THE AFRICA SHARED RESEARCH AGENDA

FOR ENDING GENDER-BASED VIOLENCE

NOVEMBER 2023

SVRI sexual violence research initiative

UN WOMEN

Foreword

In order to accelerate progress on the Sustainable Development Goal 5 target on eliminating all forms of violence against women and girls (VAWG), it is essential to close evidence and knowledge gaps perpetuating VAWG and other forms of gender-based violence (GBV). Across sub-regions in Africa, there are more actors and institutions working to better understand the diverse manifestations of GBV, how policies and programmes can prevent and respond to this pervasive human rights violation, what is needed to expand the reach of interventions and how research can best contribute to these efforts.

UN Women in Africa and the Sexual Violence Research Initiative (SVRI) are committed to contributing to a world where women in all their diversity and children can enjoy their right to live free from violence. Recognizing the power of knowledge generation and the need for more equitable and inclusive research processes in efforts to end GBV, we have collaborated to facilitate the Africa Shared Research Agenda for ending GBV (ASRA). The ASRA draws from the lessons of the Global Shared Research Agenda on Violence against Women and has been shaped through a collective process of learning and consultation. It is a contribution to the Generation Equality Action Coalition on Gender-based Violence and provides insight into the key research questions identified as priorities for ending GBV by diverse experts based in and working in Central, East, Southern and West Africa.

The research priorities highlighted in the ASRA reaffirm the need for building a deeper understanding on how GBV is experienced by women, girls and individuals facing other forms of discrimination. It encourages investment in growing the evidence-base of what works in a variety of contexts and across a range of approaches. It points to the importance of improving how research on GBV contributes to more accurate data on experiences of survivors. The findings also call for greater attention to the accessibility and uptake of knowledge produced on the issue.

We are pleased to share this report as a collectively created and shared resource for women's rights, gender equality and feminist practitioners, activists and advocates, academics and researchers, policymakers, private sector, UN agencies, philanthropies and other development partners, and all actors working to end violence against women and other forms of GBV in Africa and beyond. The ASRA aims to support the ongoing efforts of the many actors working to end GBV across the continent and could not have been realized without the expertise and time of many individuals who contributed to the research priority-setting exercise.

It is our hope that the ASRA will: contribute to advocacy for increased resourcing and shape research investments on ending GBV in the region based on the priorities identified; support the work of researchers from the region; inform more targeted and inclusive evidence generation practices; and encourage individuals and institutions to make the knowledge they produce and use more accessible to the range of actors working on the issue. Through collective and collaborative action, we can make progress towards an Africa free from gender-based violence.

Elizabeth Dartnall
Executive Director
The Sexual Violence Research Initiative

Dr. Maxime Houinato
Regional Director
UN Women East and Southern Africa

Acknowledgements

The Africa Shared Research Agenda (ASRA) for ending gender-based violence (GBV) is a collective offering to anyone working to advance gender equality, based on a process of continued learning, and the commitment of many diverse experts from and with a focus on Central, Eastern, West and Southern Africa.

Appreciation to the ASRA Stewardship Group who provided the vision, technical leadership to the process and preparation of the final report and related presentations: Sunita Caminha, Julienne Corboz, Elizabeth Dartnall, Arlette Mvondo, Priti Prabhughate, Mark Tomlinson, and earlier members Celia Zayas Espinosa and Angelica Pino. UN Women Regional Offices in East and Southern Africa and West and Central Africa and the SVRI are grateful for the valuable contributions and time commitment from the Regional Advisory Group to shape the ASRA and enable a more inclusive process of setting regional research priorities for ending GBV. Advisory Group Members included: Hala Al-Karib, Jennifer Amadi, Dr. Addo-Lartey Adolphina, Peter Dolo, Dr. Annabel Erulkar, Sarah Furrer, Natsnet Ghebrebrhan, Angelina Jial, Caroline Kabiru, Itumeleng Komanyane, Nicky Le Roux, Gracinda Mataveia, Abigail Matsvai, Therese Mekombe, Kalliopi Mingeirou, Diago Ndiaye, Dinnah Nabwire, Eugine Ngalim Nyuydine, Nobah Celine Kakou, Ritha Nyiratunga, Ohotuowo Ogbeche, Naile Salima, Mabel Sengendo, Dr. Doumbia Seydou, Chi-Chi Undie, and Joyce Wamoyi.
The Stewardship Group extends its thanks to Advisory Group member Ohotuwo Ogbeche and colleague Dr. Kristin Dunkle who conducted key informant interviews with lesbian, gay, bisexual, transgender, intersex and queer + (LGBTIQ+) people to enhance the diversity of perspectives in the process. The ASRA would not be possible without the Regional Expert Group, who offered research questions and contributed to identifying priorities, as well as extending the process to ensure a wider range of perspectives and voices.

Finally, an acknowledgement to the SVRI and UN Women East and Southern Africa and West and Central Africa staff, especially Dalila Aurelle Dossou, Philomena Mathiu and partners (Moon and Honey Design and the team at Ladbury Communications) who supported key aspects of the process behind the scenes.

A note on terminology

Previous SVRI priority-setting exercises have used the term violence against women (VAW). However, after consultation with diverse experts working on VAW and other forms of GBV, the Africa Shared Research Agenda (ASRA) is framed around 'gender-based violence'. This is due to the language 'violence against women and girls' excluding non-binary and gender-non-conforming people and people with other marginalised gender identities who are at high risk of experiencing GBV in Africa. The ASRA is committed to improving GBV prevention and response for populations at increased risk of violence who are underserved by current prevention and response initiatives in the region, and under-represented in GBV research. This includes but is not limited to lesbian, gay, bisexual, transgender, intersex and queer + (LGBTIQ+) people, women and girls with disabilities, women and girls living with HIV/AIDS, sex workers, migrants and adolescents. It is therefore important to ensure that language is inclusive, and SVRI and UN Women are committed to advancing the GBV prevention and response field in this regard. Some research questions in the ASRA priority-setting survey refer to 'women and girls in all their diversity', which is intended to include all individuals who identify as women, including transwomen. The language 'women and girls in all their diversity' has been retained to signal that this priority-setting exercise is not targeted at violence against all people, and it is recognised that, globally, men and boys are the main perpetrators of GBV. Reference to VAW is retained in this report when referring to previous SVRI priority-setting exercises where this terminology was used.

The ASRA focuses on Central, Eastern, West and Southern Africa, all sub-regions except Northern Africa. This is because the initial collaboration between SVRI and UN Women's two regional offices covered these geographical areas and so it was decided to start with these sub-regions. Although these sub-regions are sometimes termed as 'Sub-Saharan Africa,' the Regional Advisory Group advised to frame the Agenda for Africa given the colonial history of the term 'Sub-Saharan Africa'. UN Women and SVRI remain committed to collaborating around a similar process for Northern Africa, which can be developed from and complement the priorities identified under the ASRA.

Contents

Executive Summary

The Africa Shared Research Agenda (ASRA) for ending gender-based violence (GBV) is a set of research priority recommendations for the field, which have been identified through a rigorous, comprehensive and inclusive process that centres the opinions and voices of those for whom the research will serve. It is a unique and diligent approach that carries the spirit of collaboration and collective power essential for bringing about an end to GBV.

The ASRA follows the creation, back in 2021, of the Global Shared Research Agenda (GSRA), a collaboration between the Sexual Violence Research Initiative (SVRI) and the Equality Institute (EQI), with support from funding partners and the field. The GSRA presented the results of two years of evidence informed dialogues and discussion, which drew on the wisdom of the crowd to set research priorities for the next five years for fair, effective and relevant research on violence against women (VAW) in low and middle-income countries (LMICs). For the first time, the voices of practitioners, activists, and survivors were centred alongside academics and other specialists.

To identify research priorities, and ensure the process was fair and transparent, a method called the Child Health and Nutrition Research Initiative (CHNRI) was used, which considers the views of multiple stakeholders, not just technical experts, so all views are treated equally without some voices being more dominant than others. It does this by 'crowdsourcing' multiple opinions on an issue, surpassing the 'expert' judgement of one person.

The GSRA highlighted the need for research on interventions to prevent GBV and what works to inform programming and policy investments. Recognising the diverse contexts in which violence driven by gender inequality manifests across the continent of Africa, it became clear that it is important to localise the GSRA to identify priority research areas for the region. Women and adolescent girls in Central, Eastern, West and Southern Africa face significant rates of past-year physical and sexual violence, far higher than global estimates. Because of this, evidence building and knowledge creation for these sub-regions of Africa is essential for accelerating progress and accountability to women and girls in all their diversity through the provision of better, more effective programmes.

Taking the learning from the GSRA process, UN Women (via the Regional Offices in East and Southern Africa and West and Central Africa) and the Sexual Violence Research Initiative (SVRI) have worked with multiple stakeholders since May 2022 to co-create a set of shared regional research priorities for Africa to guide, systematise and attract funding for evidence building on GBV there.

Three groups were established to govern and guide the ASRA:

1. STEWARDSHIP GROUP: Key personnel working with SVRI and UN Women Regional Offices in East and Southern Africa and West and Central Africa.
2. ADVISORY GROUP: A group of 26 experts in the VAW/GBV prevention and response field, with a focus on Eastern, Central, West and Southern Africa, was identified by the Stewardship Group. The Advisory Group included people from across the sub-regions in Africa with diverse backgrounds, including advocacy, research and academic institutions, civil society organisations, philanthropic foundations and the UN system.
3. REGIONAL EXPERT GROUP: A group of approximately 400 regional experts from Eastern, Central, West and Southern Africa working on GBV prevention and response, including researchers, practitioners, women's rights and feminist organisations, activists and networks, funders, policymakers and others.

Guided by these structures, rich with diversity and passion for the field, the ASRA developed a seven-step participatory and iterative process, with many opportunities for feedback, check and challenge from the different governance and advisory group members. The first step involved a scoping review of the literature, to identify key gaps in the field that framed the priority-setting process and led to the identification of five key research domains:

DOMAIN 1: UNDERSTANDING GBV
DOMAIN 2: GBV RESPONSE INTERVENTIONS
DOMAIN 3: GBV PREVENTION INTERVENTIONS
DOMAIN 4: GBV RESPONSE AND PREVENTION AT SCALE
DOMAIN 5: MEASURES AND METHODOLOGIES

After the domains were established, the research questions were gathered using a two-phased approach an online question-gathering survey shared with the Stewardship Group, Advisory Group and Regional Expert Group, and online key informant interviews (KIIs) and focus group discussions (FGDs) with experts. A total of 508 questions were consolidated and prioritised by the Stewardship Group through this two-phased process, and reduced in number down to 49, with approximately ten questions per domain. The questions were then shared with the different governance groups through an online survey, where respondents were asked to rank the research questions in each domain, and overall. A total of 186 experts sent in their survey responses.

The top two ranked questions in each domain are:

DOMAIN 1: UNDERSTANDING GBV

1. What are the types and prevalence of GBV specifically affecting women and girls with disabilities, and women and girls living with HIV/AIDS, including sexual violence, early marriage, structural violence (e.g., denied access to health, education and legal services) and obstetric violence (e.g., forced contraception or sterilisation)?

2. Which social and gender norms, including notions of masculinity, influence (negatively or positively) the perpetration of GBV?

DOMAIN 2: GBV RESPONSE INTERVENTIONS

1. Is multisectoral GBV support and accompaniment (e.g., to healthcare, legal, educational and empowerment services) adaptable to different contexts and the needs and characteristics of victims/survivors, including those from marginalised populations?

2. What can different interpretations of 'justice' tell us about how to shape justice programmes for survivors of violence?

DOMAIN 3: GBV PREVENTION INTERVENTIONS

1. Which interventions working with religious and/or traditional leaders, or other social structures strongly imbued with patriarchy, have been most successful in preventing GBV and why?

2. Which local, Indigenous community interventions have been developed and used to prevent GBV, and how successful have they been?

DOMAIN 4: GBV RESPONSE AND PREVENTION AT SCALE

1. Which GBV prevention interventions, including social norms change and couples' interventions, can/should be scaled in low-resource and rural environments?

2. How can community-level infrastructure and community-based organisations supporting GBV prevention and response be strengthened, professionalised and taken to scale through government systems, particularly in low-resource settings?

DOMAIN 5: MEASURES AND METHODOLOGIES

1. How can we improve research methods to increase the accuracy of data and reporting of GBV?
2. How can we incorporate Indigenous knowledge production and practices in the conduct of high-quality ethical research on GBV?

The ASRA priority-setting process has revealed important learning about the research priorities to advance the GBV prevention and response field in Africa, and the approach through which these priorities were identified.

While there were some variations in research priorities according to experts' characteristics, overall, there was substantial agreement with the top five questions per domain. The process also noted the importance of being flexible, of paying attention to decolonising research and promoting a more inclusive research priority-setting process. The ASRA methodology had to be adaptive to this feedback.

Mixed-methods approaches are also valuable to priority-setting. Previous research agenda-setting processes have been quantitative exercises in line with the idea of 'crowdsourcing' the most prioritised research questions. By adding qualitative methods, a more inclusive process was created that enabled specific population sub-groups, especially those facing intersecting forms of discrimination, to engage more fully in the priority-setting.

Despite being inclusive and democratic, prioritisation exercises can also be biased. The ASRA process and approach intentionally elevated the voices of diverse GBV experts, including those working with marginalised groups. The CHNRI method attempts to minimise such bias through its crowd-sourcing approach; however, it is important to recognise that bias can still occur.

There is a fine balance between limiting bias and increasing participation. The move towards more participatory and inclusive research priority-setting exercises requires a balance of adjusting the methods to consider the political and power structures that are inherent to traditional research priority exercises, while also considering how to keep the essence of collecting 'the wisdom of the crowd'. For example, the standard CHNRI approach uses surveys to gather research questions and to score these questions, which assumes that all respondents will have equal access and understanding of engaging in such surveys. In reality, crafting a research question is not a simple exercise, and for GBV experts that do not have a research background, this can be challenging and dissuade participants from the process.

Research priorities should be interpreted against the existing evidence. Given that there have been several research priority-setting exercises related to GBV conducted since 2015, it is important to ensure that processes consider and learn from the findings of previous exercises.

As the ASRA experience demonstrates, completing a priority-setting exercise can be complex and time-consuming. But the process for priority-setting is as important as the methodology, especially the need to actively ensure diverse voices are included. Ultimately, the ASRA will only be effective if the findings are used. Funders should increase investment in high-quality and ethical research aligned with the ASRA; researchers should use the ASRA to inform their own research agendas; practitioners should use the agenda as a guide for partnerships with researchers on the evaluation of their interventions; and as a field together, the ASRA should be used as a reference to advocate for more and better research funding that addresses critical research and knowledge gaps in the field.

Introduction

Introduction

Gender-based violence (GBV) is a phenomenon deeply rooted in gender inequality, and is one of the most notable human rights violations within all societies requiring multisectoral, complex prevention efforts and responses across all levels of societies. While a global phenomenon, the prevalence and impact of GBV varies enormously at regional and sub-regional levels and among and between population groups. Low- and middle-income countries (LMICs) suffer the greatest burden of this extensive public health problem. Despite this, evidence on effective response and prevention programmes is predominantly concentrated in high-income countries (HICs), with LMICs left having to cope with significant knowledge gaps on how to address GBV.

Women and adolescent girls in the African region face significant rates of past-year physical and sexual violence. The WHO 2018 prevalence estimates show that 20% of ever-married/partnered women aged 15–49 in Sub-Saharan Africa have experienced physical and/or sexual intimate partner violence (IPV) in the past 12 months, the highest compared to other regions, while 33% have experienced violence in their lifetime, which is higher than the global estimate of 27%.[1] Although sub-national data is limited, specific populations are particularly at risk of violence due to discriminatory practices and marginalisation, including rural women, women with disabilities, women living with or affected by HIV, internally displaced, migrant and refugee women, LGBTIQ+ persons, elderly women, among others.

Given the high prevalence of GBV in the African region, evidence building and knowledge creation is essential for accelerating progress and accountability to women and girls in all their diversity through the provision of better, more effective programmes. Across the continent, there is a growing set of commitments by African Union Member States and non-state actors to contribute to preventing GBV and improving holistic responses to support survivors. While commitments have been supported by various investments and interventions, progress remains slow and most countries are not on track to reach the Sustainable Development Goal (SDG) 5 targets by 2030.[2] Evidence building on how to prevent GBV can help support countries in Africa to deliver on their SDG commitments. UN Women (via the Regional Offices in East and Southern Africa and West and Central Africa) and the Sexual Violence Research Initiative (SVRI) have worked with multiple stakeholders since May 2022, to co-create a set of shared regional research priorities for Africa to guide, systematise and attract funding for evidence building on GBV.

