Gender Equality and Women's Voice: Supplementary Indicators

OVERVIEW   The Gender Equality Women's Voice (GEWV) indicators were developed with the aim of allowing CARE to capture, measure, and track the changes occurring as a result of the dedicated gender approach across development and humanitarian programming. The resulting data should enable CARE to systematically build a picture of the changes in agency, structures, and relations taking place in the communities in which we work. The aim of doing so is to:

- Understand the results of taking a gender approach within the complex process of gendered change;
- Test our assumptions and theory of change, and measure progress against our gender aims;
- Capture and tell the story of gender transformation;
- Learn how to better improve our work to address inequalities.

GEWV 1. AVERAGE TOTAL # AND PROPORTION OF WEEKLY HOURS SPENT ON UNPAID DOMESTIC AND CARE WORK, BY SEX, AGE AND LOCATION (FOR INDIVIDUALS FIVE YEARS AND ABOVE)

Why this indicator? What will it measure and provide information for? The provision of unpaid care and domestic work has a profound implication on our understanding of poverty and well-being. As a result of their socially ascribed roles, women and girls do the bulk of unpaid care and domestic work, which includes household maintenance activities such as cooking and cleaning as well as person-to-person care activities such as child and elder care. Producing time use statistics thus contributes to increasing the visibility of women's work through better statistics on their contribution to the economy – with particular emphasis on the value of goods and services they produce (sourced from SDG Meta Data).

What Sustainable Development Goal is the indicator connected to? SDG Indicator 5.4.1

Definitions and key terms. Unpaid domestic and care work activities include the unpaid production of goods for own final consumption, these include:

- Unpaid work that involves the production of goods for self-consumption (e.g., collecting water or firewood)
- Unpaid work that involves the provision of services for self-consumption (e.g., cooking or cleaning as well as person-to-person care for other people)
- 'Voluntary work' which consists of service or activity undertaken without pay for the benefit of the community, the environment, and persons other than close relatives or those within the household

Data and information required to calculate the indicator. Collected data from surveyed population on hours spent weekly (or possible to use a 24-hour diary and adjust as needed).
- Numerator: total number of hours spent on unpaid domestic and care work
- Denominator: total number of hours in the week

Suggested method for data collection. HH Survey. Recognizing the time-intensive nature of doing a comprehensive time analysis, one adaptation to consider if this is not a possibility is a card-sorting exercise. This can be used to highlight the activities that take the greatest amount of time for each target segment (e.g., men, women, boys, and girls) of interest. To do so, have a set of cards – on each card have a picture of an activity (e.g., collecting water, drinking tea, cooking, taking care of children, socializing with friends and neighbors, doing school-work). Ask participants to choose and rank the top 5 cards according to how much time they spend doing these activities in an average day. Use qualitative methods to investigate key points of interest that arise out of this exercise.

Possible data sources. At the international level, UN Women, UNDP and UNSD have compiled statistics from national and international surveys on time use.

Resources needed for data collection. This indicator is generally derived through time use surveys or time use modules in general purpose or labor force surveys. Multi-purpose household surveys can also be used to produce time use statistics, for example through a modular approach.

Reporting results for this indicator: number of people for which the change happened. A change in the total and percentage of hours spent on un-paid care. Data should be reported disaggregated by age and sex to the degree possible.

Questions for guiding the analysis and interpretation of data (explaining the how and why the change happened, and how CARE contributed to the change). Has CARE implemented activities and/or interventions amongst the survey group demonstrating the change? If so, were these interventions intended to promote more gender-equitable roles? If so, how and for how long? Are other organizations working to promote gender equality (or specifically focused on roles or division of labor) within the same community? Amongst the same people? Is there a comparison group to demonstrate that CARE's interventions within this area can be correlated with an increase in more gender-equitable roles or sharing or responsibilities with some evidence?

Other considerations. This supplementary indicator will be shared with WEE.Time surveys are difficult and we should consider "primary" and "secondary" activities to get a correct estimate (e.g. a woman engaged in agricultural or micro-enterprise work where she is simultaneously caring for her child, which thus limits her productivity and possibilities in the "paid" work...etc.). Further guidance on how to collect and analyze time-use data can be accessed from UNSTAT here including a sample reporting form on pg. 235.

