

# DATA COLLECTION FOR GENDER-BASED VIOLENCE RISK MITIGATION

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## Purpose

In this document, we will outline how to go about data collection for the purposes of implementing GBV risk mitigation and identifying and analyzing gender-based violence (GBV) risks. This document is accompanying the Excel-based GBV risk mitigation indicator matrix.

Gender-based violence (GBV) is the most pervasive yet least visible human rights violation in the world. At least one in three females – over one billion worldwide – will experience physical and/or sexual violence in their lifetime. Humanitarian emergencies, including conflict and displacement, increase the risk of GBV, making it a day-to-day reality for many women and girls in humanitarian settings. GBV has a direct impact the outcomes of all sectors. Unsafe programming in all sectors can also increase the risk of GBV, if these risks are not identified and addressed throughout the humanitarian programme cycle.

GBV risk analysis is based on a thorough gender analysis with a focus on specific risk factors that increase likelihoods of GBV. This guide outlines how to integrate a GBV lens in data collection and analysis so that UNICEF-led clusters/AoR can analysis GBV risks related to their sector in Humanitarian Needs Overview (HNO) and develop suitable GBV risk mitigation measures in the Humanitarian Response Plan.

*Gender-based violence (GBV) is an umbrella term for any harmful act that is perpetrated against a person's will and that is based on socially ascribed (i.e. gender) differences between males and females. It includes acts that inflict physical, sexual or mental harm or suffering, threats of such acts, coercion, and other deprivations of liberty. These acts can occur in public or in private. All humanitarian actors must be aware of the risks of GBV and—acting collectively to ensure a comprehensive response—prevent and mitigate these risks as quickly as possible within their areas of operation. [IASC GBV Guidelines 2015](#).*

Gender-based violence does not happen in a silo and is often linked to risks that occur in the (operational) environment of humanitarian contexts. As noted above, all humanitarian actors hold a duty to be aware of risks of GBV and act to mitigate those risks within their areas of operation. Yet, it is not always clear, particularly to humanitarian actors who are not GBV specialists, what data they need to collect to analyze GBV risks within their area of operation. In addition, GBV specialists may also not always have the tools to support other sectors in collecting data for GBV risk mitigation. Therefore, the purposes of these documents are twofold:

1. To provide guidance to UNICEF-led clusters/AoRs (or all clusters) on how to do GBV risk analysis for the Humanitarian Needs Overview through strengthening data collection and analysis.
2. To provide GBV actors with guidance on areas of collaboration with other sectors on data collection and analysis to strengthen overall GBV risk analysis in the Humanitarian Needs Overview.

While the GBV risk mitigation indicator matrix includes indicators mainly for needs assessment and identification for HNO purposes, but can also be used for monitoring of GBV risks and the effectiveness of GBV risk mitigation during implementation. Some of indicators in the matrix could be used for monitoring and more supplementary information is available in the [GBV Guidelines pages on Measuring GBV risk mitigation in humanitarian settings](#).

## How to use this guidance and the indicator matrix?

The indicator matrix lays out indicators to identify, analyze, and monitor risks for gender-based violence (GBV) per sector. Once GBV risks per sector are identified at large, an appropriate response strategy can be written to mitigate these risks. Please keep in mind that at programmatic level, additional indicators may be needed to identify and analyze GBV risks.

## What is GBV risk mitigation?

Concretely risk mitigation means ensuring humanitarian service delivery:

- (1) does not increase the likelihood of GBV occurring;
- (2) seeks to identify and mitigate GBV risks; and
- (3) conducts ongoing monitoring of access and barriers to services, particularly those faced by women and girls.

“All humanitarian actors must be aware of the risks of GBV and—acting collectively to ensure a comprehensive response—prevent and mitigate these risks as quickly as possible within their areas of operation.” (IASC GBV Guidelines)

Risk mitigation refers to actions undertaken across other programmatic sectors to reduce risks of GBV. GBV risk mitigation in programmatic sectors (other than GBV) means that sectors are working to make humanitarian systems and services safe, protective, and responsive to the needs of women and girls. Risk mitigation is simply quality, *safe* programming, i.e. designing and implementing programmes that uphold the principle of *Do No Harm*.

## What are GBV risks?

GBV risks are factors that increase the likelihood of GBV occurring. GBV risks contribute to – but are not the same as – incidents of GBV or forms of GBV (such as sexual violence or intimate partner violence). The figure above provides a non-exhaustive list of *examples* of GBV risks at individual/family, community and societal levels.

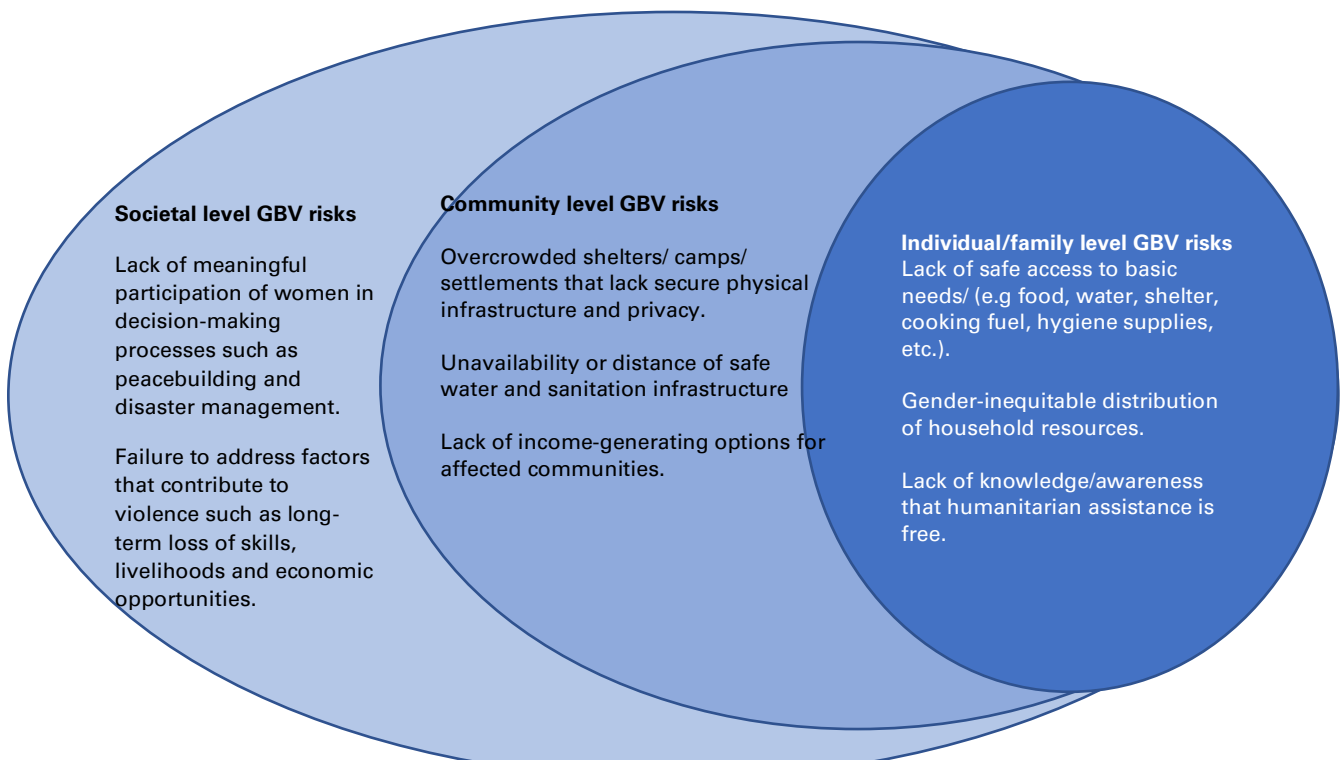


Figure 1. Examples of GBV risks in humanitarian settings.

## What type of information do you need for GBV risk analysis?

The indicator matrix include list of indicators, data collection methods and sample questions that you can use in your assessment. Broadly the following type of information is needed to analyze GBV risks in your sector<sup>1</sup>:

1. Barriers to accessing services
2. Safety perceptions of women and girls
3. Contextual information
4. Other information such as coping mechanisms

All these types of information are related to each other and some indicators could be categorized to all three types of information. That is why it is critical to triangulate different data to identify risk factors related to your sector and as needed to conduct additional data collection activities such as Focus Group Discussions to supplement more information to unpack risk factors into programmable level data. This means that for most indicators listed, there are *quantitative* (for example, household surveys or key informant interviews) and *qualitative* ways (for example, FGD) listed to obtain data. However, keep in mind that discussions with women and girls are key to including their voices and opinions and are always key to provide more in-depth understanding.

Indicators to measure GBV risks may not always be easy to identify, or it may not always be obvious how an indicator can help measure GBV risk. This is why the indicator matrix also has a 'rationale' column, where the reasons for including the indicator and how it may link to GBV are listed.

1. Barriers to accessing services

The indicators in the matrix are categorized according to the Availability, Accessibility, Acceptability and Quality ([AAAQ framework](#)). Typically, people in humanitarian situations face barriers to information, services and goods. The barriers are often divided into four to five different categories. In GBV risk mitigation, we work with the AAAQ framework: availability, accessibility, acceptability, and quality. The four identified barriers consist of larger categories that can contain different barriers. For example, 'accessibility' barriers can exist of physical constraints (e.g. a broken bridge or flooded road), economic constraints (no income or price inflation), or safety (checkpoints or armed attacks on the route).

**Availability** refers to the actual presence of goods, services, facilities, and infrastructures in the location of concern through all forms of domestic production (e.g. farming), trade (e.g. commercial imports), stock (e.g. food reserve, contingency stocks, etc.), and transfer (aid or subsidies or free services) by a third party (the national government, local authorities or humanitarian actors).

**Accessibility** refers to people's ability to obtain and benefit from goods and services, including those offered by humanitarian agencies. It often concerns the physical location of services (distance, road access, bridges, etc.), but can also be influenced by purchasing power, social discrimination, special vulnerabilities, or security issues that constrain movements.

**Acceptability** refers to whether the provision of goods and services is done in a respectful manner, and mindful of the culture of individuals, minorities, peoples and communities.

**Quality** refers to the degree of excellence, benefits or satisfaction that one can enjoy when consuming a good or a service. Quality may depend on the number of people with the required skills and knowledge to perform a given service or produce a good but is also influenced by the reliability (consistency of quality over time), diversity and safety of the provided service or good (i.e. water quality, sterilization of medical tools, pharmaceuticals, etc.). It is important to stress that affected populations may have a different perception of quality compared to humanitarian agencies.

Source: [Basic Needs Assessment Toolbox](#), Okular Analytics & Save the Children

<sup>1</sup> Classification adapted from the Harvard Humanitarian Initiative (HHI) and UNICEF project on measuring GBV risk mitigation

The barriers above contribute to programming not reaching its goal of decreasing humanitarian needs, but can also contribute to increasing the likelihood of GBV. This is why good programming across all sectors consists of a barrier analysis that is done from a gender-lens, as barriers to accessing goods and services can be, and often are, gender-based. For example, the need for a husband's approval to leave the house is a very common barrier for women and children in accessing nutrition services in a very patriarchal community. Due to this barrier, women and their children may not be able to access nutrition services even if they need it. Sometimes, women may take a risk to access services without their husband's approval. As a result, they might face domestic violence at home. For more examples of barriers per sector, see Annex 3.

The indicators that measure barriers are referred to as 'AAAQ'.

## 2. Reported safety perception of women and girls

In addition to barriers, how safe women and girls feel accessing a facility or services can help identify the overall level of risk in your sector. "Feeling safe" is of course based on perception, yet this can still help inform whether women and girls feel comfortable using services and whether they are likely to use them based on perceived risk. Measuring this requires a careful approach to data collection and analysis in order to better understand why women and girls may not feel safe accessing goods or services. Questions should be framed carefully, to focus on risks in services rather than 'general' protection risks that may occur in the environment. In addition, measuring safety is not always straightforward and some questions may work better than others (e.g. starting with "do you fear...?" rather than "do you feel safe...?"). Generally, the best way to collect this information is through consultations, specifically focus group discussions. Adding this type of data collection is best done in collaboration with GBV specialists.

These indicators are referred to as "safety perception" in the indicator matrix.

## 3. Contextual indicators

Contextual indicators are those that are key to understand more of the context surrounding GBV risks, for example gender dynamics and norms. These contextual indicators will help to better understand barriers to services and safety perceptions of women and girls, and are part of any gender analysis.

## 4. Other information e.g. coping mechanisms

Some of the information that is already being collected in sectors can be useful to incorporate into GBV risk analysis. For example, coping strategies can which in turn can increase the risk of exposure to GBV. For example, a lack of food can lead to different coping mechanisms – one of which could be engagement in survival sex, which comes with different GBV risks. These indicators can be combined with other data points to help overall analysis.

The indicators related to other information are categorized as "Other" in the indicator matrix.

## Integrating a GBV lens into needs assessment and needs identification

The common data collection techniques used to obtain data for GBV risk analysis in a humanitarian setting (key informant interviews, household surveys, focus group discussions, safety audit), lend themselves for obtaining data on different aspects of the AAAQ framework. Finding risks in your sector can be done through using these different data collecting techniques. There is usually no *one size fits all* indicator to collect information on GBV risks. Instead, combining multiple indicators and triangulating data to find potential barriers to accessing services and GBV risks is recommended. In addition, **consultations with women and girls (e.g. FGDs), particularly on access barriers and potential risks are highly recommended at every stage of the programme cycle. Not only does this allow women and girls to voice their opinions, it can lead to finding access barriers and solutions that we sometimes do not think of. Consulting with women and girls will therefore lead to better and safer programming, as well as the reduction of GBV risks.** Read more below on how the different techniques can inform different aspects on the framework.