[1] WHO (World Health Organization) (2021). Violence Against Women Prevalence Estimates, 2018. Global, Regional and National Prevalence Estimates for Intimate Partner Violence against Women and Global and Regional Prevalence Estimates for Non-partner Sexual Violence against Women. Geneva: WHO, on behalf of the United Nations Inter-Agency Working Group on Violence Against Women Estimation and Data (United Nations Children's Fund, United Nations Population Fund, United Nations Office on Drugs and Crime, United Nations Statistics Division and UN Women).

[2] UN Women and UN DESA (2023). Progress on the Sustainable Development Goals: The gender snapshot 2023. UN Women and United Nations Department of Economic and Social Affairs. https://www.unwomen.org/en/digital-library/publications/2023/09/progress-on-the-sustainable-development-goals-the-gender-snapshot-2023

DECOLONISING GBV RESEARCH PRIORITY SETTING

Research on violence driven by gender inequality has a diversity and inclusion problem, with much of the research funding on GBV in LMICs being funnelled to and led by researchers in HICs – often the same researchers time and time again. To address this, decolonising GBV research is essential. It is a process of supporting research that is identified and done by researchers in LMICs in partnership with a diversity of practitioners and local non-governmental organisations (NGOs) and community-based organisations (CBOs), which places the voices, knowledge and stories of local communities and those most affected by GBV in the centre of the research process itself.

Using rigorous consultative review processes, the SVRI together with various partners and thought leaders has been working to identify, validate and disseminate research priorities through an adapted Child Health and Nutrition Research Initiative (CHNRI) approach. CHNRI is an example of a metrics-based priority-setting system that pools individual rankings of research priorities.[3] The CHNRI model is based on the philosophy of 'crowd-sourcing', which proposes that asking multiple people for their opinion on an issue will result in accurate predictions, surpassing the expert judgement of just one individual.[4] It was developed to respond to several challenges and limitations in priority-setting exercises, often set by a small group of academic researchers or experts with power, and not always based on a set of criteria to best guide decision-making.[5]

From 2020 to 2023, SVRI carried out three research priority-setting exercises on GBV: 1) Global Shared Research Agenda on VAW (GSRA);[6] 2) regional research priorities in Latin America and the Caribbean;[7] and 3) research priorities for the intersections between violence against children (VAC) and VAW.[8] The SVRI has also conducted a separate study on GBV research priority-setting to develop key insights into processes, methods and modalities, and how to strengthen these to create more inclusive priorities.

The GSRA highlighted the need for research on interventions to prevent GBV and on what works to inform programming and policy investments. Recognising the diverse contexts in which violence driven by gender inequality manifests across the continent of Africa, it became clear that it was important to localise the GSRA to identify priority research areas specific for Africa. This is particularly valuable to support commitments made as part of the Generation Equality Action Coalition on GBV, and inform upcoming policy developments, such as the African Union Convention on Ending Violence against Women and Girls, among other investments.

[3] WHO (2020). A systematic approach for undertaking a research priority-setting exercise. Guidance for WHO staff. World Health Organization.
[4] Surowiecki, J (2005). The Wisdom of Crowds. Why the Many Are Smarter Than the Few and How Collective Wisdom Shapes Business, Economies, Societies and Nations. Anchor Books. pp xv. ISBN 978-0-385-72170-7.
[5] Tomlinson, M, Chopra, M, Sanders, D, Bradshaw, D, Hendricks, M, Greenfield, D et al (2007). Setting priorities in child health research investments for South Africa. PLoS Med, 4(8): e259.
[7] https://www.svri.org/documents/global-shared-research-agenda-vawg
[7] https://www.svri.org/regional-priority-setting-LAC
[8] http://www.svri.org/documents/vac-prevention-research-priorities

CREATING MORE INCLUSIVE PROCESSES: LESSONS LEARNED FROM THE GLOBAL SHARED RESEARCH AGENDA

The adaptation of CHNRI for the co-creation of the GSRA on VAW involved six steps:

1. A scoping review of the literature on VAW in LMICs and development of domains
2. Generation of research questions within four domains by an Advisory Group
3. The consolidation of research questions
4. Scoring of research questions by a Global Expert Group and the Advisory Group according to three criteria (Applicability, Effectiveness and Equity)
5. Consultation and validation of the findings with the Advisory Group
6. Wide dissemination of the findings

The GSRA's adaptation of the CHNRI method greatly increased the diversity and number of voices included in the identification and prioritisation of research questions. However, several voices were still unintentionally excluded, particularly from certain regions and underserved groups, and groups marginalised from research investments. To address this, participants in the GSRA process proposed that future priority-setting efforts include a more tailored stakeholder engagement approach to ensure genuine support is given for the decolonisation of knowledge and centring of diverse voices in setting research priorities.

WHY, WHO, WHAT AND WHEN?

WHY?

Following the completion of the GSRA, SVRI recognised the need to validate and localise research priorities in LMICs at the regional level. Building on the lessons learned from the GSRA, UN Women and SVRI have been collaborating since May 2022 to facilitate the development of an Africa Shared Research Agenda (ASRA) for ending GBV. This has been done in partnership with GBV practitioners, advocates, academics/researchers, policymakers and development partners across the African region. The ASRA has supported the identification of research priorities on ending GBV in Africa over the next five to ten years, with a focus on Eastern, Central, West and Southern Africa.[9] The ASRA aims to contribute to the generation of research that is both priority-driven and carried out in such a way that it provides a sound practical and empirical basis for interventions, programmes, policy and advocacy on GBV.

WHO?

The ASRA research priority-setting exercise was guided by the following three groups:

1. STEWARDSHIP GROUP:
   Key personnel working with SVRI (Julienne Corboz, Elizabeth Dartnall, Ayesha Mago, Angelica Pino, Priti Prabhughate and Mark Tomlinson) and UN Women in East and Southern Africa and West and Central Africa Regional Offices (Sunita Caminha, Arlette Mvondo, Dalila Aurelle Dossou, and Celi Zayas Espinosa) oversaw the overall process, co-ordination, design, analysis, reporting and dissemination.

2. ADVISORY GROUP:
   A group of 26 experts in the VAW/GBV prevention and response field, with a focus on Eastern,

[9] Northern Africa was excluded from the ASRA, as it was decided that a separate agenda-setting process should be implemented for the Middle East and Northern Africa.

Central, West and Southern Africa, were identified by the Stewardship Group. The Advisory Group included people from across the sub-regions in Africa with diverse backgrounds, including advocacy, research and academic institutions, civil society organisations, foundations and the UN system. The Advisory Group provided expert technical input and advice on key steps in the regional research priority-setting exercise. The Stewardship Group convened the Advisory Group three times during the priority-setting process, with meetings and materials made available in both English and French to facilitate participation of all members.

3. REGIONAL EXPERT GROUP:
A group of approximately 400 regional experts from Eastern, Central, West and Southern Africa working on GBV prevention and response, including researchers, practitioners from women's rights and feminist organisations and networks, funders, policymakers and others. The Regional Expert Group was identified through the Advisory Group and Stewardship Group networks and was invited to learn about the ASRA process, contribute priority research questions and participate in the prioritisation of research questions. Expert group communications were made in Arabic, English, French, Portuguese and Kiswahili, to reach experts across main language groups in the region.

Stewardship Group
(SVRI and UN Women Africa)

Advisory Group
(26 VAWG/ GBV experts with a focus on Eastern, Central, West and Southern Africa)

Regional Expert Group
(400 VAWG/ GBV experts from or focused on Eastern, Central, West and Southern Africa)

WHAT AND WHEN?

The ASRA process involved seven steps, rather than the GSRA's six, adapting the approach based on lessons learned from previous priority-setting exercises.

1. SCOPING REVIEW (JUNE–JULY 2022):
The literature review from the GSRA was updated for Eastern, Central, West and Southern Africa, including recent literature published since the completion of the GSRA through May 2022, and literature related to harmful practices (specifically female genital mutilation and child marriage) and GBV in humanitarian and conflict contexts (which was excluded in the GSRA scoping review). The literature was organised into key thematic areas, and then reviewed and analysed against different categorisations.

2. DOMAINS AND CRITERIA (AUGUST–OCTOBER 2022):
The findings of the scoping review influenced the development of five research domains; 1) understanding GBV, 2) GBV response interventions, 3) GBV prevention interventions, 4) GBV response and prevention at scale, and 5) measures and methodologies. Research related to humanitarian and conflict settings was cross-cutting across all domains. The exercise intentionally separated prevention and response to identify priorities in each area, while noting that in application, prevention and response actions are a continuum for addressing GBV. The Advisory Group reviewed these domains and a consensus was reached about the areas around which the research questions would be structured. (See domain definitions on Page15)

The Stewardship Group then developed a longlist of ten CHNRI criteria for scoring/ranking research questions (see Annex A) and completed an internal survey to reduce the longlist down to five. These five criteria were then voted on by the Advisory Group, who prioritised the following three criteria:

1. ANSWERABILITY
(the research question can be answered and/or reach its objective within the proposed timeline);

2. APPLICABILITY
(the knowledge produced through the proposed research will be applied in policy and practice); and

3. MAXIMUM POTENTIAL IMPACT
(the research has theoretical potential to reduce GBV).

3. GENERATING RESEARCH QUESTIONS (SEPTEMBER 2022–MARCH 2023):
Research questions were gathered via two phased approaches an online question-gathering survey shared with the Stewardship Group, Advisory Group and Regional Expert Group, and online KIIs and FGDs with experts. The Stewardship Group also facilitated a webinar with the Advisory Group and Regional Expert Group, which included capacity strengthening and tips on how to craft a research question. A total of 508 questions were consolidated through this two-phased process, and subsequently prioritised by the Stewardship Group and reduced in number down to 49, with approximately ten questions per domain.

4. RANKING AND SCORING (MAY–JUNE 2023):
A multi-language online survey was developed to invite experts working on GBV across the region to rank the 49 questions in order of priority within each of the five domains and then prioritise the top five questions in each domain. The survey was available in Arabic, English, French, Portuguese and Kiswahili, and tested in each language by select experts from UN Women and the Advisory Group. The Stewardship Group, Advisory Group and Regional Expert Group were invited to complete the survey and share with their networks over a five-week period. In total, 186 responses were received.

5. DATA ANALYSIS (JUNE–AUGUST 2023):
The question-ranking data was cleaned and scores were produced for the ranked questions within each domain, and for the overarching top five ranked questions across all domains. Question rankings were disaggregated by key expert groups, including according to gender, professional role/type of organisation, sub-region of respondent, and their self-identification and/or work with any marginalised groups.

6. MAKING MEANING OF THE DATA (AUGUST 2023):
The Stewardship Group and Advisory Group reviewed the findings from the priority questions and noted key themes and lessons that were generated from the process and priorities identified.

7. PUBLICATION AND DISSEMINATION (OCTOBER 2023 ONWARD):
The ASRA will be made available in various formats (report, presentation and videos) in Arabic, French, English, Kiswahili, Portuguese and Spanish, to enable diverse experts around Africa and across regions to use the findings to inform their advocacy, research, policy and programming efforts.

DOMAIN DEFINITIONS

DOMAIN 1: UNDERSTANDING GBV

This domain includes research on the prevalence of different types of GBV, the causes of and risk and protective factors for GBV experience and perpetration, and the consequences and impacts of GBV, including health and psychosocial consequences, and economic and social impacts and costs of violence. GBV includes IPV (physical, sexual, emotional and economic IPV, and forms of controlling behaviour), by a current or former partner or spouse; non-partner sexual violence; sexual harassment; GBV in public and workplace settings; online or digital GBV; femicide; and harmful practices, such as female genital mutilation (FGM), so-called 'honour killing', and early marriage.

DOMAIN 2: GBV RESPONSE INTERVENTIONS

This domain includes research on, or the evaluation of, GBV response interventions aimed at mitigating or treating the consequences of GBV or providing services to victims/survivors. It refers to the development and/or evaluation of any intervention or programme aimed at responding to violence, and may include various types of evaluation, including process, formative and impact evaluations. It also includes wider research on the methodologies and approaches used to respond to GBV. GBV response interventions attempt to meet the needs of victims/survivors and seek to prevent further violence through provision of essential services, such as health (including mental health and psychosocial), justice, legal, police or social services (including economic and livelihood support), as well as the co-ordination and governance of and legal provisions for such services. GBV response interventions may also include Indigenous interventions, including local and community responses or less formal or institutionalised interventions.

DOMAIN 3: GBV PREVENTION INTERVENTIONS

This domain includes research on, or the evaluation of, GBV interventions or programmes aimed at preventing or reducing violence, and may include various types of evaluation, including process, formative and impact evaluations. The domain also includes research that supports the development of, or tests change pathways within, theories of change for violence prevention interventions, including how people (including with different characteristics) experience and respond to prevention interventions. GBV prevention interventions aim to reduce violence or prevent it from occurring in the first place and may use a wide range of approaches including: curriculum-based approaches; social and/or economic empowerment; social norms and behaviour change; community activism; or safe cities and public space interventions.

DOMAIN 4: GBV RESPONSE AND PREVENTION AT SCALE

This domain includes any research done to support GBV response and prevention at scale, and may include research on: social movements related to GBV prevention; lessons or experiences related to intervention adaptation; scaling up existing interventions; costing violence prevention or response interventions; the impact of laws and policies on GBV; or other forms of research that generate innovative solutions to making interventions more deliverable, affordable or sustainable. 'At scale' refers to understanding how positive or promising impacts of interventions can be scaled up to access larger populations, benefit more people and foster policy and programme development on a more sustainable basis, including generating knowledge about the costs of implementing GBV prevention and response interventions. This also includes the impact of developing, implementing and scaling up sustainable initiatives at national government level, including policies, frameworks and laws that aim to prevent and respond to GBV.

DOMAIN 5: MEASURES AND METHODOLOGIES

This domain includes new and innovative ways to measure GBV, hierarchies of knowledge, practice-based learning, difficult ethical issues, and methodologies for monitoring and evaluating GBV interventions. Measures and methodologies refers to the approaches and research instruments we use to measure the different forms of GBV, and their validity (e.g., are they measuring what they are supposed to), reliability (e.g., the consistency of how a person answers over time to the same question/scale) accuracy (e.g., how can we mitigate limitations in measuring accurate GBV prevalence data, including recall bias and social desirability bias), standardisation (e.g., can we use standardised methods and measures of GBV across studies).

HOW?

The ASRA process used a mixed-methods approach, including a scoping review of the literature, and both qualitative and quantitative methods.

SCOPING REVIEW

The ASRA scoping review extracted 158 papers on GBV in Africa from the GSRA literature review,[10] and updated and expanded the review to include a total of 474 papers by:

REVISING THE INCLUSION AND EXCLUSION CRITERIA. The scoping review for the GSRA focused mainly on intimate partner violence (IPV) and non-partner sexual violence (NPSV), and excluded literature on harmful practices, violence against women in workplace and educational settings, and violence against women in conflict and humanitarian settings. Given the particular relevance of these issues to the African continent, the ASRA scoping review was expanded to include literature on these thematic areas. Other modifications to inclusion criteria included:

- Literature in English, French and Portuguese;
- Literature published from November 2014 to May 2022;[11] and
- Literature reporting on various types of GBV, including IPV, NPSV, sexual harassment, femicide, female genital mutilation (FGM), early marriage.

REVISING THE SEARCH STRATEGY. In line with the revised inclusion criteria, search terms were expanded for types of GBV, and narrowed for geographical context (ie, countries in Central, Eastern, Southern and West Africa). Search terms were combined into a phrase including Boolean terms (AND, OR).

UPDATING THE GSRA LITERATURE SEARCH. The Stewardship Group applied the revised search strategy to the databases used in the GSRA to capture studies originally screened out due to exclusion criteria and more recent studies published. These databases included: the SVRI online repository, the Prevention Collaborative website, the What Works to Prevent Violence Against Women and Girls Global Programme website, Cochrane and Campbell, an evidence and gap map of systematic reviews on engaging men in sexual and reproductive health and rights (SRHR) according to the World Health Organization (WHO) SRHR outcomes, and 3ie's evidence and gap map on IPV prevention.

