming, see the Centers for Disease Control Tip Sheet Types of Evaluations at cdc.gov/std/program/pupestd/types%20of%20evaluation.pdf

[8] OECD (2021), Applying Evaluation Criteria Thoughtfully, OECD Publishing, Paris, doi.org/10.1787/543e84ed-en.

Prevalence Data

What proportion of a population is affected?

Data that reflects what is happening within an entire population is collected through population-based surveys, which must be constructed using rigorous methods and ethical guidelines in a subset of the population, i.e. a representative sample. This is known as prevalence data. Prevalence data allows us to identify, for example, the percentage of women within defined age groups who have experienced some form of GBV during a specified period (such as the past 12 months, or over a lifetime).[9] Prevalence data does not provide information on how many people are accessing services for GBV; it is not collected as part of service delivery nor is it used for monitoring purposes.[10] It is typically collected in stable (non-emergency) settings as part of national surveys undertaken at household level by government authorities, with technical support from UN or other partners. Actual prevalence of GBV cannot be precisely known because not all survivors will disclose their experience to a survey enumerator, but prevalence surveys are the best method available for obtaining reliable data on the magnitude of the problem in a population, as well as for collecting information in a manner that makes it comparable across countries.[11]

The distinction between prevalence and service data is an essential one for communicating with policy makers, government officials, media, and the public.

Stakeholder Needs for Data

Data may be shared with a range of stakeholders including donors, coordination bodies, government ministries, civil society, etc. that have legitimate interests in understanding whether a GBV program or intervention is effective in terms of resources, costs and results. However, it is common to find that external sharing of sensitive service and monitoring data is expected by these actors and others, including non-GBV program personnel, non-GBV coordination bodies, sectoral partners, and others unaware of the harm this can cause. For an individual survivor whose identity is compromised, consequences can include a range of repercussions, from social isolation and economic harm to retribution from the perpetrator or those supporting him, including harm to the survivor's children or family, sexual violence, forced marriage, physical assault, and femicide.

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[9] Prevalence data for GBV and harmful practices is available at UNFPA's Population Data Portal: pdp.unfpa.org/

[10] Well-constructed and implemented prevalence surveys provide a reliable source of data to inform advocacy and public policy, mobilize resources, formulate legislation, and develop interventions that address factors found to correlate with experiencing or perpetrating violence against women.

[11] For more information on the difference between prevalence and administrative data sources: asiapacific.unfpa.org/sites/default/files/pub-pdf/vaw-sources-of-data-28august2020-final.pdf

The sensitivity of GBV data requires that decisions be made carefully about what type of information a stakeholder actually needs, in order to maintain the highest level of confidentiality for survivors.

There are many meaningful measurements of GBV program achievement that do not compromise survivor identity, confidentiality or safety. Use a "need to know" standard for determining what types and levels of access to GBV data are necessary for stakeholders based on their respective roles, i.e. what information is actually needed for the data recipient to carry out their duties. For example, a GBV case worker needs the most detailed level of access to the survivor's data in order to conduct functions of case management, safety planning, referrals, etc. A case supervisor would not need identifying data (e.g. name, ID number) in order to review the case and ensure proper procedures, action plans and forms are in place. An organization's senior management, donors, and monitoring officials would need only higher-level data, which would be aggregated and anonymized, in order to fulfill their respective oversight roles.

GBV programmes and implementing partners collect data on the progress of the programme to understand patterns of access and to monitor and improve services. Data is analyzed to understand if the program is proceeding as intended, based on the monitoring framework that is constructed to measure outputs and outcomes. Regular analysis of the findings can inform course corrections or changes to program implementation.

Other types of service providers (health, legal, police, shelter, etc.) amass identifying and sensitive service data through assisting GBV survivors and making and receiving referrals. This data may be used by organizations or coordination groups to analyse referral uptake and satisfaction. In order to ensure a well-functioning referral system, all service providers participating in it should agree to Standard Operating Procedures, referral protocols, and an Information Sharing Protocol (ISP) regarding how data collected from survivors is used, how identifying data is stored and protected, and what types of non-identifying data are shared within their own organizations and with partners, donors, authorities, and coordination bodies. Sharing potentially identifying information outside a consent-based referral or case transfer is a violation of confidentiality.[12]

Donors expect periodic reports, including monitoring data, on the results of their support. Generally, activity, output and/or outcome indicators are suggested at the point of proposal development and are refined as the donor agreement is finalized. Donors may share the information from reports with administrative and political offices, and may use it for media and public relations purposes. For this reason, programmes must anticipate the potential uses of the data that is shared with donors and advocate for safe, ethical parameters for indicators and reporting on program activities and outputs.