GEWV 2. % OF INDIVIDUAL REPORTING HIGH SELF-EFFICACY (SADD)

Why this indicator? What will it measure and provide information for? This indicator looks specifically at individual self-efficacy and was chosen to look at changes over time in the percentage of individuals that report high self-efficacy. Self-efficacy (defined below), has been defined and studied by many ranging from psychologists to behavior change specialists, to those engaged in development and humanitarian work. Recognizing the instrumental role that self-efficacy has on all human endeavors, their power with and over other individuals, and their relationships with individuals, groups, and entities in their lives, this indicator was selected to help us look more closely as changes in perceived high-self efficacy among CARE project direct and indirect participants over time. Information and data collected against this indicator will CARE staff and programmers to understand more about the inter-relationships between groups' individual perceived self-efficacy and the correlation(s) this may have with behaviors of interest (e.g., health practices and behaviors).

What Sustainable Development Goal is the indicator connected to? *WEE has several indicators that look at individual capability as it relates to fiscal autonomy and productive assets.*

Definitions and key terms. Self-efficacy: Is one's individual belief in their capability to achieve their goals and/or complete tasks.

Data and information required to calculate the indicator. To collect data against this indicator, we recommend using the following measure and likert scale:

Possible option for survey measure/question: Despite the challenges that exist in your life, think about one self-defined goal that you would like to achieve in your personal life over the next year.
- How confident are you that you could achieve this goal in your personal life? (1. Not at all confident; 2. Somewhat confident; 3. Fairly confident; 4. Very confident; 5. Extremely confident)

Additional suggestions for measures that have been suggested for the humanitarian context (but could be used in longer-term development contexts as well):
- How confident are you that you could access education services?
- How confident are you that you could access health services without permission if you were ill?
- How confident are you that you could leave your home without permission?

Suggested method for data collection. HH Survey

Resources needed for data collection. Significant resources for household surveys would need to be included in the monitoring and evaluation plan and budgeted for, should CARE collect quantitative data.

Reporting results for this indicator: number of people for which the change happened
- A change in the percentage of people (respondents) reporting high self-efficacy
- An analysis of how CARE contributed to this change

Questions for guiding the analysis and interpretation of data (explaining the how and why the change happened, and how CARE contributed to the change). Has CARE implemented activities and/or interventions amongst the survey group demonstrating the change? If so, were these interventions intended to increase self-efficacy or to increase self-efficacy amongst specific individuals or groups (e.g., women and girls)? If so, how and for how long? Are other organizations working to increase self-efficacy within the same community? Amongst the same people? If so, (or even if not) is there a comparison group to demonstrate that CARE's interventions within this area can be correlated with increases in self-efficacy with some evidence?

Other considerations. WEE also has several indicators that look at individual capability as it relates to fiscal autonomy and productive assets.

GEWV 3. #OF COUNTRIES WITH LAWS AND REGULATIONS THAT GUARANTEE WOMEN AGED 15-49 YEARS ACCESS TO SEXUAL AND REPRODUCTIVE HEALTH CARE, INFORMATION AND EDUCATION

Why this indicator? What will it measure and provide information for? This indicator is connected with SDG Indicator 5.6.2 and looks to measure against the more 'structures' domain of CARE's Gender Equality Framework. This indicator can constitute several domains and qualitative policy analysis should be used to provide further texture to the understanding and interpretation of the quantitative figures provided.

What Sustainable Development Goal is the indicator connected to? SDG Indicator 5.6.2

Definitions and key terms. From UNWOMEN: "Legal/regulatory frameworks covered by this indicator include laws and regulations that explicitly guarantee:
1. Access to SRH services without third party authorization (from the spouse, guardian, parents or others)
2. Access to SRH services without restrictions in terms of age and marital status
3. Access by adolescents to SRH information and education

Data and information required to calculate the indicator. Access to detailed descriptions of laws and regulations related to SRH care, education, and information within said country. Special consideration should be made to conduct a thorough policy analysis to discern the degree to which the law and/or policy affects different segments of the population (e.g., adolescents versus adults) differently.