CONDUCTING A PUBMED SEARCH. The full, revised search strategy was applied to the PubMed database, including to the title and abstract fields.

REVIEWING GREY LITERATURE. The Stewardship Group applied the search strategy to the UN Women Africa Digital Library, to capture grey literature published by UN Women in the region, including research and evaluation reports.[12]

Abstracts of papers were reviewed and those papers in which GBV was a secondary rather than primary theme were screened out. The literature was then organised into key thematic areas based on the following framework:

1. Research to understand GBV (e.g., prevalence studies, perpetration studies and risk factors, causes and consequences of GBV);
2. Intervention research (including prevention and response interventions, and various types of evaluation of interventions, including process, formative and impact evaluations); and
3. Scale-up and costing research.

[10] For full details, see: SVRI & EQI (2021). Global shared research agenda for research on violence against women in low and middle-income countries. Sexual Violence Research Initiative, Pretoria.
[11] The GSRA scoping review included papers published from November 2014 to January 2020.
[12] https://africa.unwomen.org/en/digital-library-0

The literature was classified under these three thematic areas, and reviewed and analysed against four additional classifications of the literature:

1. Types of GBV;
2. Populations (e.g., women with disabilities, adolescents, LGBTIQ+ people, sex workers, pregnant or postpartum women, women living with HIV/AIDS);
3. Geographies (African sub-regions and countries); and
4. Methodologies.

QUESTION-GATHERING SURVEY

The Stewardship Group developed an online question-gathering survey in English and French, allowing up to three research questions to be entered per domain. The survey also allowed respondents to enter additional research questions they felt did not fit neatly under any of the five domains. The survey included demographic questions to capture the gender of respondents and the sub-region and country in which they were based.

Initial analysis of the questions generated identified gaps in questions from experts from West and Central Africa, French speakers, experts from Portuguese-speaking countries and those who had expertise on GBV against marginalised women, girls and gender-diverse persons. Gaps in questions related to conflict and humanitarian settings, and from researchers, were also identified. To address these gaps, the Stewardship Group targeted outreach to its networks, to encourage participation in the question-gathering survey. A total of 47 survey responses were received, 38 in English and nine in French.

QUALITATIVE METHODS

In order to ensure greater inclusion of voices from groups and sub-regions that were identified as under-represented in the question-gathering survey, the Stewardship Group incorporated qualitative methods into the question-gathering process.

The Stewardship Group facilitated four FGDs with experts in Africa working on GBV and representing four population or language groups, including those working: (1) in Francophone countries, (2) with women and girls with disabilities, (3) with women and girls living with HIV/AIDS and (4) with LGBTIQ+ people.[13] Experts predominantly comprised practitioners, civil society actors and researchers, and were invited to participate through the SVRI and UN Women networks in the region.

A basic tool was developed to explore four key issues or questions with experts:

1. Introduction to their work related to GBV;
2. Examples of research being conducted on GBV in their country or sub-region, or among the population group with whom they work;
3. What kind of research would advance their work; and
4. Important themes per domain that research could help to illuminate, using an interactive approach in Jamboard.

A total of 32 people participated in the four FGDs.

Only two experts participated in the LGBTIQ+ FGD, and the Stewardship Group received feedback from these experts that limited participation may have been due to the criminalisation of LGBTIQ+ people in some settings in Africa, and corresponding concerns about the FGD and its objectives. In order to ensure meaningful participation of LGBTIQ+ people in the ASRA question-gathering process, two experts working

[13] A fifth FGD for Portuguese speakers was planned but there was no attendance as it took place the week after Cyclone Freddy hit Mozambique.

on research and advocacy related to GBV against LGBTIQ+ people were contracted to conduct a series of KIIs with LGBTIQ+ experts. They conducted online interviews with 12 individuals, following the overarching objectives and tool used for the FGDs.

The qualitative data was used to develop research questions based on the gaps and needs identified by participating experts.

COMPILATION AND CONSOLIDATION OF QUESTIONS

The Stewardship Group compiled all research questions developed through the question-gathering survey and qualitative methods and, a total of 508 research questions were generated. The questions were then consolidated via a sequence of steps:

- First, questions within each domain were organised and classified into sub-themes (e.g., prevalence, risk factors or impacts) to remove duplicates, merge similar questions where relevant and remove questions that were incomprehensible or did not constitute actual research questions.[14] This step brought the number of research questions down to 154.
- Second, five members of the Stewardship Group entered a RAG (red, amber, green) rating for each question, based on three criteria selected by the Advisory Group (Answerability, Applicability and Maximum Potential Impact).

RAG ratings were converted into scores (red=0, amber=1, green=2) and summed across the five raters. Questions with an overall score of 7 or higher were retained.

Through this two-phased process, the Stewardship Group was able to reduce the number of questions down to 49: approximately ten questions per domain.

QUESTION-RANKING SURVEY

An online survey was developed to invite experts working on GBV across the region to rank the 49 selected research questions in order of priority within each of the five domains. The survey comprised the following main components:

- The survey began with a series of demographic questions, including gender, identification with any marginalised groups, expertise working with any marginalised groups, geographic area based in, geographic area working in, and professional role/type of organisation.
- For each domain, respondents were asked to rank the research questions in order of priority, thinking of the three criteria of Answerability, Applicability and Maximum Potential Impact. To mitigate ranking order effects, the order of research questions presented to respondents for each domain was randomised.
- For each domain, respondents were invited to enter any additional research questions they felt were a priority but not covered by the questions presented.
- The final survey item presented respondents' top five questions (the top-ranked question for each of the five domains) and asked them to rank these in order of priority.

The survey was available in Arabic, English, French, Portuguese and Kiswahili, and tested in each language by select experts from UN Women and the Advisory Group. The Stewardship Group, Advisory Group and

[14] There were a number of responses to the question-gathering survey that consisted of questions typically found in research tools (e.g., survey items) rather than research study questions per se. These were removed during the consolidation process.

Regional Expert Group were invited to complete the survey and share with their networks over a five-week period.

In total, 186 responses were received to the question-ranking survey. The dataset was downloaded in Excel and transferred to an SPSS database. Data was cleaned, coded and scored. For each respondent, research questions ranked within domains were scored by giving each ranking a corresponding score based on the number of questions in that domain. For example:

- In Domain 1, which had ten questions, the first-ranked question was given a score of 10, the fourth-ranked question was given a score of 7 and the tenth-ranked question was given a score of 1.
- In Domain 4, which had 11 questions, the first-ranked question was given a score of 11, the third-ranked question was given a score of 9 and the 11th-ranked question was given a score of 1.

The mean score for each research question within each domain was then calculated to determine the intra-domain ranking. When research questions in the same domain had the same mean score, the standard deviation was calculated, and the research question with the lower standard deviation (indicating smaller variation from the mean) was ranked more highly.

The overall ranking of research questions across all five domains was established through a similar procedure to intra-domain scores. For each survey respondent, the top five questions were scored by inverting rank number and score (e.g., the top-ranked question was given a score of 5 and the fifth-ranked question was given a score of 1). An overall score was then produced for each research question by summing individual respondent scores for that question.

What we found

What we found

SCOPING REVIEW FINDINGS

The scoping review noted a dominance of English literature and identified several gaps in research conducted in Africa, including geographical, thematic, population group and methodological gaps.

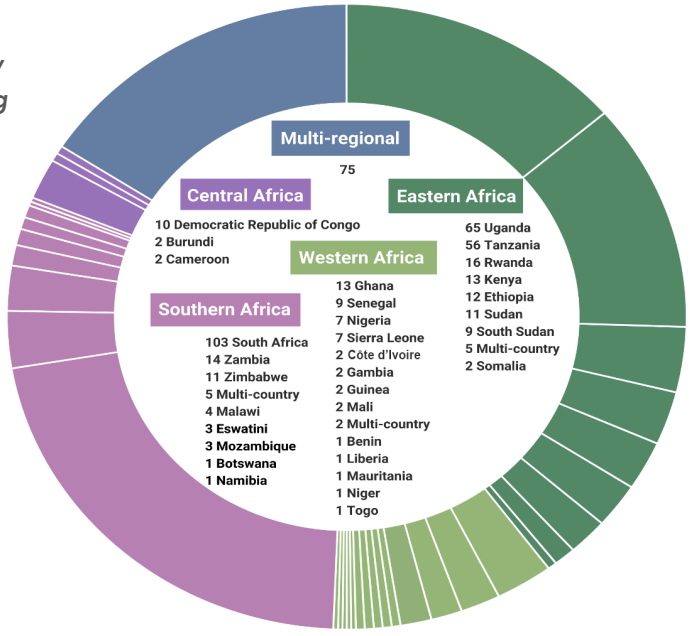
GEOGRAPHICAL GAPS

The majority of literature is concentrated in Eastern and Southern Africa, with fewer studies published in other sub-regions. Within regions, studies tend to be concentrated in particular countries (see Figure 1).

- In Southern Africa, almost three quarters of papers reviewed were from South Africa, with the remaining literature mainly based on studies conducted in Zambia and Zimbabwe (although largely based on the same intervention in Zambia).
- In Eastern Africa, the geographical coverage of papers was more spread out, although approximately a third of papers were based on research conducted in Uganda and a third in Tanzania (in both cases based on diverse interventions and studies). Rwanda was also well represented, although almost all of these studies were from the same prevention intervention.
- In West Africa, a quarter of papers were based on studies conducted in Ghana, albeit mostly from the same intervention. The majority of other studies in this sub-region were concentrated in Senegal, Nigeria and Sierra Leone.
- Almost three quarters of papers based on research conducted in Central Africa were from the Democratic Republic of Congo.

Research across all sub-regions is more concentrated in middle-income countries, with much less research in GBV being conducted in low-income countries. Some countries in Africa were not represented in the literature review at all within individual studies,[15] although a few were integrated into multi-country studies.

Figure 1: Sub-regional and country representation in scoping review papers



[15] This included: Comoros, Djibouti, Eritrea, Madagascar, Mauritius, Mayotte, Réunion and the Seychelles in Eastern Africa; Central African Republic, Chad, Congo, Equatorial Guinea, Gabon and São Tomé and Principe in Central Africa; Burkina Faso, Cape Verde and Guinea-Bissau in West Africa; and Angola and Lesotho in Southern Africa.

THEMATIC GAPS

Almost two third of the papers reviewed (n=304) related to understanding GBV.

- Of these papers, two thirds were related to associations between GBV and other variables, mainly papers exploring multiple correlates (e.g., individual, household, relationship and partner characteristics). The vast majority of these papers examined risk factors for IPV or NPSV. Very few papers explored protective factors, and few papers focused on social norms as drivers of GBV.
- Prevalence studies were also common, but these were also primarily focused on measuring IPV, particularly physical and sexual IPV, and NPSV.
- There were very few papers reporting on the prevalence of and factors associated with other types of GBV, including femicide or intimate partner homicide, sexual harassment and technology-facilitated GBV.

Almost one third of papers reviewed (n=143) were related to GBV interventions. Of these, nearly three quarters (n=104) focused on prevention interventions.

- Most of the prevention papers reviewed (two thirds) targeted IPV and comprised community mobilisation interventions, combined economic and social empowerment interventions, and group-based curricula interventions (mainly with couples). The review did not identify any prevention interventions targeting technology-facilitated GBV or sexual harassment.
- Many prevention papers reviewed were based on the same intervention. For example, most of the community mobilisation intervention papers were based on SASA!, Sonke Gender Justice's CHANGE model and the Rural Response System; most of the group-based curriculum intervention papers were based on the Indashyikirwa couples curriculum; and most of the combined economic and social empowerment intervention papers were based on Stepping Stones' Creating Futures.
- Just over a third of papers on prevention evaluated interventions that integrate IPV prevention into HIV/AIDS programming, predominantly interventions drawing from economic and social empowerment interventions or community mobilisation interventions.
- Nineteen prevention papers focused on or addressed men's or adolescent boys' perpetration of violence (although many of these were from the same studies).
- Only four prevention papers focused on interventions in humanitarian settings.
- Most FGM prevention intervention papers reviewed drew from community mobilisation or campaign approaches, and early marriage prevention papers drew from different approaches including community mobilisation, school-based interventions or girls' empowerment or life skills programming.
- Only two prevention interventions overall drew from traditional community or Indigenous approaches, one aiming to reduce early marriage and the other FGM and early marriage.

Just over one quarter of intervention papers reviewed (n=39) related to response interventions.

- Just over half were related to health (including mental health and psychosocial support), particularly the former.
- Ten papers related to GBV response were based on studies implemented in humanitarian, conflict or post-conflict settings. Most of these were implemented in countries in Eastern Africa, with very little or no coverage of interventions in other sub-regions also affected by conflict or humanitarian emergencies, including Central or West Africa.
- There were very few papers (n=4) targeting legal or justice response, two of which were based on studies of multisectoral response interventions, and only one paper focused on traditional community or Indigenous approaches to GBV response.

The scoping review found few studies (n=14) related to scaling GBV response or prevention. Except for one health intervention study, all the papers focused on prevention, particularly studies on the costs of GBV prevention interventions or scaling up early marriage prevention interventions. The scoping review identified only one paper on social movements.

Sixteen papers were focused on understanding measures and methodologies used in GBV research and evaluation. These were mainly related to the development of social norm measures, ethical research approaches in conflict and humanitarian settings, and how to reduce discrepancies and improve accuracy in measures of GBV prevalence that are prone to bias.

POPULATION GAPS

Just over one third of papers reviewed (n=170) focused on specific population groups, with the remaining papers sampling women or men in the general population or in clinical samples.

- More than half of the papers based on studies targeting specific populations sampled adolescents and young people, suggesting that there is a growing emphasis on this population group in the GBV field in Africa.

- A smaller proportion of papers were based on research sampling women living with HIV/AIDS, pregnant or postpartum women, refugee women or sex workers. Very few papers (n=5) targeted people with disabilities and these were mainly secondary analyses or evidence reviews of other studies. Only two papers focused on LGBTIQ+ people.

METHODOLOGICAL GAPS

Forty-two per cent of prevention papers were based on quantitative methods, 34% on qualitative methods, 17% on mixed methods and 7% on evidence reviews (only two of which were systematic).

- Most of the prevention intervention papers reviewed, across quantitative and mixed methods, drew from experimental, quasi-experimental and longitudinal approaches. Half of the papers reporting only qualitative data were also embedded in quasi-experimental or experimental approaches. However, there were limitations with many of these studies, including likely contamination in control or comparison groups and bias in reporting of IPV, particularly in intervention groups at endline.
- Despite the large number of longitudinal and experimental evaluations of prevention interventions, few of these had follow-up data collection one year or more post-endline to assess sustainability of outcome and impact.
- Papers attempting to understand GBV were largely based on cross-sectional studies seeking to explore associations, including risk or protective factors, which cannot establish causality or temporality of associations.
- Only two prevention intervention papers focused on women with disabilities; however, these were secondary analyses of larger experimental studies targeting reduction in IPV, and so did not include specific types of violence against people with disabilities. Furthermore, small sample sizes of people with disabilities limited analysis.
- There were few systematic reviews of studies in the African region (n=10). The systematic reviews covered a range of topics, mainly on prevalence of and factors associated with GBV (predominantly IPV) and interventions, particularly those aiming to prevent IPV.
- There was a lack of primary population-based studies, with many papers reviewed comprising secondary analysis of existing datasets, particularly the Demographic and Health Survey.

SURVEY FINDINGS

This section of the report presents the findings related to the research question-ranking survey completed by the Regional Advisory Group (inclusive of Stewardship Group) and Regional Expert Group.

OVERVIEW OF SURVEY RESPONDENTS

The question-ranking survey was completed by 186 people, including 68% female (n=126), 29% male (n=53) and 3% non-binary (n=6) respondents.[16] The majority of respondents (76%) completed the survey in English, with a small proportion of respondents completing the survey in French (17%), Portuguese (3%) and Kiswahili (3%). No respondents completed the survey in Arabic.