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[12] UNFPA, 2019. Inter-Agency Minimum Standards for Gender-Based Violence in Emergencies Programming

GBV coordination groups in both development and humanitarian settings may adopt shared indicators as part of appeals for joint, multi-agency, or pooled funding. These indicators and targets are widely shared and publicly available, and results will be reported back against the indicators. GBV coordination bodies also may collect and aggregate some limited types of service data from members in order to better understand gaps and opportunities for improved GBV response. Selected data may be further shared with national or local government partners or within the humanitarian cluster system; the indicators and data points must always be non-identifying and based on consent from survivors.

Finally, members of Gender Based Violence Information System (GBVIMS) or GBVIMS+ Task Forces share selected data points that are aggregated from individual GBV survivors who have consented[13]. As a pre-requisite, an ISP is first established among the members and only non-identifying data is aggregated for sharing and joint analysis. GBVIMS+ makes it possible to better monitor the quality of case management services, as it tracks case activity beyond the initial intake session through to case closure. GBVIMS+ only captures incidents in which survivors seek case management from participating GBV response agencies, so they do not provide prevalence data nor do they capture data related to other aspects of GBV programming.

It is essential to note that no data on a survivor may be collected or shared without informed consent. A one-time consent process is often not sufficient; the survivor must be consulted about her wishes regarding sharing her information not only for referrals but for every other purpose intended, even when her data is anonymized and aggregated for statistical or donor reports.[14]

Use of Sensitive Data

GBV programs collect and share a range of data to support decision-making throughout the program cycle. However, while sensitive data is collected and used for service provision, **it is not advised to share it for monitoring and evaluation purposes without configuring it for safety.**

The table below reviews how data at three levels of sensitivity can be collected, used, and shared. Any data collected from survivors, whether for purposes of service provision or statistical analysis, requires an informed consent process.

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[13] The Gender-Based Violence Information Management System (GBVIMS) enables those providing services to GBV survivors to effectively and safely collect, store, analyze and share data related to the reported incidents of GBV. GBVIMS+ adds features to support GBV case management. For more information, see: www.gbvims.com/

[14] For situations in which mandatory reporting requirements apply, follow best practices in informing the survivor about the process by which her data may be shared without her consent. See Inter Agency Gender-Based Violence Case Management Guidelines (2017): 35, 84.

Reason data is sensitive	Individual data	Aggregated data	Considerations
Data that is sensitive because it is directly identifying *Name, phone, ID number, etc.*	• Accessible only by **case worker**, shared with referral partners if necessary and with informed consent from survivor		
Data that is sensitive because it is indirectly identifying *Occupation, age, type of GBV, location of incident, individual referrals, ethnicity, religion, etc.*	• Accessible only by **case management team**, shared with referral partners if necessary and with informed consent from survivor. • Sharing this type of individual information must be tightly limited because, taken together, the data points are potentially revealing of the survivor's identity.	• May be used for monitoring and evaluation, trend analysis, program planning, resource allocation. • Aggregation to be performed by designated GBV personnel, not by monitoring/evaluation staff. • Internal: used by GBV program management. If shared more widely within organization, it should be expressed in percentages. • External: used by coordination/referral partners. Shared publicly only in accordance with provisions in agreed ISP, only in percentages.	• Indirect identification occurs when enough data points are provided to allow logical speculation or conclusions about identity to be made, even without names, addresses or other personal data. • Information given in percentages rather than numbers makes public speculation more difficult, thus advised. • Numbers may be used if necessary when it is clear that the aggregated number includes non-survivors.