There are several steps to take to gather information on GBV risks in your sector. The steps are adapted from the HPC guidance and [JIAF Guidance](#).

### *Step 1: Planning and design*

Go through the indicators for your sector, define your information needs and review the indicators.

### *Step 2: Data collection and collation*

List all assessments including sectoral and multisectoral assessments available, as well as other sources and surveys. Conduct a secondary data review based on all sectoral and multisectoral assessments, as well assessments conducted in other sectors that may contain information on the indicators.

From there, define what information is missing (information gaps), and which indicators you want to collect through primary data collection. Set up primary data collection exercise. Then identify data collection methods and questions for each indicator. In the indicator matrix, questions per data collection method are already listed.

These GBV risk mitigation indicators can be integrated into your sectoral assessments, or you could choose to do a specific assessment on GBV risk mitigation in your sector. In addition, GBV risk mitigation indicators can also be integrated into multi-sectoral needs assessments.

Whichever approach chosen, we do always recommend to supplement any data collection with **consultations, with women and girls**, in particular **Focus Group Discussions**. While all data collection techniques are valid, they do often reflect a male perspective (e.g. a key informant or head of household is often male). Focus Group Discussions with women and girls on the other hand, allow for them to voice their opinions and views on many issues, including safety and accessibility of goods and services in all sectors. This will give key insight into GBV risks and what (they think) can be done to mitigate them.

When setting up an assessment/data collection exercise please keep in mind some of the following overarching things:

- Female enumerators: Topics can be sensitive. To include voices of women and girls through for example consultations, it is recommendable to have female enumerators.
- Do not single out GBV survivors as participants for any data collection exercise. In other words, do not hold expert key informant interviews specifically/exclusively with survivors, or do not have a Focus Group Discussion solely with GBV survivors.
- For all data collection: train enumerators/facilitators in how to respond to GBV disclosures in the event this happens.
- Referrals: ensure your enumerators are trained on knowing how to respond to incidents of GBV should a survivor disclose to them.
- Do not include direct questions on GBV to participants in any needs assessment, regardless of data collection technique. In other words, do not ask people after direct experiences of GBV (e.g. “have you ever been raped?”).
- For examples on good and safe to use questions, consult the indicator matrix.

### *Step 3: (Joint) analysis*

Once all data has been collected, analyze both primary and secondary data to identify the barriers, safety perceptions, and other information to define what GBV risks exist in your sector. Analysis can be done jointly with GBV colleagues. Within your sector, you can also discuss measures that can be taken to mitigate GBV risks.

### *Step 4: Validation*

Present output and validate your findings within your sector. In the case of consulting communities, ensure to feed back to them as well. When sharing findings, pay close attention to data protection and once again ensure that everything is anonymized and cannot lead to identification of anyone who has participated in data collection.

# ANNEXES

## ANNEX 1: DATA COLLECTION METHODOLOGIES FOR GBV RISKS

### FOCUS GROUP DISCUSSIONS (FGD)

*What:* Focus Group Discussions (FGD) consist of dialogues between 6-10 people, guided by a facilitator. The purpose of these dialogues is to obtain in-depth information on the participants' perceptions or experiences with a particular topic/range of topics. For GBV, FGDs are particularly helpful as the sensitive topic can be introduced and talked about in non-direct ways, which helps gain understanding on the perception and potential GBV risks. FGDs are recommended to use in any sector, as it is a prime opportunity to gather different groups of people to hear their voices and opinions. Whereas other data collection techniques often reflect voices of men, with FGDs humanitarian actors can choose participants from different sex and age groups, and thus reflect the voices of women and girls in a safe environment.

*Type of data that can be collected:* FGDs lend themselves to collect data on *all aspects* of the AAAQ framework. The availability of services can be discussed beyond the quantitative number of facilities, services, or goods available. Accessibility can be discussed in more ways to really gain an understanding of what peoples' (or different groups') barriers to services or goods may be. Acceptability and quality can be discussed more in-depth. *Safety perceptions and GBV risks* can be discussed in an FGD. Rather than obtaining a quantitative measure on safety ('do you feel safe? Yes/no') people can go into depth on why the affected community may not feel safe accessing a good or service, what their challenges may be, and what potential solutions can be implemented.

In general, even if quantitative studies are available (e.g. from large-scale key informant interviews or household surveys), it is helpful to supplement with Focus Group Discussions as the qualitative information can provide more in-depth understand of the risks that women and girls may face.

#### *Analysis*

FGDs generate a wealth of *qualitative* data. Ensure that you have tools in place to process this data, such as a matrix built in Excel. Especially when having done multiple FGDs, look for recurrent themes or topics in participants' answers.

#### *Do's and don't's*

##### *Set up:*

- Inform relevant leaders/authorities of the FGDs
- Work together with a GBV specialist to review the questions asked
- Ensure you have a private and closed off space when holding FGDs
- Have facilitators/enumerators and notetakers of the same sex as participants



### *During:*

- Establish some ground rules (e.g. let each other finish speaking)
- Do not ask participants direct questions on GBV (e.g. 'have you experienced GBV?')
- When probing for GBV risks, ask participants general questions, such as 'why would someone in your community feel unsafe accessing XYZ service?'
- Use recall periods (recognizable timeframes) when asking questions, particularly when collecting data at different points in time
- Be mindful of the mix of participants. There are instances where participants may be uncomfortable sharing information. For example, younger women may feel uncomfortable sharing their opinions when there are older women present in the FGD.
- See to it that everyone has a chance to discuss and talk. Manage instances where one or some individuals dominate the conversation
- Notetaking should focus both on verbal expressions as well as non-verbal behavior

### *After:*

- Allow for participants to ask questions
- Write down full notes on FGD right after it took place
- Ensure follow up to participants

*Additional resources:* [Consulting with women and girls for GBV risk mitigation](#)

## KEY INFORMANT INTERVIEWS

*What:* A key informant interview is often done with a structured or semi-structured questionnaire. KIIs can give both quantitative and qualitative data. A key informant interview can be done with experts (e.g. humanitarian staff) or members of the community (e.g. community leaders). Sometimes, key informant interviews are done in a more targeted manner for programme evaluation (e.g. a key informant interview with a service user).

When integrating into large-scale data collection exercises such as DTM, keep in mind that key informants are mostly done with members of the community/affected population.

*Type of data that can be collected:* Key informants lend themselves for obtaining data on most aspects of the AAAQ framework. However, most key informant interviews that take place on a large scale will be collected in a quantitative way (i.e. structured interviews with set answer options). Thus, although you will have questions on e.g. 'accessibility' your answers will be limited to set options such as facility X is 'accessible' or 'not accessible'. Questions should therefore be carefully thought through to ensure that the data collected yields a useful response. For *safety perceptions and GBV risks*, this is also an issue as you may generate questions with answers of 'very safe' 'safe' 'not very safe' 'unsafe'. In general, avoid putting in questions that probe for GBV risks.

### *Do's and don't's*

- Train enumerators on referral pathways
- Ensure a private space when interviewing people
- Use recall periods (recognizable timeframes) when asking questions, particularly when collecting data at different points in time
- Do not include direct questions on GBV. For example, do not include questions on whether someone experienced GBV, or knows someone who experienced GBV, etc.
  - If a female KII is interviewed, she could be experiencing trauma or harm from this question. It could be unsafe for her to answer



- If a male KII is interviewed, they could be experiencing trauma or be offended or suspicious by the question

### *Integrating into multi-sectoral assessments.<sup>2</sup> DTM*

IOM's Displacement Tracking Matrix (DTM) is a large-scale multi-sectoral assessment where clusters usually have the possibility to feed in indicators and questions. As such, it is often used to inform the HNO. There are resources available on integrating GBV risk mitigation indicators ('proxy indicators') into DTM [here](#)

### *Analysis*

Keep in mind that the sample size and strategy will influence how the data can be used. A non-random sampling strategy and non-representative sample size is oftentimes used when doing key informant interviews. This should be reflected in the analysis and write up of your report. In other words: your findings cannot be considered as representative of the surveyed population, but are indicative only.

Mostly, large-scale key informant interviews are quantified (i.e. structured surveys) that will facilitate analysis. For open interviews (i.e. without set answer options), look for recurrent themes in the answers of participants.

When integrating into KII multi-sectoral needs assessments such as the DTM, do consider that most key informants will be *male*. In addition, there is often one voice speaking for an entire community. While this does not render data unusable nor irrelevant, it does ask for additional data collection particularly when it comes to GBV risks, as female voices and perspectives need to be included to properly assess and analyze them.

## HOUSEHOLD SURVEYS

*What:* A household survey is a questionnaire that is obtained by interviewing the (usually) head of household, or a person who can respond on behalf of the whole household and its members.

*Type of data that can be collected:* Household surveys lend themselves for obtaining data, mostly on availability and accessibility of the AAAQ framework. Other questions, for example safety perceptions are possible yet they have to be very carefully crafted. Keep in mind that respondents to HH surveys are usually male (heads of household) which influences the data and the extent to which women and girls' perspectives and voices are included. Avoid any questions that ask after experiences of GBV.

### *Do's and don't's*

- Do not include sensitive questions that are culturally inappropriate
- Do not include direct questions on GBV. For example, do not include questions on whether someone experienced GBV, or knows someone who experienced GBV, etc.
  - GBV often takes place *in* the household. A male head of household can refuse to answer this question or be upset. This could lead to dangerous situations.
  - A female in the household experiencing GBV may be very well in the vicinity of her abuser when answering questions. It is therefore extremely dangerous for her to answer such questions.

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<sup>2</sup>The DTM is chosen as one example of a key informant survey. It is chosen here as it is multi-sectoral and non-cluster specific. However, the same principles hold for integrating GBV risk mitigation into other key informant surveys, whether they are cluster-specific or not.

- Use recall periods (recognizable timeframes) when asking questions, particularly when collecting data at different points in time

#### EXAMPLE OF QUESTION TO USE

Do women and girls in this household have difficulty accessing sanitation?

- Yes
- No

If yes, what are the reasons for difficult access?

- Latrines too far
- Do not feel comfortable/safe
- Latrines unavailable (too few)
- Etc.

#### EXAMPLE OF QUESTION TO AVOID

Have you heard of anyone in your community recently experiencing any of the following?

- Sexual violence
- Physical violence
- Emotional violence

#### *Integrating into multi-sectoral assessments<sup>3</sup> MSNA*

There is often a largescale household survey in a humanitarian context, such as the MSNA. This data collection exercise can particularly be used to inform the HNO. As such, GBV risk mitigation questions can also be included into this survey. Pay careful attention not to include direct questions on GBV (see above), and keep in mind that those responding to the survey are often male. In some HH surveys there may be a 'female only' component, i.e. aspects of the survey that are only asked to women (with no one else present), yet this is not common.

When crafting questions for household surveys, keep in mind to not include questions that ask people after incidents or experiences of GBV. Rather, include questions to inquire after barriers to accessing services or safety perceptions if appropriate.

#### *Analysis*

When analyzing household surveys, particularly look at the answers from male headed vs. female headed household. Particularly when looking at GBV risks, keep in mind that female-headed households can have added vulnerability and may have less access to goods and services to cover basic needs, which can put the household at heightened risk. Although the sample size for female headed households is usually not representative, results can be used as indicated.

## SAFETY AUDITS

*What:* Safety audits usually consist of a combination of different data collection techniques. At its core however, safety audits at a minimum consist of *observations*. Observations can be supplemented with e.g. Klls or FGDs. In observing, a humanitarian actor looks at a specific space/place/facility/area to find out whether it is safe, and what potential risks or issues may be present. These audits help humanitarian actors to identify and observe risks and barriers. The analysis of findings can be used to inform risk mitigation actions and to advocate for the improved physical safety of living conditions and improved access to goods and services.

<sup>3</sup> The multi-sectoral needs assessment is one example of a household survey. It is chosen here as it is multi-sectoral and non-cluster specific. However, the same principles hold for integrating GBV risk mitigation into other household surveys whether they are cluster-specific or not, such as VAM, SMART, etc.

*Type of data that can be collected:* Observation in safety audits can be used to collect data on aspects of the AAAQ such as accessibility and quality. A practitioner can observe whether services are safe or accessible for different people. When supplemented with KIIs or FGDs, safety audits can go more in depth to also cover other types of data such as safety perceptions and risks.

#### *Do's and don't's*

- When it is not safe to do so (e.g. armed actor does not want someone to walk around and do assessments), do not walk around with a checklist/board. Observe only with looking at the surroundings and making mental notes. Write down information later when in a safe place.
- Have a checklist available
- Non-GBV specialists may require additional training on doing safety audits and observing facilities and spaces from a risk mitigation lens.