Almost half of survey respondents reside in Eastern Africa, which is the most populated sub-region in Africa (Figure 2). Approximately one in five respondents resides in Southern Africa or West Africa, which is disproportionate to the population proportions in these sub-regions. The African sub-region least represented in the survey is Central Africa (13%), although this in line with the population size of this sub-region. A small number of respondents (2%, n=3) reside in an HIC. A similar pattern was observed for the sub-regions in which respondents' work is concentrated.

Figure 2: % of survey respondents per sub-region of residence or focus of work

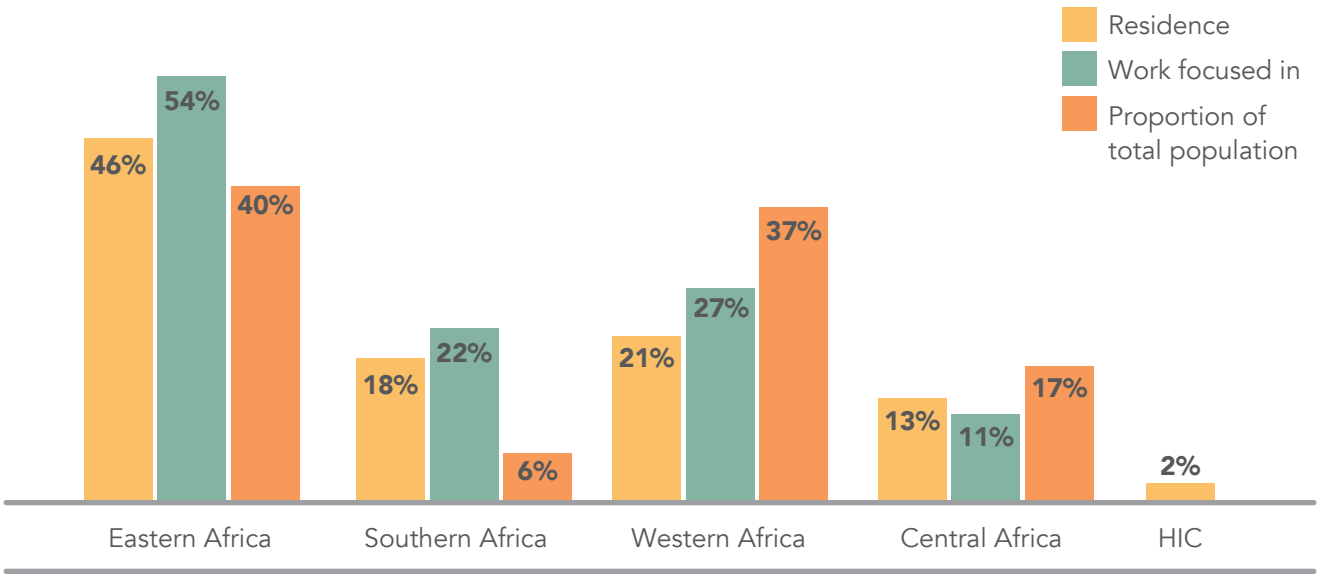


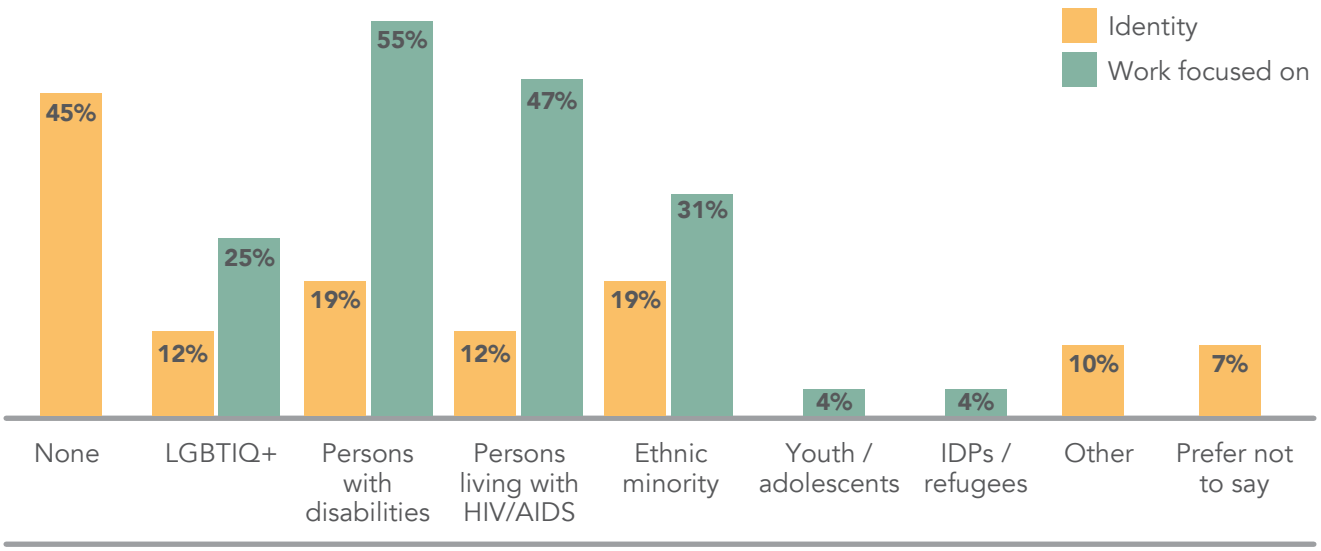
Figure 3 depicts the countries in which survey respondents reside, showing a mixture of low- and middle-income countries. In Eastern Africa, responses were mainly concentrated in Kenya and Uganda, with Somalia and Tanzania also well represented. In West Africa, the largest number of responses came from those residing in Nigeria, followed by Liberia and Côte d'Ivoire. In Southern Africa, the majority of responses came from experts in Zimbabwe and South Africa. Finally, in Central Africa the largest number of responses came from Cameroon, followed by Burundi.

[16] One respondent chose not to answer the survey question about gender.

Figure 3: Number of survey respondents per country of residence (in Africa)

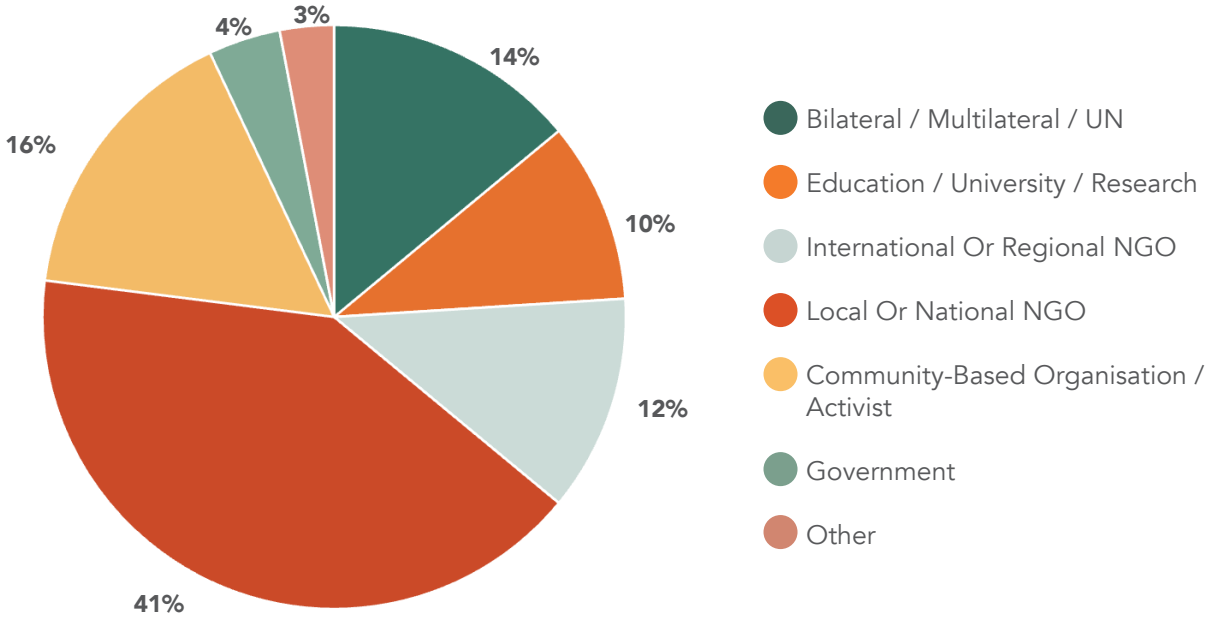
The question-ranking survey asked respondents whether they identified with any particular population group, and whether their work on GBV focused on any of these groups. About half of all respondents did not identify with any specific population group or preferred not to say if they did, with small proportions identifying as LGBTIQ+, having a disability, living with HIV/AIDS or being an ethnic minority (see Figure 4). Notably, many more respondents reported that their work focused on GBV against these population groups.

Figure 4: % of survey respondents identifying with or focusing work on different population groups



A large proportion of survey respondents (41%) reported that they work for a local or national non-governmental organisation (NGO), with smaller proportions of respondents working with other types of organisations (see Figure 5). It is notable that approximately seven in ten respondents work for an NGO, whether at the community, national or regional level. There were few respondents from a research or university organisation (10%, n=18) or government organisations (4%, n=8). The distribution of respondents from different professional backgrounds varied slightly across regional contexts. For example, the proportion of respondents from a bilateral, multilateral or UN background is slightly higher in Eastern Africa (18%) than in other sub-regions. Furthermore, between 35% and 40% of respondents in Eastern, Southern and West Africa work for a local or national NGO, compared with 70% of respondents in Central Africa. Finally, while there was a roughly even spread of respondents from a research or university organisation across most sub-regions, none was represented in Central Africa.

Figure 5: % of survey respondents according to professional/organisational background



OVERALL QUESTION RANKINGS

This section presents the top ten ranked questions overall. These rankings were compiled by asking survey respondents to rank their top five questions overall from their top-ranked questions from each domain. The full list of ranked questions overall is included in Annex B.

The top ten ranked research questions overall are presented in Table 1. The first- and sixth-ranked questions belong to Domain 1, Understanding GBV, and are related to the types, characteristics and prevalence of GBV against those in different population groups, including LGBTIQ+ people and women and girls with disabilities or living with HIV/AIDS. This suggests that understanding GBV against marginalised populations in Africa, including under-researched forms of GBV, specific types of GBV experienced by these populations and the perpetrators of these types of GBV, is a strong priority.

The second- and third-ranked questions, from Domains 3 and 4 respectively, are associated with GBV prevention, with an emphasis on working with religious and traditional leaders, and through social norms change and couples interventions at scale. This suggests that research on prevention is an important priority in Africa, particularly prevention that draws from socio-cultural and normative structures.

The fourth-ranked question, from Domain 2, is related to interpretations of justice in GBV response. This was one of the few questions in Domain 2 related to justice, with other questions focusing more on health, humanitarian response, multisectoral response or GBV response more generically. The other Domain 2 question to make it into the top ten, in ninth place, was related to local, Indigenous interventions to respond to GBV in Africa.

The fifth-ranked question was from Domain 5 and focuses on methods to increase the accuracy of data and reporting on GBV, which was also identified as a key gap in the scoping review. It is useful to note that this was one of the few more generalised questions in Domain 5, with other questions much more directly targeting specific types of method or modality (e.g., Indigenous knowledge production, digital technologies), thematic areas (e.g., social norms) or population groups (e.g., LGBTIQ+ people, women and girls with disabilities). The tenth-ranked question overall also belongs to Domain 5 and focuses on safe and effective approaches for measuring GBV against LGBTIQ+ people.

Two additional questions from Domain 4, GBV response and prevention at scale, made it into the top ten (ranked seventh and eighth), focusing on cost-effectiveness, sustainability and scalability through government systems.

Table 1: Top ten ranked research questions

OVERALL RANK	RESEARCH QUESTION	DOMAIN
1	What are the types and prevalence of GBV specifically affecting women and girls with disabilities, and women and girls living with HIV/AIDS, including sexual violence, early marriage, structural violence (eg, denied access to health, education and legal services) and obstetric violence (eg, forced contraception or sterilisation)?	Understanding GBV
2	Which interventions working with religious and/or traditional leaders, or other social structures strongly imbued with patriarchy, have been most successful in preventing GBV and why?	GBV prevention interventions
3	Which GBV prevention interventions, including social norms change and couples interventions, can/should be scaled in low-resource and rural environments?	GBV response and prevention at scale
4	What can different interpretations of 'justice' tell us about how to shape justice programmes for survivors of violence?	GBV response interventions
5	How can we improve research methods to increase the accuracy of data and reporting of GBV?	Measures and methodologies
6	Which types of GBV are most prevalent in Africa, including among key populations (eg, adolescents, older women, migrants, displaced persons, domestic workers, women and girls with disabilities, LGBTIQ+ people, sex workers, women and girls living with HIV/AIDS), and who are the different perpetrators of these types of violence?	Understanding GBV
7	What are the most cost-effective and sustainable GBV prevention and response interventions in the African region?	GBV response and prevention at scale
8	How can community-level infrastructure and community-based organisations supporting GBV prevention and response be strengthened, professionalised and taken to scale through government systems, particularly in low-resource settings?	GBV response and prevention at scale
9	What are the most successful and sustainable local, indigenous community interventions to respond to GBV in Africa?	GBV response interventions
10	What are the most effective and safest strategies, methods and tools for reaching and measuring GBV against LGBTIQ+ people, including in population-based and general population surveys, especially in settings where LGBTIQ+ relationships and identities are criminalised and persecuted?	Measures and methodologies

INTRA-DOMAIN RANKINGS

This section of the report presents the top five research questions per domain, including disaggregated by expert characteristics. The full list of ranked questions per domain is included in Annex C.

DOMAIN 1: UNDERSTANDING GBV

The top five ranked questions in Domain 1, Understanding GBV, are presented in Table 2. As per the top-ranked question overall, the top-ranked question in Domain 1 is:

> ***What are the types and prevalence of GBV specifically affecting women and girls with disabilities, and women and girls living with HIV/AIDS, including sexual violence, early marriage, structural violence (e.g., denied access to health, education and legal services) and obstetric violence (e.g., forced contraception or sterilisation)?***

The third-ranked question is also associated with the prevalence of different forms of GBV against those in marginalised groups, specifically online forms of GBV. The three remaining Domain 1 research questions in the top five are related to causes, risk and protective factors for GBV, including social and gender norms that influence perpetration, general factors driving perpetration and victimisation, and the intersection between climate change and economic collapse as a driver of GBV.

Table 2: Top five questions in Domain 1

RANK	QUESTION
1	What are the types and prevalence of GBV specifically affecting women and girls with disabilities, and women and girls living with HIV/AIDS, including sexual violence, early marriage, structural violence (eg, denied access to health, education and legal services) and obstetric violence (eg, forced contraception or sterilisation)?
2	Which social and gender norms, including notions of masculinity, influence (negatively or positively) the perpetration of GBV?
3	What are the prevalence, risk and protective factors for online GBV in Africa (eg, blackmail, cyberbullying, revenge porn, harassment, doxing, catfishing), including among marginalised groups and those facing intersecting forms of discrimination, and what are the linkages and differences between online and offline GBV?
4	What are the causes, risk and protective factors for perpetration and victimisation of different forms of GBV in different settings and sub-regions?
5	What are the linkages between climate change, economic collapse and GBV?

The top three ranked questions in Domain 1 were the same for respondents who identified as male, female and non-binary, and for those who identified as LGBTIQ+, having a disability or living with HIV/AIDS, with some minor variations in the order of ranking within the top three. There were some wider variations in the fourth- and fifth-ranked questions, according to experts' gender and identification with different characteristics. In particular, non-binary and LGBTIQ+ respondents and those with a disability prioritised additional Domain 1 questions that specifically relate to marginalised groups, including specific types of

violence experienced by these groups and the perpetrators of violence against these groups.

The top five ranked questions in Domain 1 remained consistent across African sub-regions in which experts live, with only some minor variations in the order of ranking. However, there were larger variations for experts in HICs, who ranked only two of the top questions overall in their top five, including the question about climate change (ranked in first place) and the question about online GBV (ranked in fourth place).[17] HIC experts ranked three additional questions that did not fall within the top five overall. For instance, they ranked the question 'How do traditional, cultural and religious practices and institutions influence social norms related to GBV, including the acceptability, justification and normalisation of GBV?' in second place.