Examples of unsafe use of identifying data	Examples of safer use of identifying data
38 survivors reporting IPV in District Two were 50 or older	10% of survivors reporting IPV in District Two were 50 or older
The health center assisted 9 survivors with diverse SOGIESC who reported sexual violence	5% of those reporting sexual violence at the health center identified as being of diverse SOGIESC. Of these, 100% consented to referrals to additional SOGIESC-inclusive services.
9 women with disabilities received case management at the Women's Center last month	43 women with disabilities attended meetings and events at the Women's Center last month
Monitoring and Evaluation (M&E) staff reviews case files or raw service data to compile and aggregate data points of interest	Monitoring and Evaluation (M&E) staff uses pre-established metrics that are aggregated and provided by designated data focal point

Evaluation team contacts former survivors to collect and aggregate feedback on client satisfaction with services	Evaluation team works with program team to incorporate specific questions of interest into client satisfaction surveys, which are administered by designated GBV personnel at the time of case closure. The process is acknowledged in the evaluation report for transparency
Multiple non-identifying data points, taken together, can identify individual survivors: • The survivor teaches at the high school, where her husband also works. • A 42-year old refugee was sexually assaulted at the Ambo Food Distribution Center yesterday.	

Reason data is sensitive	Individual data	Aggregated data	Considerations
Data that is sensitive because of potential to cause harm or misunderstanding *Number of GBV survivors or cases, number of referrals, number of Clinical Management of Rape cases*		• May be used for monitoring and evaluation, trend analysis, program planning, resource allocation. • GBV personnel should work with M&E staff on methods for verification of aggregated data without disclosure of identifying information. • Internal: used by GBV program management. If shared more widely within organization, expressed in percentages. • External: used by coordination/ referral partners. Shared publicly only in accordance with provisions in agreed ISP, only in percentages.	• See discussion under Risks Related to Sharing Sensitive Data • Do not construct monitoring indicators that report this data directly, configure percentages.

Examples of poentially harmful use of data	Examples of safer use of data
The center provided 92 pregnant survivors with referrals to maternity programs	31% of survivors who received case management were pregnant and referred to maternity programs
All 9 rape survivors were referred for timely CMR services	100% of survivors reporting rape were referred for timely CMR services

Risks Related to Sharing Sensitive Data

Ensuring safe and ethical use of data poses an ongoing challenge for GBV monitoring and reporting. Any metric or indicator used for GBV monitoring must be considered in light of whether it exposes sensitive data.

Directly or indirectly identifying data on individuals may never be used for any purpose besides service provision. Identification of a survivor exposes her to the danger of retaliation by the perpetrator, the community, or her own family. Her reputation, physical safety, emotional wellbeing, financial security, reproductive choices, livelihood, and even her life may all be at risk.

Aggregated data on the number of GBV cases and referrals in a given area can be useful for internal analysis by GBV teams of implementation and access patterns. However, reporting on the number of survivors (or cases, referrals or any equivalent) or constructing indicators that would require reporting numbers on that data is **not advised.**

Aggregated data is not a sufficient or especially meaningful indication of quality in either an individual program or a coordinated response, and reporting it can have negative consequences.

The practice reveals data that has potentially harmful consequences:

- **It incentivizes meeting a target.** Targets specify a number or threshold to be reached. The ability to meet targets is linked (actually or by perception) to continuation of funding and to evaluations of personnel or partner performance. Any indicator that causes pressure to obtain disclosures from survivors, for any reason, is not consistent with a survivor-centered approach that prioritizes their right to determine whether, when and to whom they will report.

- **It can result in identification of survivors.** Revealing the number of survivors in a location with a relatively low number of reported cases fuels speculation about their identities. Survivors feel further isolated and at risk as they hear rumors discussed in their communities. By piecing together bits of data, interested parties can identify a survivor and expose her to a range of negative or even lethal consequences. Even when this number is only released at district or national level where the number is larger, be aware that it can set off demand for disaggregated data to be released at local levels.

- **It increases risk of personnel harassment or danger.** In some settings, divulging survivor numbers results in pressure on GBV personnel to report those survivors to authorities regardless of consent. For example, personnel in some environments have been intimidated by authorities who gained access to monitoring data that includes survivor numbers and demanded details of the cases or explanation for lack of reporting to police. In some settings, personnel have also faced community backlash when case management numbers become known.