Suggested method for data collection
- County Office Tracking (to avoid double-counting); data against laws, regulations and policies should be disaggregated by type (e.g., those ensuring access to: care; education; information)
- Suggest using UNWOMEN/UNFPA criteria to assess the degree to which these laws and regulations are in place
- CO should conduct complementary qualitative policy analysis to provide more texture to this quantitative indicator data with a particular focus on the degree to which these laws and policies are: 1) adopted, 2) implemented, and if possible, 3) effective as well as any limitations or restrictions (e.g. AYSRH)
- Take special note to disaggregate data surrounding the laws/regulations by the area of SRH covered by it (e.g., care and/or information and/or education) as these are different things

Possible data sources. Originally sourced laws, policies and regulations; third-party (secondary source) policy analyses

Resources needed for data collection. Time; SRHR Policy and Law knowledge

Reporting results for this indicator: number of people for which the change happened. Population estimates should be made based on the # of people affected by said law, policy, or regulation

Questions for guiding the analysis and interpretation of data (explaining the how and why the change happened, and how CARE contributed to the change). Consider the implications of CARE's efforts to support and/or pass the laws/regulations/policies being reflected. Did CARE have an advocacy role? Did groups supported by CARE have an advocacy role?
If CARE did not have a role or has not had a role in the past, then this should be noted upon reporting to ensure that our advocacy efforts are not mis-represented.

Other considerations. [Additional guidance including research questions for policy analysis can be found here.](#) This would be shared with the SRHR outcome area.

GEWV 4: % OF INDIVIDUALS WHO REPORT CONFIDENCE IN THEIR OWN NEGOTIATION AND COMMUNICATION SKILLS (SADD)

Why this indicator? What will it measure and provide information for? Focusing this individual agency-related indicator on reported confidence in communication and negotiation as anecdotal and formal evidence suggest that this is one of the areas reported most important by women and girls especially as it relates to their agency and a key asset/skill for all individuals ranging from those working in the marketplace to health service providers and clients.

What Sustainable Development Goal is the indicator connected to? N/A

Data and information required to calculate the indicator. To collect data against this indicator it is recommend that the following measures and likert scale be used:

How confident do you feel that you can: (1. Not at all confident; 2. Somewhat confident, 3. Fairly confident 4. Very confident; 5. extremely confident)
- Negotiate for your needs with the head of household
- Negotiate for my needs within external forums and structures (e.g., local council, NGOs, markets, government, service providers)
- Negotiate for my wants with the head of household (e.g., within your family, with relatives, household)
- Negotiate for my wants within external forums and structures (e.g., local council, NGOs, markets, government, service providers)

To note: In displacement situations, "external forums and structures" can be replaced by community leader. If the person being asked is the head of household, do not ask 1 or 3.

Suggested method for data collection. HH survey

Resources needed for data collection. Significant resources for household surveys would need to be included in the monitoring and evaluation plan and budgeted for, should CARE collect quantitative data.

Reporting results for this indicator.
• Number of people for which the change happened
• A change in the percentage of people (respondents) reporting confidence in their communication and negotiation skills
• An analysis of how CARE contributed to this change

Questions for guiding the analysis and interpretation of data (explaining the how and why the change happened, and how CARE contributed to the change)
• Has CARE implemented activities and/or interventions amongst the survey group demonstrating the change? If so, were these interventions intended to improve communication and/or negotiation skills? If so, how and for how long?
• Are other organizations implementing activities to improve communication and negotiation skills within the same community? Amongst the same people?
• Is there a comparison group to demonstrate that CARE's interventions within this area can be correlated with an increase in individuals reporting increased confidence in their communication and negotiation skills with supporting evidence?

Other considerations. FNS and WEE are looking to include several indicators that look at different domains of skills and productive assets, adaptive capacity/resilience; best just to cross-tag:
• FNS Indicator 4: Percentage of women farmers with access to, control over, or ownership of a core set of productive resources, assets, and services
• FNS Indicator 5: Increased adaptive capacity among households and communities dependent on small-scale food production
• WEE supplementary indicator 1: US$ value of net income increase per day, by gender; [from selling product or service, from formal/informal employment]; [plus calculation of gender pay gap]
• WEE supplementary indicator 2: # of women who have increased capability to perform economic activity
• WEE supplementary indicator 3: # of women who own or control productive asset (including land)/technology and have the skills to use them productively[1]

GEWV 5: % OF RESPONDENTS WHO REPORT GENDER EQUITABLE ATTITUDES (GEM SCALE)

Why this indicator? What will it measure and provide information for? The 'domestic chores and daily life domain' sub-scale of the Gender Equitable Men (GEM) scale was selected to glean insights about the changing perceptions of roles and responsibilities between men and women among surveyed respondents. While the entire sub-scale could be used (and adapted to the context), this 5-point sub-scale can be used to measure attitudes on a 3-point likert scale of agree-; partially agree; and do not agree.