The top five ranked questions in Domain 1 remained largely consistent across experts from different professional/organisational backgrounds, albeit with varying ranking order. For example, the question about social and gender norms influencing perpetration of GBV ranked first among university/research experts, and the question about prevalence and factors associated with online violence ranked first for government experts. Several questions not ranked within the top five overall fell into the top five for some professional/organisational expert groups. For example, the question about social and gender norms (including notions of masculinity) influencing perpetration was not ranked in the top five for government stakeholders, who instead ranked in fifth place the question about types and prevalence of GBV specifically targeting members of LGBTIQ+ communities. While the question about GBV and climate change was highly ranked for international and regional NGOs and government stakeholders, it was ranked in eighth place among local/national NGO experts. Finally, the question about how traditional and religious practices and institutions influence social norms related to GBV was highly ranked among international/regional and bilateral/multilateral/UN agency experts, but was very lowly ranked among government and local/national NGO experts.

Non-binary respondents ranked the following question in fourth place:

What are the types and prevalence of GBV that specifically target members of LGBTIQ+ communities (non-consensual outing or blackmail, targeted rape, starvation, forced isolation, conversion therapy, intersex genital mutilation, etc), and how do these vary based on identity (eg, related to sexual orientation, gender identity and expression, and sex characteristics, disability, HIV status, engagement in sex work)?

Non-binary and LGBTIQ+ respondents, and respondents with a disability, ranked the following question in fifth place:

Which types of GBV are most prevalent in Africa, including among key populations (eg, adolescents, older women, migrants, displaced persons, domestic workers, women and girls with disabilities, LGBTIQ+ people, sex workers, women and girls living with HIV/AIDS), and who are the different perpetrators of these types of violence?

International/regional NGO experts and bilateral/multilateral /UN agency experts ranked third and fourth (respectively) the questions:

How do traditional, cultural and religious practices and institutions influence social norms related to GBV, including the acceptability, justification and normalisation of GBV?

Local/national NGO experts ranked fifth the question:

Which risk factors for intimate partner violence amplify the risks of femicide, and how do these differ across countries?

[17] These findings should be read with caution, given only three experts in HICs responded to the question-ranking survey.

Experts proposed several additional research priorities in Domain 1, either through the original question-gathering process (in which a series of questions were screened out during the consolidation process) or in the question-ranking survey (when asked to indicate whether there was another research question belonging to Domain 1 that was not captured within the ten questions presented). Additional research questions proposed in both processes are presented in Annex D and Annex E respectively. Common themes include:

- Characteristics and prevalence of less-researched types of GBV, including harmful practices such as FGM, breast ironing, dowry-related violence and violence against widows (e.g., forced isolation during grieving rituals and forced marriage to their husbands' male family members); politically motivated GBV; and sexual harassment and other types of violence in workplace and educational settings, including in higher education.
- Risk factors for GBV, including economic risk factors (e.g., poverty and lack of access to livelihoods), marriage practices (e.g., customary marriages and dowry/bride price) and structural drivers (e.g., colonialism, structural inequality and religion).
- Moving away from framing tradition and culture only in terms of risk, and exploring traditional, cultural practices and beliefs in African settings that are protective of GBV.
- Long-term impacts of GBV, including social and economic costs of GBV, and the impacts on work and educational outcomes.
- The motivations and experiences of perpetrators, including how and why women, particularly older women, may perpetrate GBV, including harmful practices such as FGM.
- GBV in humanitarian and conflict settings, including the most prevalent types of GBV, the impacts of conflict and emergency on GBV, the intersections of GBV and internal displacement and the humanitarian/peace nexus.

DOMAIN 2: GBV RESPONSE INTERVENTIONS

The top five ranked questions in Domain 2, GBV response interventions, are presented in Table 3.

The top-ranked question in Domain 2 is:

> ***Is multisectoral GBV support and accompaniment (e.g., to healthcare, legal, educational and empowerment services) adaptable to different contexts and the needs and characteristics of victims/survivors, including those from marginalised populations?***

The research question about interpretations of justice was ranked second within this domain,[18] and the third-ranked question is related to sanctions and incentives for dissuading practitioners of FGM. The fourth and fifth ranked questions are related, respectively, to the survivor-centred capacity of GBV duty bearers and service providers to provide services to marginalised populations, and health and psychosocial support for GBV survivors in hard-to-reach populations and complex settings, including rural areas or humanitarian and conflict settings.

[18] This question was the first-ranked Domain 2 question in the overall ranking. This means that while the question about multisectoral GBV support garnered the highest-ranking score within Domain 2 across all survey respondents, people who ranked highly the question about interpretations of justice within Domain 2 were more likely to rank this question highest in their top five overall across all five domains.

Table 3: Top five questions in Domain 2

RANK	QUESTION
1	Is multisectoral GBV support and accompaniment (e.g., to healthcare, legal, educational and empowerment services) adaptable to different contexts and the needs and characteristics of victims/survivors, including those from marginalised populations?
2	What can different interpretations of 'justice' tell us about how to shape justice programmes for survivors of violence?
3	Which approaches are most effective in convincing those who practise the circumcision of girls to abandon the practice, including sanctions (e.g., judicial measures) and incentives (e.g., alternative income-generating activities)?
4	What is the knowledge and capacity among duty bearers and service providers to provide survivor-centred GBV protection and response to marginalised populations (e.g., LGBTIQ+ people, women and girls with disabilities, women and girls living with HIV/AIDS) and how can their capacity be strengthened to provide equitable services and prevent harm?
5	Which interventions are most effective in providing quality health and psychosocial support to victims/survivors of violence, including hard-to-reach populations in remote or rural areas or settings affected by humanitarian emergency or armed conflict?

There were some minor variations in the top five ranked questions in Domain 2, and these were largely consistent across different types of expert characteristic, with three main trends observed:

1. Male and female experts' top five questions were the same, albeit with some small ranking differences. Non-binary experts also included four out of the top five questions overall in their top five, excluding the question about health and psychosocial support. Non-binary experts ranked the question about capacity of duty bearers and service providers in first place and also ranked the following question in second place:

   What are the most effective strategies for ensuring that LGBTIQ+ people, women and girls with disabilities, and others who are regularly excluded from existing emergency shelters and other mechanisms, are included in humanitarian and emergency responses, including GBV response and prevention efforts?

   A similar pattern was also observed for experts who identified themselves as LGBTIQ+, having a disability and living with HIV/AIDS, experts based in Southern and Central Africa, and experts working for local or national NGOs, all who additionally ranked in the top five the question about strategies for ensuring the inclusion of marginalised groups in emergency shelters.

2. There were some regional variations in the ranking of the Domain 2 question about sanctions and incentives related to FGM, which ranked third among experts in Eastern and West Africa, second among experts in Central Africa and first among HIC experts. This question was not, however, ranked in the top five for experts based in Southern Africa.

3. HIC experts, and experts working for bilateral/multilateral/UN agencies or in university education/research, ranked the question 'What are the most successful and sustainable local, Indigenous community interventions to respond to GBV in Africa?' in second place, although this question was ranked eighth overall by experts in all African sub-regions, and in ninth or tenth place among experts working in international, regional, national or local NGOs, community-based organisations and governments.

Experts identified additional priority research questions (see Annex D for questions generated in the question-gathering process but screened out, and Annex E for additional questions proposed in the question-ranking survey). Additional gaps in evidence proposed include the following.

- Legal and justice response to GBV, which was also identified as a significant gap in the scoping review.
- How to support reintegration of survivors back into their communities through strategies that reduce stigma and discrimination.
- GBV response in humanitarian and conflict settings, including the effectiveness of interventions designed for more stable settings.
- The role of civil society and governments in GBV response, including how to strengthen multi-stakeholder engagement to respond to GBV, and localisation of women-led organisations in GBV response.
- The experiences of survivors who access interventions and the barriers to them doing so.
- Entry points and effective interventions for increasing reporting of GBV and referrals from communities to formal services, particularly in rural settings and in locations where GBV is highly stigmatised.

DOMAIN 3: GBV PREVENTION INTERVENTIONS

The top five ranked questions in Domain 3, GBV prevention interventions, are presented in Table 4. The top-ranked question in Domain 3 was:

> ***Which interventions working with religious and/or traditional leaders, or other social structures strongly imbued with patriarchy, have been most successful in preventing GBV and why?***

The second-ranked question in Domain 3 is related to the success of local, Indigenous community prevention interventions, and the third-ranked question is related to modalities used in GBV prevention and behaviour change programming, including technology and mass communication. The fourth- and fifth-ranked questions focus on LGBTIQ+ populations, including adapting successful partner and non-partner violence interventions in university settings for LGBTIQ+ people, and prevention interventions targeting medical, psychological and spiritual/religious GBV against LGBTIQ+ people.

Table 4: Top five questions in Domain 3

RANK	QUESTION
1	Which interventions working with religious and/or traditional leaders, or other social structures strongly imbued with patriarchy, have been most successful in preventing GBV and why?
2	Which local, Indigenous community interventions have been developed and used to prevent GBV, and how successful have they been?
3	What is the impact of technology and mass communication, including media, social media and online modalities, on GBV prevention and behaviour change, including in rural and other hard-to-reach settings?
4	Which types of intimate partner violence and non-partner sexual violence prevention intervention are most effective in reaching women and girls in university environments in Africa, and how could these be adapted for LGBTIQ+ students (noting contexts of criminalisation)?
5	What are the best strategies for discouraging and preventing medical, psychological, and spiritual/religious GBV against LGBTIQ+ people in the forms of conversion practices, exorcism, and all other harmful efforts to change sexual orientation and/or gender identity?

There was substantial consistency in the top-ranked questions across expert groups, particularly for the top three questions. The question about interventions working with religious or traditional leaders or those from other patriarchal social structures was ranked first by experts across all different groups. Furthermore, the question about local, community Indigenous interventions was ranked either second or third by almost all expert groups, except for those based in Central Africa, and experts working in university/research settings or for the government, who all ranked it in fourth place. This confirms that interventions that engage local, traditional leaders or forms of prevention are seen as a priority in the field in Africa. The question about the impact of technology and mass communication on GBV prevention ranked in the top five across all expert groups except for experts based in HICs, suggesting that technological modalities are seen as important to the field at this moment.

There was more variation across expert groups in the fourth- and fifth-ranked questions in Domain 3, which specifically target LGBTIQ+ people; however, these variations do not necessarily mean that thematic issues affecting LGBTIQ+ people are not being prioritised. For example, the question about adapting university prevention interventions for LGBTIQ+ people was not ranked in the top five among experts identifying their gender as non-binary. Furthermore, the question about preventing medical, psychological and spiritual/religious GBV against LGBTIQ+ people fell out of the top five ranking for male experts, experts living with HIV/AIDS, experts based in Eastern, Southern and West Africa, and experts working in bilateral/multilateral/UN agencies, university/research settings or community-based organisations. However, the question 'Which proven strategies for preventing intimate partner violence in male-female relationships, including couple, household and community interventions, could be adapted for same-gender couples, noting contexts of criminalisation, in Africa?' was ranked fifth among male experts, experts identifying as non-binary or living with HIV/AIDS, experts living in Eastern or West Africa, and experts working in community-based organisations.

Other variations in ranking were mainly related to new questions being brought up into the top five for specific expert groups, including experts based in HICs, and those working for bilateral/multilateral/UN agencies or university/research experts.

- The question 'Which interventions work to prevent GBV, including intimate partner violence and non-partner sexual violence, against women and girls with disabilities in all their diversity?' ranked second among HIC experts and fifth among experts based in Southern Africa.
- The question 'Which prevention interventions can address multiple forms of GBV, including different forms of intimate partner violence and non-partner sexual violence?' ranked fourth among experts working for bilateral/multilateral/UN agencies.
- The question 'What are the characteristics and motivations of the perpetrators of GBV, and which prevention interventions are most successful in shifting their attitudes and behaviours, including those in the highest risk categories for perpetration?' ranked second among university/research experts.

Additional questions related to Domain 3 proposed by experts during the question-gathering process are listed in Annex D, and additional questions proposed in the question-ranking survey are listed in Annex E. Many experts shared generic questions about prevention, such as which interventions can significantly reduce GBV or which interventions can reduce multiple forms of GBV, including harmful practices. Many other proposed questions were similar to the ten research questions included in Domain 3, with small variations. There were some wider variations or notable observations:

Several additional research questions were related to understanding engagement with faith, community and Indigenous actors and interventions, further illustrating experts' prioritisation of these themes in prevention interventions.

- Research on engaging men and boys in GBV prevention emerged as a common theme, including through interventions that support positive masculinities. The issue of how to negotiate male backlash in prevention programming also emerged.

- Experts highlighted the need to develop and evaluate prevention interventions that target online and technology-facilitated GBV, which also emerged as a gap in the literature review.

- A few experts proposed research questions related to testing the extent to which effective GBV response interventions can be used as a mechanism for prevention.

DOMAIN 4: GBV RESPONSE AND PREVENTION AT SCALE

The top five ranked questions in Domain 4, GBV response and prevention at scale, are presented in Table 5. The top-ranked question in Domain 4 is:

> ***Which GBV prevention interventions, including social norms change and couples interventions, can/should be scaled in low-resource and rural environments?***

This question, and the third-ranked question related to cost-effective and sustainable prevention and response, are more general in nature, focusing on scalability, sustainability and affordability of interventions. The remaining three questions in the top five in Domain 4 are related specifically to existing actors, institutions and systems as platforms for scaling GBV prevention and response, including through community-level infrastructure and organisations, traditional and religious institutions, and government and education systems.

Table 5: Top five questions in Domain 4

RANK	QUESTION
1	Which GBV prevention interventions, including social norms change and couples interventions, can/should be scaled in low-resource and rural environments?
2	How can community-level infrastructure and community-based organisations supporting GBV prevention and response be strengthened, professionalised and taken to scale through government systems, particularly in low-resource settings?
3	What are the most cost-effective and sustainable GBV prevention and response interventions in the African region?
4	What role can and should faith and traditional leaders and institutions play in the design, adaptation, implementation and evaluation of GBV prevention and response policies and programmes?
5	How can schools and education systems be engaged in GBV prevention, including through the integration of peace education, comprehensive sexuality education and life skills education in school curricula?

The first- and second-ranked questions in Domain 4 were consistent across most expert groups, albeit sometimes reversed in ranking, with wider variations across the third-, fourth- and fifth-ranked questions. Some notable observations include the following:

- The question 'What is the impact of anti-gender movements, including misogynist, homophobic and transphobic groups, on GBV prevention and response, and what are the best strategies to counter these movements?' did not rank in the top five overall, and ranked very lowly for some expert groups. However, this question was ranked second for non-binary experts, third for LGBTIQ+ experts, fourth for local/national NGOs and government experts, and fifth for CBOs/activists and experts based in Central Africa. This suggests that research on anti-gender movements and rollback on the rights of women and LGBTIQ+ people is a priority for experts in local African contexts, particularly among those most affected by these movements.

- The question 'Which GBV prevention and response interventions in the African region can be ethically and affordably scaled while retaining effectiveness and impact?' was ranked tenth overall, but ranked third among experts in HICs and fifth among experts working in bilateral/multilateral/UN agencies.
- The question 'How can successful Indigenous community interventions to prevent GBV in Africa be sustained and scaled up to reach hard-to-reach populations?' was ranked fifth by experts working in university/research settings. That a focus on Indigenous community preventions interventions was ranked second in Domain 3 suggests that the field is not yet prioritising research on how to scale up these interventions.

Experts responding to the question-ranking survey identified a large number of additional priority thematic areas and research questions they felt were not adequately captured in the 11 Domain 4 questions presented, and these are included in Annex E. Additional research questions developed during the question-gathering process but screened out during consolidation are presented in Annex D.

- Many of the additional research questions proposed related to the role of, and linkages and coordination between, different stakeholders implicated in GBV prevention and response, particularly civil society and government actors.
- Several proposed questions were related to understanding the most effective, impactful and cost-efficient ways to scale GBV prevention and response through government systems, such as health, social welfare and economic systems.
- Conducting research to support legislation and policy development for GBV prevention and response emerged as a strong theme, including on laws targeting online GBV, femicide and GBV in institutional settings. The importance of monitoring and evaluating the implementation and impact of laws and policies also emerged.
- Several experts provided questions about the modalities that would be most effective at scale, particularly those that would reach larger populations and achieve wider geographic coverage such as digital platforms.
- A few questions were related to the impact of social and feminist movements on the adoption and implementation of GBV laws and, ultimately, eliminating GBV.