## **ANNEX 2: AAAQ FRAMEWORKS**

The “Availability, Accessibility, Acceptability, Quality” (AAAQ) framework was originally developed for the healthcare sector. Barriers that impede access to services – including those that may not be immediately apparent – can increase the risk of multiple forms of gender-based violence (GBV), particularly in humanitarian emergencies. As such, this adapted AAAQ framework, which helps to identify barriers women and girls may face accessing humanitarian aid and services, forms part of UNICEF’s set of tools for GBV risk mitigation. [Read more on the framework here.](#)



[AAAQ Framework, UNICEF 2019.](#)

## AAAQ framework for Child Protection

AAAQ	Questions for analysis
Availability	<ul style="list-style-type: none"> <li>• Are child protection services<sup>4</sup> available according to the minimum standards?</li> </ul>
Accessibility: Physical accessibility	<ul style="list-style-type: none"> <li>• Are CP services located within a reasonable distance for targeted girls and boys?</li> <li>• Is the route to and from the CP services safe to travel for girls and boys taking into account different age groups and disabilities?</li> <li>• Are there other forms of physical barriers, such as armed guards outside the facility?</li> <li>• Are there any safety concerns for girls and boys in accessing schools?</li> </ul>
Financial Accessibility	<ul style="list-style-type: none"> <li>• Do users have to pay a fee for any CP service? If so, is the fee reasonable/manageable given the economic circumstances/means? Is there a system to provide financial support to those who have no financial means? Who would be the most affected by a fee?</li> <li>• If no formal fee, are there any other hidden fees such as transportation, levy and others that hinder children's access to CP services?</li> </ul>
Bureaucratic/administrative accessibility	<ul style="list-style-type: none"> <li>• Are there procedural steps that children must complete to receive any CP service? Are there any children who are more affected than others?</li> <li>• Are there any children who are not receiving services due to lack of civil documents like registration? Is there a plan to support birth registration and access to other civil documents?</li> <li>• Are there any other bureaucratic/administrative barriers that hinder girls/boys access to CP/other services?</li> </ul>
Social accessibility	<ul style="list-style-type: none"> <li>• Do CP services respect and practice non-discrimination in the provision of services?</li> <li>• Are certain groups excluded from CP services because of language barriers?</li> <li>• Are there adequate numbers of female frontline workers i.e. caseworkers, animators at CFS, volunteers related to FTR, those who accompany children for reunification etc?</li> <li>• Are there social norms/cultural barriers that hinder girls' and boys' access to CP services and other humanitarian services?</li> <li>• Are there social norms/cultural barriers that hinder local women from working at CP services?</li> </ul>
Information	<ul style="list-style-type: none"> <li>• How is information about CP services communicated to the community? Do both women and men know? Do both girls and boys know?</li> </ul>

<sup>4</sup> This includes any of child protection services and facilities such as CFS, a place where case management services are provided, a place where CP related information are provided, CBCPMs.

	<ul style="list-style-type: none"> <li>• Is there an analysis of who makes a decision related CP at home and targeting and do the sector target a right person for information campaign based on the analysis?</li> <li>• Are there any groups of people who are unlikely to receive the information?</li> <li>• Are there alternatives to printed information in order to reach illiterate members of the community?</li> <li>• Is personal information treated confidentially?</li> </ul>
Acceptability	<ul style="list-style-type: none"> <li>• Are the opinions of girls and boys reflected in CP services?</li> <li>• Are CP services respectful of the culture of individuals, minorities, peoples and communities?</li> <li>• Are CP services respectful and open to girls who are pregnant and married?</li> <li>• Is the CP service gender-sensitive?</li> <li>• Are there certain characteristics of the CP (gender balance of teachers, attitude/behaviours of frontline workers etc) that make the community more/less comfortable accessing services?</li> <li>• Are there adequate numbers of female staff and volunteers? If not, are there a plan to increase numbers of female staff/volunteers?</li> </ul>
Quality	<ul style="list-style-type: none"> <li>• Is there a Code of Conduct (CoC) for CP frontline workers which include PSEA and child safeguarding? Are they trained and signed the CoC?</li> <li>• Do CP frontline workers know how to ethically and safely refer GBV survivors to services?</li> <li>• Are the quality of CP services meet the CP minimum standards?</li> <li>• Do all children regardless sex, age, disability and their social status such as refugee, IDPs etc feel respected in CP services?</li> </ul>

## AAAQ framework for Education

AAAQ	Questions to keep in mind:
Availability	<ul style="list-style-type: none"> <li>• Are education services<sup>5</sup> available according to the minimum standards?</li> </ul>
Accessibility: Physical accessibility	<ul style="list-style-type: none"> <li>• Are Education facilities located within a reasonable distance for targeted girls and boys and teachers?</li> <li>• Is the route to and from the Education facility safe to travel for girls and boys also taking into account different age groups and disabilities?</li> <li>• Are there gender segregated latrines in schools?</li> <li>• Are there other forms of physical barriers, such as armed guards outside the facility?</li> <li>• Are there any safety concerns for girls, boys and female teachers in accessing schools?</li> </ul>
Financial Accessibility	<ul style="list-style-type: none"> <li>• Do users have to pay a fee? If so, is the fee reasonable/manageable given the economic circumstances/means? Is there a system to provide financial support to those who have no financial means? Who would be the most affected by a fee?</li> <li>• If no formal fee, are there any other hidden fees such as transportation, levy and others that hinders children's access from education?</li> </ul>
Bureaucratic/administrative accessibility	<ul style="list-style-type: none"> <li>• Are there procedural steps that learners must complete to enroll in education? Are there any children who more affected than the others?</li> <li>• Do children need to have civil documents such as birth registration, documents related to refugee status etc to enroll in schools? If so, is it easy to obtain the documents? Who would have challenges in accessing civil documents and thus enrolling in education?</li> <li>• Is there a policy that prevents pregnant girls and married girls from accessing school?</li> <li>• Are there any other bureaucratic/administrative barriers that hinders girls/boys access to education?</li> </ul>
Social accessibility	<ul style="list-style-type: none"> <li>• Do schools respect and practice non-discrimination in the provision of services?</li> <li>• Are certain groups excluded from education because of language barriers?</li> <li>• Are there female teachers?</li> <li>• Are there social norms/cultural barriers that hinder girls' and boys' access to education?</li> <li>• Are there social norms/cultural barriers that hinder women from working as teachers?</li> </ul>
Information	<ul style="list-style-type: none"> <li>• How is information about education communicated to the community?</li> </ul>

<sup>5</sup> This includes any of education services and facilities such as schools, ECD centres, any place where alternative education is provided, and any places where community mobilisation or information campaign happens.

	<ul style="list-style-type: none"> <li>• Is there an analysis of who makes a decision regarding education at home and targeting a right person for information campaign?</li> <li>• Are there any groups of people who are unlikely to receive the information?</li> <li>• Are there alternatives to printed information in order to reach illiterate members of the community?</li> <li>• Is personal information treated confidentially?</li> </ul>
Acceptability	<ul style="list-style-type: none"> <li>• Are the opinions of target groups, girls and boys reflected in education services?</li> <li>• Are schools respectful of the culture of individuals, minorities, peoples and communities?</li> <li>• Are schools respectful and open to girls who are pregnant and married?</li> <li>• Is the education service gender-sensitive for both students and teachers?</li> <li>• Are there certain characteristics of the education (gender balance of teachers, attitude/behaviours of teachers etc) that make the community more/less comfortable accessing services?</li> <li>• Are there adequate numbers of female teachers?</li> </ul>
Quality	<ul style="list-style-type: none"> <li>• Is there a Code of Conduct (CoC) for teachers which include PSEA and child safeguarding? Are teachers trained and signed the CoC?</li> <li>• Do teachers know how to ethically and safely refer GBV survivors to services?</li> <li>• Does education quality meet the minimum standards?</li> <li>• Do all children regardless sex, age, disability and their social status such as refugee, IDPs etc feel respected in schools?</li> </ul>



## AAAQ framework for Nutrition

AAAQ	Questions to keep in mind:
Availability	<ul style="list-style-type: none"> <li>• Are the nutrition services<sup>6</sup> available according to the minimum standards?</li> </ul>
Accessibility: Physical accessibility	<ul style="list-style-type: none"> <li>• Are nutrition facilities located within a reasonable distance for all women, girls and boys in the targeted area?</li> <li>• Is the route to and from the nutrition facility safe to travel for pregnant and lactating women, mothers with children and other users?</li> <li>• Are there other forms of physical barriers, such as armed guards outside the facility?</li> <li>• Are there any other safety concerns in accessing nutrition services?</li> </ul>
Financial Accessibility	<ul style="list-style-type: none"> <li>• Do users have to pay a fee? If so, is the fee reasonable/manageable given the economic circumstances/means? Who would be most affected by a fee?</li> <li>• If no formal fee, are there any other hidden fees such as transportation that affect people's access to nutrition services?</li> </ul>
Bureaucratic/administrative accessibility	<ul style="list-style-type: none"> <li>• Are there procedural steps that users must complete to access services?</li> <li>• Do the users need to have civil documents such as birth registration, documents related to refugee status etc to enroll in schools? If so, is it easy to obtain the documents? Who would have challenges in accessing civil documents and thus using nutrition services?</li> <li>• Are there any other bureaucratic/administrative barriers that hinder people's access to education services?</li> <li>• Are the facilities open at times that are convenient given the daily/weekly rhythm of women?</li> </ul>
Social accessibility	<ul style="list-style-type: none"> <li>• Are the opinions of target groups i.e. women reflected in nutrition services?</li> <li>• Is non-discrimination respected and practiced in the provision of services?</li> <li>• Are certain groups excluded from nutrition because of language barriers?</li> <li>• Are there adequate numbers of female frontline workers?</li> <li>• Are there social norms/cultural barriers that hinder women, men i.e. single father with children under 5 and children's access nutrition services?</li> <li>• Are there social norms/cultural barriers that hinder local women from working at nutrition services?</li> </ul>

<sup>6</sup> It includes all facilities or places where nutrition services are provided such as IYCF centre, OTP services, health facilities, places where nutrition services are provided, places where distribution happens, places where mothers to mothers groups happen.

Information accessibility	<ul style="list-style-type: none"> <li>• How is information about nutrition services communicated to the community? Do both men and women receive the information?</li> <li>• Do men understand the importance of nutrition services, proper diet and breastfeeding?</li> <li>• Is there an analysis of who makes a decision regarding nutrition at home and targeting the right person for information campaign?</li> <li>• Are there alternatives to printed information in order to reach illiterate members of the community?</li> <li>• Is personal information treated confidentially?</li> </ul>
Acceptability	<ul style="list-style-type: none"> <li>• Are nutrition services respectful of the culture of individuals, minorities, peoples and communities?</li> <li>• Is the nutrition service gender-sensitive?</li> <li>• Are there certain characteristics of the nutrition services (gender balance of frontline workers, attitude/behaviours of teachers etc) that make the community more/less comfortable accessing services?</li> <li>• Are there adequate numbers of female staff and volunteers in WASH? If not, are there a plan to increase numbers of female staff/volunteers?</li> </ul>
Quality	<ul style="list-style-type: none"> <li>• Is there a Code of Conduct (CoC) for nutrition frontline workers which include PSEA? Are they trained and signed the CoC?</li> <li>• Do nutrition frontline workers know how to ethically and safely refer GBV survivors to services?</li> <li>• Does quality of services meet the nutrition minimum standards?</li> <li>• Do all users regardless sex, age, disability and their social status such as refugee, IDPs etc feel respected in nutrition services?</li> </ul>

## AAAQ framework for WASH

AAAQ	Questions to keep in mind:
Availability	<ul style="list-style-type: none"> <li>• Are WASH facilities<sup>7</sup> available according to the minimum standards?</li> </ul>
Accessibility: Physical accessibility	<ul style="list-style-type: none"> <li>• Are WASH facilities located within a reasonable distance in the targeted area? Who are most likely have a problem in accessing?</li> <li>• Is the route to and from the WASH facilities safe to travel for all i.e. women, girls and boys in taking into account disabilities and age groups? Who would have a problem and why?</li> <li>• Are there street lights on the route to and from the WASH facilities i.e. latrines?</li> <li>• Are there other forms of physical barriers, such as armed guards outside the facility?</li> <li>• Are there any other safety concerns in accessing WASH facilities?</li> </ul>
Financial Accessibility	<ul style="list-style-type: none"> <li>• Do users have to pay a fee i.e. water supply? If so, is the fee reasonable/manageable given the economic circumstances/means</li> <li>• If no formal fee, are there any other hidden fees such as maintenance cost?</li> <li>• Is there a financial support for those who cannot afford the fee both formal and hidden fees? Who would be the most affected by a fee?</li> </ul>
Bureaucratic/administrative accessibility <sup>8</sup>	<ul style="list-style-type: none"> <li>• Are the hygiene promotion and other WASH activities organized at times that are convenient given the daily/weekly rhythm of affected population e.g. women?</li> <li>• Are there procedural steps that users must complete to access to WASH related services?</li> </ul>
Social accessibility	<ul style="list-style-type: none"> <li>• Is the design of WASH facilities i.e. latrines and bathing cubes/spaces culturally acceptable? Is it designed based on consultation with affected population i.e. women, girls and boys?</li> <li>• Are the MHM kits or any items related to MHM culturally acceptable? Are they selected based on consultations with women and girls in reproductive age?</li> <li>• Do female staff/volunteers prove the MHM kits and information related to MHM?</li> <li>• Is hygiene promotion culturally relevant? Is it giving burden to women?</li> </ul>

<sup>7</sup> It includes all WASH facilities such as latrine, bathing space, water points, waste disposal points, the point where distribution happens in case of NFI distribution is implemented, and where hygiene promotion takes place.