What Sustainable Development Goal is the indicator connected to? N/A

Definitions and key terms. 'Domestic chores and daily life domain' sub-scale of GEM Scale. While the entire scale could be used and measured against, it is quite large. See the C-change gender scales compendium.

Data and information required to calculate the indicator.
How strongly do you agree with the following statements: (1. agree, 2. partially agree, and 3. do not agree)

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1. Informs SDG indicator 5.a 1 (b) 'share of women among owners or rights-bearers of agricultural land, by type of tenure' (global data collected by FAO, UN Women).

- Changing diapers, giving a bath, and feeding kids is the woman's responsibility
- A woman's main role responsibility is taking care of her home and family
- The man should decide to buy the major household items
- A man should have the final word about decisions in his home
- A woman should obey her the man/men in her life (e.g., husband, boyfriend, father) in all things

High scores represent high support for gender equitable norms. Certain items were reverse scored if a high score would reflect low support for gender equity. Responses to each item were summed.

Additional recommendations for measures/questions that could be used in the humanitarian context (or longer-term development if applicable and/or appropriate):
- How has your role in the household changed from before the crisis until now? (1. Very negative, 2. Negative 3. Neutral 4 Positive 5. Very positive)
- Do you feel has been a positive or negative change in your life? (1. Very negative, 2. Negative 3. Neutral 4 Positive 5. Very positive)
- Do you have more help with your workload? (Yes / No)

Suggested method for data collection. HH survey

Possible data sources. HH Survey; or additional surveys of the same population area that have included GEM scale measures (less reliable).

Resources needed for data collection. Significant resources for household surveys would need to be included in the monitoring and evaluation plan and budgeted for, should CARE collect quantitative data.

Reporting results for this indicator.
- Number of people for which the change happened
- A change in the percentage of people (respondents) reporting gender-equitable attitudes
- An analysis of how CARE contributed to this change

GEWV 6: % OF INDIVIDUALS REPORTING THEY CAN RELY ON A COMMUNITY MEMBER IN TIMES OF NEED (SADD)

Why this indicator? What will it measure and provide information for? This indicator was adapted to look specifically at social capital with our operating hypothesis being that social capital is instrumental to individual and collective agency and also an important illustrator of relationships. Notably, this adaptation of the indicator focuses on being able to rely on community members in times of need, not thinking that they could, or whether or not they have in the last 12 months (as many indicators of social capital do).

What Sustainable Development Goal is the indicator connected to? N/A

Definitions and key terms. Social capital: Social capital refers to the norms and networks that enable collective action. Increasing evidence shows that social cohesion — social capital — is critical for poverty alleviation and sustainable human and economic development. (Source from this World Bank article).

Data and information required to calculate the indicator. How strongly do you agree with the following statement: "I can rely on a community member in a time of need"? (1. Strongly disagree; 2. Disagree; 3. Neither agree nor disagree; 4. Agree; 5. Strongly agree)
- Numerator: total # of individuals reporting that they can rely on a community member in times of need
- Denominator: total # of surveyed respondents

Recommendations for additional qualitative data collection: Where possible use qualitative methods to unpack what type of

needs and the social network. How to unpack look at page 15 of WE-MEASR).

ALTERNATIVE OPTION FOR MEASURING. Using a multi-select survey tool function and allowing respondents (and enumerators) to tick all that apply:
- Who would you reach out to if faced with a day-to-day problem? (Husband/wife; extended family member; neighbor; friend; community/religious leader; police; other _)
- Who would you reach out to if you had a critical problem? (Husband/wife, extended family member; neighbor; friend; community/religious leader; police; other _)

Suggested method for data collection. HH Survey (or survey of target-segmented individuals)

Possible data sources. Survey

Resources needed for data collection. Significant resources for household surveys would need to be included in the monitoring and evaluation plan and budgeted for, should CARE collect quantitative data.