DOMAIN 5: MEASURES AND METHODOLOGIES

The top five ranked questions in Domain 5, Measures and methodologies, are presented in Table 6. The top-ranked question in Domain 5 is:

How can we improve research methods to increase the accuracy of data and reporting of GBV?

Other questions ranking in the top five are related to incorporating Indigenous knowledge into GBV research, methods and tools for measuring GBV against LGBTIQ+ people, appropriate indicators to measure the success of GBV referrals, and tools and methods for measuring disability to improve the measurement of GBV prevalence.

Table 6: Top five questions in Domain 5

RANK	QUESTION
1	How can we improve research methods to increase the accuracy of data and reporting of GBV?
2	How can we incorporate Indigenous knowledge production and practices in the conduct of high-quality ethical research on GBV?
3	What are the most effective and safest strategies, methods and tools for reaching and measuring GBV against LGBTIQ+ people, including in population-based and general population surveys, especially in settings where LGBTIQ+ relationships and identities are criminalised and persecuted?
4	What are the most appropriate indicators to measure the success of referrals of GBV cases?
5	How can tools and methods that measure disability be refined, and disaggregation, analysis and interpretation strengthened, to enable more accurate measurement of prevalence of GBV?

Domain 5 is where the most consistency and agreement in ranking of questions across expert groups are observed, although this may be related to the smaller number of questions overall in this domain (n=8). There is very little variation outside the top five questions, albeit with variation in ranking order within the top five. For example, the question about strategies for measuring GBV against LGBTIQ+ people went from third to first ranking for experts identifying as non-binary, LGBTIQ+ or having a disability, and those based in Central Africa and HICs. Two notable variations were observed in Domain 5:

- The question 'What are the best methodologies for assessing the impact of social norms and behaviour change interventions to prevent GBV, including intimate partner violence?' did not make it into the top overall. However, it was ranked fifth for experts based in Eastern Africa and third for experts working in bilateral/multilateral/UN agencies.
- The question 'How can international methodologies, methods, tools and measures of GBV, including intimate partner violence, be adapted and standardised in Africa so that they are more culturally salient and locally appropriate, including for African family and community dynamics?' did not make it into the top five overall. However, it was ranked third among experts in HICs and those working in university/research settings, and fifth among experts working in bilateral/multilateral/UN agencies.

Additional questions related to Domain 5 proposed by experts during the question-gathering process are listed in Annex D, and additional questions proposed in the question-ranking survey are listed in Annex E. Several themes emerged:

- Experts highlighted the importance of using and expanding local and Indigenous knowledge related to GBV. One expert suggested that instead of adapting and standardising international measures of GBV in Africa, we should be trying to understand how 'African-grown' methods can be adapted in other parts of the world.
- Experts proposed questions related to elevating practice-based knowledge in evidence building on GBV and the effectiveness of GBV prevention and response interventions.
- Experts also proposed questions related to the most effective and ethical qualitative and participatory methods in GBV research, including with survivors.
- Several additional questions related to ethical research were proposed, including ethical engagement with marginalised groups and how to conduct ethical research on online violence.

Discussion

Discussion

The ASRA priority-setting process has revealed important lessons about the research priorities to advance the GBV prevention and response field in Africa, and the process through which these priorities were identified.

THERE IS WIDESPREAD AGREEMENT AMONG EXPERTS ON THE RESEARCH PRIORITIES ACROSS ALL FIVE DOMAINS:

While there were some variations in research priorities according to experts' characteristics, overall, there was substantial agreement with the top five questions per domain. Several themes emerged across the priorities identified, including an emphasis on research and interventions that focus on marginalised populations, address social norms and engage local, Indigenous structures and forms of knowledge in GBV prevention and response.

IT IS IMPORTANT TO BE FLEXIBLE IN ADAPTING THE PROCESS AS IT DEVELOPS:

The attention to decolonising research and promoting a more inclusive research priority-setting process required the ASRA methodology to be adaptive to feedback received from the Advisory Group and build in sufficient time to incorporate changes into the process. For example, the composition of the Advisory Group was adjusted to expand the diversity of perspectives represented, and the question-gathering stage was extended to allow for targeted FGDs and KIIs to ensure a broad range of experts was reached.

MIXED-METHODS APPROACHES ARE VALUABLE TO PRIORITY SETTING:

Previous research priority-setting processes have been quantitative exercises in line with the idea of 'crowd-sourcing' the most prioritised research questions. By adding qualitative methods, a more-inclusive process was created, that enabled specific population sub-groups, especially those facing intersecting forms of discrimination, to engage more fully in the process. It is notable that research questions on intersectionality were among the top-ranking questions overall, reaffirming the importance of using a mixed-methods approach in adapting the CHNRI.

DESPITE BEING INCLUSIVE AND DEMOCRATIC, PRIORITISATION EXERCISES CAN ALSO BE BIASED:

The ASRA process and approach intentionally elevated the voices of diverse GBV experts, including those working with marginalised groups. However, the process of prioritisation can be susceptible to bias. Research priorities may be established with political intentions rather than scientific ones, and individuals could use their contribution or scoring of individual questions to affirm or reduce attention to specific issues. For example, two experts responding to the question-ranking survey, entered comments such as "LGBTIQ+ is not relevant in my country." In a context of backlash against LGBTIQ+ groups in some African settings, any deprioritisation of research related to GBV against LGBTIQ+ people could be related to political bias, rather than lack of need for research addressing this population group. The CHNRI method attempts to minimise such bias through its crowd-sourcing approach; however, it is important to recognise that bias still can occur.

RESEARCH PRIORITIES SHOULD BE INTERPRETED AGAINST THE EXISTING EVIDENCE:

During the process of generating research questions and ranking them, some questions proposed were related to areas where evidence already exists. For example:

- The third-ranked question in Domain 2 is related to sanctions and incentives for dissuading practitioners of FGM. However, there is already evidence available indicating that providing practitioners with alternative income sources is ineffective in reducing FGM, and that fear of legal sanctions may motivate some practitioners to obey the law, but also tends to increase FGM practised in secrecy.[19] Nevertheless, it is notable that a recent research priority-setting exercise on FGM in Africa identified a priority research question related more broadly to community and individual motivations:

[19] Matanda, D, Croce-Galis, M, Gay, J & Hardee, K (2021). Effectiveness of interventions designed to prevent or respond to female genital mutilation: A review of evidence. UNFPA, UNICEF, WHO and Population Council Kenya.

'What context-specific factors (mechanisms) motivate communities or individuals to stop practising FGM?'[20] This suggests that while the first part of the research question is a current priority, there is already existing evidence related to the second part of the question about sanctions and incentives.

- Similarly, the third-ranked question in Domain 3 is about the impact of technology and mass communication on GBV prevention and behaviour change. However, there is existing evidence to suggest that standalone communication campaigns are not sufficient in producing behaviour change and reducing GBV, unless bundled with wider GBV prevention approaches.[21]

This suggests that there are limitations in experts' awareness of the existing evidence on ending GBV, which may be related to low accessibility of the evidence, weak dissemination or poor uptake. While the ASRA process aims to allow for priorities to be identified with limited bias in the process, the prioritisation of areas where there is already an existing evidence base has resourcing implications, particularly if ineffective approaches continue to be funded and evaluated. This highlights the importance of amplifying existing evidence with GBV experts and investing in evidence outreach/uptake alongside investments into priority research areas.

THERE IS A NEED TO CURATE EVIDENCE IN AN ACCESSIBLE WAY FOR DIFFERENT STAKEHOLDERS IN THE GBV RESPONSE AND PREVENTION FIELDS:

Given that there have been a number of research priority-setting exercises related to GBV conducted since 2015, it is important to ensure that processes consider and learn from the findings of previous exercises. This should be done while also building in a more defined set of actions to elevate attention to existing research and evidence on areas identified as priorities. Dissemination and uptake of evidence also need to be adapted to reach a wider range of experts, and evidence from a wider range of experts needs to be packaged and shared effectively, so that what is considered 'evidence' is more reflective of the diverse experts working in the region.

ANNEXING ALL QUESTIONS GENERATED THROUGH THE PRIORITY-SETTING EXERCISES SUPPORTS ACCOUNTABILITY OF THE PROCESS FOLLOWED:

Considering that the inclusion of the top ten ranked questions overall is an artificial cut-off, the full set of questions included in the question-ranking survey has been provided as an annex. Additionally, separate annexes show the questions identified by the survey respondents when ranking questions, and the questions screened out by the Stewardship Group when selecting the top ten questions to be included in each domain of the ranking survey.

THERE IS A FINE BALANCE BETWEEN LIMITING BIAS AND INCREASING PARTICIPATION:

The move towards more participatory and inclusive research priority-setting exercises requires a balance of adjusting the methods to consider the political and power structures that are inherent to traditional research priority exercises, while also considering how to keep the essence of collecting 'the wisdom of the crowd'. For example, the standard CHNRI approach uses surveys to gather research questions and to score these questions, which assumes that all respondents will have equal access and understanding of engaging in such surveys. In reality, crafting a research question is not a simple exercise, and for GBV experts that do not have a research background, this can be challenging and dissuade participants from the process. Similarly, recognising that the 'crowd' is a diverse group of individuals, the ASRA Stewardship Group took note of gaps in language, location and background of experts contributing questions, and agreed on the need to make the question-gathering process more tailored and accessible through outreach and the use of qualitative methods. While this contributed to a greater number of practitioners from diverse backgrounds, including population groups less visible in the literature on GBV, it could also be seen as biasing the priority-setting process toward these respondents.

[20] Matanda, D & Lwanga-Walgwe, E (2022). A Research Agenda to Strengthen Evidence Generation and Utilisation to Accelerate the Elimination of Female Genital Mutilation. UNFPA, UNICEF, WHO and Population Council Kenya.
[21] Kerr-Wilson, A, Gibbs, A, McAslan Fraser E, Ramsoomar, L, Parke, A, Khuwaja, HMA & Jewkes, R (2020). A rigorous global evidence review of interventions to prevent violence against women and girls, What works to prevent violence against women and girls? Pretoria, South Africa.

Way forward

Way forward

The process of developing a global shared research agenda is complex, political and, at times, seemingly impossible, but working together with care and kindness highlights the importance, value and power of working collectively. With great insight from that first global process – and recognising the need for a specific regional focus on Africa – the UN Women (via the Regional Offices in East and Southern Africa and West and Central Africa) and the SVRI collaboration has co-created this set of shared regional research priorities for Africa to guide, systematise and attract funding for evidence building on GBV.

The process has demonstrated that gaps in research remain. Evidence-building and knowledge creation is essential for accelerating progress and accountability to women and girls in all their diversity across Africa, through the provision of better, more effective programmes. Evidence building on how to prevent GBV can help support countries in Africa to deliver on their SDG and related regional commitments (e.g. under the Maputo Protocol).

With this research agenda dedicated to Africa, we can start to reduce those gaps in research and target funding towards the research priorities as outlined. Research priorities have been identified through a rigorous, inclusive and fair process. It is this method of decolonising GBV research priority setting that will enable the interventions that emerge from it to be effective and sustainable.

The way forward from here is simple: this Africa Shared Research Agenda, the ASRA, must be shared, and it must be shared widely. It can only be effective if it is used. To this end, a dedicated and comprehensive communications campaign must be created and crafted so that researchers, policymakers, grant-makers, activists and academics know that it exists and can shape their work and be influenced by it. Through this knowledge and engagement, diverse GBV experts can lead the process to closing the evidence gaps in the region and collectively contribute to ending GBV in all its forms.

Annex A to E

Annex A: Longlist of CHNRI criteria

ANSWERABILITY: the likelihood that the research question can be answered and/or reach its objective within the proposed timeline

APPLICABILITY: the likelihood that the knowledge produced through the proposed research will be applied in policy and practice

COMMUNITY INVOLVEMENT: some research ideas will have more additional positive side–effects through community involvement

EFFECTIVENESS: some research ideas will be more likely to generate/improve truly effective interventions

FEASIBILITY: some research ideas will be more likely to lead to translation at the current stage of knowledge

FILLS KEY GAP: some research ideas will be more likely to fill a key gap in knowledge that is required for translation and/or implementation than others

MAXIMUM POTENTIAL IMPACT: some research ideas will have a theoretical potential to reduce GBV more than others

NOVELTY: some research ideas will be more likely to generate truly novel and non–existing knowledge

POTENTIAL FOR TRANSLATION: some research ideas will be more likely to generate knowledge that will be translated into interventions

RELEVANCE: some research ideas will be more relevant to the context than others

EQUITY: the likelihood that the research findings will lead to interventions that will be accessible and equitable to underprivileged or marginalised groups, or conversely, the likelihood that the research findings could perpetuate inequalities

Annex B: Overall ranking of research questions

OVERALL RANK	RESEARCH QUESTION	DOMAIN
1	What are the types and prevalence of GBV specifically affecting women and girls with disabilities, and women and girls living with HIV/AIDS, including sexual violence, early marriage, structural violence (eg, denied access to health, education and legal services) and obstetric violence (eg, forced contraception or sterilisation)?	Understanding GBV
2	Which interventions working with religious and/or traditional leaders, or other social structures strongly imbued with patriarchy, have been most successful in preventing GBV and why?	GBV prevention interventions
3	Which GBV prevention interventions, including social norms change and couples interventions, can/should be scaled in low-resource and rural environments?	GBV response and prevention at scale
4	What can different interpretations of 'justice' tell us about how to shape justice programmes for survivors of violence?	GBV response interventions
5	How can we improve research methods to increase the accuracy of data and reporting of GBV?	Measures and methodologies
6	Which types of GBV are most prevalent in Africa, including among key populations (eg, adolescents, older women, migrants, displaced persons, domestic workers, women and girls with disabilities, LGBTIQ+ people, sex workers, women and girls living with HIV/AIDS), and who are the different perpetrators of these types of violence?	Understanding GBV
7	What are the most cost-effective and sustainable GBV prevention and response interventions in the African region?	GBV response and prevention at scale
8	How can community-level infrastructure and community-based organisations supporting GBV prevention and response be strengthened, professionalised and taken to scale through government systems, particularly in low-resource settings?	GBV response and prevention at scale
9	What are the most successful and sustainable local, indigenous community interventions to respond to GBV in Africa?	GBV response interventions
10	What are the most effective and safest strategies, methods and tools for reaching and measuring GBV against LGBTIQ+ people, including in population-based and general population surveys, especially in settings where LGBTIQ+ relationships and identities are criminalised and persecuted?	Measures and methodologies
11	Which social and gender norms, including notions of masculinity, influence (negatively or positively) the perpetration of GBV?	Understanding GBV

OVERALL RANK	RESEARCH QUESTION	DOMAIN
12	Which local, Indigenous community interventions have been developed and used to prevent GBV, and how successful have they been?	GBV prevention interventions
13	What is the knowledge and capacity among duty bearers and service providers to provide survivor-centred GBV protection and response to marginalised populations (e.g., LGBTIQ+ people, women and girls with disabilities, women and girls living with HIV/AIDS) and how can their capacity be strengthened to provide equitable services and prevent harm?	GBV response interventions
14	What are the prevalence, risk and protective factors for online GBV in Africa (e.g., blackmail, cyberbullying, revenge porn, harassment, doxing, catfishing), including among marginalised groups and those facing intersecting forms of discrimination, and what are the linkages and differences between online and offline GBV?	Understanding GBV
15	Is multisectoral GBV support and accompaniment (e.g., to healthcare, legal, educational and empowerment services) adaptable to different contexts and the needs and characteristics of victims/survivors, including those from marginalised populations?	GBV response interventions
16	Which types of intimate partner violence and non-partner sexual violence prevention interventions are most effective in reaching women and girls in university environments in Africa, and how could these be adapted for LGBTIQ+ students (noting contexts of criminalisation)?	GBV prevention interventions
17	Which approaches are most effective in convincing those who practise the circumcision of girls to abandon the practice, including sanctions (e.g., judicial measures) and incentives (e.g., alternative income-generating activities)?	GBV response interventions
18	Which prevention interventions can address multiple forms of GBV, including different forms of intimate partner violence and non-partner sexual violence?	GBV prevention interventions
19	What are the linkages between climate change, economic collapse and GBV?	Understanding GBV
20	Which interventions are most effective in providing quality health and psychosocial support to victims/survivors of violence, including hard-to-reach populations in remote or rural areas or settings affected by humanitarian emergency or armed conflict?	GBV response interventions
21	How do traditional, cultural and religious practices and institutions influence social norms related to GBV, including the acceptability, justification and normalisation of GBV?	Understanding GBV
22	What are the characteristics and motivations of the perpetrators of GBV, and which prevention interventions are most successful in shifting their attitudes and behaviours, including those in the highest risk categories for perpetration?	GBV prevention interventions