<sup>8</sup> This might be more relevant to urban context where people have to register and pay water.

	<ul style="list-style-type: none"> <li>• Are there social norms/cultural barriers that hinder especially women and girls access to WASH facilities and services?</li> <li>• Are there social norms/cultural barriers that hinder local women from working at WASH services?</li> </ul>
Information accessibility	<ul style="list-style-type: none"> <li>• How is information about WASH services communicated to the community? Do both men and women receive the information?</li> <li>• Is there an analysis of who makes WASH related decisions at home and are the right people targeted in information campaigns?</li> <li>• Are there alternatives to printed information in order to reach illiterate members of the community?</li> <li>• Is personal information treated confidentially?</li> </ul>
Acceptability	<ul style="list-style-type: none"> <li>• Are the opinions of target groups i.e. women and girls reflected in WASH services?</li> <li>• Are there certain characteristics of the WASH services (gender balance of frontline workers, attitude/behaviours of teachers etc) that make the community more/less comfortable accessing services?</li> <li>• Same questions as the social accessibility.</li> </ul>
Quality	<ul style="list-style-type: none"> <li>• Is there a Code of Conduct (CoC) for WASH frontline workers which include PSEA? Are they trained and signed the CoC?</li> <li>• Do WASH frontline workers i.e. those who engage with women and girls know how to ethically and safely refer GBV survivors to services?</li> <li>• Are the quality of WASH services meet the WASH minimum standards?</li> <li>• Do WASH facilities meet SPHERE standards which also include a lock, gender segregation, and appropriate distance?</li> <li>• Do all users regardless fo sex, age, disability and their social status such as refugee, IDPs etc feel respected in WASH services?</li> </ul>

## ANNEX 3: EXAMPLES OF BARRIERS AND RISKS

Below are **examples** of barriers women and girls may face in humanitarian contexts. The barriers are only examples and are not an exhaustive list. The examples have been taken from the [Emergency Preparedness and Response guidance \(2020\)](#).

### WASH

- **Lack of available WASH facilities and services:** a lack of latrines (barrier) for example can promote open defecation. Women and girls may even delay eating on time just to avoid open defecation.
- A lack of access to water could for example contribute to tension and domestic violence among community members particularly in water-scarce or drought-affected areas. Queuing for extended periods increases the time that women and girls are out collecting water, which can create tensions at the water points and at home. Women, girls and sometimes boys may have to walk long distances to collect water or to find water to do laundry. At times they must walk to remote locations. They may even use unsafe routes including passing through heavily militarized terrains to access WASH facilities or services. Without adequate hygiene supplies, women and girls in reproductive age may not participate in group activities because they cannot afford dignity/hygiene supplies.
- **Unsafe WASH facilities/services:** women and girls may not be consulted in the design of facilities. WASH facilities/services that are designed can be insensitive to the gender dynamics of a given society or cultural context. For example the location of facilities, materials used, and design can all influence the safety of women and girls. Due to certain social norms, women and girls may wait to use existing latrines after dark, for example if they should not be seen outside the home and/or without a male companion, or if they feel unsafe accessing services. Vice versa, facilities in the dark can also be unsafe which may lead women and girls to not use them.
- **Lack of women and girls' participation in WASH programming:** men providing WASH services may be potential perpetrators of GBV and SEA and might not be aware of the specific needs of women and girls.

### NUTRITION

- **Existing gender inequalities and social norms:** social norms/cultural practices may impede women and girls from making decisions about what to eat and when. During displacement resulting from conflict or natural disaster, food may be lacking or scarce. Where food is available, men often are the ones to decide on food which has significant impact on pregnant and lactating women. Men may trade family food for personal reasons. Where child marriage or polygamy are practiced, adolescent girls or women with special needs may have increased barriers accessing food on time. Cultural eating practices differ, and in some contexts women and girls can be among the ones to eat last and less nutritious scraps. In addition, barriers for women to own land may also limit their access to food. Female headed households tend to have less access to food and markets as in many contexts women should not be in public without a male companion.
- **The Lack of basic needs including food** may push women and adolescent girls to engage in negative coping mechanisms, including survival sex. Child marriage rates can also increase due to food insecurity
- **Design of nutrition facilities and services:** locations wherein nutrition facilities are located can put women and girls at risk. It is often women who take children to facilities, the route to and from facilities can be dangerous. At the facility itself, there should be checks for safety,

including safe WASH facilities. The waiting time at facilities can be another risk factor if women and children take too long to return home.

- **Behavior and attitude of nutrition personnel:** during emergencies, personnel are often recruited quickly to life-saving interventions. If not trained on protection, this may increase potential for sexual exploitation and abuse.

## **EDUCATION**

- **Existing gender inequality and social norms:** Boys can be favored over girls to pursue education. In some contexts, girls may only be able to go to school up to a certain age (usually before adolescence), or not at all, as it is deemed unnecessary for girls to pursue education.
- **Lack of learning spaces:** existing learning spaces may be unavailable or damaged/destroyed by conflict or disaster. Armed groups can occupy learning spaces. When learning spaces are located far away, children may have to go dangerous routes to access school which exposes them to risks including GBV. The unavailability of learning spaces means children will have to stay at home. After long periods of staying at home, it is more difficult for girls to return to school. Girls in particular can be married off earlier when not attending school, child protection risks for both boys and girls increase outside school.
- **Loss of legal documents:** during emergencies, children may lose their legal documentation including school documents. This may affect them accessing education services in displaced settings.
- **Language barriers:** language barrier may also deprive children from accessing education services in some displaced settings.
- **Unsafe design of Education facilities/services:** Education facilities and services may be designed without community inputs thus increasing safety risks for children, particularly girls.
- **Limited basic needs:** the loss of livelihoods, family and community support network can make life difficult for adolescent girls. In many cases, they may not be able to meet their needs of clothing, shoes, etc. to go to school. This may in turn increase their vulnerability to sexual abuse.

## ANNEX 4: EXAMPLE OF OUTPUT FROM GBV RISK ANALYSIS (USING PRIMARY AND SECONDARY DATA): AFGHANISTAN

### CRISIS OVERVIEW

Continued fighting in Afghanistan leads to immediate and long-lasting burdens on the civilian populations. The Taliban still holds large swaths of territory, and the political situation has become more complicated in recent years with the emergence of different non-state armed groups (pro- and anti- government) including Islamic State. Postponed elections contribute to unrest and conflict. In the first half of 2020, at least 1,280 people were killed and 2,170 people were injured. Children continue to be recruited and used by parties to the conflict, including for sexual exploitation and sexual violence. Women continue to face many protection issues stemming from conflict. Over 40% of casualties in the first half of 2020 were women and children.

Next to conflict, the country faces several natural disasters that affect the population, such as floods, as well as drought in the west. Since the beginning of 2020 and as of June/July, over 6,000 households were affected by natural disasters and over 100,000 people were displaced due to conflict ([OCHA 06/2020](#); [WHO 08/2020](#)). On top of the displaced population, around 450,000 people returned to Afghanistan mostly from Iran during the period January–July ([UNHCR 08/2020](#)).

On top of the conflict, COVID-19 has led to many measures that restrict peoples' freedom of movement and increases their barriers to access facilities and services ([UNAMA 08/2020](#)).

### SOCIODEMOGRAPHIC ENVIRONMENT

As of 2019, Afghanistan ranks 170/189 on the gender inequality index, making it one of the least gender equal countries worldwide ([UNWOMEN 30/04/2020](#)).

**People with disabilities:** Among adults, the disabilities rates are estimated to be as follows: 13.9% have severe disabilities, 40.4% moderate disabilities, 24.6% mild disabilities. For children those percentages are 3.5%; 7.1%; and 6.6% respectively. This means that almost 80% of adults in Afghanistan have some form of physical, sensory, functional, or other impairment. Severe disability is more prevalent among women (14.9%) than men (12.6%). Next to that severe disability is also more common among uneducated, unemployed and divorced and widowed adults. The incidence is highest in South East (20.5%), West (25.4%), and Central Highland (25.4%) regions ([Asia Foundation 13/05/2020](#)).

**Female-headed households:** Across the 2020 Whole of Afghanistan assessment, generally less than 5% of surveyed households constituted female-headed households. Though this does not represent the total number of female-headed households in Afghanistan, some of the answers given by female heads of household can shed some light on the conditions they live in. For example, 61% of female heads of household that responded to the WoA were widows, compared to only 1% of male head of household respondents. Thus it appears that for a woman to be head of household she is likely widowed. Generally the female HoH respondents to the WoA did not appear to live in different conditions compared to male HoHs, but (e.g. not using more negative coping mechanisms, having more debt, etc.) yet there seems to be a clear difference in their ability to access goods and services.

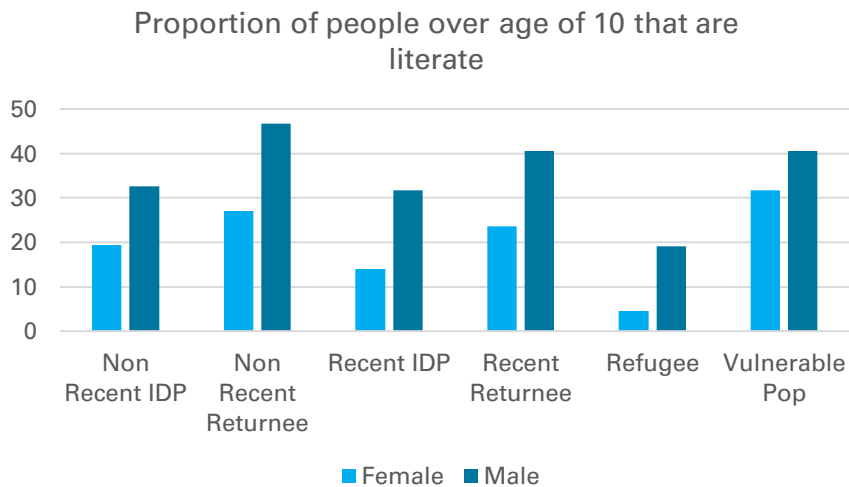
**Economy:** The poverty rate is expected to be up to 72% over 2020. The real GDP is expected to contract between 5.5%– 7.4% due to economic disruptions related to COVID. The impact of COVID is expected to be most noticeable for households that depend on activities vulnerable to the COVID measures such as lockdowns, which includes small-scale retail and daily laborers. An estimated 15 million Afghans live in households that derive more than half of their income from such activities.



30% of them live in urban areas where lockdowns were implemented. ([World Bank 07/2020](#)). GBV and poverty have been interlinked in numerous studies.

**Substance abuse:** Both heroine and opium abuse are common in Afghanistan. Studies have shown that there are linkages between GBV and substance abuse. 40 residential drug treatment centres in Afghanistan, seven drop-in (outreach) centres operate throughout the country and ten community centres which are funded by the Counter Narcotics Trust Fund. Sixteen of these centres provide residential treatment for men and outpatient services for women. Two services provide treatment for adolescents

**Education:** The illiteracy rate for women in Afghanistan is estimated at 83%. The high rates of illiteracy, combined with the fact that many women and girls are confined to their houses, means that they access information in limited ways. In a survey done across all provinces in Afghanistan, 43% of respondents thought that a lack of educational opportunities is the biggest problem women and girls face ([Asia Foundation 2019](#)).



When looking at the Whole of Afghanistan assessment (WoA REACH 2020) data, across six different population groups it is shown that male and female literacy rates differ with male literacy rates about twice as high according to displaced household respondents.

## SOCIALCULTURAL AND RELIGIOUS ENVIRONMENT

The social standing of women and girls can vary according to education, local culture, economics, ethnicity, religion, and geography. In more urban areas such as Kabul, the standing of women and girls in society is better than those in rural areas, particularly those under Taliban control. In urban areas, women and girls do have opportunities to work outside the home, whereas opportunities may be fewer in rural areas. Women are generally considered property of their fathers, and later on of their husbands ([UK Government 03/2020](#)). Over the years, there have been slow steps towards increasing women’s participation in public life, education, and the workforce. However, there are fears that due to COVID-19 measures, gains made in those areas may be eroded ([Oxfam 04/2020](#)).

**GBV perception:** As women are generally seen as property of a male family member (fathers or husbands), it is generally considered that treatment of women is a private affair that is taken care of

within the household. Generally, violence or abuse of women and girls is not seen as a crime in many communities ([UK Government 03/2020](#); [UNAMA 27/11/2019](#)). According to the 2015 Demographic Health Survey, an estimated 72% of ever-married men and 80% of ever-married women believe that a husband is justified in beating his wife ([UNFPA 06/2020](#)).

Due to the high levels of particularly domestic violence and intimate partner violence, GBV has been normalized in Afghan society. There are many reports of retaliation against women and girls who speak out. This includes beating, maiming, murder, or women and girls killed under the name of ‘honor’ killings.

**Religious and legal practices:** While the Afghan government has in place laws that should prevent violence against women, the rule of law in Afghanistan is weak in many areas. This means there are different justice systems at play: the Taliban has its parallel justice system in areas under its control. Mediation for violence against women is common. In addition, local or traditional justice systems (*Jirga*) are still practiced in many rural areas without government representatives. A *jirga* dispute can be settled with *baad*, or the giving away of a woman. Typically, the dispute is then settled through ‘giving’ a woman from the offender’s family to the victim’s family. Mediation for disputes regarding violence against women, including honor killings, remain very common approaches to justice in *jirga* ([UNAMA 2018](#); [UK Government 03/2020](#)). Though *baad* has reportedly become more rare over the years, and some *jirga* have increasingly voiced against domestic abuse, the lack of female representation at any stage of *jirga* obviously remains of concern. In addition, there are many other actions of women that can be punished by *jirga*. This includes when a woman runs away from her house, for example in the case of forced marriage ([UNAMA 2018](#)).