- **It can impede community awareness and action.** Linked to the inadequacy of this indicator as a measure of prevalence (discussed below), dissemination of survivor numbers will promote public misunderstanding. "Low" reporting numbers can be interpreted as meaning that GBV is not happening at a significant level within the community and therefore attention to response and prevention activities are given lesser priority.

The practice is highly inadequate for the intended purpose:

- **Case or survivor numbers are not indicators of GBV prevalence.** It is crucial to be able to differentiate between service data and prevalence data in order to explain this. The number of survivors seeking help is not an *indication of prevalence*.[15] Cases documented by GBV programs represent only those survivors who have come forward for case management assistance and consented to be counted in program data. This data is far from representative – globally, fewer than 40 per cent of GBV survivors tell anyone about their experience, including family or friends; reporting rates to services such as police or health are estimated to be below 10 per cent.[16] Therefore, when reported or used as an indicator, the number of cases/survivors gives a false (low) impression of GBV prevalence and provides a misleading basis for assessing the need for continued or expanded services and resources.

- **It is not necessarily linked to quality of GBV services.** Where policies of mandatory reporting are in place, many survivors will not access formal case management because they do not want involvement with police, courts, social services, local officials, etc. They fear loss of privacy and increased danger through public exposure. Even if the case worker does not have to report, some referral service providers (e.g. health) may be mandated reporters, so the case worker must inform the survivor of this when the referral is discussed. Therefore, where mandatory reporting is required, lower service or referral uptake is not a straightforward measure of survivor need, provider competence, or community awareness. Mandatory reporting policies may be only one of several structural barriers to GBV services that will affect uptake regardless of quality of service.

An increase or decrease in the number is not meaningful in itself. Changes in the number of survivors accessing services must be interpreted using contextual factors. An increase in reports could be interpreted positively (e.g. a prevention initiative built more

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[15] UNFPA, 2020. kNOwVAWdata: Sources of Data

[16] UN Department of Economics and Social Affairs, Statistics Division. 2015. The World's Women 2015: Trends and Statistics. New York: United Nations.

understanding of rights, leading more survivors to seek services) or negatively (e.g. a risk factor has escalated and GBV perpetration has increased).

- **It is not indicative of the actual assistance rendered to survivors.** Many survivors are able to access the services they need without making a direct disclosure. Instead, they access GBV programming that that can range from awareness raising sessions, psychosocial group activities, womens friendly spaces, information sessions on sexual and reproductive health options, material support, livelihoods training, and other services facilitated by GBV personnel that are not directed primarily for GBV survivors. GBV case management services are not the only or the most common way that survivors receive the support, knowledge, or referrals they want to address their particular situations at a particular time.

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Annex 1

Key Terms and Definitions

Administrative data (also called service data or implementation data) is information regularly collected by services, agencies and government departments as part of routine operations such as record keeping, registrations or transactions, usually as part of service provision.[1] For the purposes of GBV programming, administrative data refers to information collected through the provision of GBV response and prevention services, law enforcement and the justice system.

GBV Case Management is a structured method for providing help to a survivor. It involves one organization, usually a psychosocial support or social services actor, taking responsibility for making sure that survivors are informed of all the options available to them, referring them to relevant services based on consent, identifying and following up on issues that a survivor is facing in a coordinated way and providing the survivor with emotional support throughout the process.[2]

Identifying data is information that can directly or indirectly reveal the identity of a particular survivor. Examples of data that directly identify an individual include name, address, phone number, or national ID number. Directly identifying data is restricted to use by a GBV service provider, with informed consent from a survivor, for the sole purpose of arranging services the survivor has requested. Other specific pieces of information about a case can be combined to indirectly identify a survivor; for example, workplace, job title, age, ethnicity, perpetrator identity, time frame, referrals, etc.