Reporting results for this indicator: number of people for which the change happened
- A change in the percentage of people (respondents) reporting that they could rely on a community member in times of need
- An analysis of how CARE contributed to this change

Questions for guiding the analysis and interpretation of data (explaining the how and why the change happened, and how CARE contributed to the change)
- Has CARE implemented activities and/or interventions amongst the survey group demonstrating the change? If so, were these interventions intended to promote more gender-equitable attitudes? If so, how and for how long?
- Are other organizations working to increase social capital among individuals (participants) within the same community? Amongst the same people?
- Is there a comparison group to demonstrate that CARE's interventions within this area can be correlated with the increase in perceived social capital with supporting evidence?

GEWV 7: % OF INDIVIDUALS REPORTING THAT THEY COULD WORK COLLECTIVELY WITH OTHERS IN THE COMMUNITY TO ACHIEVE A COMMON GOAL (SADD)

Why this indicator? What will it measure and provide information for? This indicator was adapted in recognition that collective efficacy (beyond individual efficacy) is instrumental to individuals' realization of their human rights as well as health and development outcomes more broadly.

What Sustainable Development Goal is the indicator connected to? N/A

Definitions and key terms. Collective efficacy: is the belief that a group has the capability to affect change within their environment; within this is the inherent believe that individual contributions add to the collective effort.

This indicator was not pulled from a specific source, but it was adapted from multiple sources of measures looking at social cohesions and collective efficacy including the collective efficacy and collective action sub-scales of WE-MEASR.

Data and information required to calculate the indicator. How strongly do you agree with the following statement: (1. Strongly disagree; 2. Disagree; 3. Neither agree nor disagree; 4. Agree; 5. Strongly agree)
- I could collaborate with other members of the community to address a community need
- We can collaborate as a community to improve our quality of life

Consider disaggregation by different associations by identity. For guidance on how to unpack, look at page 19 of WE-MEASR.

Note: There may be different understandings and interpretations of what constitutes 'community' depending on the context, target segment, situation, etc.; to the degree possible, please use the comments and qualitative sections of the PIIRS and supplementary indicator forms to describe what 'community' may constitute in the case of your project (if applicable).

Suggested method for data collection. HH survey (or survey of target-segmented population)

Possible data sources. HH Survey

Resources needed for data collection. Significant resources for household surveys would need to be included in the monitoring and evaluation plan and budgeted for, should CARE collect quantitative data.

Reporting results for this indicator. Number of people for which the change happened
- A change in the percentage of people (respondents) reporting high certainty that they could work collectively with other in the community to achieve a common goal
- An analysis of how CARE contributed to this change

Questions for guiding the analysis and interpretation of data (explaining the how and why the change happened, and how CARE contributed to the change). Has CARE implemented activities and/or interventions amongst the survey group demonstrating the change? If so, were these interventions intended to promote more gender-equitable attitudes? If so, how and for how long? Are other organizations working to increase collective efficacy among groups (of participants) within the same community? Amongst these same groups? Are there comparison group(s)/communities to demonstrate that CARE's interventions within this area (amongst these group(s)) can be correlated with the increase in perceived collective efficacy with supporting evidence?

Other considerations. The Inclusive Governance approach supplementary indicators look at organizational capacity and collective action this indicator looks more at collective efficacy (perceptions of collective capability).

GEWV 8: # OF EXAMPLES IN THE MEDIA REPRESENTING RELEVANT NORMS

Why this indicator? What will it measure and provide information for? Myriad groups within and across CARE are beginning to looking to understand and address the role that social norms play in relation to seeing positive behavior change. Much of CARE's work to-date in the area of social norms measurement has been in recognition that in order to measure changes in social norms, the metrics used must be quite tailored and context specific. In recognition of both this and the surmounting interest (and need) in measuring social norms at an impact level, the idea has been proposed to look at the representation of social norms at an impact level through the lens of mass media. Mass media is an un-tapped space for CARE and the aim is to look at both norms and media throughout the activities recommended to measure against this indicator.

What Sustainable Development Goal is the indicator connected to? N/A

Definitions and key terms. Total number of representations of relevant social norms 'flagged' during the FY.

Social norms: Social norms are unspoken rules that influence human behavior. They are made up of 2 kinds of expectations we have about other people:
1. What I expect or think other people do, and,
2. what I expect other people think that I should do.

Together these social expectations about others tell us whether a behavior or practice is a social norm. Example of a norm: waiting your turn in line at a bank or at a shop in the marketplace. Individuals wait in line for service because everyone else around him/her does, and because they think he/she should, too. We know this because if that person skipped the line, we expect that people around him/her would be upset and would probably voice their disapproval. Changing norms can entail abandoning a norm, or creating a new norm.