**Gender roles: Division of labor:** While some women may work jobs outside the home, this is not very common. In a survey done across all provinces in Afghanistan, about 18% of respondents said that women contribute to income generation for the household. Some 87% of urban residents and 80% of rural residents said that women do not contribute to household income ([Asia Foundation 2019](#)). However, in some provinces such as Herat, Balkh, and Daikundi, it is not uncommon for women to earn some income through teaching, or home-based activities such as dairy production or handicrafts ([Oxfam 04/2020](#)).

When looking at female respondents only, only 10% of females say they earn an income. This is lowest in Helmand (0.4%), Kunar and Wardak (3.6%), and Badakhshan (3,8%) provinces ([Asia Foundation 2019](#)).



FIG. 3.8: D-3. Do you yourself do any activity that generates money? (Female respondents only, percent who say yes.)

Women are generally responsible for all household chores, including fetching water, meaning her labor while a lot and time-consuming, is unpaid. Women are also responsible to take care of family members. While COVID-19 may have restricted livelihood activities, it is unlikely that women who have to take care of the household has seen any reduction in their chores, and if they did get sick due to COVID it is unlikely that they could have sufficient recovery time at home as household chores still remain ([CordAid 20/06/2020](#)).

*Household decision-making:* In general, before the pandemic, the majority of the decisions in the household around the use and management of resources and access to services, including health care, had been made by men. Similar decision-making trends during COVID-19 persist.

In a Rapid Gender Analysis for COVID-19 by CARE, only 50% of women respondents stated that they are involved in a range of decision making, while only 19% of them hold decision-making power, the remaining 31% reported no involvement in household decision-making. On the contrary, 56.68% of men respondents indicated they have decision-making power, and only 17.6% claimed no involvement in important household decisions. 5% of men responded that their decision-making power is shifting since COVID-19, and they are jointly making decisions with the women in their family. None of the female respondents highlighted such changes ([CARE 08/2020](#)).

*Women in education:* Though women and girls particularly in more urban areas do have some opportunities to pursue education, educated women may face hostility and harassment from more conservative family members or Islamist groups ([UK Government 03/2020](#)).

*Participation:* The participation of women and girls in the public sphere is generally not a common affair, given the status of women and girls in Afghan society. This in reality also means that there is a lack of women government personnel, lawmakers, or female engagement in a wide range of professions ([UK Government 03/2020](#)). A 2019 survey across all provinces in Afghanistan showed that there is a preference for not having female representation in politics. For example, 62% of surveyed men wanted to be represented by a male in parliament, and those stating explicitly wanting to have female representation is only at 4% ([Asia Foundation 2019](#)).

*Freedom of movement:* Freedom of movement of women and girls is limited, particularly in conservative rural areas where most women live. It is generally unacceptable for a woman or girl to go out alone without the accompaniment of a male family member (*mahram*). This practice can sometimes be bypassed if women go out in groups in their local villages. If women and girls do go out alone, they are likely to face harassment and abuse ([UK Government 03/2020](#)).

Women also need to adhere to clothing regulations: the burka is the most popular choice of dress for women in public spaces (38% of survey respondents across all provinces in Afghanistan), followed by a niqab (28%), chador (14%). No covering was only seen as acceptable by 07% of respondents ([Asia Foundation 2019](#)).

## TYPES OF GBV

As is common in many emergencies, the extent of GBV in Afghanistan cannot be exactly established, as incidents of GBV are underreported due to fear, stigma, and other reasons. In a 2015 Demographic Health Survey it was estimated that at least 51% of women will experience physical or sexual violence in their lifetime. Note that this includes only physical and sexual violence and not other forms of GBV. This percentage is extremely high, considering that globally 33% of women will experience GBV in their lifetime. In a more recent 2019 survey across all provinces of Afghanistan, 18% of respondents thought violence was the biggest problem women face. Women were more likely than men to say violence was the biggest problem (20% vs. 15%), and women from the Pashtun

ethnic group in rural areas were more likely to say that violence was a problem (23% vs. Tajiks 14.%; Uzbeks 15%; Hazaras 16%) ([Asia Foundation 2019](#)). In addition, figures from the GBVIMS show that over 7,000 incidents were reported from January–March 2020 alone ([GBV Sub-Cluster 03/2020](#)).

Due to stigmatization, retaliation, and fear, it is very difficult for women to seek help. This also limits the ways in which GBV practitioners can provide help. For example, in a hospital women may schedule a medical appointment as a cover up to talk to psychologists or caseworkers about physical abuse. Due to COVID-19, most of such operations have halted as buildings needed to be converted to house more patients, and measures on restriction of movement have increased ([The Guardian 21/04/2020](#)).

As women and girls in Afghanistan have limited rights in the family and public life, and rates of violence against women and girls are extremely high, it is very likely that rates of violence and abuse have increased due to COVID-19. Even though reported incidents through GBVIMS may not increase as reporting is limited due to further restrictions on movement, this does not mean that rates of GBV have not increased. In fact, Oxfam reported in a survey done in 20 districts across five provinces that 97% of female respondents indicated that GBV has increased since the start of the COVID-19 outbreak ([Oxfam 04/2020](#)). They are not alone in this assessment, virtually all humanitarian actors who have undertaken assessments on measuring GBV since COVID indicate that female respondents have reported an increase in GBV across various provinces in Afghanistan ([OCHA 06/2020](#); [Samuel Hall 07/2020](#)). The restriction on freedom of movement, normal to many women and girls in non-COVID times, has now also impacted the male members of the family. It is likely that additional stressors due to the pandemic such as loss of income and livelihood, and the fact that men need to be inside the house more, have led to increases in incidents of GBV that will go underreported or completely unreported. With women and girls trapped in the house even more due to COVID, it is unlikely that they have many ways to seek help. For example, data from one week in June alone already shows 400 reported cases of GBV. However, these are only *reported* cases, and since many women and girls are confined to their homes, it is likely that there are many incidents of GBV that are unreported ([UNFPA 06/2020](#)).

**Intimate partner violence:** As women and girls are seen as property of their fathers or husbands, the treatment of women and girls is also seen as a private affair. Domestic abuse and intimate partner violence are estimated to be very common. Though it is difficult to quantify this, levels of intimate partner violence are estimated to stand at 40% for women in Afghanistan ([UK Government 03/2020](#)).

**Murder/‘Honor’ killings:** Are considered one of the most widespread forms of violence against women in Afghanistan. Honor killings tend to go unreported, uninvestigated, and unpunished ([UNAMA 2018](#)). Honor killings are more common in the Pashtun ethnic group, but happens across all groups. Shame is strongly connected to a woman’s behavior, which is believed to reflect her reputation and her family’s reputation. Since men are responsible for the accumulation of honor and reputation through (among other things) the protection of their family, it is seen as their duty to protect women in their family. This results in high regulation of women’s lives and can result in death should a woman commit a deed that is considered shameful ([EASO 07/2020](#)).

**Forced marriage** is considered common practice in Afghanistan. An estimated 70– 80% of women have faced forced marriage ([Amnesty International 2019](#)). If a woman runs away because she does not want to be forcibly married, she may be subject to beating or worse. One way of forced marriage includes *baddal*, or the exchange of two daughters within two families. 27% of male respondents across all provinces in Afghanistan strongly or somewhat agree with this practice ([Asia Foundation 2019](#)).

**Harmful traditional practices:**

**Baad:** the practice of ‘giving’ a woman (for marriage) from the offender’s family to the victim’s family as a means to settle disputes, is a common practice. In a survey done across all provinces in Afghanistan, 9% of male respondents somewhat agree with this practice ([Asia Foundation 2019](#)).

**Access to services:** As in all sectors, the access to GBV services has also decreased due to measures taken against COVID-19. For example, the closure of courts leads to administrative delays, but also means referrals from government institutions (e.g. for women who need immediate safe shelter), has decreased also means that some survivors are left in extremely dangerous situations, particularly in cases where they need a safe shelter – which highly increases the chance of injury, abuse, or death. Referrals from short-term to long-term shelters have been hampered as new arrivals at short-term shelters first need to isolate for two weeks before they can go to a long-term shelter ([The New Arab 12/05/2020](#)).

In total, there are only 27 Family Protection Centers in 22 provinces across Afghanistan, where comprehensive GBV service provision is offered in a one-stop center ([UNFPA 06/2020](#)).

In addition, social workers or case workers have less interaction with survivors as they also face restrictions due to COVID-19. Women who would come to services where they could talk to psychologists or aid providers, now have to stay inside the house. With COVID-19 it has become very difficult to reach these women, as there are very few safe ways to do this. Some women can still be reached by phone, even though this is difficult and potentially dangerous. The option of reaching survivors by phone will be even more strained for those without access, including IDP women, older women, or women with disabilities ([UNWOMEN 30/04/2020](#)).

Prior to COVID-19 women and girls already had limited access to GBV services, as they are mostly available in urban areas only, have limited community coverage, are often underfunded and understaffed, and can lack coordination with other services ([UNWOMEN 30/04/2020](#)).

## RESPONSE ENVIRONMENT: GBV RISKS AND BARRIERS TO HUMANITARIAN RESPONSE

GBV does not happen in a silo and is never a standalone incident. Disasters, conflicts, pre-crisis vulnerabilities, stressed living conditions, a lack of resources are all exacerbating factors for the manifestation of GBV and related negative coping mechanisms. Reduced availability and accessibility of basic services as a result of the conflict and COVID-19 disproportionately affect women and girls. Generally in Afghanistan, women and girls have reduced access to all services as the cultural norm of being accompanied by a *mahram*, renders it difficult for women and girls to leave the house without an accompanying male family member. All services have become more limitedly accessible due to COVID restrictions, women and girls particularly will face more barriers to accessing services. As of June, another three month national lockdown was announced including closure of schools and educational centers, hotels, parks, sport complexes, and other public areas. In reality provincial authorities regulate the lockdowns, leading to differences in provinces. Within provinces, areas may face very different restrictions, e.g. in urban areas there are many road closures and checkpoints, rendering it difficult to access services ([OCHA 06/2020](#)).

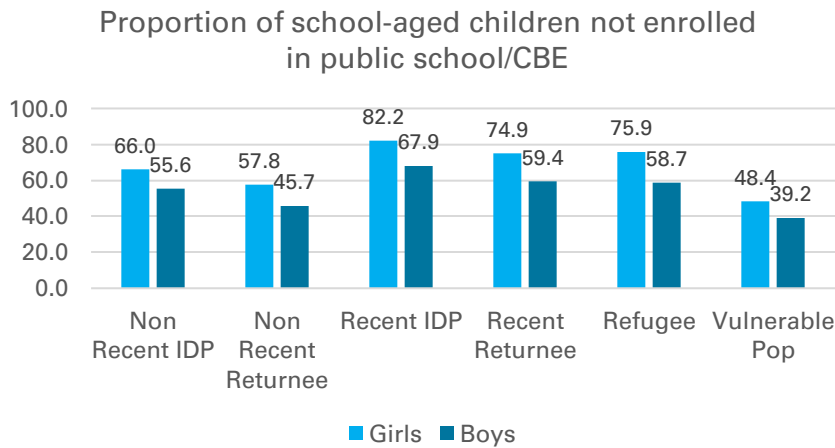
Generally, women and girls face more movement restrictions which hampers their ability to access services. For example, 11% key informants in informal settlements said women and girls cannot move freely due to fears for personal safety (55%) and socio-cultural barriers (33%).

Female single headed households are left in difficult situations. IDPs are even more at risk as their living conditions are more precarious. In addition, they may face stigmatization, as groups like

refugees, migrants IDPs and returnees can be accused of spreading the disease further ([OCHA 06/2020](#)). In general, particular attention needs to be paid to vulnerable groups including IDPs, female-headed households, people with disabilities, and others as they are disproportionately affected. Those who face intersecting forms of discrimination (e.g. a girl with disabilities) will face multiple barriers. Though more recent data is lacking, the 2019 Whole of Afghanistan assessment for examples showed that female-headed shock-affected households scored higher on the multisectoral needs index than male-headed households, meaning they faced higher multisectoral needs than male-headed households. Findings were similar for households with people with a disability ([REACH 09/2019](#)).

In the sectoral pieces below a lot of data from the Whole of Afghanistan household survey (REACH 2020) is used. The results for population groups at national level are representative.

**Education:** Due to COVID-19, the government closed schools in mid-March. Prior to COVID, an estimated 3.5 million children were already out of school. 60% of out of school children were girls. These figures are estimated to be much higher for children with disabilities: an estimated 80% of girls with disabilities are out of school ([HRW 05/2020](#)). Now, this number has increased with seven million children who cannot attend regular school programs as well as 500,000 children who benefitted from community-based education programs ([UNHCR 06/07/2020](#); [OCHA 06/2020](#)). Though schools are scheduled to reopen in late August; at the time of writing this is yet to happen and no plans have been made for reopening community-based education programs ([OCHA 22/08/2020](#)). Further, key informant interviews (KIIs) done across 125 districts containing hard to reach areas show that girls have less access (56%) to remote teaching and learning activities than boys (23%). Around 40% of key informants also indicated that children with disabilities and children from poorer households have less opportunities to access remote learning opportunities, putting them at a more significant disadvantage (REACH, KII Hard to Reach Areas 2020). As indicated in the Food Security and Livelihoods and general situation, female headed HHs are likely be poorer than male headed HHs. According to the 2020 Whole of Afghanistan assessment, the majority of children across different assessed population groups were not attending school or community-based education this year.