Information Sharing Protocol refers to an agreement among organizations that guides safe and ethical data-sharing under clearly defined conditions. Information sharing protocols (ISP) aim at sharing aggregated, non-identifiable data for the purpose of analysing trends in GBV reporting, identifying specific risk factors, and determining the uptake of GBV referrals. Inter-agency data-sharing agreements must take into account: (1) what information will be shared, (2) how it will be used, and (3) at what levels (e.g., among all signatories to the protocol, external to protocol signatories, geographic levels of sharing).[3]

Informed consent is the voluntary agreement of an individual who has the legal capacity to give consent. To provide informed consent the individual must be able to understand the services being offered and how their information may be used and shared and be legally able to give their consent. To ensure consent is "informed," service providers must: (1) Provide all

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[1] Diemer, K., & Isobe, J. (2022). Gender-based Violence Administrative Data Toolkit for the Pacific Region: Collecting better information to enhance safety, decision-making and service delivery. Melbourne, Australia: University of Melbourne, UNFPA, Spotlight Initiative.

[2] UNFPA, 2019, p. 44

[3] UNFPA, 2019.

the possible information and options available to the person so she can make choices; (2) Inform the person that she may need to share her information with others who can provide additional services; (3) Explain to the person what will happen as you work with her; (4) Explain the benefits and risks of services to the person; (5) Explain to the person that she has the right to decline or refuse any part of services; and (6) Explain limits to confidentiality.[4]

Metadata are data that define or describe other data. They are the information needed to explain and understand the data or values being presented[5] and how they were measured.

Prevalence data. Prevalence is the proportion of a population who have a specific characteristic in a given time period.[6] Prevalence is determined through population-based surveys that collect data through rigorous methods in a subset of the population — a representative sample — to find out what is happening in the entire population.[7] Prevalence estimates usually present the percentage of women who have experienced violence either during the previous 12 months or at any time in their life.[8]

Sensitive data includes any GBV data that (1) is likely to be misunderstood by those without GBV expertise, thereby endangering funding decisions, policy making, and community mobilization; (2) exposes local GBV survivors or service providers to threats or extrajudicial penalties; OR (3) is from an individual survivor's case records (survivor data).

Survivor data includes (1) personal or identifiable data about an individual survivor; (2) details of the GBV incident (e.g., type of violence, location of incident, relationship of survivor to perpetrator, etc.); and (3) case management data, e.g. information about support provided to an individual survivor.[9]

Survivor-centered approach. A survivor-centered approach creates a supportive environment in which the survivor's rights and wishes are respected, their safety is ensured, and they are treated with dignity and respect. It follows the guiding principles of safety, confidentiality, respect, and non-discrimination.[10]

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[4] UNFPA, 2019.

[5] United Nations Economic Commission for Europe, 2013. Getting the Facts Right - A guide to presenting metadata

[6] National Institute of Mental Health. https://www.nimh.nih.gov/health/statistics/what-is-prevalence

[7] UNFPA, 2020.

[8] UNFPA Asia and the Pacific Regional Office, August 2016. Measuring Prevalence of Violence Against Women: Key Terminology.

[9] UNFPA, 2019, p.106

[10] IASC. 2015a. Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action: Reducing risk, promoting resilience and aiding recovery.

Annex 2

Constructing Indicators

Good Practices in Constructing Indicators for Monitoring GBV Programmes

- **Use "field-tested," globally comparable indicators** where possible. However, be sure to contextualize indicators as needed, since factors differ from place to place in ways that change what the data may actually represent.

- **Use clearly defined terms.** What does "sexual violence" include? How is "increased resilience" measured? Add metadata with definitions of concepts and methodology for measurement of indicators to increase consistency in data collection and transparency in reporting.

- **Think about which outputs demonstrate progress toward an outcome.** There should be a logical relationship between what is measured and the change that you are aiming to achieve.

- **Keep survivor-centered objectives central,** e.g. how does the indicator reflect confidentiality, respect, safety, nondiscrimination empowerment, and/or informed consent for survivors?

- **Keep standards of service in mind,** e.g. measure increases in availability, accessibility, quality of services and interventions.

- **Consider how indicators need to change over time** as the situation changes (e.g. from emergency to protracted displacement) or as learning evolves (e.g. integrated SRHR/GBV services, enhanced psychosocial interventions).