OVERALL RANK	RESEARCH QUESTION	DOMAIN
23	What are the best methodologies for assessing the impact of social norms and behaviour change interventions to prevent GBV, including intimate partner violence?	Measures and methodologies
24	How can we incorporate Indigenous knowledge production and practices in the conduct of high-quality ethical research on GBV?	Measures and methodologies
25	What are the best strategies for discouraging and preventing medical, psychological and spiritual/religious GBV against LGBTIQ+ people in the forms of conversion practices, exorcism, and all other harmful efforts to change sexual orientation and/or gender identity?	GBV prevention interventions
26	How can international methodologies, methods, tools and measures of GBV, including intimate partner violence, be adapted and standardised in Africa so that they are more culturally salient and locally appropriate, including for African family and community dynamics?	Measures and methodologies
27	How can tools and methods that measure disability be refined, and disaggregation, analysis and interpretation strengthened, to enable more-accurate measurement of prevalence of GBV?	Measures and methodologies
28	What are the causes, risk and protective factors for perpetration and victimisation of different forms of GBV in different settings and sub-regions?	Understanding GBV
29	Which GBV prevention and response interventions in the African region can be ethically and affordably scaled while retaining effectiveness and impact?	GBV response and prevention at scale
30	What are the most appropriate indicators to measure the success of referrals of GBV cases?	Measures and methodologies
31	What are the most effective strategies for ensuring that LGBTIQ+ people, women and girls with disabilities, and others who are regularly excluded from existing emergency shelters and other mechanisms, are included in humanitarian and emergency responses, including GBV response and prevention efforts?	GBV response interventions
32	Which interventions work to prevent GBV, including intimate partner violence and non-partner sexual violence, against women and girls with disabilities in all their diversity?	GBV prevention interventions
33	Which risk factors for intimate partner violence amplify the risks of femicide, and how do these differ across countries?	Understanding GBV
34	How can schools and education systems be engaged in GBV prevention, including through the integration of peace education, comprehensive sexuality education and life skills education in school curricula?	GBV response and prevention at scale
35	What is the impact of technology and mass communication, including media, social media and online modalities, on GBV prevention and behaviour change, including in rural and other hard-to-reach settings?	GBV prevention interventions

OVERALL RANK	RESEARCH QUESTION	DOMAIN
36	How can the needs of marginalised groups and groups facing intersecting forms of discrimination be addressed in GBV prevention and response approaches in the African region?	GBV response interventions
37	What are the most effective strategies for promoting legal reform to decriminalise LGBTIQ+ relationships, identities, organisations, and information sharing in African states (thus removing legal cover for GBV against LGBTIQ+ people perpetrated by state actors)?	GBV response and prevention at scale
38	Which types of intimate partner violence prevention intervention are most effective, including for diverse women and girls and those facing multiple and intersecting forms of discrimination?	GBV prevention interventions
39	How can gender and disability disaggregated GBV data be used to support national and local government planning to ensure that GBV services are accessible to women and girls with disabilities?	GBV response interventions
40	Which proven strategies for preventing intimate partner violence in male-female relationships, including couple, household and community interventions, could be adapted for same-gender couples, noting contexts of criminalisation, in Africa?	GBV prevention interventions
41	What is the impact of anti-gender movements, including misogynist, homophobic and transphobic groups, on GBV prevention and response, and what are the best strategies to counter these movements?	GBV response and prevention at scale
42	What are the types and prevalence of GBV that specifically target members of LGBTIQ+ communities (non-consensual outing or blackmail, targeted rape, starvation, forced isolation, conversion therapy, intersex genital mutilation, etc), and how do these vary based on identity (e.g., related to sexual orientation, gender identity and expression, and sex characteristics, disability, HIV status, engagement in sex work)?	Understanding GBV
43	What is best practice in integrating GBV prevention into large-scale sectoral programmes such as livelihoods and economic interventions and infrastructure development programmes, including in humanitarian settings and programmes?	GBV response and prevention at scale
44	How can we use digital technologies in a safe and ethical way to track violence at community level, and 'hotspot' locations with high incidents of GBV?	Measures and methodologies
45	What are the most effective strategies for mainstreaming disability inclusion in GBV prevention and response interventions, policies and programmes, and what are the barriers to doing so?	GBV response and prevention at scale
46	What role can and should faith and traditional leaders and institutions play in the design, adaptation, implementation and evaluation of GBV prevention and response policies and programmes?	GBV response and prevention at scale

OVERALL RANK	RESEARCH QUESTION	DOMAIN
47	How can successful Indigenous community interventions to prevent GBV in Africa be sustained and scaled up to reach hard-to-reach populations?	GBV response and prevention at scale
48	What are the impacts, such as physical, psychosocial or mental health impacts, of different forms of GBV, including multiple and intersecting forms of violence (polyvictimisation), on women and adolescent girls in all their diversity?	Understanding GBV
49	Which strategies are most effective in addressing sexual violence and sexual exploitation in transborder settings in the region, including due to forced migration or displacement?	GBV response interventions

Annex C: Intra-domain ranking of research questions

RANK	RESEARCH QUESTION IN DOMAIN 1: UNDERSTANDING GBV
1	What are the types and prevalence of GBV specifically affecting women and girls with disabilities, and women and girls living with HIV/AIDS, including sexual violence, early marriage, structural violence (e.g., denied access to health, education and legal services) and obstetric violence (e.g., forced contraception or sterilisation)?
2	Which social and gender norms, including notions of masculinity, influence (negatively or positively) the perpetration of GBV?
3	What are the prevalence, risk and protective factors for online GBV in Africa (e.g., blackmail, cyberbullying, revenge porn, harassment, doxing, catfishing), including among marginalised groups and those facing intersecting forms of discrimination, and what are the linkages and differences between online and offline GBV?
4	What are the causes, risk and protective factors for perpetration and victimisation of different forms of GBV in different settings and sub-regions?
5	What are the linkages between climate change, economic collapse and GBV?
6	Which types of GBV are most prevalent in Africa, including among key populations (e.g., adolescents, older women, migrants, displaced persons, domestic workers, women and girls with disabilities, LGBTIQ+ people, sex workers, women and girls living with HIV/AIDS), and who are the different perpetrators of these types of violence?
7	How do traditional, cultural and religious practices and institutions influence social norms related to GBV, including the acceptability, justification and normalisation of GBV?
8	Which risk factors for intimate partner violence amplify the risks of femicide, and how do these differ across countries?
9	What are the types and prevalence of GBV that specifically target members of LGBTIQ+ communities (non-consensual outing or blackmail, targeted rape, starvation, forced isolation, conversion therapy, intersex genital mutilation, etc), and how do these vary based on identity (e.g., related to sexual orientation, gender identity and expression, and sex characteristics, disability, HIV status, engagement in sex work)?
10	What are the impacts, such as physical, psychosocial or mental health impacts, of different forms of GBV, including multiple and intersecting forms of violence (polyvictimisation), on women and adolescent girls in all their diversity?

RANK	RESEARCH QUESTION IN DOMAIN 2: GBV RESPONSE INTERVENTIONS
1	Is multisectoral GBV support and accompaniment (e.g., to healthcare, legal, educational and empowerment services) adaptable to different contexts and the needs and characteristics of victims/survivors, including those from marginalised populations?
2	What can different interpretations of 'justice' tell us about how to shape justice programmes for survivors of violence?
3	Which approaches are most effective in convincing those who practise the circumcision of girls to abandon the practice, including sanctions (e.g., judicial measures) and incentives (e.g., alternative income-generating activities)?
4	What is the knowledge and capacity among duty bearers and service providers to provide survivor-centred GBV protection and response to marginalised populations (e.g., LGBTIQ+ people, women and girls with disabilities, women and girls living with HIV/AIDS) and how can their capacity be strengthened to provide equitable services and prevent harm?
5	Which interventions are most effective in providing quality health and psychosocial support to victims/survivors of violence, including hard-to-reach populations in remote or rural areas or settings affected by humanitarian emergency or armed conflict?
6	What are the most effective strategies for ensuring that LGBTIQ+ people, women and girls with disabilities, and others who are regularly excluded from existing emergency shelters and other mechanisms, are included in humanitarian and emergency responses, including GBV response and prevention efforts?
7	How can gender and disability disaggregated GBV data be used to support national and local government planning to ensure that GBV services are accessible to women and girls with disabilities?
8	What are the most successful and sustainable local, Indigenous community interventions to respond to GBV in Africa?
9	How can the needs of marginalised groups and groups facing intersecting forms of discrimination be addressed in GBV prevention and response approaches in the African region?
10	Which strategies are most effective in addressing sexual violence and sexual exploitation in transborder settings in the region, including due to forced migration or displacement?

RANK	RESEARCH QUESTION IN DOMAIN 3: GBV PREVENTION INTERVENTIONS
1	Which interventions working with religious and/or traditional leaders, or other social structures strongly imbued with patriarchy, have been most successful in preventing GBV and why?
2	Which local, Indigenous community interventions have been developed and used to prevent GBV, and how successful have they been?
3	What is the impact of technology and mass communication, including media, social media and online modalities, on GBV prevention and behaviour change, including in rural and other hard-to-reach settings?
4	Which types of intimate partner violence and non-partner sexual violence prevention interventions are most effective in reaching women and girls in university environments in Africa, and how could these be adapted for LGBTIQ+ students (noting contexts of criminalisation)?
5	What are the best strategies for discouraging and preventing medical, psychological, and spiritual/religious GBV against LGBTIQ+ people in the forms of conversion practices, exorcism, and all other harmful efforts to change sexual orientation and/or gender identity?
6	Which proven strategies for preventing intimate partner violence in male-female relationships, including couple, household and community interventions, could be adapted for same-gender couples, noting contexts of criminalisation, in Africa?
7	What are the characteristics and motivations of the perpetrators of GBV, and which prevention interventions are most successful in shifting their attitudes and behaviours, including those in the highest risk categories for perpetration?
8	Which prevention interventions can address multiple forms of GBV, including different forms of intimate partner violence and non-partner sexual violence?
9	Which interventions work to prevent GBV, including intimate partner violence and non-partner sexual violence, against women and girls with disabilities in all their diversity?
10	Which types of intimate partner violence prevention intervention are most effective, including for diverse women and girls, and those facing multiple and intersecting forms of discrimination?

RANK	RESEARCH QUESTION IN DOMAIN 4: GBV RESPONSE AND PREVENTION AT SCALE
1	Which GBV prevention interventions, including social norms change and couples interventions, can/should be scaled in low-resource and rural environments?
2	How can community-level infrastructure and community-based organisations supporting GBV prevention and response be strengthened, professionalised and taken to scale through government systems, particularly in low-resource settings?
3	What are the most cost-effective and sustainable GBV prevention and response interventions in the African region?
4	What role can and should faith and traditional leaders and institutions play in the design, adaptation, implementation and evaluation of GBV prevention and response policies and programmes?
5	How can schools and education systems be engaged in GBV prevention, including through the integration of peace education, comprehensive sexuality education and life skills education in school curricula?
6	What is the impact of anti-gender movements, including misogynist, homophobic and transphobic groups, on GBV prevention and response, and what are the best strategies to counter these movements?
7	How can successful Indigenous community interventions to prevent GBV in Africa be sustained and scaled up to reach hard-to-reach populations?
8	What is best practice in integrating GBV prevention into large-scale sectoral programmes such as livelihoods and economic interventions and infrastructure development programmes, including in humanitarian settings and programmes?
9	What are the most effective strategies for mainstreaming disability inclusion in GBV prevention and response interventions, policies and programmes, and what are the barriers to doing so?
10	Which GBV prevention and response interventions in the African region can be ethically and affordably scaled while retaining effectiveness and impact?
11	What are the most effective strategies for promoting legal reform to decriminalise LGBTIQ+ relationships, identities, organisations, and information sharing in African states (thus removing legal cover for GBV against LGBTIQ+ people perpetrated by state actors)?

RANK	RESEARCH QUESTION IN DOMAIN 5: MEASURES AND METHODOLOGIES
1	How can we improve research methods to increase the accuracy of data and reporting of GBV?
2	How can we incorporate Indigenous knowledge production and practices in the conduct of high-quality ethical research on GBV?
3	What are the most effective and safest strategies, methods and tools for reaching and measuring GBV against LGBTIQ+ people, including in population-based and general population surveys, especially in settings where LGBTIQ+ relationships and identities are criminalised and persecuted?
4	What are the most appropriate indicators to measure the success of referrals of GBV cases?
5	How can tools and methods that measure disability be refined, and disaggregation, analysis and interpretation strengthened, to enable more accurate measurement of prevalence of GBV?
6	What are the best methodologies for assessing the impact of social norms and behaviour change interventions to prevent GBV, including intimate partner violence?
7	How can we use digital technologies in a safe and ethical way to track violence at community level, and 'hotspot' locations with high incidents of GBV?
8	How can international methodologies, methods, tools and measures of GBV, including intimate partner violence, be adapted and standardised in Africa so that they are more culturally salient and locally appropriate, including for African family and community dynamics?

Annex D: Research questions screened out during the consolidation process

The table below contains the questions that were screened out of the priority setting by the Stewardship Group, through a process of consolidation that involved rating and scoring research questions based on the three criteria of Answerability, Applicability and Maximum Potential Impact.

DOMAIN 1: UNDERSTANDING GBV
What are the types and prevalence of different forms of structural violence perpetrated against women and girls living with HIV/AIDS, including by healthcare providers (e.g., break of confidentiality, obstetric violence, forced sterilisation, denial of treatments)?
What is the prevalence of GBV, including sexual harassment, in public, workplace and educational settings, and other institutional settings, and how have trends changed in the last five to ten years?
How has the prevalence of FGM changed in the past ten years, and what are the external social factors (ie, in the absence of interventions) that can support or impede change?
What are the characteristics of under-researched types of GBV?
What are the short-term and long-term social and economic costs of GBV, including the impacts of GBV on women and girls' work and education outcomes?
What are the socioeconomic and health impacts of FGM and early marriage on women and girls?
What is the impact of sexual harassment against women in the film and entertainment industry?
What are the root causes of GBV in Africa, and why does GBV continue to be prevalent despite many interventions over the years trying to address the issue? Is there any region in Africa where there has been a decrease in GBV in the last decade and, if so, what are the contributing factors to this decrease?
What are the risk factors and structural drivers for GBV against those in different vulnerable groups (e.g., LGBTIQ+ people, women with disabilities, women living with HIV/AIDS)?
What are the factors and barriers that drive victims/survivors to stay in abusive relationships?
What are the factors driving silence about GBV for both communities and victims/survivors?
What are the impacts of conflict and humanitarian emergencies on the prevalence of GBV against women, girls and people in all their diversity, including LGBTIQ+ populations?
How do stigma and patriarchy intersect to make women and girls with disabilities more vulnerable to GBV?
To what extent is it possible to disentangle culture and religion as factors that influence GBV, including harmful practices?