Source: REACH, Whole of Afghanistan Assessment 2020.

The graph above clearly demonstrates how almost more than 50% of girls and boys across all population groups did not attend school. These percentage of children not enrolled in school in the most recent school year is higher across the more recent displaced populations: it is safe to assume that recently displaced populations have less access to educational facilities or programs and that displacement is a key barrier to accessing education. In addition, across almost all population groups the percentage of girls not enrolled is higher than the percentage of boys not enrolled. Particularly



among the recently displaced, the disparities between girls and boys being enrolled increases. COVID-19 is thought to be a major contributor for children not being enrolled in school this year. Across most population groups, only 5–10 % of children already dropped out of school prior to the COVID-19 pandemic. Only in the refugee population an estimated 19% of children were already out of school before the start of COVID (REACH, Whole of Afghanistan 2020). When looking at only the displaced population groups (IDPs and cross-border returnees), over 90% of girls do not attend school in Hilmand, Uruzgan, Samangan, Paktika, Kunar, and Kandahar provinces. The top three provinces where boys do not attend school are Kunar (90.9%), Samangan (87.4%), and Uruzgan (84.5%).

According to the Whole of Afghanistan (2020) assessment, the top three reasons<sup>9</sup> for boys and girls not to attend school before Hamal/Now Ruz<sup>10</sup> were:

<b>Reason for not attending school</b>	<b>Boys</b>	<b>Girls</b>
Top reason 1	Displacement	Displacement
Top reason 2	Have to earn money	Cultural reasons
Top reason 3	Conflict	Safety concern when traveling to school

The responses to this question clearly show that the barriers for girls and boys to attend school are quite different. Boys barriers to accessing school are more related to the general safety and security environment (displacement, conflict), but they also face protection concerns as they are expected to earn money and help out the household. Girls on the other hand face more cultural reasons for not attending school, and household respondents also fear more for their safety when going to school. When looking only at the answers across the displaced populations<sup>11</sup> it is worth noting that no female-headed household said cultural reasons formed a barrier for their girls to attend school, against 15% of male-headed households. This denotes that among these population groups, girls are subject to stricter cultural barriers when a man is heading the household, which can significantly limit their access to education. For female-headed households in the displaced population groups rather the lack of facilities/distance to facilities was a major reason for girls not attending school (75%) denoting they would send their girls to school if facilities were more available or closer by. For the same displaced population groups, female-headed households much more often indicated that their boys had to earn money (62% of female-HH respondents), compared to male-headed household respondents (15%). It again points to a vulnerability for children in female-headed households.

Though child marriage was not a top reason for either boys or girls not to attend school, the percentage of households stating child marriage was a barrier for girls was about twice as high as for boys. Interestingly, across the surveyed refugee households, one out four indicated that boys did not attend school because of child marriage. When looking at the answers across the displaced populations (IDPs and cross-border returnees), there is some difference between female- and male-headed households. One in five female-headed households in those population groups (approximately 21%) said that their girls did not attend school due to child marriage, against 9% of male-headed households. This can point to girls in female-headed households being married off earlier – decreasing their chances to attending education, and further leading them to be dependent on their husband and stuck in a cycle of heightened vulnerability.

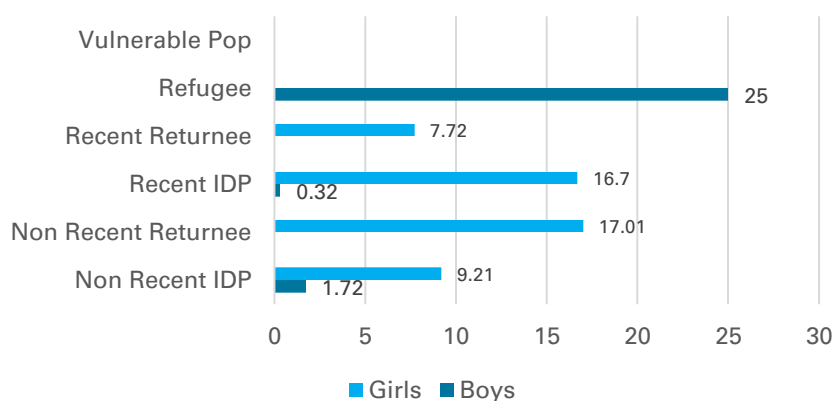
<sup>9</sup> The responses to this question were calculated across six different population groups. For the purposes of analysis the percentages for population groups were combined – the reasons listed with the highest percentages were included. This means that not all population groups have this as their main reason – just that this is the main reason for not attending school on average.

<sup>10</sup> New year

<sup>11</sup> IDPs and cross-border returnees



Before Hamal/Now Ruz, what were the reasons your children were not attending school?: Child marriage



Graph: %households per population group that responded child marriage as a reason for child not to attend school. Source: REACH, Whole of Afghanistan Assessment 2020.

**Availability:** Remote education programs are difficult to facilitate, particularly in hard to reach areas. In hard to reach areas, 66% of key informants indicated that they did not know about remote educational activities; 19% of KIIs knew of educational activities taking place via radio. Of all KIIs that knew of remote education activities, more than half indicated that girls were least likely to benefit from these activities, followed by children with disabilities (46%) ([REACH 22/08/2020](#)).

**Accessibility:** As children are unable to access education, they are likely increasingly asked to contribute to household income by doing child labor. Engaging in labor or taking on more risky jobs increases children’s exposure to GBV risks.

In a survey done across all provinces in Afghanistan, approximately 78% of households said they have school-aged girls and 83% have school-aged boys. Girls are less likely to attend school than boys, as of those who responded having school-aged children, about 15% said their girls do not attend school, whereas approximately 6% said the boys do not attend school. The reasons for not attending school varied as well: approximately 20% said that girls do not need education, whereas the main reason for boys not attending school was that they have to work (38%) ([Asia Foundation 2019](#)). There is still the belief that girls should not attend school and be at home. A lack of education will increase girls’ dependence on men and further weaken their access to the labor market. This in turn increases GBV risks in their lifetimes.

Girls with disabilities face even more difficulties in accessing education. Next to the gender inequalities that they face, children with disabilities often need special transportation to access schools, which is not available. Public schools and classrooms are often not equipped for children with disabilities which makes it difficult for them to attend classes and activities ([HRW 05/2020](#)).

In addition, children being out of school increases the risk for them to be recruited by armed forces. This includes recruitment as fighters or suicide bombers, but children are also recruited by Afghan national security forces in different roles such as drivers, bodyguards, or otherwise ([UNAMA 08/2020](#)). Through several quantitative and qualitative assessments, it has become clear that child protection risks, including those related to GBV have increased.

*Quality:* According to the education cluster, many schools do not have adequate WASH facilities ([OCHA 22/08/2020](#)). This can further serve as a barrier to accessing education, particularly for girls as they will face issues with menstrual hygiene management, and safety in accessing WASH facilities.

**Nutrition:** Prior to COVID, already three million children and women were estimated to be suffering from malnutrition. GAM levels are above emergency thresholds of 10% in 22/34 provinces. Food security, already strained prior to COVID, is further strained due to the pandemic. Girls are likely to eat last, leaving less nutritious scraps for them and further reducing their food intake. This also increases their risk of malnutrition ([CARE 08/2020](#)). Over 690,000 are estimated to suffer from severe acute malnutrition (SAM) in 2020. The highest SAM rates are found in provinces where people are facing most food insecurity (IPC Phase 3 and 4), and where there are higher numbers of IDPs. As especially female-headed households have difficulty obtaining food through market access, children and women in those households are also at further risk. Challenges in accessing nutrition facilities and services remain – as they may be far away, or the situation is unsafe due to conflict. An estimated 50% of children with SAM are without access to health facilities ([Nutrition Cluster 07/05/2020](#)). It is therefore also plausible that mothers who need to take their children to lifesaving nutrition services face heightened GBV and other protection risks on their way to facilities, which hinders their access.

Health part above includes more information on barriers to health services which could be applicable for nutrition services i.e. those services based in health facilities. Please see the food security and livelihoods sections for more information related to drivers of malnutrition and its gender dimension.

**Food security:** Around eight million people are expected to be facing Crisis food insecurity outcomes (IPC Phase 3) in June–November 2020, while almost four million people are facing Emergency (IPC Phase 4) food insecurity outcomes in the same period. People facing IPC Phase 4 food insecurity were mostly located in Badakhshan, Daikundi, Hirat urban, and Kandahar urban provinces/areas ([IPC 05/2020](#); [OCHA 06/2020](#)).

#### *Availability*

As 70% of the population relies on daily income (see livelihoods section), it is likely that due to COVID many people have lost access to sufficient food to sustain their families. In addition, western Afghanistan is also facing a situation of drought, furthering limiting food availability. This is likely to lead to coping mechanisms such as reducing the number of meals or types of food eaten. When food is available and needs to be divided among family members, it is likely that girls will receive less food as boys are seen as more valuable. They are also more likely to eat last, therefore having less food ([Oxfam 04/2020](#); [UNFPA 06/2020](#)). Though men and women are reportedly both missing meals, women reportedly miss one more day worth of meals than men ([CARE 08/2020](#)).

The loss of income and food insecurity can also increase further negative coping mechanisms such as marrying off children, particularly for people facing IPC 3 and 4 food insecurity outcomes. These risks are exacerbated for more vulnerable households including IDPs and female headed households. Forced marriage is a risk for both sexes. Yet, girls are likely to bear the brunt as they can be sold off and dowry will be paid for them in marriage ([Oxfam 04/2020](#)). Young girls can also be married off to become a second or even third wife, a position that is also lower in rank in the household which could further increase the risk of abuse ([CARE 08/2020](#)).

In addition, the stressors that people will face due to a loss of income and food, combined with being confined at home, is highly likely to increase abuse in the household, aimed at both children and women.

### Accessibility

People have reported that prices of foods and essential commodities in the markets are rising, as some commodities have become less available due to restrictions. The rise in prices will further limit the availability of food to the household, increasing the risk of negative coping mechanisms. For example, in May reports of food prices increasing included wheat flour (+19%), pulses (+32%), sugar (+19%), cooking oil (+36%), and rice (+22%). Price rises are likely to disproportionately affect IDPs, female headed households, people with unsteady income sources, and other vulnerable populations ([JIA 04/2020](#); [OCHA 06/2020](#); [WFP 08/2020](#)).

The lack of access to food is likely worse for IDP families who have more limited means of accessing markets, stable income sources or distributions ([UNWOMEN 06/2020](#)). The same holds true for female-headed households. In the 2019 Whole of Afghanistan assessment it was found that female-headed households have higher food security related needs. A lack to the market place, particularly for female-headed households was a key underlying factor ([REACH 09/2019](#)).

**Livelihoods:** An estimated 70% of the Afghan population relies on daily income for survival. With the measures taken against the spread of COVID-19, it is likely that for many Afghans, their livelihoods have been restricted or compromised, particularly in urban areas. This includes not being able to access jobs, not being able to sell harvests and crops, not being able to access markets, not being able to care for livestock e.g. leading them to cooler pastures, etc. Those who have lost immediate access to daily wages may face additional stress. However, people who will face longer-term effects such as reduction of income later on or the loss of livestock will also experience additional stress. In rural areas, people will exhaust their harvest and crops, and will have more difficulties selling off their products. In addition, this sets them up for a further stressed agricultural season as seeds etc. are depleted. Stress and confinement are known contributors to domestic violence ([CordAid 20/06/2020](#); [JIA 04/2020](#)).

Male IDPs or those who work away from their homes to find employment, likely need to have returned to their homes or places where their family resides. This could lead to potentially dangerous situations as some areas still face active conflict. If people are killed, it also leaves the family behind with no breadwinner ([UNWOMEN 06/2020](#)).

When women are working, they are most likely employed in the informal sector, such as approximately 75% working in home-based crafts industry. In the informal sector there are little safety nets. The added pressure of COVID may contribute to the drying up of opportunities in the informal sector, which would leave these women without income. This increases women's risk for poverty which in itself can lead to negative coping mechanisms. In addition, the generation of income for the household can oftentimes be one of the few reasons why women and girls are allowed to leave the house. Thus, the loss of these livelihood opportunities will further reduce their independence and further leave women and girls in confinement ([UNWOMEN 30/04/2020](#); [Oxfam 04/2020](#)).



FIG.3.2: Q-8. Compared to one year ago, would you say that the situation for your household has gotten better, remained the same, or gotten worse with respect to the following? (a) Employment opportunities. (Percent who say worse)

Source: ([Asia Foundation 2019](#))

Negative coping mechanisms that were already reported prior to COVID-19 include selling children, child labor, and child marriage. There have already been reports of increases in child marriage and child labor particularly among IDP populations due to COVID-19 as income is being lost ([UNWOMEN 10/06/2020](#)).

Do women have access to income generating activities? What type of activities can women do? What restricts their access to other activities? What unpaid work are women and girls engaged in and does that increase the risk to GBV?