- Take into account **whether personnel capacity building or technical supervision is a meaningful achievement** in your context and if so, advocate for use of indicators related to it. In GBV programs, the outputs relate more to human capacity than to physical infrastructure or material supplies. Developing and sustaining a skilled GBV workforce requires ongoing training, mentoring, and skills practice and is the single biggest factor in quality of response.

Impact

The positive and negative long-term effects on identifiable population groups produced by a development intervention, directly or indirectly, intended or unintended.

Outcomes

Institutional and behavioural performance or changes in development conditions. They are immediate and direct benefits of outputs.

Outputs

Changes in knowledge, skills or abilities, or the availability of goods, products and services, produced by an intervention or activity.

Activities

and strategies are what we do to achieve outputs.

Inputs

Resources required to implement activities and strategies.

Results-Based Management Policy, UNFPA Policies and Procedures Manual, May 2011

Annex 3

Sample Indicators

In the table below, examples of indicators are provided. Sources include:

DIGBV	UNFPA GBV and Disability Inclusion Assessment Tool
EU	EU GAP III Indicators
GBVHC	GBV AoR Handbook for Coordinating GBV in Emergencies
GBVIMS	GBV Information Management System Steering Committee
GBVIE	Inter Agency Minimum Standards for Gender Based Violence in Emergencies Programming
IRC	IRC Outcomes and Evidence Framework
UNDIS	UN Disability Inclusion Strategy
USAID	USAID/Measure Violence Against Women and Girls: A Compendium of Monitoring and Evaluation Measures
MISP	Minimum Initial Services Package
UNFPA MS	UNFPA Minimum Standards for Prevention and Response to Gender Based Violence in Emergencies
WGSS	IRC, IMC Women and Girls Safe Spaces Toolkit for Advancing Women's and Girls' Empowerment in Humanitarian Settings

Check the UNOCHA Humanitarian Indicator Registry for more examples of indicators, some of which are also suitable or can be modified for development/nexus settings. .

As some of the resources listed above are older or have not been compiled with an exclusively survivor-centered focus, not every indicator reflected in them will be in compliance with the recommendations provided in this guidance note; however, each resource does include some suitable indicators for consideration.

For UNFPA users:
UNFPA APRO Humanitarian Indicator Database
The UNFPA Strategic Plan Indicator Guide is a tool for measuring UNFPA's progress on the strategic plan. It includes indicators along with metadata on measurement standards. However, where an indicator includes service data on GBV cases, a note is included:

> […] *incident data may be protected by information sharing protocols preventing the sharing of data related to number of incidents as opposed to trend data. For the CM programme the number of service delivery points is measured, but not the number of cases or the number of women. Only prevention and empowerment programmes can provide information on the number of girls/women*.

Note: indicators for GBV prevention monitoring have not been included here but are available from most of the above resources.

Table 1: Suggested indicators for GBV response monitoring

Focus	Indicators (Source)	Type	Measurement
Accessibility	Percentage of survivors reporting to (service provider) during (time frame) who accessed at least one support service within 48 hours of reporting *IRC*	Outcome	Data derived from case action plans and follow up
	Percentage or number of population living within (distance) of a (type of service, e.g. Women and Girls Safe Space) *IRC*	Output	
	Percentage of (smallest geographical unit) reached with specialized GBV Services *GBVHC*	Output	Define what will be included in "specialized GBV services"
	Number of service delivery points providing (type of service, e.g. health, legal, etc.) that meet (relevant standard, e.g. from ESP or Interagency Minimum Standards)	Output	For use when quality assessments can be made with service partners
	Transportation or cash/voucher to reach GBV referrals is available (Y/N)	Output	
	Percentage of (survivors, participants) with a disability who have been accommodated at (facility) Number of facilities with accessibility measures fully implemented	Outcome Output	Denominator is total number of participants or survivors The measures to be monitored need to be pre-defined and noted for specificity
Safety	Percentage and/or number of (police officers, security personnel, other specific officer) in service location trained on GBV	Activity	
	Percentage and/or number of police stations in service location that provide services by trained officers/staff	Output	
	Percentage of reported cases for which a survivor safety plan was implemented with survivor	Output	