DOMAIN 2: GBV RESPONSE INTERVENTIONS
Which response interventions have been implemented in the African region and how have they impacted on GBV and victims/survivors?
Which types of GBV response intervention are most needed/important to victims/survivors and why?
What are the different procedures and tools to screen for GBV?
What is the role of cross-country support networks for victims/survivors of violence?
What services or support are available for caregivers of victims/survivors of GBV?
Why are GBV response interventions mainly financed by development partners in the African region?
What are the most effective strategies for ensuring that policing and criminal justice services respond appropriately and effectively to LGBTIQ+ survivors of GBV and do not assault or revictimise them, both in settings where LGBTIQ+ people do and do not have the protection of law, and what are the training needs of duty bearers (e.g., police, prosecutors, lawyers)?
How effective are justice systems, institutions and interventions to strengthen access to justice for victims/survivors in the region, including special courts, legal aid, police, and what are the facilitators and barriers to access to justice?
What is the best approach to introduce a transformative justice framework into GBV response interventions?
How can mediation be streamlined into provision of justice in a survivor-centred manner?
How can women and girls who have suffered violence be supported to access their rights, and recover from and obtain reparations for the damage they have suffered?
What is the impact of formal and informal justice, and different forms of justice (e.g., restorative and transitional justice), on the prevalence of GBV?
How does the legal status of LGBTIQ+ people in different African countries impact their experiences of GBV and access to GBV response services?
How can national and international GBV legal frameworks be strengthened to address the needs of victims/survivors in all their diversity (e.g., LGBTIQ+ people, women and girls with disabilities, women and girls living with HIV/AIDS, sex workers), and prevent the perpetration of GBV?
What are the most effective strategies for ensuring that quality health and psychosocial GBV response services are available to and able to effectively address the needs of GBV survivors, including LGBTIQ+ people, women and girls with disabilities, and women and girls living with HIV/AIDS)?
How can girls report FGM plans safely?
Which interventions are effective in increasing reporting of GBV, especially in locations where it is highly stigmatised?
Which entry points for referrals from the community level to formal services work well in rural Sub-Saharan Africa?

What are the most effective mechanisms and cost-effective approaches to linking health/psychosocial, police, justice and economic/livelihoods services (e.g., through one-stop centres), including in resource-scarce and service-poor environments, and which approaches have the most uptake for institutionalisation and financing through government budgets?
How can collaboration between key actors, including civil society organisations, government and development partners, contribute to providing a comprehensive response to victims/survivors of violence?
How is GBV defined by African national and state institutions, who is specifically included or excluded, and how does this impact access to resources and services for marginalised and vulnerable groups (e.g., LGBTIQ+ people, sex workers, people with disabilities)?
Where is the most effective policy and institutional home to address GBV against LGBTIQ+ people and other LGBTIQ+ health issues in different African settings?
What are effective and sustainable economic and livelihoods interventions for GBV survivors, including in poor-resource settings?

DOMAIN 3: GBV PREVENTION INTERVENTIONS
What are the different GBV prevention interventions in the African region, and which are most effective and impactful?
Which prevention interventions can address multiple forms of GBV, including different forms of IPV and non-partner sexual violence?
Which FGM and child marriage prevention programmes, including those that engage parents, have been successful and sustainable in the African region and why, and what have been the challenges of unsuccessful interventions?
Which prevention approaches can address both GBV and harmful traditional practices?
Where does the evidence stand on maximum effective duration and intensity for GBV prevention interventions?
How acceptable are the different types of IPV prevention intervention in local contexts?
What works to engage families, and younger and older women, in GBV prevention interventions?
Is public and community awareness raising an effective means of preventing GBV, and which are the best modalities for raising awareness about GBV in all its forms?
Which holistic approaches and mechanisms for change are most inclusive and feasible for violence prevention interventions?
How can effective GBV response be used as a mechanism for GBV prevention?
Which interventions are most effective in changing social and gender norms that are accepting of violence, reproduce stigma against survivors, and prevent them from seeking help or reporting the violence they have experienced?
What works to engage men and boys in the prevention of and response to GBV (including child marriage and FGM) as advocates, role models and agents of change?

What works to challenge myths that preventing GBV means replacing boys' and men's rights?
What is the role of masculine hegemony in the perpetration of IPV in African countries, and which behaviour change interventions are most effective in mobilising positive masculinities?
Do economic interventions aimed at increasing livelihoods, including income-generating activities and vocational education, lead to a reduction in GBV, including harmful practices such as FGM and child marriage?
Can bringing women together in community associations reduce GBV?
What are promising practices and interventions for the protection and prevention of violence, including sexual violence, against women and girls with disabilities?
How can a shift in focus on the gender lens (Without to Within) reduce GBV, especially against LBQT womxn?
What is the relationship between higher rates of violence and laws that criminalise women's and LGBTIQ+ people's rights and identities?
What factors influence the perpetuation of GBV by state actors including the police, prosecutors, investigators and healthcare providers, and what strategies can be implemented to prevent this violence against LGBTIQ+ people, sex workers and other sexual minorities?
What are the sources and means of spreading misogynistic, homophobic, biphobic, transphobic and interphobic narratives in the media, among state and public institutions that foster exclusion and GBV?

DOMAIN 4: GBV RESPONSE AND PREVENTION AT SCALE
What legislative bills should be introduced and passed to prevent GBV in institutions, including educational and workplace settings?
What legislative responses are needed to address online GBV?
Which policies, laws, legislation and legal frameworks exist, or could be developed or strengthened, to support GBV prevention and response in different countries in the region, what is their impact and how can their effectiveness be improved?
How do rigid gender norms impact on the enforcement of laws and policies on GBV?
What is the role of national advisory groups to monitor the implementation of policies on GBV and gender equality?
Which GBV prevention and response actors, policies and programmes have been systematically mapped in the region?
What is the African continent doing to support conventions and treaties that advocate for the prevention and elimination of GBV?
How is GBV defined by African state institutions in laws and policies, who is specifically included or excluded, and what is the impact of gender-neutral and gender-expansive language? How does this impact access to resources and services for marginalised and vulnerable groups (LGBTIQ+ people, sex workers, people with disabilities)?
What does it mean, in practice, to scale up GBV prevention through a feminist lens?

How can governments work with community members to prevent child marriages?
What is the effectiveness of platforms that can be leveraged to implement FGM prevention interventions at scale?
Which prevention and response interventions can be scaled through health systems?
How can anti-corruption efforts be leveraged to advance GBV prevention and response interventions at scale?
How can we motivate the private sector to embark on and fund large-scale interventions to prevent or respond to GBV in the realm of their economic sectors?
How can the safe corners in schools and health facilities contribute to GBV protection and response?
What is the role and impact of the women's movement on ending GBV, including the successful adoption and implementation of laws and policies on GBV prevention and response, and how can they be strengthened?
How can disability rights be more strongly integrated into GBV movements?
What are examples of effective interventions by regional and sub-regional bodies to improve state accountability for preventing GBV?
How can we ensure that state institutions integrate gender structures in legal, health and psychosocial services for women and girls who have experienced violence?
Which types of prevention and response intervention have the greatest potential for scaling through government systems, including social welfare systems, and what investment is needed to do so?
Is advocacy for integrating gender-responsive budgeting into national budgets an effective strategy for scaling up GBV prevention and response programmes from a fiscal perspective?
How can national and regional GBV data management systems be strengthened, including through stronger multisectoral co-ordination?
How to integrate youth associations from towns and villages in the fight against GBV in order to reach all social strata?
What role can non-governmental and civil society organisations, particularly women's rights organisations, play in supporting the work of government and development partners in preventing GBV, and vice versa, in the region?
How can women's rights organisations and leaders be more meaningfully linked to national statistics and data management systems, and supported to use data more effectively to advocate for strengthened violence prevention and response?
Which different stakeholder engagement and co-ordination processes and capacities would yield the most valuable outputs in relation to GBV prevention and response interventions?
How can collaboration between programmers and researchers be maximised to impact intervention delivery and acceptability?
To what extent do organisations and institutions in the region use evidence-based advocacy to confront GBV?
What are emerging lessons in resourcing GBV prevention interventions, including in relation to the availability of funding and different actors' access to funding, including for marginalised and under-represented groups and grassroots activists and national organisations?
What are the best strategies for ensuring that LGBTIQ+ people in Africa have unrestricted access to accurate online information about LGBTIQ+ health, rights and political organising, while also being given skills to protect themselves from online victimisation?

DOMAIN 5: MEASURES AND METHODOLOGIES
What is the role of governments in monitoring and documenting cases of GBV, and elements of prevention and response, including through national statistics?
What are the most important ethical issues related to research on GBV, including for women and girls who are both survivors and research participants?
What are the best approaches for conducting good-quality, ethical research on GBV using online methods in a context with limited internet connectivity and uneven access to internet and data?
What are the best and most innovative strategies to validate methodologies used to measure different forms of GBV, and evaluate GBV interventions, in the African region?
How do women and girls define GBV, how do these definitions differ from conventional GBV measures, and how can they be integrated into existing tools measuring GBV?
What accessible alternatives exist for research to inform GBV prevention work other than the gold-standard methodologies?
How can we most effectively use and integrate qualitative and participatory methodologies and methods in the implementation of high-quality, ethical research on GBV?
What are the most appropriate and effective methodologies for measuring GBV in institutions, including in educational environments?
What are the most appropriate methodologies to measure reduction in early marriage outside long-term national-level studies?
What is the most effective balance between practice-based knowledge/learning and large-scale research evidence in informing IPV programming?
How can researchers elevate the voices of marginalised women and girls in GBV research, including through qualitative and participatory methods that allow them to tell their stories and, where appropriate, lead on the research process?
What are the most common indicators for assessing impact and effectiveness of GBV response and prevention interventions in the African region?
Which are the most appropriate and effective methodologies to evaluate GBV interventions?
How do we harness undocumented research evidence and data in local contexts?
To what extent is programming on GBV supported with existing data and research?
To what extent is GBV data disaggregated to inform GBV prevention and response interventions?

Annex E: Additional questions proposed in question-ranking survey

DOMAIN 1: UNDERSTANDING GBV
What are the most common forms of GBV in regions affected by conflict, crisis and climate change in Africa?
What are the types and prevalence of politically motivated violence against women and girls, especially in conflict settings, and the impact on women's meaningful participation in politics and decision-making?
What are the types and prevalence of school-related GBV in Africa, including in higher education settings?
How do societal attitudes, stereotypes and cultural norms contribute to the vulnerability of women with disabilities to GBV in African communities?
What are the risk and protective factors for perpetration and victimisation of, and social norms influencing, school-related GBV, including in higher education settings?
How do multiple forms of structural inequality impact on the prevalence of different types of GBV across different country contexts?
How does colonial history impact the social determinants of GBV?
How do customary marriage and high dowry prices drive IPV against women, and violence against widows by their in-laws?
What is the role of religion in reproducing harmful practices, including FGM?
How has climate-induced food shortage predisposed women to the commodification of their sexual agency and self-determination in exchange for sex, subsequently leading to GBV?
What are the African traditional cultural practices and beliefs that support gender equality and are protective against GBV, such as (traditional) egalitarian forms of social organisation?
What are the endogenous measures for managing GBV in African communities?
What is the role of older women in perpetrating violence and harmful practices against other women and girls (e.g., FGM, widow violence, breast ironing), including using these as a source of livelihoods?

DOMAIN 2: GBV RESPONSE INTERVENTIONS
What is the impact of court rulings on community perception of justice and deterrence of GBV crimes?
What type of collaboration can be made between the government, elders and justice providers to protect communities from sexual violence?
What are the most successful strategies for holistic care, reparation for survivors and the fight against impunity?
What factors hinder the criminalisation of GBV, particularly IPV, in Africa?
What reform needs to happen around customary marriage in Africa to stop it being a driver of GBV?
What needs to be done to improve the capacity of legal support centres to respond to cases of GBV?
In which ways can GBV survivors, including those living with HIV/AIDS, be supported to reintegrate back into their communities without being discriminated against?
To what extent do current GBV response approaches and strategies promote reintegration of both victims and perpetrators to avoid the recurrence of violence?
How effective are GBV response interventions designed for stable settings that have been implemented in conflict and politically unstable environments?
How can we ensure that response protocols for GBV are holistic and provide the minimum standards for interventions?
How effective are one-stop centres in providing multiple interventions and how can we sustain and maximise the use of one-stop centres in Africa?
How can we best support effective and efficient localisation of GBV response, including through local, women-led organisations?
What are the different roles of governments and CSOs in providing GBV response services, and how can they be more effectively co-ordinated?
What are survivors' experiences of GBV response systems and services, and how can their voices help to shape better-quality, survivor-centred responses that do not retraumatise?
What are the experiences and perspectives of women with disabilities who have successfully accessed GBV support services or prevention programmes?
What are the barriers to GBV survivors' access to services, and how do these differ for survivors from different marginalised groups and different geographical locations?
What are the specific challenges and barriers faced by women with disabilities in reporting and accessing GBV support services?
What are the main reasons for under-reporting of GBV, including among different population groups?

DOMAIN 3: GBV PREVENTION INTERVENTIONS
In contexts of extreme insecurity and displacement, what are the community strategies used to prevent the perpetration of non-partner GBV?
What are the endogenous measures for managing GBV according to African communities?
How can we ensure that those who have the most influence (faith and cultural leaders) are leading the advocacy to shift social norms and cultural/religious narratives that tacitly encourage GBV?
Which approaches are most effective in sensitising local community and cultural leaders on the dangers of harmful norms driving GBV, and alternative ways to prevent GBV?
Which interventions are most effective in preventing GBV in schools?
What is the impact of early childhood or early prevention programmes in shaping social change and transforming attitudes and behaviour?
Which interventions are successful in preventing online violence, including revenge porn?
What are the most effective ways to integrate the concept of non-violence into GBV prevention curricula?
Which GBV prevention interventions are most successful at supporting positive masculinities in different African contexts?
DOMAIN 4: GBV RESPONSE AND PREVENTION AT SCALE
What is the strategic role of community-based and national women-led organisations in responding to GBV?
What are the best mechanisms to establish effective co-ordination between the chain of stakeholders implicated in GBV prevention and response, including government and civil society?
How can interventions be implemented in countries of very limited political willingness, where civil society cannot act independently, and international organisations are frequently not allowed to work?
How can collaboration between various stakeholders, such as government agencies, disability organisations, NGOs and communities, be improved to enhance GBV prevention efforts for women with disabilities in Africa?
How can climate-risk mitigation interventions be linked to GBV prevention programmes in fragile contexts?
How far have governments gone on the implementation of frameworks, policies and by-laws in protection of GBV victims/survivors, and what are the key achievements, lessons learnt and challenges?
What are the existing legal frameworks and policies in African countries regarding GBV prevention and protection of women with disabilities, and how effectively are they implemented?
What policies support budgeting and implementation of anti-femicide-related programming in different African countries?
What are the impacts of both government and institutional policies on GBV response and prevention efforts, including in workplace and educational settings?

How can technology and digital platforms be leveraged to facilitate the delivery, monitoring and evaluation of GBV interventions at scale, ensuring wider reach, real-time data collection and swift response?
Which innovative approaches can be used to ensure the widespread dissemination of educational materials in proven GBV prevention methodologies/curricula/toolkits, considering that current methods often have limited reach, benefiting a fraction of the population, and whose change is difficult to sustain?
Should GBV prevention and response programmes come as a block or can they be separated, particularly with funding from donors?
What are the interlinkages between GBV prevention and response, and how can integrated approaches enhance effectiveness and impact?
DOMAIN 5: MEASURES AND METHODOLOGIES
How can advancements in technology, such as digital data collection tools and machine-learning algorithms, be leveraged to improve the accuracy and efficiency of measuring and monitoring GBV, while addressing ethical considerations?
How can new ways of knowing that are less scientific, including practice-based knowledge, also be considered to expand our knowledge about GBV?
Which local practices/methods that have been proven to work in measuring changes in GBV, are worthy of replication elsewhere in the continent?
How can the design of methods in GBV research be strengthened through deeper engagement with survivors?
When collecting data related to GBV, what are the strategies and methods to ensure confidentiality and consent for persons with different types of disability, including those with cognitive, hearing and speaking impairments?

UN Women in Africa and the Sexual Violence Research Initiative (SVRI) are committed to contributing to a world where women in all their diversity and children can enjoy their right to live free from violence. Recognizing the power of knowledge generation and the need for more equitable and inclusive research processes in efforts to end GBV, UN Women and the SVRI have collaborated to facilitate the Africa Shared Research Agenda for ending GBV (ASRA).

The Africa Shared Research Agenda (ASRA) for ending gender-based violence (GBV) is a set of research priority recommendations for the field, which have been identified through a rigorous, comprehensive and inclusive process that centres the opinions and voices of those for whom the research will serve. It is a unique and diligent approach that carries the spirit of collaboration and collective power essential for bringing about an end to GBV. The ASRA draws from the lessons of the Global Shared Research Agenda on Violence against Women and has been shaped through a collective process of learning and consultation. It is a contribution to the Generation Equality Action Coalition on Gender-based Violence and provides insight into the key research questions identified as priorities for ending GBV by diverse experts based in and working in Central, East, Southern and West Africa.

SVRI sexual violence research initiative

UN WOMEN