**Health:** The health system, already in fragile prior to COVID-19, has become extremely strained in combination with the pandemic. In addition, healthcare facilities continue to be under attack: in the first six months of 2020 at least 36 incidents involving attacks against healthcare facilities were recorded ([UNAMA 08/2020](#)). As women and girls are primary caregivers in the household, they are also more likely to contract COVID due to them caring for sick family members. As of June 2020, men aged 40–69 made up more than half of registered COVID deaths ([OCHA 06/2020](#)). As men are the breadwinners and income generators in the family, this will increase the number of female headed households. These women and their families are more vulnerable as they have limited means to generate income and face many restrictions in their freedom of movement and access to services.

Next to COVID, Afghanistan is also dealing with measles and Crimean-Congo Hemorrhagic Fever (CCHF) outbreaks ([WHO 08/2020](#)).

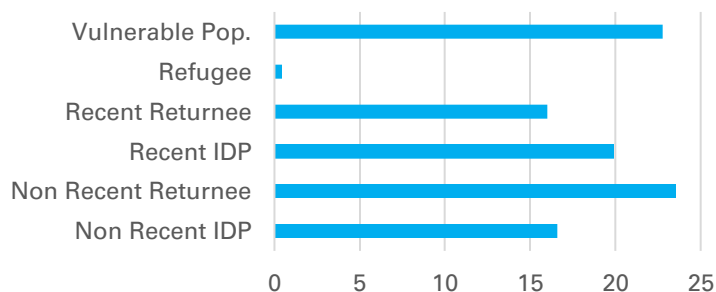
#### *Availability*

Due to COVID-19 the availability of health services has decreased, as more health services need to be converted to help COVID-related patients ([UNWOMEN 30/04/2020](#)). Only 30% of the population has access to a health facility within a two hour radius from their homes, meaning the availability of health facilities across the country is limited. 27% of KIIs in an assessment in hard to reach areas indicated that they do not have access to any type of health facility ([REACH 22/08/2020](#)).

Whole of Afghanistan (2020) data shows that across the different population groups, non-recent returnees and vulnerable populations (facing IPC 3 and 4 food insecurity outcomes) have the hardest time accessing active health centers. In hard-to-reach areas, around 30% of KIIs across 120 districts indicated that there was no health facility available to them.

In terms of GBV, some health clinics have GBV focal persons but generally services are limited and holistic service provision for GBV is not available in most clinics. However, health clinics do function as a first entry point for GBV survivors.

Percentage of household who have not had access to an active health center in their village/nearby in the past three months



### *Accessibility*

In terms of physical distance, 30% of the population has limited access to health facilities within a two hour radius from their homes ([OCHA 06/2020](#)). If a health facility is far away, people have limited means to reach these facilities.

In the WoA (REACH 2020), the top reasons (combined across all groups) for not accessing a health facility were: cost, transportation, and feeling unsafe traveling to/from facilities.

Transportation: Sometimes, if a taxi needs to be taken – the fares are steep. Due to COVID measures, roads to health facilities have become increasingly blocked which further limits access ([JIA 04/2020](#)).

Safety: Traveling to facilities can also be a problem, as going to and from the facility, as well as being at the facility, can be very unsafe. In an assessment done in hard to reach areas, 32% of KIIs mentioned they feel unsafe traveling to/being at a health facility ([REACH 22/08/2020](#)). A further 22% of KIIs indicated that women and girls avoid health facilities due to unsafety (REACH WoA 2020). The WoA (2020) assessment also links safety to women and girls' ability to access health facilities. For example, of those respondents who said women and girls feel unsafe in certain areas, around 10% of households among recent IDPs and returnees, and non-recent returnees said that women and girls feel unsafe at the health facility. When looking at female and male-headed respondents, female-headed households for displaced populations (IDPs and cross-border returnees) much more often indicated that women and girls feel unsafe at a health facility (27% for female HoH vs. 10% for male HoH).

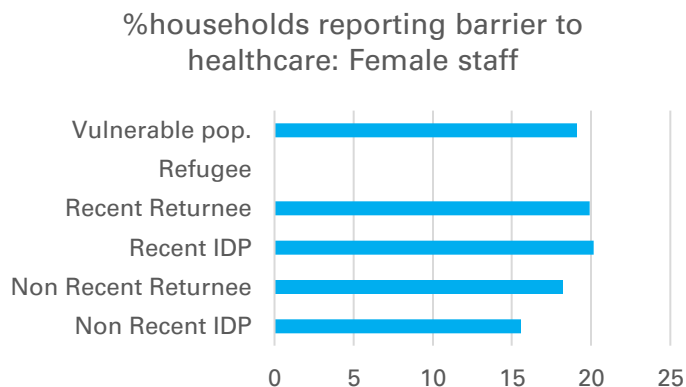
Cost: The cost of healthcare has long been mentioned as a main barrier to accessing services. This includes the cost of the service as well as medicines and traveling to/from the facility. It is no surprise that in a country with a high percentage of people living under the poverty line, any additional costs are unaffordable ([Medica Mondiale 2016](#)). This is also again reflected in more recent assessments, for example 64% of KIIs in hard to reach areas cite costs as a main barrier to accessing health services ([REACH 22/08/2020](#)). Based on the WoA (2020) data, households most mentioned cost as a barrier in Kabul (100%), Zabul (100%), and Ghor (99.7%).

Gender: Due to gender inequality, it is unlikely that women and girls are prioritized for healthcare, for example when they fall ill due to COVID-19. Where families have limited resources, priorities will be set – and it is more likely that if limited money is available a male member of the family is prioritized for healthcare ([CordAid 20/06/2020](#)). For example, men in Afghanistan make up 70% of confirmed COVID cases. This may indicate that women have less access to testing as they face additional barriers to accessing services ([OCHA 20/08/2020](#)). Other examples come from over 1,100 informal settlements where key informants were asked about barriers to accessing healthcare. Of the KIIs who mentioned barriers to healthcare exist, 41% said that some groups are more affected than others. 73% said women and girls faced more barriers. (REACH ISET WoA 2020).

Less access to healthcare also limits the way women and girls can seek help for GBV as well as sexual and reproductive health, as healthcare facilities in Afghanistan are usually the entry point to GBV service provision. For example, in a hospital women may schedule a medical appointment as a cover up to talk to psychologists or caseworkers about physical abuse. Due to COVID-19, most of such operations have halted as buildings needed to be converted to house more patients, and measures on restriction of movement have increased ([The Guardian 21/04/2020](#); [Medica Mondiale 2016](#)). Family Planning Centers which provide holistic GBV service provision are also located in hospitals. The need for male accompaniment is another compounding difficulty for women and girls. As women and girls oftentimes need a *mahram* to come with them, it is reasonable to assume that accessing health services and GBV entry points in a private and safe manner is difficult.

### Quality

Only 15% of nurses and 2% of doctors in are female. A lack of female staff poses another barrier for women and girls to access healthcare facilities, as many people do not wish for their female relatives to be treated by a male doctor. As women generally need to be accompanied by a *mahram*, even recruiting more female staff also poses a challenge ([Oxfam 04/2020](#)). Indeed, a lack of female staff was cited as a main barrier to access health facilities by 47% of KIIs in hard to reach areas ([REACH 22/08/2020](#)).



According to the Whole of Afghanistan (2020) assessment, a lack of female staff was cited as a barrier by around 20% of households among vulnerable populations, recent IDPs and returnees, and non-recent returnees. A lack of female staff was cited as a problem by around 17% of male headed households, compared to only 2.4% of female headed household respondents. Though the female HoH sample size is much smaller, it can still be indicative of gender inequalities within the household and how women and girls are can be more restricted in their ability to access health services than men and boys.

Recent figures are not available but a 2016 study showed that capacity on GBV among health personnel could be improved, in terms of bringing up GBV, referring people to services, etc. ([Medica Mondiale 2016](#)).

The Afghan health system functions on a pay for performance (P4P) salary scheme, meaning healthcare workers need to finish a preset number of tasks to earn their full salary. While this scheme came into existence to increase efficiency, it often leaves GBV out in terms of tasks that need to be completed ([UNFPA 06/2020](#))

**Child protection:** Children have long borne the brunt of the conflict in Afghanistan, as they are being recruited into armed groups, and suffer sexual exploitation and violence at the hands of the parties to the conflict. In the first half of 2020 at least 23 children were verified to have been recruited by the Taliban, however these numbers are likely much higher. Children recruited by armed forces are trained to fight, but also to carry out suicide missions. In addition, Afghan national security forces reportedly also recruit children for example as drivers, or to be posted at checkpoints. The recruitment of children has reportedly gone up since COVID-19, and is linked to more children being out of school as schools have been closed as a measure to contain the spread of disease. Children working to generate income may take on a variety of jobs. Some, such as shoe polishing, which can also leave them more exposed to COVID ([UNAMA 08/2020](#); [OCHA 06/2020](#)).

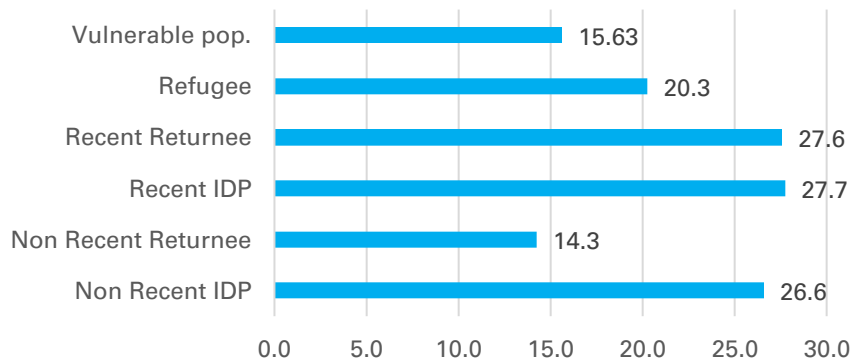
*Bacha bazi*, or the sexual exploitation and abuse of children and adolescent boys by adult men, is a custom in many areas. It is a practice where boys are exploited (mostly by more powerful men), and boys need to provide entertainment in the form of dancing and are sexually exploited.



In addition, over the first half of 2020, children made up almost one third of civilian casualties. The use of IEDs by parties to the conflict (particularly Taliban) poses a great risk to children, as mere bodyweight sets off detonation of many devices. Over one third of casualties from IEDs were children. Pro-government forces, including Afghan national security forces, international military forces, and pro-government armed groups, have the highest contribution in child deaths particularly due to airstrikes ([UNAMA 08/2020](#)).

As highlighted in the education section, boys and girls drop out of school for different reasons. Of course, school drop-out is related to conflict, displacement, and safety issues, but children are also out of school due to closures as measurements against the spread of COVID. Child protection issues and also those related to GBV are likely to increase when children are out of school and families experience loss of income. These protection risks include child labor and child marriage/early/forced marriage). In an assessment by World Vision International<sup>12</sup>, around 49% of households mentioned that children were being sent to work due to a loss of income, a further 8% of families sent their children to relatives as they could not take care of them ([WVI 24/08/2020](#)). Data from the Whole of Afghanistan assessment (REACH 2020), shows that boys in particular need to work. In Farah province, 80% of displaced (IDP and cross-border returnee) households responded that boys in their household work, followed by Hilmand (57%). The percentage of households reporting that girls work is much lower, but is around 10% in Maidan Wardak, Kunduz, and Hilmand provinces. In addition, 94% of key informants across 120 hard-to-reach areas said they were aware of a boy under the age of 16 working in their settlement. A further 69% of KIs said they were aware of girls under the age of 16 working at their settlement.

Percentage of boys between the age of 11-17 working outside of the household in the last 30 days



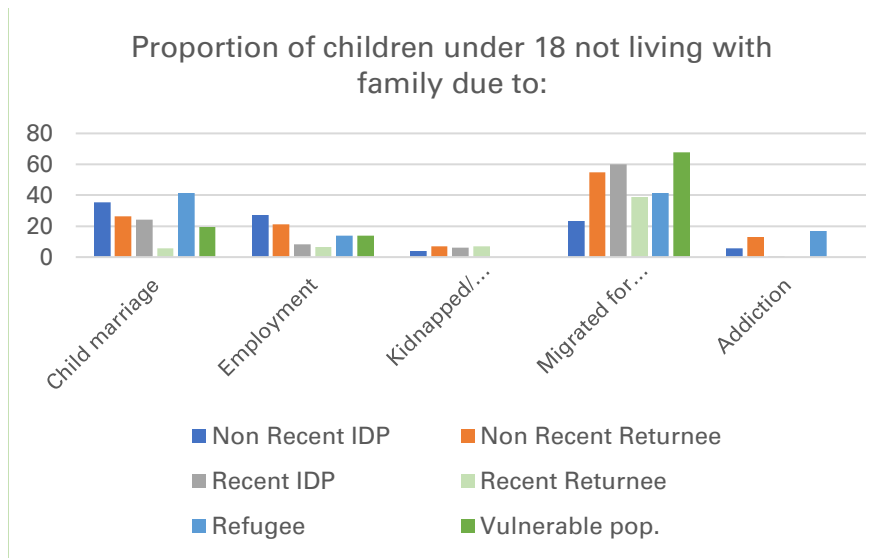
Source: REACH, Whole of Afghanistan Assessment 2020.

The above graph shows that among the groups assessed in the WoA, the percentage of boys working outside of the household is above 25% for the recently displaced and returned, as well as for non-recent internally displaced populations.