Inclusion	Accessibility policy/strategy for GBV response to (X population) is in place and has been implemented Y/N *UNDIS*	Output	Note: adapt indicator for ethnic groups, religious minorities, diverse SOGIE, or other population to be measured for inclusion
	Persons (from X population) are reflected in mainstream communications (Y/N) *UNDIS*	Activity	Note: adapt indicator for ethnic groups, religious minorities, diverse SOGIE, or other population to be measured for inclusion
	Percentage of survivors using GBV case management services who are (subpopulation, e.g. people with disabilities)	Outcome	Note: adapt indicator for ethnic groups, religious minorities, diverse SOGIE, or other population to be measured for inclusion
	GBV staff have completed training on disability inclusion and rights (Y/N) *DIGBV*	Activity	
	Percentage of women and girls with disabilities who report satisfaction with (type of response - GBV case management, women friendly spaces, etc.), compared to women and girls without disabilities *DIGBV*	Outcome	
Awareness	% of women and adolescent girls in program area who can state at least one benefit of timely care for rape *IRC*	Output	
	Percentage of women and adolescent girls participating in safe space activities who report knowing where to go for support if they or someone they know experiences violence *IRC*	Output	Number can be used assuming activities for non-survivors are also conducted at safe space
	Mean number of formal GBV service providers known to women/girls in the community	Output	This requires baseline and follow up assessment
	Percentage of women/girls in the community who know where to safely receive formal GBV response assistance	Output	This requires baseline and follow up assessment

Consultation	Number of women and girls consulted to inform (type of intervention), disaggregated by age, disability, ethnicity, etc. *GBVIE*	Activity	
	Percentage of feedback from women and girls received through (mechanism) that has been addressed within (time period) *WGSS*	Output	
	Direct consultations with local women's organizations have taken place and their inputs integrated into the Humanitarian Needs overview/Humanitarian Response Plan *UNFPA MS*	Activity	
Safe house/ shelter	Occupancy rate during (period) for (number of shelters in location)	Output	
	Occupancy rate during (period) for (number of shelters in location)	Output	
	Number of adequate, easily accessible and protected shelters for survivors of gender-based violence available *EU*	Output	Agree on definitions for adequate, accessible, protected. Consider how to interpret the number of shelters compared to the area population (e.g 1 family space per X population)
	Percentage of shelter occupants requesting (skills training, job placement, individual counseling, other onsite service) who received it during (time period)	Output	
	Percentage of shelter occupants requiring long term housing placement/assistance who received it	Output	Based on case action plan # of occupants who acquired long term housing = numerator # of occupants whose action plan included long term housing goal = denominator

Safe house/ shelter	Average number of needs identified by shelter occupants at entry and exit	Activity	Based on a standardized checklist of common needs in context
Hotlines	Percentage increase in calls for GBV information, services or referrals (beginning and end of specified period)	Output	
	Percentage of callers who accepted a (social services, police, health, PSS, legal, etc.) referral	Output	
	Percentage of calls for GBV information, services or referrals by callers (age groups - under 18, etc.)	Output	
	Percentage of calls relating to information, services or referrals for (type of GBV)	Output	
	Percentage of calls from survivors in which a safety plan was created	Output	
	Percentage of women/girls in the community who are aware of existing GBV hotlines	Output	This indicator requires baseline and follow up assessment
	Percentage of callers by referral source (self, friend/family, healthcare provider, etc.)	Output	
Safe spaces	Percentage/or/Number of Safe Space activities led by women and girls from the community *WGSS*	Outcome	
	Percentage of surveyed Safe Space participants who report developing a social support network there *WGSS*	Outcome	Set criteria for measurement, e.g. interviewee can name 2 other participants met in Safe Space whom she would go to with a problem
	Percentage and/or number of Women and Girls Safe Spaces in which users have been formally included in administrative decision-making	Output	Specify criteria for measurement, e.g. included on Safe Space advisory committee, included in facility operations meetings, etc.