Data and information required to calculate the indicator. Total number of counted examples (representations) of the identified 'relevant' social norms over the course of the FY (counting period).

Suggested method for data collection
- Each project should identify the norms they will 'watch' (short exercise prior to the start of implementation)
- Each project should then identify which media (e.g., newspaper advertisements, radio, television shows, etc.) they are going to monitor and at what level (e.g., local, national, etc.)
- Each project should then assign a staff person to review those identified media on a monthly basis (or other previously established frequency) and count the number of times the relevant norms have been 'flagged' as present in the media channels/platforms being monitored

Possible data sources. Project monitoring and evaluation

Resources needed for data collection. Time; access to identified media channels/platforms

Reporting results for this indicator: number of people for which the change happened. Possible to do population estimates of who can be reached with the media channels/platforms that are being monitored.

Questions for guiding the analysis and interpretation of data (explaining the how and why the change happened, and how CARE contributed to the change). Has CARE implemented activities and/or interventions with an explicit focus on social norms and the representation of social norms in media? Is CARE working with the media on the representation (upholding) of social norms in different media streams/channels/platforms? What does the increase or decrease in the number of social norms reflected in the media tell us about CARE's work in this area? What is the potential impact of this work with the media (e.g., target-segmented population reach, changes in perceptions, attitudes, etc.).

Other considerations. This is an area of CARE's work that is being piloted and will require further testing to discern if this measurement approach (and indicator) are functional.

GEWV 9: PROPORTION OF WOMEN AGED 20-24 YEARS WHO WERE MARRIED OR IN A UNION BEFORE AGE 15 AND BEFORE AGE 18

Why this indicator? What will it measure and provide information for? Marriage before the age of 18 is a fundamental violation of human rights. Child marriage often compromises a girl's development by resulting in early pregnancy and social isolation, interrupting her schooling, limiting her opportunities for career and vocational advancement and placing her at increased risk of intimate partner violence. In many cultures, girls reaching puberty are expected to assume gender roles associated with womanhood. These include entering a union and becoming a mother (pulled from this SDG justification).

What Sustainable Development Goal is the indicator connected to? SDG Indicator 5.3.1

Definitions and key terms. From SDG: This indicator provides the proportion of women aged 20 to 24 years who were first married or in union by age 18. It is calculated by dividing the number of women aged 20-24 who were first married or in union by age 18 by the total number of women aged 20-24 in the population.

Data and information required to calculate the indicator.
For proportion married before 15:
- Numerator: total # of women aged 20-24 who were married before 15
- Denominator: total # of women aged 20-24 who were surveyed

For proportion married before 18:
- Numerator: total # of women aged 20-24 who were married before 18

- Denominator: total # of women aged 20-24 who were surveyed

Suggested method for data collection. HH Survey

Possible data sources. MICS; DHS

Resources needed for data collection. Significant resources for household surveys would need to be included in the monitoring and evaluation plan and budgeted for, should CARE collect quantitative data.

Reporting results for this indicator. Number of people for which the change happened
- A change in the percentage of people (respondents) reporting high certainty that they could work collectively with other in the community to achieve a common goal.
- An analysis of how CARE contributed to this change.

Questions for guiding the analysis and interpretation of data (explaining the how and why the change happened, and how CARE contributed to the change).
- Has CARE implemented activities and/or interventions with an explicit the prevention of child, early, and/or forced marriage (CEFM)?
- What does the increase or decrease in the proportion of women and girls who have been married within the ages denoted tell us about CARE's work in this area? What is the potential impact of this work with the communities within which it is implemented (e.g., target-segmented population reach, changes in perceptions, attitudes, etc.)?
- Has CARE been doing advocacy work in this area? If so, to what degree can a policy analysis and process documentation help to support CARE's contributions to changes in CEFM practices and/or prevalence?

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Additional information and guidance on collection and disaggregation of this indicator can be found in this SDG indicator document on pages 16-17. Birth certificates are not always used and/or accurate especially in more rural contexts; in geographies where CEFM practices are prevalent, the age of the girls in particular is less known and contributes to ambiguity around data collected against this indicator as we well as whether laws against CEFM are being 'broken'.