Girls are especially vulnerable to early marriage as their families will receive dowry in exchange. Child marriage has also been linked to honor crimes and the practice of *baad* (the giving away of a woman of the offender's family to the victim's family as a form to settle disputes). It happens in *baad* that the woman that is being given away for marriage to settle a dispute, is underage ([UNICEF 2020](#)). In

<sup>12</sup> Small household survey based on 409 respondents, remote (phone) survey in northwestern provinces of Herat, Bagdhis, and Ghor.

a same World Vision assessment, 6% of respondents indicated that they married off their girls early ([WVI 24/08/2020](#)). Another assessment found that, while marrying off children early is not the first coping mechanism families resort to, incidence of this may increase as the economic impact of conflict and COVID measures continue to increase ([Samuel Hall 07/2020](#)). The WoA assessment (REACH 2020) data shows that among displaced (IDP and cross-border returnee) households, marriage of daughters earlier than intended was highest in Faryab (37%), Nuristan (33%), and Sar-e-Pul (25%) provinces. In hard-to-reach areas across 120 districts, 59% of key informants respondent they knew of a girl under the age of 16 that was married off in the past three months. An exception to early or forced marriage may be girls with disabilities. Because of their disabilities, they can be deemed unfit for marriage. However, this puts them at further risk of violence in the homes, as they may be seen as an additional burden to the family ([HRW 05/2020](#)).



Source: REACH, Whole of Afghanistan Assessment 2020.

Generally, reasons as to why children under 18 are not living with the household vary, but employment or migration for employment combined are the top reason, followed by child marriage.

**Water, Sanitation, and Hygiene:** Due to the crisis prior to COVID, an estimated 63% of Afghans had access to basic drinking water, and 39% had access to basic sanitation. A further 57% of displaced households have insufficient access to water and 65% of returnees living in settlements were estimated to not have access to WASH services ([CARE 07/2020](#)).

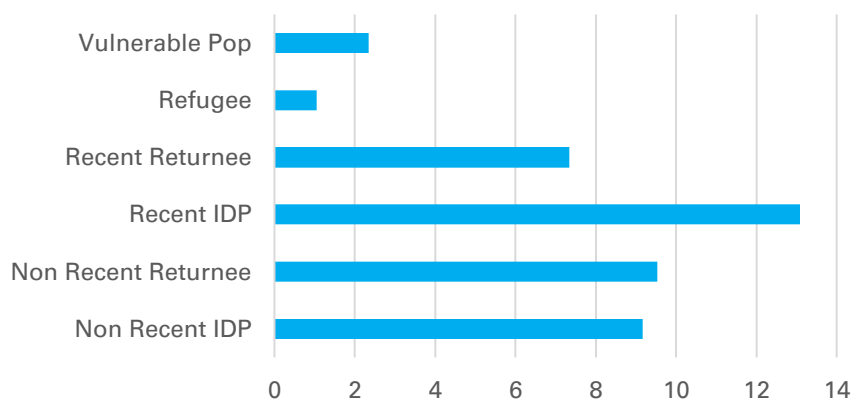
*Availability:* Water and sanitation facilities are not always available to the Afghan population. For example, a multi-sectoral assessment in five provinces (Daykundi, Hirat, Bamyán, Nangarhar, and Kunduz) showed that 72% of respondents in both IDP and host communities do not have access to soap for handwashing and 45% of people lacked clean water ([OCHA 06/2020](#)).

In another assessment done for people in hard to reach areas, 66% of KIIs indicated that water sources were too far away or not available ([REACH 22/08/2020](#)). The unavailability of water sources as well as the distance to water sources are known to heighten the risk of GBV for women, girls, and boys who are responsible for fetching water. Similar concerns arise over the unavailability of safe latrines, which heightens GBV risks ([CARE 07/2020](#)). In addition to water points being too far, 19% of KIIs in hard to reach areas indicated that there are insufficient water points/waiting times are too long (REACH, KII Hard to Reach Areas 2020).



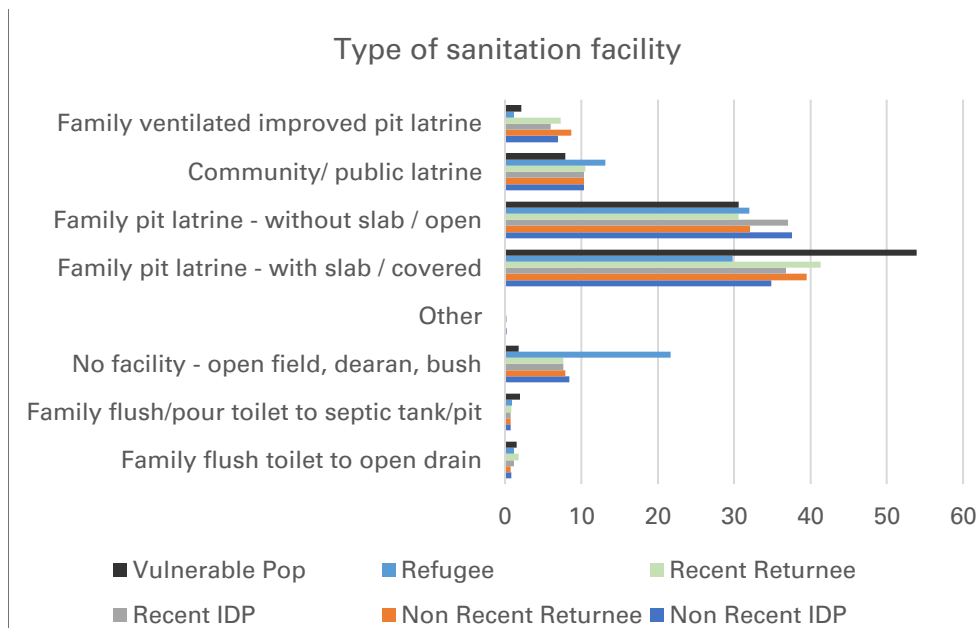
The Whole of Afghanistan (2020) assessment shows that water sources are generally within an acceptable distance to the surveyed households across different population groups. Generally less than 10% of households indicated that they had to spend more than 31 minutes fetching water, which includes traveling to and from water sources and queuing at the water source. However, when analyzing this data at a province level for the displaced population groups (IDPs and cross-border returnees) there are a few outliers. 37% of surveyed households in Faryab province said that fetching water took over 31 minutes, as well as 19% of household respondents in Paktya, 15.8% in Baghlan, and 15,5% in Hirat.

Time spent fetching water (to/from source and queuing): More than 31 minutes



Graph: percentage of households per population group that responded they had to spend more than 31 minutes fetching water. Source: REACH, Whole of Afghanistan Assessment 2020.

Regarding sanitation facilities, most household respondents across all population groups indicated using family pit latrines – either covered or uncovered. Over 20% of refugee household respondents indicated they resorted to open defecation in the bush or field as they do not have sanitation facilities – this is at 8% for respondents from the other displaced populations. However across the displaced populations (IDPs and cross-border returnees), there are significant differences at province level: in Daykundi 43% of household respondents indicated resorting to open defecation, followed by Khost (35%), Nuristan (31%), and Ghor (27%). It should be noted that this increases GBV risks for women and girls who can be at heightened risk of attacks. Among female HoH respondents across displaced populations (IDPs and cross-border returnees) that indicated women and girls feel unsafe in certain areas (31.5%), 75% said that women and girls feel unsafe in areas away from settlements such as the surrounding fields and forests. A further 80% of key informants in hard to reach areas across 120 districts indicated that women and girls feel unsafe in those areas (REACH, KII Hard to Reach Areas 2020).



Graph: percentage of households per population group having type of sanitation facility. Source: REACH, Whole of Afghanistan Assessment 2020.

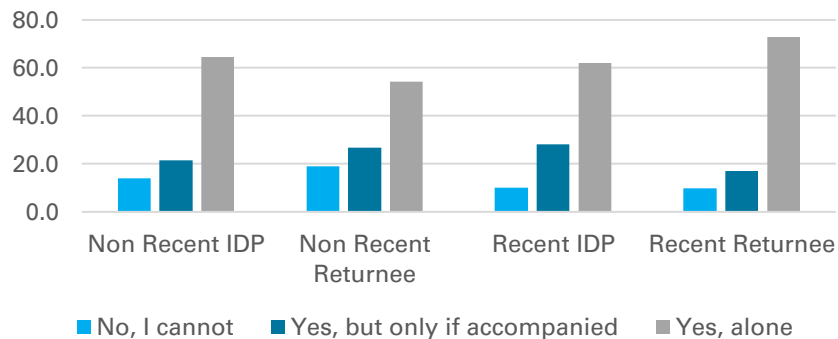
*Accessibility:* The rise in prices (see Livelihoods) has also affected minimum expenditure baskets (MEBs), which includes female hygiene pads. As prices for menstrual hygiene products have increased in prices (22% in previous round), it is likely that fewer women and girls will have access to these products – if they had access to them prior to price hikes ([REACH JMMI 07/2020](#)). According to the 2020 WoA assessment, reusable cloths are the most used menstrual item.

The 2019 Whole of Afghanistan assessment showed that shock-affected female-headed households had higher WASH needs compared to male-headed households. The difference in WASH needs was particularly driven by a lack of access to soap, which may be because women have a more difficult time accessing the market ([REACH 09/2019](#)). This also means that female-headed households can be more susceptible to contracting different diseases including COVID, as they have less access to hygienic products and proper handwashing.

According to the 2020 WoA assessment, there are those within the households who cannot access water sources.<sup>13</sup> Generally the non-recent returnees face the most challenges in personally accessing a primary water source as they either cannot do so alone or cannot access it at all. Key informants done across 1,148 informal settlements in 133 districts show that 16% of respondents say that water points are not safely accessible for women and girls.

<sup>13</sup> This question was specifically asked to a member of the household member with the opposite sex of the head of household. Thus for male HoH, women and girls were asked whether they could access water sources.

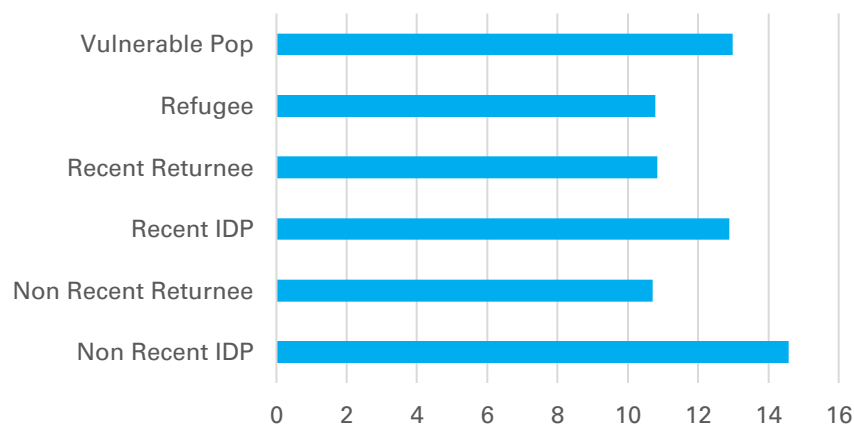
### Are you generally able to personally access the primary water source for your HH?



Graph: percentage of households where respondent of opposite sex (e.g. female for male HoH) indicated whether they were able to access primary water source. Source: REACH, Whole of Afghanistan Assessment 2020.

**Quality:** According to the WoA 2020, over 10% of households across all surveyed population groups share latrines with multiple families (around 2.7 on average).

### Sharing latrines



Graph: percentage of households per population group that indicated sharing a latrine Source: REACH, Whole of Afghanistan Assessment 2020.

Among the displaced populations (IDPs and cross-border returnees), some 17% of female-headed household respondents indicated sharing sanitation facilities, compared to 13.6% among male HoH respondents. Sharing latrines with many people can increase the risk of GBV.

## INFORMATION GAPS AND NEEDS

List information gaps and needs. List the main information gaps and needs first. Extend list for as long as possible.

- The numbers on GBV such as incidents reported in a certain timespan do not represent the full number of incidents in Afghanistan. These numbers are unknown. Any numbers listed in this report should be taken as mere examples underpinning the point that GBV is widespread.

- While the data shows much quantitative and qualitative information on forms of GBV such as domestic violence and IPV, there is more limited information on other types of GBV including sexual violence. This is likely because it is even more sensitive in nature.
- No information on negative coping mechanisms related to GBV such as survival sex, also due to the sensitive nature of the topic
- Most of the data used in this report comes from household surveys or key informant interviews. Due to the COVID situation and generally the cultural constraints, it is difficult to obtain more information on GBV from women and girls in qualitative ways that can yield more useful information, such as through Focus Group Discussions. Both KII and HH surveys pose restrictions on the type of questions and information on GBV that can be collected through this methods.
- Detailed information on operational environment (e.g. through safety audits), e.g. lights, locks, in camp or informal settlements.

## LIMITATIONS

The number of incidents listed in this report do not imply prevalence and should not be interpreted as such.

- The data from the Whole of Afghanistan assessment conducted by REACH is available at national level for six different population groups (non-recent returnees, non-recent IDPs, recent IDPs, recent returnees, refugees, and vulnerable populations. The vulnerable population denotes non-displaced populations facing IPC Phase 3 and 4 food security outcomes in eight districts. The results for the population groups at *national* level are representative.
- At national level, only households for displaced populations (IDPs and cross-border returnees) can be disaggregated into male- and female-headed households. The percentage of female-headed households surveyed is generally less than 5% across the population groups.