Safe spaces	Number of women and girls attending the Safe Space *WGSS*	Output	Use only if activities for non-survivors are also conducted at site
Staff capacity	Percentage of GBV caseworkers who, after training, meet 80 per cent of supervision criteria for attitudes, knowledge and skills required to provide quality GBV case management services *GBVIMS*	Output	
	Percentage of survivors (disaggregated by sex and age) who completed a feedback survey who are satisfied with the case management services *GBVIMS*	Outcome	
	Percentage of (staff position)able to demonstrate increased understanding of (topic) following (training type)	Output	
	Percentage of GBV (staff position) who meet quality criteria for (type of)skills *WGSS*	Output	
	Percentage of GBV casework supervisors who are professionally accredited or certified	Activity	Agree on definition in context of what constitutes accreditation or certification
	Percentage of GBV service provider personnel who demonstrate increase in knowledge after (training type)	Output	
	Percentage of GBV caseworkers with active cases at or below the 1 to 15 recommended ratio *GBVIE*	Output	
	Percentage of GBV supervisors supporting caseworkers at or below the 1 to 8 recommended ratio *GBVIE*	Output	
	Percentage of all GBV programme job profiles that are aligned with the GBV Core Competency framework	Activity	
SRH Integration	Percentage/ OR / number of (Safe Spaces or other case management service point) that provide information sessions on sexual and reproductive health and rights	Output	
	Percentage/ OR / number of SRH clinics staffed with at least one trained and designated GBV caseworker onsite	Output	

Coordination	Functional referral system in place that includes multi-sectoral services (health, psychosocial, legal and security) for GBV survivors (Y/N)	Output	
	Multi-sectoral coordinated mechanisms to prevent sexual violence are in place (Y/N) *MISP*	Output	
	Written Standard Operating Procedures (SOPs) for GBV prevention and response developed and agreed upon by all relevant humanitarian actors (Y/N)	Output	
	Percentage of referrals not completed due to client ineligibility at recipient service (measurement of referral pathway accuracy)	Output	
	Multi-sectoral referral pathway and referral protocols have been adopted and implemented by service providers (Y/N)	Output	
	Multisectoral assessments include questions relevant to GBV service provision, while avoiding questions regarding GBV incidents or prevalence (Y/N) *GBVIE*	Activity	
	Humanitarian Response Plan is implemented which includes (1) GBV risk mitigation, (2) GBV specialised programming, including response services, and (3) protection from sexual exploitation and abuse (Y/N) *GBVIE*	Outcome or output	
	Updated referral pathway is produced at a minimum every 6 months with information on available, accessible multisectoral services in (location) (Y/N)	Activity	
	GBV coordination group/subsector strategy developed and workplan in place (Y/N)	Activity	
	Percentage and/or number of government social workers trained in GBV case management in (location) during (time period) *GBVHC*	Activity	
	Percentage and/or number of GBV coordination working groups led/co-led by national partners and stakeholders *UNFPA MS*	Activity	
Other multi-sectoral	Humanitarian Needs Overview is based on gender analysis, and sex- and age-disaggregated data (Y/N) *UNFPA MS*	Activity	

Other multi-sectoral	Percentage of reported rape cases where survivor receives post-exposure prophylaxsis for HIV (PEP) within 72 hours of incident *MISP*	Outcome	
	Percentage and/or number of trained community-based workers able to provide psychological first aid (PFA) for GBV survivors *OCHA*	Output	
	Number of service providers providing (type, e.g. legal) services to survivors of GBV *OCHA*	Output	
	Percentage/ OR / number of health facilities in service area with at least one medical personnel trained on CMR *OCHA*	Output	
	Proportion of health units with at least one service provider trained to care for and refer VAW/G survivors *UNAID*	Output	
	Percentage and/or number of (safe spaces, one stop centers, or other case management service point) that provide evidence-based psychosocial intervention for GBV survivors	Output	
	Percentage and/or number of active clusters/ sectors with a GBV focal point *GBVIE*	Activity	
	Percentage of gender-based violence cases reported to the police, brought to court which resulted in the perpetrators being sentenced, disaggregated at least by sex of the victim *EU*	Output	
	Percentage and/or number of humanitarian cluster/sector working groups supported in GBV mainstreaming by GBV Subcluster focal point *UNFPA MS*	Activity	

UNFPA Asia and the Pacific Regional Office
United Nations Service Building
Rajdamnern Nok Avenue,
Bangkok 10200, Thailand
Email: apro@unfpa.org
www.unfpa.org